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104TH CONGRESS
1ST SESSION

H. R. 2486

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

IN THE HOUSE OF REPRESENTATIVES

OCTOBER 17, 1995

Mr. PETERSON of Minnesota 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.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

TITLE XV—MEDICARE

SEC. 15000. SHORT TITLE; REFERENCES IN TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE OF 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.

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

TITLE VIII—MEDICARE

Sec. 15000. Short title; references in title; table of contents.

Subtitle A—Medicare Choice Program

PART 1—INCREASING CHOICE UNDER THE MEDICARE PROGRAM

Sec. 15001. Increasing choice under Medicare.
Sec. 15002. Medicare Choice Program.

''PART C—PROVISIONS RELATING TO MEDICARE CHOICE

''Sec. 1851. Requirements for Medicare Choice organizations.
''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 Medicare choice organizations.
''Sec. 1856. Establishment of standards for Medicare choice organizations and products.

''Sec. 1857. Medicare choice certification.
''Sec. 1858. Contracts with Medicare Choice organizations.
''Sec. 1859. Demonstration project for high deductible/medisave products.
Sec. 15003. Reports.
Sec. 15004. Transitional rules for current Medicare HMO program.

PART 2—SPECIAL RULES FOR MEDICARE CHOICE MEDICAL SAVINGS ACCOUNTS

Sec. 15011. Medicare Choice 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.

PART 5—PREEMPTION OF STATE ANTI-MANAGED CARE LAWS

Sec. 15041. Preemption of State law restrictions on managed care arrangements.
Sec. 15042. Preemption of State laws restricting utilization review programs.

Subtitle B—Provisions Relating to Regulatory Relief

PART 1—PROVISIONS RELATING TO PHYSICIAN FINANCIAL RELATIONSHIPS

Sec. 15101. Repeal of prohibitions based on compensation arrangements.
Sec. 15102. Revision of designated health services subject to prohibition.
Sec. 15103. Delay in implementation until promulgation of regulations.
Sec. 15104. Exceptions to prohibition.
Sec. 15105. Repeal of reporting requirements.
Sec. 15106. Preemption of State law.
Sec. 15107. Effective date.

PART 2—ANTITRUST REFORM

Sec. 15111. Publication of antitrust guidelines on activities of health plans.
Sec. 15112. Issuance of health care certificates of public advantage.
Sec. 15113. Study of impact on competition.
Sec. 15114. Antitrust exemption.
Sec. 15115. Requirements.
Sec. 15116. Definitions.

PART 3—MALPRACTICE REFORM

SUBPART A—UNIFORM STANDARDS FOR MALPRACTICE CLAIMS

Sec. 15121. Applicability.
Sec. 15122. Requirement for initial resolution of action through alternative dispute resolution.
Sec. 15123. Optional application of practice guidelines.
Sec. 15124. Treatment of noneconomic and punitive damages.
Sec. 15125. Periodic payments for future losses.

Sec. 15126. Treatment of attorney's fees and other costs.
Sec. 15127. Uniform statute of limitations.
Sec. 15128. Special provision for certain obstetric services.
Sec. 15129. Jurisdiction of Federal courts.
Sec. 15130. Preemption.

SUBPART B—REQUIREMENTS FOR STATE ALTERNATIVE DISPUTE RESOLUTION (ADR) SYSTEMS

Sec. 15131. Basic requirements.
Sec. 15132. Certification of State systems; applicability of alternative Federal system.
Sec. 15133. Reports on implementation and effectiveness of alternative dispute resolution systems.

SUBPART C—DEFINITIONS

Sec. 15141. Definitions.

PART 4—PAYMENT AREAS FOR PHYSICIANS' SERVICES UNDER MEDICARE

Sec. 15151. Modification of payment areas used to determine payments for physicians' services under medicare.

Subtitle C—Medicare Payments to Health Care Providers

PART 1—PROVISIONS AFFECTING ALL PROVIDERS

Sec. 15201. One-year freeze in payments to providers.

PART 2—PROVISIONS AFFECTING DOCTORS

Sec. 15211. Updating fees for physicians' services.
Sec. 15212. Use of real GDP to adjust for volume and intensity.

PART 3—PROVISIONS AFFECTING HOSPITALS

Sec. 15221. Reduction in update for inpatient hospital services.
Sec. 15222. Elimination of formula-driven overpayments for certain outpatient hospital services.
Sec. 15223. Establishment of prospective payment system for outpatient services.
Sec. 15224. Reduction in medicare payments to hospitals for inpatient capital-related costs.
Sec. 15225. Moratorium on PPS exemption for long-term care hospitals.
Sec. 15226. Elimination of certain additional payments for outlier cases.

PART 4—PROVISIONS AFFECTING OTHER PROVIDERS

Sec. 15231. Revision of payment methodology for home health services.
Sec. 15232. Limitation of home health coverage under part A.
Sec. 15233. Reduction in fee schedule for durable medical equipment.
Sec. 15234. Nursing home billing.
Sec. 15235. Freeze in payments for clinical diagnostic laboratory tests.

PART 5—GRADUATE MEDICAL EDUCATION AND TEACHING HOSPITALS

Sec. 15241. Teaching Hospital and Graduate Medical Education Trust Fund.

''TITLE XXI—TEACHING HOSPITAL AND GRADUATE MEDICAL EDUCATION TRUST FUND

''PART A—ESTABLISHMENT OF FUND

''Sec. 2101. Establishment of fund.

''PART B—PAYMENTS TO TEACHING HOSPITALS

''Sec. 2111. Formula payments to teaching hospitals.
Sec. 15242. Reduction in payment adjustments for indirect medical education.

Subtitle D—Provisions Relating to Medicare Beneficiaries

Sec. 15301. Extending medicare part B premium.
Sec. 15302. Relating medicare part B premium to income for certain high income individuals.
Sec. 15303. Expanded coverage of preventive benefits.

Subtitle E—Medicare Fraud Reduction

Sec. 15401. Increasing beneficiary awareness of fraud and abuse.
Sec. 15402. Beneficiary incentives to report fraud and abuse.
Sec. 15403. Elimination of home health overpayments.
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Sec. 15405. Direct spending for anti-fraud activities under medicare.
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Subtitle F—Improving Access to Health Care

PART 1—IMPROVING ACCESS TO HEALTH CARE IN RURAL AREAS

Sec. 15501. Community rural health network grants.
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Sec. 15504. Creation of hospital-affiliated primary care centers.
Sec. 15505. Establishment of rural emergency access care hospitals.
Sec. 15506. Medical education.
Sec. 15507. Telemedicine payment methodology.
Sec. 15508. Demonstration project to increase choice in rural areas.

PART 2—MEDICARE SUBVENTION

Sec. 15511. Medicare program payments for health care services provided in the military health services system.

Subtitle G—Other Provisions

Sec. 15601. Extension and expansion of existing secondary payer requirements.
Sec. 15602. Clarification of medicare coverage of items and services associated with certain medical devices approved for investigational use.
Sec. 15603. Additional exclusion from coverage.

Subtitle H—Monitoring Achievement of Medicare Reform Goals

Sec. 15701. Establishment of budgetary and program goals.
Sec. 15702. Medicare Reform Commission.

Subtitle I—Lock-Box Provisions for Medicare Part B Savings From Growth Reductions

Sec. 15801. Establishment of Medicare Growth Reduction Trust Fund for part B savings.

Subtitle A—Medicare Choice Program

PART 1—INCREASING CHOICE UNDER THE MEDICARE PROGRAM

SEC. 15001. INCREASING CHOICE UNDER MEDICARE.

(a) IN GENERAL.—Title XVIII is amended by inserting after section 1804 the following new section:

''PROVIDING FOR CHOICE OF COVERAGE

''SEC. 1805. (a) CHOICE OF COVERAGE.—

''(1) IN GENERAL.—Subject to the provisions of this section, every individual who is entitled to benefits under part A and enrolled under part B shall elect to receive benefits under this title through one of the following:

''(A) THROUGH FEE-FOR-SERVICE SYSTEM.—Through the provisions of parts A and B.

''(B) THROUGH A MEDICARE CHOICE PRODUCT.—Through a Medicare Choice product (as defined in paragraph (2)), which may be—

''(i) a product offered by a provider-sponsored organization,

"(ii) a product offered by an organization that is a union, Taft-Hartley plan, or association, or

"(iii) a product providing for benefits on a fee-for-service or other basis.

Such a product may be a high deductible/medisave product (and a contribution into a Medicare Choice medical savings account (MSA)) under the demonstration project provided under section 1859.

"(2) MEDICARE CHOICE PRODUCT DEFINED.—For purposes this section and part C, the term 'Medicare Choice product' means health benefits coverage offered under a policy, contract, or plan by a Medicare Choice organization (as defined in section 1851(a)) pursuant to and in accordance with a contract under section 1858.

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

"(A) NON-MEDICARE-CHOICE OPTION.—An individual who has made the election described in paragraph (1)(A) is considered to have elected the 'Non-Medicare Choice option'.

"(B) MEDICARE CHOICE OPTION.—An individual who has made the election described in

paragraph (1)(B) to obtain coverage through a Medicare Choice product is considered to have elected the 'Medicare Choice option' for that product.

''(b) SPECIAL RULES.—

''(1) RESIDENCE REQUIREMENT.—Except as the Secretary may otherwise provide, an individual is eligible to elect a Medicare Choice product offered by a Medicare Choice organization only if the organization in relation to the product serves the geographic area in which the individual resides.

''(2) AFFILIATION REQUIREMENTS FOR CERTAIN PRODUCTS.—

''(A) IN GENERAL.—Subject to subparagraph (B), an individual is eligible to elect a Medicare Choice product offered by a limited enrollment Medicare Choice organization (as defined in section 1852(c)(4)(D)) only if—

''(i) the individual is eligible under section 1852(c)(4) to make such election, and

''(ii) in the case of a Medicare Choice organization that is a union sponsor or Taft-Hartley sponsor (as defined in section 1852(c)(4)), the individual elected under

this section a Medicare Choice product offered by the sponsor during the first enrollment period in which the individual was eligible to make such election with respect to such sponsor.

''(B) NO REELECTION AFTER DISENROLLMENT FOR CERTAIN PRODUCTS.—An individual is not eligible to elect a Medicare Choice product offered by a Medicare Choice organization that is a union sponsor or Taft-Hartley sponsor if the individual previously had elected a Medicare Choice product offered by the organization and had subsequently discontinued to elect such a product offered by the organization.

''(c) PROCESS FOR EXERCISING CHOICE.—

''(1) IN GENERAL.—The Secretary shall establish a process through which elections described in subsection (a) are made and changed, including the form and manner in which such elections are made and changed. Such elections shall be made or changed only during coverage election periods specified under subsection (e) and shall become effective as provided in subsection (f).

"(2) EXPEDITED IMPLEMENTATION.—The Secretary shall establish the process of electing coverage under this section during the transition period (as defined in subsection (e)(1)(B)) in such an expedited manner as will permit such an election for Medicare Choice products in an area as soon as such products become available in that area.

"(3) COORDINATION THROUGH MEDICARE CHOICE ORGANIZATIONS.—

"(A) ENROLLMENT.—Such process shall permit an individual who wishes to elect a Medicare Choice product offered by a Medicare Choice organization to make such election through the filing of an appropriate election form with the organization.

"(B) DISENROLLMENT.—Such process shall permit an individual, who has elected a Medicare Choice product offered by a Medicare Choice organization and who wishes to terminate such election, to terminate such election through the filing of an appropriate election form with the organization.

"(4) DEFAULT.—

"(A) INITIAL ELECTION.—

"(i) IN GENERAL.—Subject to clause (ii), an individual who fails to make an election during an initial election period under subsection (e)(1) is deemed to have chosen the Non-Medicare Choice option.

"(ii) SEAMLESS CONTINUATION OF COVERAGE.—The Secretary shall establish procedures under which individuals who are enrolled with a Medicare Choice organization at the time of the initial election period and who fail to elect to receive coverage other than through the organization are deemed to have elected an appropriate Medicare Choice product offered by the organization.

"(B) CONTINUING PERIODS.—An individual who has made (or deemed to have made) an election under this section is considered to have continued to make such election until such time as—

"(i) the individual changes the election under this section, or

"(ii) a Medicare Choice product is discontinued, if the individual had elected

such product at the time of the discontinuation.

''(5) AGREEMENTS WITH COMMISSIONER OF SOCIAL SECURITY TO PROMOTE EFFICIENT ADMINISTRATION.—In order to promote the efficient administration of this section and the Medicare Choice program under part C, the Secretary may enter into an agreement with the Commissioner of Social Security under which the Commissioner performs administrative responsibilities relating to enrollment and disenrollment in Medicare Choice products under this section.

''(d) PROVISION OF BENEFICIARY INFORMATION TO PROMOTE INFORMED CHOICE.—

''(1) IN GENERAL.—The Secretary shall provide for activities under this subsection to disseminate broadly information to medicare beneficiaries (and prospective medicare beneficiaries) on the coverage options provided under this section in order to promote an active, informed selection among such options. Such information shall be made available on such a timely basis (such as 6 months before the date an individual would first attain eligibility for medicare on the basis of age) as to permit individ-

uals to elect the Medicare Choice option during the initial election period described in subsection (e)(1).

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

''(3) SPECIFIC ACTIVITIES.—In carrying out this subsection, the Secretary shall provide for at least the following activities in all areas in which Medicare Choice products are offered:

''(A) INFORMATION BOOKLET.—

''(i) IN GENERAL.—The Secretary shall publish an information booklet and disseminate the booklet to all individuals eligible to elect the Medicare Choice option under this section during coverage election periods.

''(ii) INFORMATION INCLUDED.—The booklet shall include information presented in plain English and in a standardized format regarding—

''(I) the benefits (including cost-sharing) and premiums for the various Medicare Choice products in the areas involved;

"(II) the quality of such products, including consumer satisfaction information; and

"(III) rights and responsibilities of medicare beneficiaries under such products.

"(iii) PERIODIC UPDATING.—The booklet shall be updated on a regular basis (not less often than once every 12 months) to reflect changes in the availability of Medicare Choice products and the benefits and premiums for such products.

"(B) TOLL-FREE NUMBER.—The Secretary shall maintain a toll-free number for inquiries regarding Medicare Choice options and the operation of part C.

"(C) GENERAL INFORMATION IN MEDICARE HANDBOOK.—The Secretary shall include information about the Medicare Choice option provided under this section in the annual notice of medicare benefits under section 1804.

"(e) COVERAGE ELECTION PERIODS.—

"(1) INITIAL CHOICE UPON ELIGIBILITY TO MAKE ELECTION.—

"(A) IN GENERAL.—In the case of an individual who first becomes entitled to benefits under part A and enrolled under part B after the beginning of the transition period (as defined in subparagraph (B)), the individual shall make the election under this section during a period (of a duration and beginning at a time specified by the Secretary) at the first time the individual both is entitled to benefits under part A and enrolled under part B. Such period shall be specified in a manner so that, in the case of an individual who elects a Medicare Choice product during the period, coverage under the product becomes effective as of the first date on which the individual may receive such coverage.

"(B) TRANSITION PERIOD DEFINED.—In this subsection, the term 'transition period' means, with respect to an individual in an area, the period beginning on the first day of the first month in which a Medicare Choice product is first made available to individuals in the area and ending with the month preceding the beginning of the first annual, coordinated election period under paragraph (3).

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

"(A) CONTINUOUS OPEN ENROLLMENT INTO A MEDICARE CHOICE OPTION.—During the transition period, an individual who is eligible to make an election under this section and who has elected the non-Medicare Choice option may change such election to a Medicare Choice option at any time.

"(B) OPEN DISENROLLMENT BEFORE END OF TRANSITION PERIOD.—During the transition period, an individual who has elected a Medicare Choice option for a Medicare Choice product may change such election to another Medicare Choice product or to the non-Medicare Choice option.

"(3) ANNUAL, COORDINATED ELECTION PERIOD.—

"(A) IN GENERAL.—Subject to paragraph (5), each individual who is eligible to make an election under this section may change such election during annual, coordinated election periods.

"(B) ANNUAL, COORDINATED ELECTION PERIOD.—For purposes of this section, the

term 'annual, coordinated election period' means, with respect to a calendar year (beginning with 1998), the month of October before such year.

''(C) MEDICARE CHOICE HEALTH FAIR DURING OCTOBER, 1996.—In the month of October, 1996, the Secretary shall provide for a nationally coordinated educational and publicity campaign to inform individuals, who are eligible to elect Medicare Choice products, about such products and the election process provided under this section (including the annual, coordinated election periods that occur in subsequent years).

''(4) SPECIAL 90-DAY DISENROLLMENT OPTION.—

''(A) IN GENERAL.—In the case of the first time an individual elects a Medicare Choice option under this section, the individual may discontinue such election through the filing of an appropriate notice during the 90-day period beginning on the first day on which the individual's coverage under the Medicare Choice product under such option becomes effective.

"(B) EFFECT OF DISCONTINUATION OF ELECTION.—An individual who discontinues an election under this paragraph shall be deemed at the time of such discontinuation to have elected the Non-Medicare Choice option.

"(5) SPECIAL ELECTION PERIODS.—An individual may discontinue an election of a Medicare Choice product offered by a Medicare Choice organization other than during an annual, coordinated election period and make a new election under this section if—

"(A) the organization's or product's certification under part C has been terminated or the organization has terminated or otherwise discontinued providing the product;

"(B) in the case of an individual who has elected a Medicare Choice product offered by a Medicare Choice organization, the individual is no longer eligible to elect the product because of a change in the individual's place of residence or other change in circumstances (specified by the Secretary, but not including termination of membership in a qualified association in the case of a product offered by a qualified association or termination of the individual's

enrollment on the basis described in clause (i) or (ii) section 1852(c)(3)(B));

''(C) the individual demonstrates (in accordance with guidelines established by the Secretary) that—

''(i) the organization offering the product substantially violated a material provision of the organization's contract under part C in relation to the individual and the product; or

''(ii) the organization (or an agent or other entity acting on the organization's behalf) materially misrepresented the product's provisions in marketing the product to the individual; or

''(D) the individual meets such other conditions as the Secretary may provide.

''(f) EFFECTIVENESS OF ELECTIONS.—

''(1) DURING INITIAL COVERAGE ELECTION PERIOD.—An election of coverage made during the initial coverage election period under subsection (e)(1)(A) shall take effect upon the date the individual becomes entitled to benefits under part A and enrolled under part B, except as the Secretary may

provide (consistent with section 1838) in order to prevent retroactive coverage.

''(2) DURING TRANSITION; 90-DAY DISENROLLMENT OPTION.—An election of coverage made under subsection (e)(2) and an election to discontinue a Medicare Choice option under subsection (e)(4) at any time shall take effect with the first calendar month following the date on which the election is made.

''(3) ANNUAL, COORDINATED ELECTION PERIOD AND MEDISAVE ELECTION.—An election of coverage made during an annual, coordinated election period (as defined in subsection (e)(3)(B)) in a year shall take effect as of the first day of the following year.

''(4) OTHER PERIODS.—An election of coverage made during any other period under subsection (e)(5) shall take effect in such manner as the Secretary provides in a manner consistent (to the extent practicable) with protecting continuity of health benefit coverage.

''(g) EFFECT OF ELECTION OF MEDICARE CHOICE OPTION.—Subject to the provisions of section 1855(f), payments under a contract with a Medicare Choice organization under section 1858(a) with respect to an individual electing a Medicare Choice product offered by the organi-

zation shall be instead of the amounts which (in the absence of the contract) would otherwise be payable under parts A and B for items and services furnished to the individual.

''(h) DEMONSTRATION PROJECTS.—The Secretary shall conduct demonstration projects to test alternative approahces to coordinated open enrollments in different markets, including different annual enrollment periods and models of rolling open enrollment periods. The Secretary may waive previous provisions of this section in order to carry out such projects.''.

SEC. 15002. MEDICARE CHOICE PROGRAM.

(a) IN GENERAL.—Title XVIII is amended by redesignating part C as part D and by inserting after part B the following new part:

''PART C—PROVISIONS RELATING TO MEDICARE CHOICE

''REQUIREMENTS FOR MEDICARE CHOICE ORGANIZATIONS

''SEC. 1851. (a) MEDICARE CHOICE ORGANIZATION DEFINED.—In this part, subject to the succeeding provisions of this section, the term 'Medicare Choice organization' means a public or private entity that is certified under section 1857 as meeting the requirements and standards of this part for such an organization.

"(b) ORGANIZED AND LICENSED UNDER STATE LAW.—

"(1) IN GENERAL.—A Medicare Choice organization shall be organized and licensed under State law to offer health insurance or health benefits coverage in each State in which it offers a Medicare Choice product.

"(2) EXCEPTION FOR UNION AND TAFT-HARTLEY SPONSORS.—Paragraph (1) shall not apply to a Medicare Choice organization that is a union sponsor or Taft-Hartley sponsor (as defined in section 1852(c)(4)).

"(3) EXCEPTION FOR PROVIDER-SPONSORED ORGANIZATIONS.—Paragraph (1) shall not apply to a Medicare Choice organization that is a provider-sponsored organization (as defined in section 1854(a)) except to the extent provided under section 1857(b).

"(4) EXCEPTION FOR QUALIFIED ASSOCIATIONS.—Paragraph (1) shall not apply to a Medicare Choice organization that is a qualified association (as defined in section 1852(c)(4)(B)).

"(c) PREPAID PAYMENT.—A Medicare Choice organization shall be compensated (except for deductibles, coinsurance, and copayments) for the provision of health

care services to enrolled members by a payment which is paid on a periodic basis without regard to the date the health care services are provided and which is fixed without regard to the frequency, extent, or kind of health care service actually provided to a member.

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

''(1) may obtain insurance or make other arrangements for the cost of providing to any enrolled member such services the aggregate value of which exceeds $5,000 in any year,

''(2) may obtain insurance or make other arrangements for the cost of such services provided to its enrolled members other than through the organization because medical necessity required their provision before they could be secured through the organization,

''(3) may obtain insurance or make other arrangements for not more than 90 percent of the amount by which its costs for any of its fiscal years

exceed 115 percent of its income for such fiscal year, and

''(4) may make arrangements with physicians or other health professionals, health care institutions, or any combination of such individuals or institutions to assume all or part of the financial risk on a prospective basis for the provision of basic health services by the physicians or other health professionals or through the institutions.

In the case of a Medicare Choice organization that is a union sponsor or Taft-Hartley sponsor (as defined in section 1852(c)(4)) or a qualified association (as defined in section 1852(c)(4)(B)), this subsection shall not apply with respect to Medicare Choice products offered by such organization and issued by an organization to which subsection (b)(1) applies or by a provider-sponsored organization (as defined in section 1854(a)).

''(e) PROVISION AGAINST RISK OF INSOLVENCY.—

''(1) IN GENERAL.—Each Medicare Choice organization shall meet standards under section 1856 relating to the financial solvency and capital adequacy of the organization. Such standards shall take into account the nature and type of Medicare Choice products offered by the organization.

"(2) TREATMENT OF TAFT-HARTLEY SPONSORS.—An entity that is a Taft-Hartley sponsor is deemed to meet the requirement of paragraph (1).

"(3) TREATMENT OF CERTAIN QUALIFIED ASSOCIATIONS.—An entity that is a qualified association is deemed to meet the requirement of paragraph (1) with respect to Medicare Choice products offered by such association and issued by an organization to which subsection (b)(1) applies or by a provider-sponsored organization.

"(f) ORGANIZATIONS TREATED AS MEDICAREPLUS ORGANIZATIONS DURING TRANSITION.—Any of the following organizations shall be considered to qualify as a MedicarePlus organization for contract years beginning before January 1, 1997:

"(1) HEALTH MAINTENANCE ORGANIZATIONS.—An organization that is organized under the laws of any State and that is a qualified health maintenance organization (as defined in section 1310(d) of the Public Health Service Act), an organization recognized under State law as a health maintenance organization, or a similar organization regulated under State law for solvency in the same manner and to the same extent as such a health maintenance organization.

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

"(A) is licensed by a State agency as an insurer for the offering of health benefit coverage, or

"(B) is licensed by a State agency as a service benefit plan,

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

"(3) CURRENT RISK-CONTRACTORS.—An organization that is an eligible organization (as defined in section 1876(b)) and that has a risk-sharing contract in effect under section 1876 as of the date of the enactment of this section.

"REQUIREMENTS RELATING TO BENEFITS, PROVISION OF SERVICES, ENROLLMENT, AND PREMIUMS

"SEC. 1852. (a) BENEFITS COVERED.—

"(1) IN GENERAL.—Each Medicare Choice product offered under this part shall provide benefits for at least the items and services for which benefits are available under parts A and B consistent with the standards for coverage of such items and services applicable under this title.

"(2) ORGANIZATION AS SECONDARY PAYER.—Notwithstanding any other provision of law, a Medi-

care Choice organization may (in the case of the provision of items and services to an individual under this part under circumstances in which payment under this title is made secondary pursuant to section 1862(b)(2)) charge or authorize the provider of such services to charge, in accordance with the charges allowed under such law or policy—

"(A) the insurance carrier, employer, or other entity which under such law, plan, or policy is to pay for the provision of such services, or

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

"(3) SATISFACTION OF REQUIREMENT.—A Medicare Choice product offered by a Medicare Choice organization satisfies paragraph (1) with respect to benefits for items and services if the following requirements are met:

"(A) FEE FOR SERVICE PROVIDERS.—In the case of benefits furnished through a provider that does not have a contract with the organization, the product provides for at least the dollar amount of payment for such items and

services as would otherwise be provided under parts A and B.

''(B) PARTICIPATING PROVIDERS.—In the case of benefits furnished through a provider that has such a contract, the individual's liability for payment for such items and services does not exceed (after taking into account any deductible, which does not exceed any deductible under parts A and B) the lesser of the following:

''(i) NON-MEDICARE CHOICE LIABILITY.—The amount of the liability that the individual would have had (based on the provider being a participating provider) if the individual had elected the non-Medicare Choice option.

''(ii) MEDICARE COINSURANCE APPLIED TO PRODUCT PAYMENT RATES.—The applicable coinsurance or copayment rate (that would have applied under the non-Medicare Choice option) of the payment rate provided under the contract.

''(b) ANTIDISCRIMINATION.—A Medicare Choice organization may not deny, limit, or condition the coverage or provision of benefits under this part based on the health

status, claims experience, receipt of health care, medical history, or lack of evidence of insurability, of an individual.

''(c) GUARANTEED ISSUE AND RENEWAL.—

''(1) IN GENERAL.—Except as provided in this subsection, a Medicare Choice organization shall provide that at any time during which elections are accepted under section 1805 with respect to a Medicare Choice product offered by the organization, the organization will accept without restrictions individuals who are eligible to make such election.

''(2) PRIORITY.—If the Secretary determines that a Medicare Choice organization, in relation to a Medicare Choice product it offers, has a capacity limit and the number of eligible individuals who elect the product under section 1805 exceeds the capacity limit, the organization may limit the election of individuals of the product under such section but only if priority in election is provided—

''(A) first to such individuals as have elected the product at the time of the determination, and

''(B) then to other such individuals in such a manner that does not discriminate among the individuals (who seek to elect the product) on a basis described in subsection (b).

"(3) LIMITATION ON TERMINATION OF ELECTION.—

"(A) IN GENERAL.—Subject to subparagraph (B), a Medicare Choice organization may not for any reason terminate the election of any individual under section 1805 for a Medicare Choice product it offers.

"(B) BASIS FOR TERMINATION OF ELECTION.—A Medicare Choice organization may terminate an individual's election under section 1805 with respect to a Medicare Choice product it offers if—

"(i) any premiums required with respect to such product are not paid on a timely basis (consistent with standards under section 1856 that provide for a grace period for late payment of premiums),

"(ii) the individual has engaged in disruptive behavior (as specified in such standards), or

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

Any individual whose election is so terminated is deemed to have elected the Non-Medicare

Choice option (as defined in section 1805(a)(3)(A)).

''(C) ORGANIZATION OBLIGATION WITH RESPECT TO ELECTION FORMS.—Pursuant to a contract under section 1858, each Medicare Choice organization receiving an election form under section 1805(c)(2) shall transmit to the Secretary (at such time and in such manner as the Secretary may specify) a copy of such form or such other information respecting the election as the Secretary may specify.

''(4) SPECIAL RULES FOR LIMITED ENROLLMENT MEDICARE CHOICE ORGANIZATIONS.—

''(A) TAFT-HARTLEY SPONSORS.—

''(i) IN GENERAL.—Subject to subparagraph (D), a Medicare Choice organization that is a Taft-Hartley sponsor (as defined in clause (ii)) shall limit eligibility of enrollees under this part for Medicare Choice products it offers to individuals who are entitled to obtain benefits through such products under the terms of an applicable collective bargaining agreement.

''(ii) TAFT-HARTLEY SPONSOR.—In this part and section 1805, the term 'Taft-

Hartley sponsor' means, in relation to a group health plan that is established or maintained by two or more employers or jointly by one or more employers and one or more employee organizations, the association, committee, joint board of trustees, or other similar group of representatives of parties who establish or maintain the plan.

''(B) QUALIFIED ASSOCIATIONS.—

''(i) IN GENERAL.—Subject to subparagraph (D), a Medicare Choice organization that is a qualified association (as defined in clause (iii)) shall limit eligibility of individuals under this part for products it offers to individuals who are members of the association (or who are spouses of such individuals).

''(ii) LIMITATION ON TERMINATION OF COVERAGE.—Such a qualifying association offering a Medicare Choice product to an individual may not terminate coverage of the individual on the basis that the individual is no longer a member of the association except pursuant to a change of election during an open election period oc-

curring on or after the date of the termination of membership.

''(iii) QUALIFIED ASSOCIATION.—In this part and section 1805, the term 'qualified association' means an association, religious fraternal organization, or other organization (which may be a trade, industry, or professional association, a chamber of commerce, or a public entity association) that the Secretary finds—

''(I) has been formed for purposes other than the sale of any health insurance and does not restrict membership based on the health status, claims experience, receipt of health care, medical history, or lack of evidence of insurability, of an individual,

''(II) does not exist solely or principally for the purpose of selling insurance, and

''(III) has at least 1,000 individual members or 200 employer members.

Such term includes a subsidiary or corporation that is wholly owned by one or more qualified organizations.

''(C) UNIONS.—

''(i) IN GENERAL.—Subject to subparagraph (D), a union sponsor (as defined in clause (ii)) shall limit eligibility of enrollees under this part for MedicarePlus products it offers to individuals who are members of the sponsor and affiliated with the sponsor through an employment relationship with any employer or are the spouses of such members.

''(ii) UNION SPONSOR.—In this part and section 1805, the term 'union sponsor' means an employee organization in relation to a group health plan that is established or maintained by the organization other than pursuant to a collective bargaining agreement.

''(D) LIMITATION.—Rules of eligibility to carry out the previous subparagraphs of this paragraph shall not have the effect of denying eligibility to individuals on the basis of health status, claims experience, receipt of health care,

medical history, or lack of evidence of insurability.

"(E) LIMITED ENROLLMENT MEDICARE CHOICE ORGANIZATION.—In this part and section 1805, the term 'limited enrollment Medicare Choice organization' means a Medicare Choice organization that is a union sponsor, a Taft-Hartley sponsor, or a qualified association.

"(F) EMPLOYER, ETC.—In this paragraph, the terms 'employer', 'employee organization', and 'group health plan' have the meanings given such terms for purposes of part 6 of subtitle B of title I of the Employee Retirement Income Security Act of 1974.

"(d) SUBMISSION AND CHARGING OF PREMIUMS.—

"(1) IN GENERAL.—Each Medicare Choice organization shall file with the Secretary each year, in a form and manner and at a time specified by the Secretary—

"(A) the amount of the monthly premiums for coverage under each Medicare Choice product it offers under this part in each payment area (as determined for purposes of section 1855) in which the product is being offered; and

"(B) the enrollment capacity in relation to the product in each such area.

"(2) AMOUNTS OF PREMIUMS CHARGED.—The amount of the monthly premium charged by a Medicare Choice organization for a Medicare Choice product offered in a payment area to an individual under this part shall be equal to the amount (if any) by which—

"(A) the amount of the monthly premium for the product for the period involved, as established under paragraph (3) and submitted under paragraph (1), exceeds

"(B) 1/12 of the annual Medicare Choice capitation rate specified in section 1855(b)(2) for the area and period involved.

"(3) UNIFORM PREMIUM.—The premiums charged by a Medicare Choice organization under this part may not vary among individuals who reside in the same payment area.

"(4) TERMS AND CONDITIONS OF IMPOSING PREMIUMS.—Each Medicare Choice organization shall permit the payment of monthly premiums on a monthly basis and may terminate election of individuals for a Medicare Choice product for failure to

make premium payments only in accordance with subsection (c)(3)(B).

''(5) RELATION OF PREMIUMS AND COST-SHARING TO BENEFITS.—In no case may the portion of a Medicare Choice organization's premium rate and the actuarial value of its deductibles, coinsurance, and copayments charged (to the extent attributable to the minimum benefits described in subsection (a)(1) and not counting any amount attributable to balance billing) to individuals who are enrolled under this part with the organization exceed the actuarial value of the coinsurance and deductibles that would be applicable on the average to individuals enrolled under this part with the organization (or, if the Secretary finds that adequate data are not available to determine that actuarial value, the actuarial value of the coinsurance and deductibles applicable on the average to individuals in the area, in the State, or in the United States, eligible to enroll under this part with the organization, or other appropriate data) and entitled to benefits under part A and enrolled under part B if they were not members of a Medicare Choice organization.

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

"(1) REQUIREMENT.—

"(A) IN GENERAL.—Each Medicare Choice organization (in relation to a Medicare Choice product it offers) shall provide that if there is an excess amount (as defined in subparagraph (B)) for the product for a contract year, subject to the succeeding provisions of this subsection, the organization shall provide to individuals such additional benefits (as the organization may specify), a monetary rebate (paid on a monthly basis) of the part B monthly premium, or a combination thereof, in an total value which is at least equal to the adjusted excess amount (as defined in subparagraph (C)).

"(B) EXCESS AMOUNT.—For purposes of this paragraph, the 'excess amount', for an organization for a product, is the amount (if any) by which—

"(i) the average of the capitation payments made to the organization under this part for the product at the beginning of contract year, exceeds

"(ii) the actuarial value of the minimum benefits described in subsection (a)(1) under the product for individuals

under this part, as determined based upon an adjusted community rate described in paragraph (5) (as reduced for the actuarial value of the coinsurance and deductibles under parts A and B).

''(C) ADJUSTED EXCESS AMOUNT.—For purposes of this paragraph, the 'adjusted excess amount', for an organization for a product, is the excess amount reduced to reflect any amount withheld and reserved for the organization for the year under paragraph (3).

''(D) UNIFORM APPLICATION.—This paragraph shall be applied uniformly for all enrollees for a product in a service area.

''(E) CONSTRUCTION.—Nothing in this subsection shall be construed as preventing a Medicare Choice organization from providing health care benefits that are in addition to the benefits otherwise required to be provided under this paragraph and from imposing a premium for such additional benefits.

''(2) LIMITATION ON AMOUNT OF PART B PREMIUM DISCOUNT REBATE.—In no case shall the amount of a part B premium discount rebate under paragraph (1)(A) exceed, with respect to a month,

the amount of premiums imposed under part B (not taking into account section 1839(b) (relating to penalty for late enrollment) or 1839(h) (relating to affluence testing)), for the individual for the month. Except as provided in the previous sentence, a Medicare Choice organization is not authorized to provide for cash or other monetary rebates as an inducement for enrollment or otherwise.

''(3) STABILIZATION FUND.—A Medicare Choice organization may provide that a part of the value of an excess actuarial amount described in paragraph (1) be withheld and reserved in the Federal Hospital Insurance Trust Fund and in the Federal Supplementary Medical Insurance Trust Fund (in such proportions as the Secretary determines to be appropriate) by the Secretary for subsequent annual contract periods, to the extent required to stabilize and prevent undue fluctuations in the additional benefits and rebates offered in those subsequent periods by the organization in accordance with such paragraph. Any of such value of amount reserved which is not provided as additional benefits described in paragraph (1)(A) to individuals electing the Medicare Choice product in accordance with

such paragraph prior to the end of such periods, shall revert for the use of such trust funds.

''(4) DETERMINATION BASED ON INSUFFICIENT DATA.—For purposes of this subsection, if the Secretary finds that there is insufficient enrollment experience (including no enrollment experience in the case of a provider-sponsored organization) to determine an average of the capitation payments to be made under this part at the beginning of a contract period, the Secretary may determine such an average based on the enrollment experience of other contracts entered into under this part.

''(5) ADJUSTED COMMUNITY RATE.—

''(A) IN GENERAL.—For purposes of this subsection, subject to subparagraph (B), the term 'adjusted community rate' for a service or services means, at the election of a Medicare Choice organization, either—

''(i) the rate of payment for that service or services which the Secretary annually determines would apply to an individual electing a Medicare Choice product under this part if the rate of payment were determined under a 'community rating system' (as defined in section 1302(8) of the

Public Health Service Act, other than subparagraph (C)), or

''(ii) such portion of the weighted aggregate premium, which the Secretary annually estimates would apply to such an individual, as the Secretary annually estimates is attributable to that service or services,

but adjusted for differences between the utilization characteristics of the individuals electing coverage under this part and the utilization characteristics of the other enrollees with the organization (or, if the Secretary finds that adequate data are not available to adjust for those differences, the differences between the utilization characteristics of individuals selecting other Medicare Choice coverage, or individuals in the area, in the State, or in the United States, eligible to elect Medicare Choice coverage under this part and the utilization characteristics of the rest of the population in the area, in the State, or in the United States, respectively).

''(B) SPECIAL RULE FOR PROVIDER-SPONSORED ORGANIZATIONS.—In the case of a Med-

icare Choice organization that is a provider-sponsored organization, the adjusted community rate under subparagraph (A) for a Medicare Choice product may be computed (in a manner specified by the Secretary) using data in the general commercial marketplace or (during a transition period) based on the costs incurred by the organization in providing such a product.

''(f) RULES REGARDING PHYSICIAN PARTICIPATION.—

''(1) PROCEDURES.—Each Medicare Choice organization shall establish reasonable procedures relating to the participation (under an agreement between a physician and the organization) of physicians under Medicare Choice products offered by the organization under this part. Such procedures shall include—

''(A) providing notice of the rules regarding participation,

''(B) providing written notice of participation decisions that are adverse to physicians, and

''(C) providing a process within the organization for appealing adverse decisions, including

the presentation of information and views of the physician regarding such decision.

''(2) CONSULTATION IN MEDICAL POLICIES.—A Medicare Choice organization shall consult with physicians who have entered into participation agreements with the organization regarding the organization's medical policy, quality, and medical management procedures.

''(3) LIMITATIONS ON PHYSICIAN INCENTIVE PLANS.—

''(A) IN GENERAL.—Each Medicare Choice organization may not operate any physician incentive plan (as defined in subparagraph (B)) unless the following requirements are met:

''(i) No specific payment is made directly or indirectly under the plan to a physician or physician group as an inducement to reduce or limit medically necessary services provided with respect to a specific individual enrolled with the organization.

''(ii) If the plan places a physician or physician group at substantial financial risk (as determined by the Secretary) for services not provided by the physician or physician group, the organization—

''(I) provides stop-loss protection for the physician or group that is adequate and appropriate, based on standards developed by the Secretary that take into account the number of physicians placed at such substantial financial risk in the group or under the plan and the number of individuals enrolled with the organization who receive services from the physician or the physician group, and

''(II) conducts periodic surveys of both individuals enrolled and individuals previously enrolled with the organization to determine the degree of access of such individuals to services provided by the organization and satisfaction with the quality of such services.

''(iii) The organization provides the Secretary with descriptive information regarding the plan, sufficient to permit the Secretary to determine whether the plan is in compliance with the requirements of this subparagraph.

"(B) PHYSICIAN INCENTIVE PLAN DEFINED.—In this paragraph, the term 'physician incentive plan' means any compensation arrangement between a Medicare Choice organization and a physician or physician group that may directly or indirectly have the effect of reducing or limiting services provided with respect to individuals enrolled with the organization under this part.

"(4) EXCEPTION FOR CERTAIN FEE-FOR-SERVICE PLANS.—The previous provisions of this subsection shall not apply in the case of a Medicare Choice organization in relation to a Medicare Choice product if the organization does not have agreements between physicians and the organization for the provision of benefits under the product.

"(g) PROVISION OF INFORMATION.—A Medicare Choice organization shall provide the Secretary with such information on the organization and each Medicare Choice product it offers as may be required for the preparation of the information booklet described in section 1805(d)(3)(A).

"(h) COORDINATED ACUTE AND LONG-TERM CARE BENEFITS UNDER A MEDICARE CHOICE PRODUCT.—Nothing in this part shall be construed as preventing a

State from coordinating benefits under its medicaid program under title XIX with those provided under a Medicare Choice product in a manner that assures continuity of a full-range of acute care and long-term care services to poor elderly or disabled individuals eligible for benefits under this title and under such program.

''PATIENT PROTECTION STANDARDS

''SEC. 1853. (a) DISCLOSURE TO ENROLLEES.—A Medicare Choice organization shall disclose in clear, accurate, and standardized form, information regarding all of the following for each Medicare Choice product it offers:

''(1) Benefits under the Medicare Choice product offered, including exclusions from coverage.

''(2) Rules regarding prior authorization or other review requirements that could result in nonpayment.

''(3) Potential liability for cost-sharing for out-of-network services.

''(4) The number, mix, and distribution of participating providers.

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

"(6) Statistics on enrollee satisfaction with the product and organization, including rates of reenrollment.

"(7) Enrollee rights and responsibilities, including the grievance process provided under subsection (f).

"(8) A statement that the use of the 911 emergency telephone number is appropriate in emergency situations and an explanation of what constitutes an emergency situation.

"(9) A description of the organization's quality assurance program under subsection (d).

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

"(b) ACCESS TO SERVICES.—

"(1) IN GENERAL.—A Medicare Choice organization offering a Medicare Choice product may restrict the providers from whom the benefits under the product are provided so long as—

"(A) the organization makes such benefits available and accessible to each individual electing the product within the product service area with reasonable promptness and in a manner

which assures continuity in the provision of benefits;

''(B) when medically necessary the organization makes such benefits available and accessible 24 hours a day and 7 days a week;

''(C) the product provides for reimbursement with respect to services which are covered under subparagraphs (A) and (B) and which are provided to such an individual other than through the organization, if—

''(i) the services were medically necessary and immediately required because of an unforeseen illness, injury, or condition, and

''(ii) it was not reasonable given the circumstances to obtain the services through the organization; and

''(D) coverage is provided for emergency services (as defined in paragraph (5)) without regard to prior authorization or the emergency care provider's contractual relationship with the organization.

''(2) MINIMUM PAYMENT LEVELS WHERE PROVIDING POINT-OF-SERVICE COVERAGE.—If a Medicare Choice product provides benefits for items and

services (not described in paragraph (1)(C)) through a network of providers and also permits payment to be made under the product for such items and services not provided through such a network, the payment level under the product with respect to such items and services furnished outside the network shall be at least 70 percent (or, if the effective cost-sharing rate is 50 percent, at least 35 percent) of the lesser of—

''(A) the payment basis (determined without regard to deductibles and cost-sharing) that would have applied for such items and services under parts A and B, or

''(B) the amount charged by the entity furnishing such items and services.

''(3) PROTECTION OF ENROLLEES FOR CERTAIN OUT-OF-NETWORK SERVICES.—

''(A) PARTICIPATING PROVIDERS.—In the case of physicians' services or renal dialysis services described in subparagraph (C) which are furnished by a participating physician or provider of services or renal dialysis facility to an individual enrolled with a MedicarePlus organization under this section, the applicable participation agreement is deemed to provide

that the physician or provider of services or renal dialysis facility will accept as payment in full from the organization the amount that would be payable to the physician or provider of services or renal dialysis facility under part B and from the individual under such part, if the individual were not enrolled with such an organization under this part.

''(B) NONPARTICIPATING PROVIDERS.—In the case of physicians' services described in subparagraph (C) which are furnished by a nonparticipating physician, the limitations on actual charges for such services otherwise applicable under part B (to services furnished by individuals not enrolled with a MedicarePlus organization under this section) shall apply in the same manner as such limitations apply to services furnished to individuals not enrolled with such an organization.

''(C) SERVICES DESCRIBED.—The physicians' services or renal dialysis services described in this subparagraph are physicians' services or renal dialysis services which are furnished to an enrollee of a MedicarePlus organization under this part by a physician, provider

of services, or renal dialysis facility who is not under a contract with the organization.

''(4) PROTECTION FOR NEEDED SERVICES.—A Medicare Choice organization that provides covered services through a network of providers shall provide coverage of services provided by a provider that is not part of the network if the service cannot be provided by a provider that is part of the network and the organization authorized the service directly or through referral by the primary care physician who is designated by the organization for the individual involved.

''(5) DEFINITION OF EMERGENCY SERVICES.—In this subsection, the term 'emergency services' means, with respect to an individual enrolled with an organization, covered inpatient and outpatient services that—

''(A) are furnished by an appropriate source other than the organization,

''(B) are needed immediately because of an injury or sudden illness, and

''(C) are needed because the time required to reach the organization's providers or suppliers would have meant risk of serious damage to the patient's health.

"(c) CONFIDENTIALITY AND ACCURACY OF ENROLLEE RECORDS.—Each Medicare Choice organization shall establish procedures—

"(1) to safeguard the privacy of individually identifiable enrollee information, and

"(2) to maintain accurate and timely medical records for enrollees.

"(d) QUALITY ASSURANCE PROGRAM.—

"(1) IN GENERAL.—Each Medicare Choice organization must have arrangements, established in accordance with regulations of the Secretary, for an ongoing quality assurance program for health care services it provides to such individuals.

"(2) ELEMENTS OF PROGRAM.—The quality assurance program shall—

"(A) stress health outcomes;

"(B) provide for the establishment of written protocols for utilization review, based on current standards of medical practice;

"(C) provide review by physicians and other health care professionals of the process followed in the provision of such health care services;

''(D) monitors and evaluates high volume and high risk services and the care of acute and chronic conditions;

''(E) evaluates the continuity and coordination of care that enrollees receive;

''(F) has mechanisms to detect both underutilization and overutilization of services;

''(G) after identifying areas for improvement, establishes or alters practice parameters;

''(H) takes action to improve quality and assesses the effectiveness of such action through systematic follow-up;

''(I) makes available information on quality and outcomes measures to facilitate beneficiary comparison and choice of health coverage options (in such form and on such quality and outcomes measures as the Secretary determines to be appropriate);

''(J) is evaluated on an ongoing basis as to its effectiveness; and

''(K) provide for external accreditation or review, by a utilization and quality control peer review organization under part B of title XI or other qualified independent review organization, of the quality of services furnished by the orga-

nization meets professionally recognized standards of health care (including providing adequate access of enrollees to services).

''(3) EXCEPTION FOR CERTAIN FEE-FOR-SERVICE PLANS.—Paragraph (1) and subsection (c)(2) shall not apply in the case of a Medicare Choice organization in relation to a Medicare Choice product to the extent the organization provides for coverage of benefits without restrictions relating to utilization and without regard to whether the provider has a contract or other arrangement with the plan for the provision of such benefits.

''(4) TREATMENT OF ACCREDITATION.—The Secretary shall provide that a Medicare Choice organization is deemed to meet the requirements of paragraphs (1) and (2) of this subsection and subsection (c) if the organization is accredited (and periodically reaccredited) by a private organization under a process that the Secretary has determined assures that the organization meets standards that are no less stringent than the standards established under section 1856 to carry out this subsection and subsection (c).

''(e) COVERAGE DETERMINATIONS.—

"(1) DECISIONS ON NONEMERGENCY CARE.—A Medicare Choice organization shall make determinations regarding authorization requests for nonemergency care on a timely basis, depending on the urgency of the situation.

"(2) APPEALS.—

"(A) IN GENERAL.—Appeals from a determination of an organization denying coverage shall be decided within 30 days of the date of receipt of medical information, but not later than 60 days after the date of the decision.

"(B) PHYSICIAN DECISION ON CERTAIN APPEALS.—Appeal decisions relating to a determination to deny coverage based on a lack of medical necessity shall be made only by a physician.

"(C) EMERGENCY CASES.—Appeals from such a determination involving a life-threatening or emergency situation shall be decided on an expedited basis.

"(f) GRIEVANCES AND APPEALS.—

"(1) GRIEVANCE MECHANISM.—Each Medicare Choice organization must provide meaningful procedures for hearing and resolving grievances between the organization (including any entity or individual

through which the organization provides health care services) and enrollees under this part.

''(2) APPEALS.—An enrollee with an organization under this part who is dissatisfied by reason of the enrollee's failure to receive any health service to which the enrollee believes the enrollee is entitled and at no greater charge than the enrollee believes the enrollee is required to pay is entitled, if the amount in controversy is $100 or more, to a hearing before the Secretary to the same extent as is provided in section 205(b), and in any such hearing the Secretary shall make the organization a party. If the amount in controversy is $1,000 or more, the individual or organization shall, upon notifying the other party, be entitled to judicial review of the Secretary's final decision as provided in section 205(g), and both the individual and the organization shall be entitled to be parties to that judicial review. In applying sections 205(b) and 205(g) as provided in this subparagraph, and in applying section 205(l) thereto, any reference therein to the Commissioner of Social Security or the Social Security Administration shall be considered a reference to the Secretary or the Department of Health and Human Services, respectively.

"(3) COORDINATION WITH SECRETARY OF LABOR.—The Secretary shall consult with the Secretary of Labor so as to ensure that the requirements of this subsection, as they apply in the case of grievances referred to in paragraph (1) to which section 503 of the Employee Retirement Income Security Act of 1974 applies, are applied in a manner consistent with the requirements of such section 503.

"(g) INFORMATION ON ADVANCE DIRECTIVES.—Each Medicare Choice organization shall meet the requirement of section 1866(f) (relating to maintaining written policies and procedures respecting advance directives).

"(h) APPROVAL OF MARKETING MATERIALS.—

"(1) SUBMISSION.—Each Medicare Choice organization may not distribute marketing materials unless—

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

"(B) the Secretary has not disapproved the distribution of such material.

"(2) REVIEW.—The standards established under section 1856 shall include guidelines for the review of all such material submitted and under

such guidelines the Secretary shall disapprove such material if the material is materially inaccurate or misleading or otherwise makes a material misrepresentation.

''(3) DEEMED APPROVAL (1-STOP SHOPPING).—In the case of material that is submitted under paragraph (1)(A) to the Secretary or a regional office of the Department of Health and Human Services and the Secretary or the office has not disapproved the distribution of marketing materials under paragraph (1)(B) with respect to a Medicare Choice product in an area, the Secretary is deemed not to have disapproved such distribution in all other areas covered by the product and organization.

''(4) PROHIBITION OF CERTAIN MARKETING PRACTICES.—Each Medicare Choice organization shall conform to fair marketing standards in relation to Medicare Choice products offered under this part, included in the standards established under section 1856. Such standards shall include a prohibition against an organization (or agent of such an organization) completing any portion of any election form under section 1805 on behalf of any individual.

''(i) ADDITIONAL STANDARDIZED INFORMATION ON QUALITY, OUTCOMES, AND OTHER FACTORS.—

"(1) IN GENERAL.—In addition to any other information required to be provided under this part, each Medicare Choice organization shall provide the Secretary (at a time, not less frequently than annually, and in an electronic, standardized form and manner specified by the Secretary) such information as the Secretary determines to be necessary, consistent with this part, to evaluate the performance of the organization in providing benefits to enrollees.

"(2) INFORMATION TO BE INCLUDED.—Subject to paragraph (3), information to be provided under this subsection shall include at least the following:

"(A) Information on the characteristics of enrollees that may affect their need for or use of health services and the determination of risk-adjusted payments under section 1855.

"(B) Information on the types of treatments and outcomes of treatments with respect to the clinical health, functional status, and well-being of enrollees.

"(C) Information on health care expenditures and the volume and prices of procedures.

"(D) Information on the flexibility permitted by plans to enrollees in their selection of providers.

"(3) SPECIAL TREATMENT.—The Secretary may waive the provision of such information under paragraph (2), or require such other information, as the Secretary finds appropriate in the case of a newly established Medicare Choice organization for which such information is not available.

"(j) DEMONSTRATION PROJECTS.—The Secretary shall provide for demonstration projects to determine the effectiveness, cost, and impact of alternative methods of providing comparative information about the performance of Medicare Choice organizations and products and the performance of medicare supplemental policies in relation to such products. Such projects shall include information about health care outcomes resulting from coverage under different products and policies.

"PROVIDER-SPONSORED ORGANIZATIONS

"SEC. 1854. (a) PROVIDER-SPONSORED ORGANIZATION DEFINED.—

"(1) IN GENERAL.—In this part, the term 'provider-sponsored organization' means a public or private entity that (in accordance with standards established under subsection (b)) is a provider, or group of affiliated providers, that provides a substantial proportion (as defined by the Secretary under such standards) of the health care items and services

under the contract under this part directly through the provider or affiliated group of providers.

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

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

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

''(3) AFFILIATION.—For purposes of this subsection, a provider is 'affiliated' with another provider if, through contract, ownership, or otherwise—

''(A) one provider, directly or indirectly, controls, is controlled by, or is under common control with the other,

''(B) each provider is a participant in a lawful combination under which each provider shares, directly or indirectly, substantial financial risk in connection with their operations,

"(C) both providers are part of a controlled group of corporations under section 1563 of the Internal Revenue Code of 1986, or

"(D) both providers are part of an affiliated service group under section 414 of such Code.

"(4) CONTROL.—For purposes of paragraph (3), control is presumed to exist if one party, directly or indirectly, owns, controls, or holds the power to vote, or proxies for, not less than 51 percent of the voting rights or governance rights of another.

"(b) PREEMPTION OF STATE INSURANCE LICENSING REQUIREMENTS.—

"(1) IN GENERAL.—This section supersedes any State law which—

"(A) requires that a provider-sponsored organization meet requirements for insurers of health services or health maintenance organizations doing business in the State with respect to initial capitalization and establishment of financial reserves against insolvency, or

"(B) imposes requirements that would have the effect of prohibiting the organization

from complying with the applicable requirements of this part,

insofar as such the law applies to individuals enrolled with the organization under this part.

''(2) EXCEPTION.—Paragraph (1) shall not apply with respect to any State law to the extent that such law provides standards or requirements, or provides for enforcement thereof, so as to meet the requirements of section 1857(b) with respect to approval by the Secretary of State certification requirements thereunder.

''(3) CONSTRUCTION.—Nothing in this subsection shall be construed as affecting the operation of section 514 of the Employee Retirement Income Security Act of 1974.

''PAYMENTS TO MEDICARE CHOICE ORGANIZATIONS

''SEC. 1855. (a) PAYMENTS.—

''(1) IN GENERAL.—Under a contract under section 1858 the Secretary shall pay to each Medicare Choice organization, with respect to coverage of an individual under this part in a payment area for a month, an amount equal to the monthly adjusted Medicare Choice capitation rate (as provided under subsection (b)) with respect to that individual for that area.

"(2) ANNUAL ANNOUNCEMENT.—The Secretary shall annually determine, and shall announce (in a manner intended to provide notice to interested parties) not later than September 7 before the calendar year concerned—

"(A) the annual Medicare Choice capitation rate for each payment area for the year, and

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

"(3) ADVANCE NOTICE OF METHODOLOGICAL CHANGES.—At least 45 days before making the announcement under paragraph (2) for a year, the Secretary shall provide for notice to Medicare Choice organizations of proposed changes to be made in the methodology or benefit coverage assumptions from the methodology and assumptions used in the previous announcement and shall provide such organizations an opportunity to comment on such proposed changes.

"(4) EXPLANATION OF ASSUMPTIONS.—In each announcement made under paragraph (2) for a year, the Secretary shall include an explanation of the assumptions (including any benefit coverage assump-

tions) and changes in methodology used in the announcement in sufficient detail so that Medicare Choice organizations can compute monthly adjusted Medicare Choice capitation rates for classes of individuals located in each payment area which is in whole or in part within the service area of such an organization.

''(b) MONTHLY ADJUSTED MEDICARE CHOICE CAPITATION RATE.—

''(1) IN GENERAL.—For purposes of this section, the 'monthly adjusted Medicare Choice capitation rate' under this subsection, for a month in a year for an individual in a payment area (specified under paragraph (3)) and in a class (established under paragraph (4)), is 1/12 of the annual Medicare Choice capitation rate specified in paragraph (2) for that area for the year, adjusted to reflect the actuarial value of benefits under this title with respect to individuals in such class compared to the national average for individuals in all classes.

''(2) ANNUAL MEDICARE CHOICE CAPITATION RATES.—

''(A) IN GENERAL.—For purposes of this section, the annual Medicare Choice capitation rate for a payment area for a year is equal to

the annual Medicare Choice capitation rate for the area for the previous year (or, in the case of 1996, the average annual per capita rate of payment described in section 1876(a)(1)(C) for the area for 1995) increased by the per capita growth rate for that area and year (as determined under subsection (c)).

''(B) SPECIAL RULES FOR 1996.—

''(i) FLOOR AT 85 PERCENT OF NATIONAL AVERAGE.—In no case shall the annual Medicare Choice capitation rate for a payment area for 1996 be less than 85 percent of the national average of such rates for such year for all payment areas (weighted to reflect the number of medicare beneficiaries in each such area).

''(ii) REMOVAL OF MEDICAL EDUCATION AND DISPROPORTIONATE SHARE HOSPITAL PAYMENTS FROM CALCULATION OF ADJUSTED AVERAGE PER CAPITA COST.—In determining the annual Medicare Choice capitation rate for 1996, the average annual per capita rate of payment described in section 1876(a)(1)(C) for 1995 shall be determined as though the

Secretary had excluded from such rate any amounts which the Secretary estimated would have been payable under this title during the year for—

''(I) payment adjustments under section 1886(d)(5)(F) for hospitals serving a disproportionate share of low-income patients; and

''(II) the indirect costs of medical education under section 1886(d)(5)(B) or for direct graduate medical education costs under section 1886(h).

''(3) PAYMENT AREA DEFINED.—

''(A) IN GENERAL.—In this section, the term 'payment area' means—

''(i) a metropolitan statistical area, or

''(ii) all areas of a State outside of such an area.

''(B) SPECIAL RULE FOR ESRD BENEFICIARIES.—Such term means, in the case of the population group described in paragraph (5)(C), each State.

''(4) CLASSES.—

"(A) IN GENERAL.—For purposes of this section, the Secretary shall define appropriate classes of enrollees, consistent with paragraph (5), based on age, gender, welfare status, institutionalization, and such other factors as the Secretary determines to be appropriate, so as to ensure actuarial equivalence. The Secretary may add to, modify, or substitute for such classes, if such changes will improve the determination of actuarial equivalence.

"(B) RESEARCH.—The Secretary shall conduct such research as may be necessary to provide for greater accuracy in the adjustment of capitation rates under this subsection. Such research may include research into the addition or modification of classes under subparagraph (A). The Secretary shall submit to Congress a report on such research by not later than January 1, 1997.

"(5) DIVISION OF MEDICARE POPULATION.—In carrying out paragraph (4) and this section, the Secretary shall recognize the following separate population groups:

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

"(B) DISABLED.—Disabled individuals who are under 65 years of age and not described in subparagraph (C).

"(C) INDIVIDUALS WITH END STAGE RENAL DISEASE.—Individuals who are determined to have end stage renal disease.

"(c) PER CAPITA GROWTH RATES.—

"(1) FOR 1996.—

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

"(i) BELOW AVERAGE SERVICE UTILIZATION COHORT.—For areas assigned to the below average service utilization cohort, 11.5 percent.

"(ii) ABOVE AVERAGE SERVICE UTILIZATION COHORT.—For areas assigned to the above average service utilization cohort, 6.4 percent.

"(iii) HIGHEST SERVICE UTILIZATION COHORT.—For areas assigned to the highest service utilization cohort, 3.2 percent.

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

"(2) FOR SUBSEQUENT YEARS.—

"(A) IN GENERAL.—For purposes of this section and subject to subparagraph (B), the Secretary shall compute a per capita growth rate for each year after 1996, for each payment area as assigned to a service utilization cohort under subsection (d), consistent with the following rules:

"(i) BELOW AVERAGE SERVICE UTILIZATION COHORT SET AT 143 PERCENT OF NATIONAL AVERAGE PER CAPITA GROWTH

RATE.—The per capita growth rate for areas assigned to the below average service utilization cohort for the year shall be 143 percent of the national average per capita growth rate for the year (as specified under paragraph (3)).

''(ii) ABOVE AVERAGE SERVICE UTILIZATION COHORT SET AT 80 PERCENT OF NATIONAL AVERAGE PER CAPITA GROWTH RATE.—The per capita growth rate for areas assigned to the above average service utilization cohort for the year shall be 80 percent of the national average per capita growth rate for the year.

''(iii) HIGHEST SERVICE UTILIZATION COHORT SET AT 40 PERCENT OF NATIONAL AVERAGE PER CAPITA GROWTH RATE.—The per capita growth rate for areas assigned to the highest service utilization cohort for the year shall be 40 percent of the national average per capita growth rate for the year.

''(B) AVERAGE PER CAPITA GROWTH RATE AT NATIONAL AVERAGE TO ASSURE BUDGET NEUTRALITY.—The Secretary shall compute per

capita growth rates for a year under subparagraph (A) in a manner so that the weighted average per capita growth rate for all areas for the year (weighted to reflect the number of medicare beneficiaries in each area) is equal to the national average per capita growth rate under paragraph (3) for the year.

''(3) NATIONAL AVERAGE PER CAPITA GROWTH RATES.—In this subsection, the 'national average per capita growth rate' for—

''(A) 1996 is 8.0 percent,

''(B) 1997 is 7.5 percent,

''(C) 1998 is 7.0 percent,

''(D) 1999 is 7.0 percent,

''(E) 2000 is 7.0 percent,

''(F) 2001 is 7.0 percent,

''(G) 2002 is 6.0 percent, and

''(H) each subsequent year is 6.0 percent.

''(d) ASSIGNMENT OF PAYMENT AREAS TO SERVICE UTILIZATION COHORTS.—

''(1) IN GENERAL.—For purposes of determining per capita growth rates under subsection (c) for areas for a year, the Secretary shall assign each payment area to a service utilization cohort (based on

the service utilization index value for that area determined under paragraph (2)) as follows:

"(A) BELOW AVERAGE SERVICE UTILIZATION COHORT.—Areas with a service utilization index value of less than 1.00 shall be assigned to the below average service utilization cohort.

"(B) ABOVE AVERAGE SERVICE UTILIZATION COHORT.—Areas with a service utilization index value of at least 1.00 but less than 1.20 shall be assigned to the above average service utilization cohort.

"(C) HIGHEST SERVICE UTILIZATION COHORT.—Areas with a service utilization index value of at least 1.20 shall be assigned to the highest service utilization cohort.

"(2) DETERMINATION OF SERVICE UTILIZATION INDEX VALUES.—In order to determine the per capita growth rate for a payment area for each year (beginning with 1996), the Secretary shall determine for such area and year a service utilization index value, which is equal to—

"(A) the annual Medicare Choice capitation rate under this section for the area for the year in which the determination is made (or, in the case of 1996, the average annual per capita

rate of payment (described in section 1876(a)(1)(C)) for the area for 1995); divided by

''(B) the input-price-adjusted annual national Medicare Choice capitation rate (as determined under paragraph (3)) for that area for the year in which the determination is made.

''(3) DETERMINATION OF INPUT-PRICE-ADJUSTED RATES.—

''(A) IN GENERAL.—For purposes of paragraph (2), the 'input-price-adjusted annual national Medicare Choice capitation rate' for a payment area for a year is equal to the sum, for all the types of medicare services (as classified by the Secretary), of the product (for each such type) of—

''(i) the national standardized Medicare Choice capitation rate (determined under subparagraph (B)) for the year,

''(ii) the proportion of such rate for the year which is attributable to such type of services, and

''(iii) an index that reflects (for that year and that type of services) the relative input price of such services in the area

compared to the national average input price of such services.

In applying clause (iii), the Secretary shall, subject to subparagraph (C), apply those indices under this title that are used in applying (or updating) national payment rates for specific areas and localities.

''(B) NATIONAL STANDARDIZED MEDICARE CHOICE CAPITATION RATE.—In this paragraph, the 'national standardized Medicare Choice capitation rate' for a year is equal to—

''(i) the sum (for all payment areas) of the product of (I) the annual Medicare Choice capitation rate for that year for the area under subsection (b)(2), and (II) the average number of medicare beneficiaries residing in that area in the year; divided by

''(ii) the total average number of medicare beneficiaries residing in all the payment areas for that year.

''(C) SPECIAL RULES FOR 1996.—In applying this paragraph for 1996—

"(i) medicare services shall be divided into 2 types of services: part A services and part B services;

"(ii) the proportions described in subparagraph (A)(ii) for such types of services shall be—

"(I) for part A services, the ratio (expressed as a percentage) of the average annual per capita rate of payment for the area for part A for 1995 to the total average annual per capita rate of payment for the area for parts A and B for 1995, and

"(II) for part B services, 100 percent minus the ratio described in subclause (I);

"(iii) for the part A services, 70 percent of payments attributable to such services shall be adjusted by the index used under section 1886(d)(3)(E) to adjust payment rates for relative hospital wage levels for hospitals located in the payment area involved;

"(iv) for part B services—

"(I) 66 percent of payments attributable to such services shall be adjusted by the index of the geographic area factors under section 1848(e) used to adjust payment rates for physicians' services furnished in the payment area, and

"(II) of the remaining 34 percent of the amount of such payments, 70 percent shall be adjusted by the index described in clause (iii);

"(v) the index values shall be computed based only on the beneficiary population described in subsection (b)(5)(A).

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

"(e) PAYMENT PROCESS.—

"(1) IN GENERAL.—Subject to section 1859(f), the Secretary shall make monthly payments under this section in advance and in accordance with the rate determined under subsection (a) to the plan for each individual enrolled with a Medicare Choice organization under this part.

"(2) ADJUSTMENT TO REFLECT NUMBER OF ENROLLEES.—

"(A) IN GENERAL.—The amount of payment under this subsection may be retroactively adjusted to take into account any difference between the actual number of individuals enrolled with an organization under this part and the number of such individuals estimated to be so enrolled in determining the amount of the advance payment.

"(B) SPECIAL RULE FOR CERTAIN ENROLLEES.—

"(i) IN GENERAL.—Subject to clause (ii), the Secretary may make retroactive adjustments under subparagraph (A) to take into account individuals enrolled during the period beginning on the date on which the individual enrolls with a Medicare Choice organization under a product operated, sponsored, or contributed to by the individual's employer or former employer (or the employer or former employer of the individual's spouse) and ending on the date on which the individual is enrolled in the organization under this part, except

that for purposes of making such retroactive adjustments under this subparagraph, such period may not exceed 90 days.

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

"(f) PAYMENTS FROM TRUST FUND.—The payment to a Medicare Choice organization under this section for individuals enrolled under this part with the organization, and payments to a Medicare Choice MSA under subsection (f)(1)(B), shall be made from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund in such proportion as the Secretary determines reflects the relative weight that benefits under part A and under part B represents of the actuarial value of the total benefits under this title.

"(g) SPECIAL RULE FOR CERTAIN INPATIENT HOSPITAL STAYS.—In the case of an individual who is receiving inpatient hospital services from a subsection (d) hos-

pital (as defined in section 1886(d)(1)(B)) as of the effective date of the individual's—

''(1) election under this part of a Medicare Choice product offered by a Medicare Choice organization—

''(A) payment for such services until the date of the individual's discharge shall be made under this title through the Medicare Choice product or Non-Medicare Choice option (as the case may be) elected before the election with such organization,

''(B) the elected organization shall not be financially responsible for payment for such services until the date after the date of the individual's discharge, and

''(C) the organization shall nonetheless be paid the full amount otherwise payable to the organization under this part; or

''(2) termination of election with respect to a Medicare Choice organization under this part—

''(A) the organization shall be financially responsible for payment for such services after such date and until the date of the individual's discharge,

"(B) payment for such services during the stay shall not be made under section 1886(d) or by any succeeding Medicare Choice organization, and

"(C) the terminated organization shall not receive any payment with respect to the individual under this part during the period the individual is not enrolled.

"ESTABLISHMENT OF STANDARDS FOR MEDICARE CHOICE ORGANIZATIONS AND PRODUCTS

"SEC. 1856. (a) INTERIM STANDARDS.—

"(1) IN GENERAL.—The Secretary shall issue regulations regarding standards for Medicare Choice organizations and products within 180 days after the date of the enactment of this section. Such regulations shall be issued on an interim basis, but shall become effective upon publication and shall be effective through the end of 1999.

"(2) SOLICITATION OF VIEWS.—In developing standards under this subsection relating to solvency of Medicare Choice organizations, the Secretary shall solicit the views of the American Academy of Actuaries.

"(3) EFFECT ON STATE REGULATIONS.—Regulations under this subsection shall not preempt State

regulations for Medicare Choice organizations for products not offered under this part.

''(b) PERMANENT STANDARDS.—

''(1) IN GENERAL.—The Secretary shall develop permanent standards under this subsection.

''(2) CONSULTATION.—In developing standards under this subsection, the Secretary shall consult with the National Association of Insurance Commissioners, associations representing the various types of Medicare Choice organizations, and medicare beneficiaries.

''(3) EFFECTIVENESS.—The standards under this subsection shall take effect for periods beginning on or after January 1, 2000.

''(c) SOLVENCY.—In establishing interim and permanent standards under this section relating to solvency of organizations, the Secretary shall recognize the multiple means of demonstrating solvency, including—

''(1) reinsurance purchased through a recognized commerce company or through a capitive company owned directly or indirectly by 3 or more provider-sponsored organizations,

''(2) unrestricted surplus,

''(3) guarantees, and

''(4) letters of credit.

In such standards, the Secretary may treat as admitted assets the assets used by a provider-sponsored organization in delivering covered services.

''(d) APPLICATION OF NEW STANDARDS TO ENTITIES WITH A CONTRACT.—In the case of a Medicare Choice organization with a contract in effect under this part at the time standards applicable to the organization under this section are changed, the organization may elect not to have such changes apply to the organization until the end of the current contract year (or, if there is less than 6 months remaining in the contract year, until 1 year after the end of the current contract year).

''(e) RELATION TO STATE LAWS.—The standards established under this section shall supersede any State law. The standard or regulation with respect to Medicare Choice products which are offered by Medicare Choice organizations and are issued by organizations to which section 1851(b)(1) applies, to the extent such law or regulation is inconsistent with such standards.

''MEDICARE CHOICE CERTIFICATION

''SEC. 1857. (a) IN GENERAL.—

''(1) ESTABLISHMENT.—The Secretary shall establish a process for the certification of organizations and products offered by organizations as meeting the applicable standards for Medicare Choice or-

ganizations and Medicare Choice products established under section 1856.

''(2) INVOLVEMENT OF SECRETARY OF LABOR.—Such process shall be established and operated in cooperation with the Secretary of Labor with respect to union sponsors and Taft-Hartley sponsors.

''(3) USE OF STATE LICENSING AND PRIVATE ACCREDITATION PROCESSES.—

''(A) IN GENERAL.—The process under this subsection shall, to the maximum extent practicable, provide that Medicare Choice organizations and products that are licensed or certified through a qualified private accreditation process that the Secretary finds applies standards that are no less stringent than the requirements of this part are deemed to meet the corresponding requirements of this part for such an organization or product.

''(B) PERIODIC ACCREDITATION.—The use of an accreditation under subparagraph (A) shall be valid only for such period as the Secretary specifies.

''(4) USER FEES.—The Secretary may impose user fees on entities seeking certification under this

subsection in such amounts as the Secretary deems sufficient to finance the costs of such certification.

''(b) STATE CERTIFICATION PROCESS.—

''(1) APPROVAL OF STATE PROCESS.—Effective for periods beginning on or after January 1, 2000, the Secretary shall approve a Medicare Choice certification and enforcement program established by a State for applying the standards established under section 1856 to Medicare Choice organizations and Medicare Choice products offered by such organizations if the Secretary determines that the program fairly and efficiently provides for the application and enforcement of such standards in the State with respect to such organizations and products and such program does not provide for the imposition (for organizations only offering products under this part) of any standards in addition to the standards provided under section 1856. Such program shall provide for certification of compliance of Medicare Choice organizations and products with the applicable requirements of this part not less often than once every 3 years.

''(2) EFFECT OF CERTIFICATION UNDER STATE PROCESS.—A Medicare Choice organization and Medicare Choice product offered by such an organi-

zation that is certified under such program is considered to have been certified under this subsection with respect to the offering of the product to individuals residing in the State.

''(3) USER FEES.—The State may impose user fees on organizations seeking certification under this subsection in such amounts as the State deems sufficient to finance the costs of such certification. Nothing in this paragraph shall be construed as restricting a State's authority to impose premium taxes, other taxes, or other levies.

''(4) REVIEW.—The Secretary periodically shall review State programs approved under paragraph (1) to determine if they continue to provide for the fair and efficient certification and enforcement described in such paragraph. If the Secretary finds that a State program no longer so provides, before making a final determination, the Secretary shall provide the State an opportunity to adopt such a plan of correction as would permit the State program to meet the requirements of paragraph (1). If the Secretary makes a final determination that the State program, after such an opportunity, fails to meet such requirements, the provisions of paragraph

(2) shall no longer apply to Medicare Choice organizations and products in the State.

''(5) PUBLICATION OF LIST OF APPROVED STATE PROGRAMS.—The Secretary shall publish (and periodically update) a list of those State programs which are approved for purposes of this subsection.

''(c) NOTICE TO ENROLLEES IN CASE OF DECERTIFICATION.—If a Medicare Choice organization or product is decertified under this section, the organization shall notify each enrollee with the organization and product under this part of such decertification.

''(d) QUALIFIED ASSOCIATIONS.—In the case of Medicare Choice products offered by a Medicare Choice organization that is a qualified association (as defined in section 1854(c)(4)(C)) and issued by an organization to which section 1851(b)(1) applies or by a provider-sponsored organization (as defined in section 1854(a)), nothing in this section shall be construed as limiting the authority of States to regulate such products.

''CONTRACTS WITH MEDICARE CHOICE ORGANIZATIONS

''SEC. 1858. (a) IN GENERAL.—The Secretary shall not permit the election under section 1805 of a Medicare Choice product offered by a Medicare Choice organization under this part, and no payment shall be made under section 1856 to an organization, unless the Secretary has en-

tered into a contract under this section with an organization with respect to the offering of such product. Such a contract with an organization may cover more than one Medicare Choice product. Such contract shall provide that the organization agrees to comply with the applicable requirements and standards of this part and the terms and conditions of payment as provided for in this part.

''(b) ENROLLMENT REQUIREMENTS.—

''(A) MINIMUM ENROLLMENT REQUIREMENT.—Subject to subparagraphs (B) and (C), the Secretary may not enter into a contract under this section with a Medicare Choice organization (other than a union sponsor or Taft-Hartley sponsor) unless the organization has at least 5,000 individuals (or 1,500 individuals in the case of an organization that is a provider-sponsored organization) who are receiving health benefits through the organization, except that the standards under section 1856 may permit the organization to have a lesser number of beneficiaries (but not less than 500 in the case of an organization that is a provider-sponsored organization) if the organization primarily serves individuals residing outside of urbanized areas.

"(B) ALLOWING TRANSITION.—The Secretary may waive the requirement of subparagraph (A) during the first 3 contract years with respect to an organization.

"(C) TREATMENT OF AREAS WITH LOW MANAGED CARE PENETRATION.—The Secretary may waive the requirement of subparagraph (A) in the case of organizations operating in areas in which there is a low proportion of medicare beneficiaries who have made the Medicare Choice election.

"(2) REQUIREMENT FOR ENROLLMENT OF NON-MEDICARE BENEFICIARIES.—

"(A) IN GENERAL.—Each Medicare Choice organization with which the Secretary enters into a contract under this section shall have, for the duration of such contract, an enrolled membership at least one-half of which consists of individuals who are not entitled to benefits under this title or under a State plan approved under title XIX.

"(B) EXCEPTION.—Subparagraph (A) shall not apply to—

"(i) an organization that has been certified by a national organization recog-

nized by the Secretary and has been found to have met performance standards established by the Secretary for at least 2 years, or

''(ii) a provider-sponsored organization for which commercial payments to providers participating in the organization exceed the payments to the organization under this part.

''(C) MODIFICATION AND WAIVER.—The Secretary may modify or waive the requirement imposed by subparagraph (A)—

''(i) to the extent that more than 50 percent of the population of the area served by the organization consists of individuals who are entitled to benefits under this title or under a State plan approved under title XIX, or

''(ii) in the case of an organization that is owned and operated by a governmental entity, only with respect to a period of three years beginning on the date the organization first enters into a contract under this section, and only if the organization has taken and is making reasonable

efforts to enroll individuals who are not entitled to benefits under this title or under a State plan approved under title XIX.

''(D) ENFORCEMENT.—If the Secretary determines that an organization has failed to comply with the requirements of this paragraph, the Secretary may provide for the suspension of enrollment of individuals under this part or of payment to the organization under this part for individuals newly enrolled with the organization, after the date the Secretary notifies the organization of such noncompliance.

''(c) CONTRACT PERIOD AND EFFECTIVENESS.—

''(1) PERIOD.—Each contract under this section shall be for a term of at least one year, as determined by the Secretary, and may be made automatically renewable from term to term in the absence of notice by either party of intention to terminate at the end of the current term.

''(2) TERMINATION AUTHORITY.—In accordance with procedures established under subsection (h), the Secretary may at any time terminate any such contract or may impose the intermediate sanctions described in an applicable paragraph of sub-

section (g) on the Medicare Choice organization if the Secretary determines that the organization—

''(A) has failed substantially to carry out the contract;

''(B) is carrying out the contract in a manner inconsistent with the efficient and effective administration of this part;

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

''(D) no longer substantially meets the applicable conditions of this part.

''(3) EFFECTIVE DATE OF CONTRACTS.—The effective date of any contract executed pursuant to this section shall be specified in the contract.

''(4) PREVIOUS TERMINATIONS.—The Secretary may not enter into a contract with a Medicare Choice organization if a previous contract with that organization under this section was terminated at the request of the organization within the preceding five-year period, except in circumstances which warrant special consideration, as determined by the Secretary.

''(5) NO CONTRACTING AUTHORITY.—The authority vested in the Secretary by this part may be

performed without regard to such provisions of law or regulations relating to the making, performance, amendment, or modification of contracts of the United States as the Secretary may determine to be inconsistent with the furtherance of the purpose of this title.

''(d) PROTECTIONS AGAINST FRAUD AND BENEFICIARY PROTECTIONS.—

''(1) INSPECTION AND AUDIT.—Each contract under this section shall provide that the Secretary, or any person or organization designated by the Secretary—

''(A) shall have the right to inspect or otherwise evaluate (i) the quality, appropriateness, and timeliness of services performed under the contract and (ii) the facilities of the organization when there is reasonable evidence of some need for such inspection, and

''(B) shall have the right to audit and inspect any books and records of the Medicare Choice organization that pertain (i) to the ability of the organization to bear the risk of potential financial losses, or (ii) to services performed or determinations of amounts payable under the contract.

"(2) ENROLLEE NOTICE AT TIME OF TERMINATION.—Each contract under this section shall require the organization to provide (and pay for) written notice in advance of the contract's termination, as well as a description of alternatives for obtaining benefits under this title, to each individual enrolled with the organization under this part.

"(3) DISCLOSURE.—

"(A) IN GENERAL.—Each Medicare Choice organization shall, in accordance with regulations of the Secretary, report to the Secretary financial information which shall include the following:

"(i) Such information as the Secretary may require demonstrating that the organization has a fiscally sound operation.

"(ii) A copy of the report, if any, filed with the Health Care Financing Administration containing the information required to be reported under section 1124 by disclosing entities.

"(iii) A description of transactions, as specified by the Secretary, between the organization and a party in interest. Such transactions shall include—

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

"(II) any furnishing for consideration of goods, services (including management services), or facilities between the organization and a party in interest, but not including salaries paid to employees for services provided in the normal course of their employment and health services provided to members by hospitals and other providers and by staff, medical group (or groups), individual practice association (or associations), or any combination thereof; and

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

The Secretary may require that information reported respecting an organization which controls, is controlled by, or is under common control with, another entity be in the form of a consolidated financial statement for the organization and such entity.

"(B) PARTY IN INTEREST DEFINED.—For the purposes of this paragraph, the term 'party in interest' means—

"(i) any director, officer, partner, or employee responsible for management or administration of a Medicare Choice organization, any person who is directly or indirectly the beneficial owner of more than 5 percent of the equity of the organization, any person who is the beneficial owner of a mortgage, deed of trust, note, or other interest secured by, and valuing more than 5 percent of the organization, and, in the case of a Medicare Choice organization organized as a nonprofit corporation, an incorporator or member of such corporation under applicable State corporation law;

"(ii) any entity in which a person described in clause (i)—

"(I) is an officer or director;

"(II) is a partner (if such entity is organized as a partnership);

"(III) has directly or indirectly a beneficial interest of more than 5 percent of the equity; or

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

"(iii) any person directly or indirectly controlling, controlled by, or under common control with an organization; and

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

"(C) ACCESS TO INFORMATION.—Each Medicare Choice organization shall make the information reported pursuant to subparagraph (A) available to its enrollees upon reasonable request.

"(4) LOAN INFORMATION.—The contract shall require the organization to notify the Secretary of loans and other special financial arrangements which are made between the organization and subcontractors, affiliates, and related parties.

"(f) ADDITIONAL CONTRACT TERMS.—The contract shall contain such other terms and conditions not inconsistent with this part (including requiring the organization to provide the Secretary with such information) as the Secretary may find necessary and appropriate.

"(g) INTERMEDIATE SANCTIONS.—

"(1) IN GENERAL.—If the Secretary determines that a Medicare Choice organization with a contract under this section—

"(A) fails substantially to provide medically necessary items and services that are required (under law or under the contract) to be provided to an individual covered under the contract, if the failure has adversely affected (or has substantial likelihood of adversely affecting) the individual;

"(B) imposes premiums on individuals enrolled under this part in excess of the premiums permitted;

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

"(D) engages in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment (except as permitted by this part) by eligible individuals with the organization whose medical condition or history indicates a need for substantial future medical services;

"(E) misrepresents or falsifies information that is furnished—

"(i) to the Secretary under this part, or

"(ii) to an individual or to any other entity under this part;

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

"(G) employs or contracts with any individual or entity that is excluded from participation under this title under section 1128 or 1128A for the provision of health care, utilization review, medical social work, or administrative services or employs or contracts with any entity for the provision (directly or indirectly) through such an excluded individual or entity of such services;

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

"(2) REMEDIES.—The remedies described in this paragraph are—

"(A) civil money penalties of not more than $25,000 for each determination under paragraph (1) or, with respect to a determination under subparagraph (D) or (E)(i) of such paragraph, of not more than $100,000 for each

such determination, plus, with respect to a determination under paragraph (1)(B), double the excess amount charged in violation of such paragraph (and the excess amount charged shall be deducted from the penalty and returned to the individual concerned), and plus, with respect to a determination under paragraph (1)(D), $15,000 for each individual not enrolled as a result of the practice involved,

''(B) suspension of enrollment of individuals under this part after the date the Secretary notifies the organization of a determination under paragraph (1) and until the Secretary is satisfied that the basis for such determination has been corrected and is not likely to recur, or

''(C) suspension of payment to the organization under this part for individuals enrolled after the date the Secretary notifies the organization of a determination under paragraph (1) and until the Secretary is satisfied that the basis for such determination has been corrected and is not likely to recur.

''(3) OTHER INTERMEDIATE SANCTIONS.—In the case of a Medicare Choice organization for which

the Secretary makes a determination under subsection (c)(2) the basis of which is not described in paragraph (1), the Secretary may apply the following intermediate sanctions:

''(A) civil money penalties of not more than $25,000 for each determination under subsection (c)(2) if the deficiency that is the basis of the determination has directly adversely affected (or has the substantial likelihood of adversely affecting) an individual covered under the organization's contract;

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

''(C) suspension of enrollment of individuals under this part after the date the Secretary notifies the organization of a determination under subsection (c)(2) and until the Secretary is satisfied that the deficiency that is the basis for the determination has been corrected and is not likely to recur.

"(4) PROCEDURES FOR IMPOSING SANCTIONS.—The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under paragraph (1) or (2) in the same manner as they apply to a civil money penalty or proceeding under section 1128A(a).

"(h) PROCEDURES FOR IMPOSING SANCTIONS.—The Secretary may terminate a contract with a Medicare Choice organization under this section or may impose the intermediate sanctions described in subsection (g) on the organization in accordance with formal investigation and compliance procedures established by the Secretary under which—

"(1) the Secretary provides the organization with the opportunity to develop and implement a corrective action plan to correct the deficiencies that were the basis of the Secretary's determination under subsection (c)(2);

"(2) the Secretary shall impose more severe sanctions on organizations that have a history of deficiencies or that have not taken steps to correct deficiencies the Secretary has brought to their attention;

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

"(4) the Secretary provides the organization with reasonable notice and opportunity for hearing (including the right to appeal an initial decision) before imposing any sanction or terminating the contract.

"DEMONSTRATION PROJECT FOR HIGH DEDUCTIBLE/MEDISAVE PRODUCTS

"SEC. 1859. (a) IN GENERAL.—The Secretary shall permit, on a demonstration project basis, the offering of high deductible/medisave products under this part, subject to the special rules provided under this section.

"(b) HIGH DEDUCTIBLE/MEDISAVE PRODUCT DEFINED.—

"(1) IN GENERAL.—In this part, the term 'high deductible/medisave product' means a Medicare Choice product that—

"(A) provides reimbursement for at least the items and services described in section 1852(a)(1) in a year but only after the enrollee incurs countable expenses (as specified under the product) equal to the amount of a deductible (described in paragraph (2));

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

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

"(i) 100 percent of such expenses, or

"(ii) 100 percent of the amounts that would have been paid (without regard to any deductibles or coinsurance) under parts A and B with respect to such expenses,

whichever is less. Such term does not include the Medicare Choice MSA itself or any contribution into such account.

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

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

"(B) for a subsequent contract year shall be not more than the maximum amount of such deductible for the previous contract year under this paragraph increased by the national average per capita growth rate under section 1855(c)(3) for the year.

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

"(c) SPECIAL RULES RELATING TO ENROLLMENT.—The rule under section 1805 relating to election of Medicare Choice products shall apply to election of high deductible/medisave products offered under the demonstration project under this section, except as follows:

"(1) SPECIAL RULE FOR CERTAIN ANNUITANTS.—An individual is not eligible to elect a high deductible/medisave product under section 1805 if the individual is entitled to benefits under chapter 89 of title 5, United States Code, as an annuitant or spouse of an annuitant.

"(2) TRANSITION PERIOD RULE.—During the transition period (as defined in section 1805(e)(1)(B)), an individual who has elected a high deductible/medisave product may not change such election to a Medicare Choice product that is not a

high deductible/medisave product unless the individual has had such election in effect for 12 months.

''(3) NO 90-DAY DISENROLLMENT OPTION.—Paragraph (4)(A) of section 1805(e) shall not apply to an individual who elects a high deductible/medisave product.

''(4) TIMING OF ELECTION.—An individual may elect a high deductible/medisave product only during an annual, coordinated election period described in section 1805(e)(3)(B) or during the month of October, 1996.

''(5) EFFECTIVENESS OF ELECTION.—An election of coverage for a high deductible/medisave product made in a year shall take effect as of the first day of the following year.

''(d) SPECIAL RULES RELATING TO BENEFITS.—

''(1) IN GENERAL.—Paragraphs (1) and (3) of section 1852(a) shall not apply to high deductible/medisave products.

''(2) PREMIUMS.—

''(A) APPLICATION OF ALTERNATIVE PREMIUM.—In applying section 1852(d)(2) in the case of a high deductible/medisave product, instead of the amount specified in subparagraph (B) there shall be substituted the monthly ad-

justed Medicare Choice capitation rate specified in section 1855(b)(1) for the individual and period involved.

"(B) CLASS ADJUSTED PREMIUMS.—Notwithstanding section 1852(d)(3), a Medicare Choice organization shall establish premiums for any high deductible/medisave product it offers in a payment area based on each of the risk adjustment categories established for purposes of determining the amount of the payment to Medicare Choice organizations under section 1855(b)(1) and using the identical demographic and other adjustments among such categories as are used for such purposes.

"(C) REQUIREMENT FOR ADDITIONAL BENEFITS NOT APPLICABLE.—Section 1852(e)(1)(A) shall not apply to a high deductible/medisave product.

"(e) ADDITIONAL DISCLOSURE.—In any disclosure made pursuant to section 1853(a)(1) for a high deductible/medisave product, the disclosure shall include a comparison of benefits under such a product with benefits under other Medicare Choice products.

"(f) SPECIAL RULES FOR INDIVIDUALS ELECTING HIGH DEDUCTIBLE/MEDISAVE PRODUCT.—

"(1) IN GENERAL.—In the case of an individual who has elected a high deductible/medisave product, notwithstanding the provisions of section 1855—

"(A) the amount of the payment to the Medicare Choice organization offering the high deductible/medisave product shall not exceed the premium for the product, and

"(B) subject to paragraph (2), the difference between the amount of payment that would otherwise be made and the amount of payment to such organization shall be made directly into a Medicare Choice MSA established (and, if applicable, designated) by the individual under paragraph (2).

"(2) ESTABLISHMENT AND DESIGNATION OF MEDICARE CHOICE MEDICAL SAVINGS ACCOUNT AS REQUIREMENT FOR PAYMENT OF CONTRIBUTION.—In the case of an individual who has elected coverage under a high deductible/medisave product, no payment shall be made under paragraph (1)(B) on behalf of an individual for a month unless the individual—

"(A) has established before the beginning of the month (or by such other deadline as the Secretary may specify) a Medicare Choice MSA

(as defined in section 137(b) of the Internal Revenue Code of 1986), and

''(B) if the individual has established more than one Medicare Choice MSA, has designated one of such accounts as the individual's Medicare Choice MSA for purposes of this part.

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

''(3) LUMP SUM DEPOSIT OF MEDICAL SAVINGS ACCOUNT CONTRIBUTION.—In the case of an individual electing a high deductible/medisave product effective beginning with a month in a year, the amount of the contribution to the Medicare Choice MSA on behalf of the individual for that month and all successive months in the year shall be deposited during that first month. In the case of a termination of such an election as of a month before the end of a year, the Secretary shall provide for a procedure for the recovery of deposits attributable to the remaining months in the year.

''(g) SPECIAL CONTRACT RULES.—

''(1) ENROLLMENT REQUIREMENTS WAIVED.—Subsection (b) of section 1858 shall not apply with

respect to a contract that relates only to one or more high deductible/medisave products.

''(2) EFFECTIVE DATE OF CONTRACTS.—In no case shall a contract under section 1858 which provides for coverage under a high deductible/medisave account be effective before January 1997 with respect to such coverage.''.

(b) CONFORMING REFERENCES TO PREVIOUS PART C.—Any reference in law (in effect before the date of the enactment of this Act) to part C of title XVIII of the Social Security Act is deemed a reference to part D of such title (as in effect after such date).

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

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

(1) in paragraph (1)—

(A) by inserting ''1853(g),'' after ''1833(s),'', and

(B) by inserting '', Medicare Choice organization,'' after ''provider of services'', and

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

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

(e) CONFORMING AMENDMENT.—Section 1866(a)(1)(O) (42 U.S.C. 1395cc(a)(1)(O)) is amended by inserting before the semicolon at the end the following: ''and in the case of hospitals to accept as payment in full for inpatient hospital services that are covered under this title and are furnished to any individual enrolled under part C with a Medicare Choice organization which does not have a contract establishing payment amounts for services furnished to members of the organization the amounts that would be made as a payment in full under this title if the individuals were not so enrolled''.

SEC. 15003. REPORTS.

(a) ALTERNATIVE PAYMENT APPROACHES.—By not later than ____, the Secretary of Health and Human Services (in this title referred to as the ''Secretary'') shall submit to Congress a report on alternative provider payment approaches under the medicare program, including—

(1) combined hospital and physician payments per admission,

(2) partial capitation models for subsets of medicare benefits, and

(3) risk-sharing arrangements in which the Secretary defines the risk corridor and shares in gains and losses.

Such report shall include recommendations for implementing and testing such approaches and legislation that may be required to implement and test such approaches.

(b) COVERAGE OF RETIRED WORKERS.—

(1) IN GENERAL.—The Secretary shall work with employers and health benefit plans to develop standards and payment methodologies to allow retired workers to continue to participate in employer health plans instead of participating in the medicare program. Such standards shall also cover workers covered under the Federal Employees Health Benefits Program under chapter 89 of title 5, United States Code.

(2) REPORT.—Not later than 18 months after the date of the enactment of this Act, the Secretary shall submit to Congress a report on the development of such standards and payment methodologies. The report shall include recommendations relating to such legislation as may be necessary.

SEC. 15004. TRANSITIONAL RULES FOR CURRENT MEDICARE HMO PROGRAM.

(a) TRANSITION FROM CURRENT CONTRACTS.—

(1) LIMITATION ON NEW CONTRACTS.—

(A) NO NEW RISK-SHARING CONTRACTS AFTER NEW STANDARDS ESTABLISHED.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall not enter into any risk-sharing contract under section 1876 of the Social Security Act with an eligible organization for any contract year beginning on or after the date standards for Medicare Choice organizations and products are first established under section 1856(a) of such Act with respect to Medicare Choice organizations that are insurers or health maintenance organizations unless such a contract had been in effect under section 1876 of such Act for the organization for the previous contract year.

(B) NO NEW COST REIMBURSEMENT CONTRACTS.—The Secretary shall not enter into any cost reimbursement contract under section 1876 of the Social Security Act beginning for any contract year beginning on or after the date of the enactment of this Act.

(2) TERMINATION OF CURRENT CONTRACTS.—

(A) RISK-SHARING CONTRACTS.—Notwithstanding any other provision of law, the Secretary shall not extend or continue any risk-sharing contract with an eligible organization under section 1876 of the Social Security Act (for which a contract was entered into consistent with paragraph (1)(A)) for any contract year beginning on or after 1 year after the date standards described in paragraph (1)(A) are established.

(B) COST REIMBURSEMENT CONTRACTS.—The Secretary shall not extend or continue any reasonable cost reimbursement contract with an eligible organization under section 1876 of the Social Security Act for any contract year beginning on or after January 1, 1998.

(b) CONFORMING PAYMENT RATES.—

(1) RISK-SHARING CONTRACTS.—Notwithstanding any other provision of law, the Secretary shall provide that payment amounts under risk-sharing contracts under section 1876(a) of the Social Security Act for months in a year (beginning with January 1996) shall be computed—

(A) with respect to individuals entitled to benefits under both parts A and B of title XVIII of such Act, by substituting payment rates under section 1855(a) of such Act for the payment rates otherwise established under section 1876(a) of such Act, and

(B) with respect to individuals only entitled to benefits under part B of such title, by substituting an appropriate proportion of such rates (reflecting the relative proportion of payments under such title attributable to such part) for the payment rates otherwise established under section 1876(a) of such Act.

For purposes of carrying out this paragraph for payment for months in 1996, the Secretary shall compute, announce, and apply the payment rates under section 1855(a) of such Act (notwithstanding any deadlines specified in such section) in as timely a manner as possible and may (to the extent necessary) provide for retroactive adjustment in payments made not in accordance with such rates.

(2) COST CONTRACTS.—Notwithstanding any other provision of law, the Secretary shall provide that payment amounts under cost reimbursement contracts under section 1876(a) of the Social Secu-

rity Act shall take into account adjustments in payment amounts made in parts A and B of title XVIII of such Act pursuant to the amendments made by this title.

PART 2—SPECIAL RULES FOR MEDICARE CHOICE MEDICAL SAVINGS ACCOUNTS

SEC. 15011. MEDICARE CHOICE 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. MEDICARE CHOICE MSA'S.

''(a) EXCLUSION.—Gross income shall not include any payment to the Medicare Choice MSA of an individual by the Secretary of Health and Human Services under section 1859(f)(1)(B) of the Social Security Act.

''(b) MEDICARE CHOICE MSA.—For purposes of this section—

''(1) MEDICARE CHOICE MSA.—The term 'Medicare Choice MSA' means a trust created or organized in the United States exclusively for the purpose of paying the qualified medical expenses of the account holder, but only if the written governing in-

strument creating the trust meets the following requirements:

''(A) Except in the case of a trustee-to-trustee transfer described in subsection (d)(4), no contribution will be accepted unless it is made by the Secretary of Health and Human Services under section 1859(f)(1)(B) of the Social Security Act.

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

''(C) No part of the trust assets will be invested in life insurance contracts.

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

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

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

"(2) QUALIFIED MEDICAL EXPENSES.—

"(A) IN GENERAL.—The term 'qualified medical expenses' means, with respect to an account holder, amounts paid by such holder—

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

"(ii) for long-term care insurance for the account holder.

"(B) HEALTH INSURANCE MAY NOT BE PURCHASED FROM ACCOUNT.—Subparagraph (A)(i) shall not apply to any payment for insurance.

"(3) ACCOUNT HOLDER.—The term 'account holder' means the individual on whose behalf the Medicare Choice MSA is maintained.

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

"(c) TAX TREATMENT OF ACCOUNTS.—

"(1) IN GENERAL.—A Medicare Choice MSA is exempt from taxation under this subtitle unless such MSA has ceased to be a Medicare Choice MSA by reason of paragraph (2). Notwithstanding the preceding sentence, any such MSA is subject to the taxes imposed by section 511 (relating to imposition of tax on unrelated business income of charitable, etc. organizations).

"(2) ACCOUNT ASSETS TREATED AS DISTRIBUTED IN THE CASE OF PROHIBITED TRANSACTIONS OR ACCOUNT PLEDGED AS SECURITY FOR LOAN.—Rules similar to the rules of paragraphs (2) and (4) of section 408(e) shall apply to Medicare Choice MSA's, and any amount treated as distributed under such rules shall be treated as not used to pay qualified medical expenses.

"(d) TAX TREATMENT OF DISTRIBUTIONS.—

"(1) INCLUSION OF AMOUNTS NOT USED FOR QUALIFIED MEDICAL EXPENSES.—No amount shall be included in the gross income of the account holder by reason of a payment or distribution from a Medicare Choice MSA which is used exclusively to pay the qualified medical expenses of the account holder. Any amount paid or distributed from a Medi-

care Choice MSA which is not so used shall be included in the gross income of such holder.

''(2) PENALTY FOR DISTRIBUTIONS NOT USED FOR QUALIFIED MEDICAL EXPENSES IF MINIMUM BALANCE NOT MAINTAINED.—

''(A) IN GENERAL.—The tax imposed by this chapter for any taxable year in which there is a payment or distribution from a Medicare Choice MSA which is not used exclusively to pay the qualified medical expenses of the account holder shall be increased by 50 percent of the excess (if any) of—

''(i) the amount of such payment or distribution, over

''(ii) the excess (if any) of—

''(I) the fair market value of the assets in the Medicare Choice MSA as of the close of the calendar year preceding the calendar year in which the taxable year begins, over

''(II) an amount equal to 60 percent of the deductible under the catastrophic health plan covering the account holder as of January 1 of the

calendar year in which the taxable year begins.

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

''(i) becomes disabled within the meaning of section 72(m)(7), or

''(ii) dies.

''(C) SPECIAL RULES.—For purposes of subparagraph (A)—

''(i) all Medicare Choice MSA's of the account holder shall be treated as 1 account,

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

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

''(3) WITHDRAWAL OF ERRONEOUS CONTRIBUTIONS.—Paragraphs (1) and (2) shall not apply to any payment or distribution from a Medicare Choice MSA to the Secretary of Health and Human Serv-

ices of an erroneous contribution to such MSA and of the net income attributable to such contribution.

"(4) TRUSTEE-TO-TRUSTEE TRANSFERS.—Paragraphs (1) and (2) shall not apply to any trustee-to-trustee transfer from a Medicare Choice MSA of an account holder to another Medicare Choice MSA of such account holder.

"(5) COORDINATION WITH MEDICAL EXPENSE DEDUCTION.—For purposes of section 213, any payment or distribution out of a Medicare Choice MSA for qualified medical expenses shall not be treated as an expense paid for medical care.

"(e) TREATMENT OF ACCOUNT AFTER DEATH OF ACCOUNT HOLDER.—

"(1) TREATMENT IF DESIGNATED BENEFICIARY IS SPOUSE.—

"(A) IN GENERAL.—In the case of an account holder's interest in a Medicare Choice MSA which is payable to (or for the benefit of) such holder's spouse upon the death of such holder, such Medicare Choice MSA shall be treated as a Medicare Choice MSA of such spouse as of the date of such death.

"(B) SPECIAL RULES IF SPOUSE NOT MEDICARE ELIGIBLE.—If, as of the date of such

death, such spouse is not entitled to benefits under title XVIII of the Social Security Act, then after the date of such death—

''(i) the Secretary of Health and Human Services may not make any payments to such Medicare Choice MSA, other than payments attributable to periods before such date,

''(ii) in applying subsection (b)(2) with respect to such Medicare Choice MSA, references to the account holder shall be treated as including references to any dependent (as defined in section 152) of such spouse and any subsequent spouse of such spouse, and

''(iii) in lieu of applying subsection (d)(2), the rules of section 220(f)(2) shall apply.

''(2) TREATMENT IF DESIGNATED BENEFICIARY IS NOT SPOUSE.—In the case of an account holder's interest in a Medicare Choice MSA which is payable to (or for the benefit of) any person other than such holder's spouse upon the death of such holder—

''(A) such account shall cease to be a Medicare Choice MSA as of the date of death, and

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

"(i) if such person is not the estate of such holder, in such person's gross income for the taxable year which includes such date, or

"(ii) if such person is the estate of such holder, in such holder's gross income for last taxable year of such holder.

"(f) REPORTS.—

"(1) IN GENERAL.—The trustee of a Medicare Choice MSA shall make such reports regarding such account to the Secretary and to the account holder with respect to—

"(A) the fair market value of the assets in such Medicare Choice MSA as of the close of each calendar year, and

"(B) contributions, distributions, and other matters,

as the Secretary may require by regulations.

"(2) TIME AND MANNER OF REPORTS.—The reports required by this subsection—

''(A) shall be filed at such time and in such manner as the Secretary prescribes in such regulations, and

''(B) shall be furnished to the account holder—

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

''(ii) in such manner as the Secretary prescribes in such regulations.''

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

''SEC. 2057. MEDICARE CHOICE MSA'S.

''For purposes of the tax imposed by section 2001, the value of the taxable estate shall be determined by deducting from the value of the gross estate an amount equal to the value of any Medicare Choice MSA (as defined in section 137(b)) included in the gross estate.''

(c) TAX ON PROHIBITED TRANSACTIONS.—

(1) Section 4975 of such Code (relating to tax on prohibited transactions) is amended by adding at the end of subsection (c) the following new paragraph:

"(5) SPECIAL RULE FOR MEDICARE CHOICE MSA'S.—An individual for whose benefit a Medicare Choice MSA (within the meaning of section 137(b)) is established shall be exempt from the tax imposed by this section with respect to any transaction concerning such account (which would otherwise be taxable under this section) if, with respect to such transaction, the account ceases to be a Medicare Choice MSA by reason of the application of section 137(c)(2) to such account."

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

"(1) PLAN.—For purposes of this section, the term 'plan' means—

"(A) a trust described in section 401(a) which forms a part of a plan, or a plan described in section 403(a), which trust or plan is exempt from tax under section 501(a),

"(B) an individual retirement account described in section 408(a),

"(C) an individual retirement annuity described in section 408(b),

"(D) a medical savings account described in section 220(d),

''(E) a Medicare Choice MSA described in section 137(b), or

''(F) a trust, plan, account, or annuity which, at any time, has been determined by the Secretary to be described in any preceding subparagraph of this paragraph.''

(d) FAILURE TO PROVIDE REPORTS ON MEDICARE CHOICE MSA'S.—

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

''(a) REPORTS.—

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

''(2) PROVISIONS.—The provisions referred to in this paragraph are—

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

''(B) section 220(h) (relating to medical savings accounts), and

''(C) section 137(f) (relating to Medicare Choice MSA's).''

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

"SEC. 6693. FAILURE TO FILE REPORTS ON INDIVIDUAL RETIREMENT PLANS AND CERTAIN OTHER TAX-FAVORED ACCOUNTS; PENALTIES RELATING TO DESIGNATED NONDEDUCTIBLE CONTRIBUTIONS."

(e) CLERICAL AMENDMENTS.—

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

''Sec. 137. Medicare Choice MSA's.
''Sec. 138. Cross references to other Acts.''

(2) The table of sections for subchapter B of chapter 68 of such Code is amended by striking the item relating to section 6693 and inserting the following new item:

''Sec. 6693. Failure to file reports on individual retirement plans and certain other tax-favored accounts; penalties relating to designated nondeductible contributions.''

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

''Sec. 2057. Medicare Choice MSA's.''

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

SEC. 15012. CERTAIN REBATES EXCLUDED FROM GROSS INCOME.

(a) IN GENERAL.—Section 105 of the Internal Revenue Code of 1986 (relating to amounts received under accident and health plans) is amended by adding at the end the following new subsection:

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

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

PART 3—SPECIAL ANTITRUST RULE FOR PROVIDER SERVICE NETWORKS

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

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

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

cluding the establishment and modification of a fee schedule and the development of a panel of physicians), to the extent such contract is for the purpose of providing health care services to individuals under the terms of a Medicare Choice PSO product, and

(2) the conduct of any member of such network for the purpose of providing such health care services under such contract to such extent,

shall not be deemed illegal per se. Such conduct shall be judged on the basis of its reasonableness, taking into account all relevant factors affecting competition, including the effects on competition in properly defined markets.

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

(1) ANTITRUST LAWS.—The term ''antitrust laws'' has the meaning given it in subsection (a) of the first section of the Clayton Act (15 U.S.C. 12), except that such term includes section 5 of the Federal Trade Commission Act (15 U.S.C. 45) to the extent that such section 5 applies to unfair methods of competition.

(2) HEALTH CARE PROVIDER.—The term ''health care provider'' means any individual or entity that is engaged in the delivery of health care services in a State and that is required by State law or regulation to be licensed or certified by the State

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

(3) HEALTH CARE SERVICE.—The term ''health care service'' means any service for which payment may be made under a Medicare Choice PSO product including services related to the delivery or administration of such service.

(4) MEDICARE CHOICE PROGRAM.—The term ''Medicare Choice program'' means the program under part C of title XVIII of the Social Security Act.

(5) MEDICARE CHOICE PSO PRODUCT.—The term ''Medicare Choice PSO product'' means a Medicare Choice product offered by a provider-sponsored organization under part C of title XVIII of the Social Security Act.

(6) PROVIDER SERVICE NETWORK.—The term ''provider service network'' means an organization that—

(A) is organized by, operated by, and composed of members who are health care providers and for purposes that include providing health care services,

(B) is funded in part by capital contributions made by the members of such organization,

(C) with respect to each contract made by such organization for the purpose of providing a type of health care service to individuals under the terms of a Medicare Choice PSO product—

(i) requires all members of such organization who engage in providing such type of health care service to agree to provide health care services of such type under such contract,

(ii) receives the compensation paid for the health care services of such type provided under such contract by such members, and

(iii) provides for the distribution of such compensation,

(D) has established, consistent with the requirements of the Medicare Choice program for provider-sponsored organizations, a program to review, pursuant to written guidelines, the quality, efficiency, and appropriateness of treatment methods and setting of services for all health

care providers and all patients participating in such product, along with internal procedures to correct identified deficiencies relating to such methods and such services,

(E) has established, consistent with the requirements of the Medicare Choice program for provider-sponsored organizations, a program to monitor and control utilization of health care services provided under such product, for the purpose of improving efficient, appropriate care and eliminating the provision of unnecessary health care services,

(F) has established a management program to coordinate the delivery of health care services for all health care providers and all patients participating in such product, for the purpose of achieving efficiencies and enhancing the quality of health care services provided, and

(G) has established, consistent with the requirements of the Medicare Choice program for provider-sponsored organizations, a grievance and appeal process for such organization designed to review and promptly resolve beneficiary or patient grievances and complaints.

Such term may include a provider-sponsored organization.

(7) PROVIDER-SPONSORED ORGANIZATION.—The term ''provider-sponsored organization'' means a Medicare Choice organization under the Medicare Choice program that is a provider-sponsored organization (as defined in section ____ of the Social Security Act).

(8) STATE.—The term ''State'' has the meaning given it in section 4G(2) of the Clayton Act (15 U.S.C. 15g(2)).

(c) ISSUANCE OF GUIDELINES.—Not later than 120 days after the date of the enactment of this Act, the Attorney General and the Federal Trade Commission shall issue jointly guidelines specifying the enforcement policies and analytical principles that will be applied by the Department of Justice and the Commission with respect to the operation of subsection (a).

PART 4—COMMISSIONS

SEC. 15031. MEDICARE PAYMENT REVIEW COMMISSION.

(a) IN GENERAL.—Title XVIII, as amended by section 8001(a), is amended by inserting after section 1805 the following new section:

1 ''MEDICARE PAYMENT REVIEW COMMISSION

2 ''SEC. 1806. (a) ESTABLISHMENT.—There is hereby
3 established the Medicare Payment Review Commission (in
4 this section referred to as the 'Commission').

5 ''(b) DUTIES.—

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

20 ''(2) SPECIFIC DUTIES RELATING TO MEDICARE
21 CHOICE PROGRAM.—Specifically, the Commission
22 shall review, with respect to the Medicare Choice
23 program under part C—

24 ''(A) the appropriateness of the methodol-
25 ogy for making payment to plans under such

program, including the making of differential payments and the distribution of differential updates among different payment areas,

''(B) the appropriateness of the mechanisms used to adjust payments for risk and the need to adjust such mechanisms to take into account health status of beneficiaries,

''(C) the implications of risk selection both among Medicare Choice organizations and between the Medicare Choice option and the non-Medicare Choice option,

''(D) in relation to payment under part C, the development and implementation of mechanisms to assure the quality of care for those enrolled with Medicare Choice organizations,

''(F) the impact of the Medicare Choice program on access to care for medicare beneficiaries, and

''(G) other major issues in implementation and further development of the Medicare Choice program.

''(3) SPECIFIC DUTIES RELATING TO THE FEE-FOR-SERVICE SYSTEM.—Specifically, the Commission shall review payment policies under parts A and B, including—

1 ''(A) the factors affecting expenditures for
2 services in different sectors, including the proc-
3 ess for updating hospital, physician, and other
4 fees,
5 ''(B) payment methodologies; and
6 ''(C) the impact of payment policies on ac-
7 cess and quality of care for medicare bene-
8 ficiaries.
9 ''(4) SPECIFIC DUTIES RELATING TO INTER-
10 ACTION OF PAYMENT POLICIES WITH HEALTH CARE
11 DELIVERY GENERALLY.—Specifically the Commis-
12 sion shall review the effect of payment policies under
13 this title on the delivery of health care services
14 under this title and assess the implications of
15 changes in the health services market on the medi-
16 care program.
17 ''(c) MEMBERSHIP.—
18 ''(1) NUMBER AND APPOINTMENT.—The Com-
19 mission shall be composed of 15 members appointed
20 by the Comptroller General.
21 ''(2) QUALIFICATIONS.—The membership of the
22 Commission shall include individuals with national
23 recognition for their expertise in health finance and
24 economics, actuarial science, health facility manage-
25 ment, health plans and integrated delivery systems,

reimbursement of health facilities, physicians, and other providers of services, and other related fields, who provide a mix of different professionals, broad geographic representation, and a balance between urban and rural representatives, including physicians and other health professionals, employers, third party payors, individuals skilled in the conduct and interpretation of biomedical, health services, and health economics research and expertise in outcomes and effectiveness research and technology assessment. Such membership shall also include representatives of consumers and the elderly.

''(3) CONSIDERATIONS IN INITIAL APPOINTMENT.—To the extent possible, in first appointing members to the Commission the Comptroller General shall consider appointing individuals who (as of the date of the enactment of this section) were serving on the Prospective Payment Assessment Commission or the Physician Payment Review Commission.

''(4) TERMS.—

''(A) IN GENERAL.—The terms of members of the Commission shall be for 3 years except that the Comptroller General shall des-

ignate staggered terms for the members first appointed.

''(B) VACANCIES.—Any member appointed to fill a vacancy occurring before the expiration of the term for which the member's predecessor was appointed shall be appointed only for the remainder of that term. A member may serve after the expiration of that member's term until a successor has taken office. A vacancy in the Commission shall be filled in the manner in which the original appointment was made.

''(5) COMPENSATION.—While serving on the business of the Commission (including traveltime), a member of the Commission shall be entitled to compensation at the per diem equivalent of the rate provided for level IV of the Executive Schedule under section 5315 of title 5, United States Code; and while so serving away from home and member's regular place of business, a member may be allowed travel expenses, as authorized by the Chairman of the Commission. Physicians serving as personnel of the Commission may be provided a physician comparability allowance by the Commission in the same manner as Government physicians may be provided such an allowance by an agency under section 5948

of title 5, United States Code, and for such purpose subsection (i) of such section shall apply to the Commission in the same manner as it applies to the Tennessee Valley Authority. For purposes of pay (other than pay of members of the Commission) and employment benefits, rights, and privileges, all personnel of the Commission shall be treated as if they were employees of the United States Senate.

''(6) CHAIRMAN; VICE CHAIRMAN.—The Comptroller General shall designate a member of the Commission, at the time of appointment of the member, as Chairman and a member as Vice Chairman for that term of appointment.

''(7) MEETINGS.—The Commission shall meet at the call of the Chairman.

''(d) DIRECTOR AND STAFF; EXPERTS AND CONSULTANTS.—Subject to such review as the Comptroller General deems necessary to assure the efficient administration of the Commission, the Commission may—

''(1) employ and fix the compensation of an Executive Director (subject to the approval of the Comptroller General) and such other personnel as may be necessary to carry out its duties (without regard to the provisions of title 5, United States Code, governing appointments in the competitive service);

''(2) seek such assistance and support as may be required in the performance of its duties from appropriate Federal departments and agencies;

''(3) enter into contracts or make other arrangements, as may be necessary for the conduct of the work of the Commission (without regard to section 3709 of the Revised Statutes (41 U.S.C. 5));

''(4) make advance, progress, and other payments which relate to the work of the Commission;

''(5) provide transportation and subsistence for persons serving without compensation; and

''(6) prescribe such rules and regulations as it deems necessary with respect to the internal organization and operation of the Commission.

''(e) POWERS.—

''(1) OBTAINING OFFICIAL DATA.—The Commission may secure directly from any department or agency of the United States information necessary to enable it to carry out this section. Upon request of the Chairman, the head of that department or agency shall furnish that information to the Commission on an agreed upon schedule.

''(2) DATA COLLECTION.—In order to carry out its functions, the Commission shall collect and assess information to—

''(A) utilize existing information, both published and unpublished, where possible, collected and assessed either by its own staff or under other arrangements made in accordance with this section,

''(B) carry out, or award grants or contracts for, original research and experimentation, where existing information is inadequate, and

''(C) adopt procedures allowing any interested party to submit information for the Commission's use in making reports and recommendations.

''(3) ACCESS OF GAO TO INFORMATION.—The Comptroller General shall have unrestricted access to all deliberations, records, and data of the Commission, immediately upon request.

''(4) PERIODIC AUDIT.—The Commission shall be subject to periodic audit by the General Accounting Office.

''(f) AUTHORIZATION OF APPROPRIATIONS.—

''(1) REQUEST FOR APPROPRIATIONS.—The Commission shall submit requests for appropriations in the same manner as the Comptroller General submits requests for appropriations, but amounts ap-

propriated for the Commission shall be separate from amounts appropriated for the Comptroller General.

''(2) AUTHORIZATION.—There are authorized to be appropriated such sums as may be necessary to carry out the provisions of this section. 60 percent of such appropriation shall be payable from the Federal Hospital Insurance Trust Fund, and 40 percent of such appropriation shall be payable from the Federal Supplementary Medical Insurance Trust Fund.''.

(b) ABOLITION OF PROPAC AND PPRC.—

(1) PROPAC.—

(A) IN GENERAL.—Section 1886(e) (42 U.S.C. 1395ww(e)) is amended—

(i) by striking paragraphs (2) and (6); and

(ii) in paragraph (3), by striking ''(A) The Commission'' and all that follows through ''(B)''.

(B) CONFORMING AMENDMENT.—Section 1862 (42 U.S.C. 1395y) is amended by striking ''Prospective Payment Assessment Commission'' each place it appears in subsection

(a)(1)(D) and subsection (i) and inserting ''Medicare Payment Review Commission''.

(2) PPRC.—

(A) IN GENERAL.—Title XVIII is amended by striking section 1845 (42 U.S.C. 1395w–1).

(B) CONFORMING AMENDMENTS.—

(i) Section 1834(b)(2) (42 U.S.C. 1395m(b)(2)) is amended by striking ''Physician Payment Review Commission'' and inserting ''Medicare Payment Review Commission''.

(ii) Section 1842(b) (42 U.S.C. 1395u(b)) is amended by striking ''Physician Payment Review Commission'' each place it appears in paragraphs (2)(C), (9)(D), and (14)(C)(i) and inserting ''Medicare Payment Review Commission''.

(iii) Section 1848 (42 U.S.C. 1395w–4) is amended by striking ''Physician Payment Review Commission'' and inserting ''Medicare Payment Review Commission'' each place it appears in paragraph (2)(A)(ii), (2)(B)(iii), and (5) of subsection (c), subsection (d)(2)(F), paragraphs (1)(B), (3), and (4)(A)of subsection (f),

and paragraphs (6)(C) and (7)(C) of subsection (g).

(c) EFFECTIVE DATE; TRANSITION.—

(1) IN GENERAL.—The Comptroller General shall first provide for appointment of members to the Medicare Payment Review Commission (in this subsection referred to as ''MPRC'') by not later than March 31, 1996.

(2) TRANSITION.—Effective on a date (not later than 30 days after the date a majority of members of the MPRC have first been appointed, the Prospective Payment Assessment Commission (in this subsection referred to as ''ProPAC'') and the Physician Payment Review Commission (in this subsection referred to as ''PPRC''), and amendments made by subsection (b), are terminated. The Comptroller General, to the maximum extent feasible, shall provide for the transfer to the MPRC of assets and staff of ProPAC and PPRC, without any loss of benefits or seniority by virtue of such transfers. Fund balances available to the ProPAC or PPRC for any period shall be available to the MPRC for such period for like purposes.

(3) CONTINUING RESPONSIBILITY FOR REPORTS.—The MPRC shall be responsible for the

preparation and submission of reports required by law to be submitted (and which have not been submitted by the date of establishment of the MPRC) by the ProPAC and PPRC, and, for this purpose, any reference in law to either such Commission is deemed, after the appointment of the MPRC, to refer to the MPRC.

SEC. 15032. COMMISSION ON THE EFFECT OF THE BABY BOOM GENERATION ON THE MEDICARE PROGRAM.

(a) ESTABLISHMENT.—There is established a commission to be known as the Commission on the Effect of the Baby Boom Generation on the Medicare Program (in this section referred to as the ''Commission'').

(b) DUTIES.—

(1) IN GENERAL.—The Commission shall—

(A) examine the financial impact on the medicare program of the significant increase in the number of medicare eligible individuals which will occur beginning approximately during 2010 and lasting for approximately 25 years, and

(B) make specific recommendations to the Congress respecting a comprehensive approach to preserve the medicare program for the period

during which such individuals are eligible for medicare.

(2) CONSIDERATIONS IN MAKING RECOMMENDATIONS.—In making its recommendations, the Commission shall consider the following:

(A) The amount and sources of Federal funds to finance the medicare program, including the potential use of innovative financing methods.

(B) The most efficient and effective manner of administering the program, including the appropriateness of continuing the application of the failsafe budget mechanism under section 1895 of the Social Security Act for fiscal years after fiscal year 2002 and the appropriate long-term growth rates for contributions electing coverage under Medicare Choice under part C of title XVIII of such Act.

(C) Methods used by other nations to respond to comparable demographic patterns in eligibility for health care benefits for elderly and disabled individuals.

(D) Modifying age-based eligibility to correspond to changes in age-based eligibility under the OASDI program.

(E) Trends in employment-related health care for retirees, including the use of medical savings accounts and similar financing devices.

(c) MEMBERSHIP.—

(1) APPOINTMENT.—The Commission shall be composed of 15 members appointed as follows:

(A) The President shall appoint 3 members.

(B) The Majority Leader of the Senate shall appoint, after consultation with the minority leader of the Senate, 6 members, of whom not more than 4 may be of the same political party.

(C) The Speaker of the House of Representatives shall appoint, after consultation with the minority leader of the House of Representatives, 6 members, of whom not more than 4 may be of the same political party.

(2) CHAIRMAN AND VICE CHAIRMAN.—The Commission shall elect a Chairman and Vice Chairman from among its members.

(3) VACANCIES.—Any vacancy in the membership of the Commission shall be filled in the manner in which the original appointment was made and

shall not affect the power of the remaining members to execute the duties of the Commission.

(4) QUORUM.—A quorum shall consist of 8 members of the Commission, except that 4 members may conduct a hearing under subsection (e).

(5) MEETINGS.—The Commission shall meet at the call of its Chairman or a majority of its members.

(6) COMPENSATION AND REIMBURSEMENT OF EXPENSES.—Members of the Commission are not entitled to receive compensation for service on the Commission. Members may be reimbursed for travel, subsistence, and other necessary expenses incurred in carrying out the duties of the Commission.

(d) STAFF AND CONSULTANTS.—

(1) STAFF.—The Commission may appoint and determine the compensation of such staff as may be necessary to carry out the duties of the Commission. Such appointments and compensation may be made without regard to the provisions of title 5, United States Code, that govern appointments in the competitive services, and the provisions of chapter 51 and subchapter III of chapter 53 of such title that relate to classifications and the General Schedule pay rates.

(2) CONSULTANTS.—The Commission may procure such temporary and intermittent services of consultants under section 3109(b) of title 5, United States Code, as the Commission determines to be necessary to carry out the duties of the Commission.

(e) POWERS.—

(1) HEARINGS AND OTHER ACTIVITIES.—For the purpose of carrying out its duties, the Commission may hold such hearings and undertake such other activities as the Commission determines to be necessary to carry out its duties.

(2) STUDIES BY GAO.—Upon the request of the Commission, the Comptroller General shall conduct such studies or investigations as the Commission determines to be necessary to carry out its duties.

(3) COST ESTIMATES BY CONGRESSIONAL BUDGET OFFICE.—

(A) Upon the request of the Commission, the Director of the Congressional Budget Office shall provide to the Commission such cost estimates as the Commission determines to be necessary to carry out its duties.

(B) The Commission shall reimburse the Director of the Congressional Budget Office for expenses relating to the employment in the of-

fice of the Director of such additional staff as may be necessary for the Director to comply with requests by the Commission under subparagraph (A).

(4) DETAIL OF FEDERAL EMPLOYEES.—Upon the request of the Commission, the head of any Federal agency is authorized to detail, without reimbursement, any of the personnel of such agency to the Commission to assist the Commission in carrying out its duties. Any such detail shall not interrupt or otherwise affect the civil service status or privileges of the Federal employee.

(5) TECHNICAL ASSISTANCE.—Upon the request of the Commission, the head of a Federal agency shall provide such technical assistance to the Commission as the Commission determines to be necessary to carry out its duties.

(6) USE OF MAILS.—The Commission may use the United States mails in the same manner and under the same conditions as Federal agencies and shall, for purposes of the frank, be considered a commission of Congress as described in section 3215 of title 39, United States Code.

(7) OBTAINING INFORMATION.—The Commission may secure directly from any Federal agency

information necessary to enable it to carry out its duties, if the information may be disclosed under section 552 of title 5, United States Code. Upon request of the Chairman of the Commission, the head of such agency shall furnish such information to the Commission.

(8) ADMINISTRATIVE SUPPORT SERVICES.—Upon the request of the Commission, the Administrator of General Services shall provide to the Commission on a reimbursable basis such administrative support services as the Commission may request.

(9) ACCEPTANCE OF DONATIONS.—The Commission may accept, use, and dispose of gifts or donations of services or property.

(10) PRINTING.—For purposes of costs relating to printing and binding, including the cost of personnel detailed from the Government Printing Office, the Commission shall be deemed to be a committee of the Congress.

(f) REPORT.—Not later than May 1, 1997, the Commission shall submit to Congress a report containing its findings and recommendations regarding how to protect and preserve the medicare program in a financially solvent manner until 2030 (or, if later, throughout the period of projected solvency of the Federal Old-Age and Survivors

Insurance Trust Fund). The report shall include detailed recommendations for appropriate legislative initiatives respecting how to accomplish this objective.

(g) TERMINATION.—The Commission shall terminate 60 days after the date of submission of the report required in subsection (f).

(h) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated $1,500,000 to carry out this section. Amounts appropriated to carry out this section shall remain available until expended.

PART 5—PREEMPTION OF STATE ANTI-MANAGED CARE LAWS

SEC. 15041. PREEMPTION OF STATE LAW RESTRICTIONS ON MANAGED CARE ARRANGEMENTS.

(a) LIMITATION ON RESTRICTIONS ON NETWORK PLANS.—Effective as of January 1, 1997—

(1) a State may not prohibit or limit a carrier or group health plan providing health coverage from including incentives for enrollees to use the services of participating providers;

(2) a State may not prohibit or limit such a carrier or plan from limiting coverage of services to those provided by a participating provider, except as provided in section 1013;

(3) a State may not prohibit or limit the negotiation of rates and forms of payments for providers by such a carrier or plan with respect to health coverage;

(4) a State may not prohibit or limit such a carrier or plan from limiting the number of participating providers;

(5) a State may not prohibit or limit such a carrier or plan from requiring that services be provided (or authorized) by a practitioner selected by the enrollee from a list of available participating providers or, except for services of a physician who specializes in obstetrics and gynecology, from requiring enrollees to obtain referral in order to have coverage for treatment by a specialist or health institution; and

(6) a State may not prohibit or limit the corporate practice of medicine.

(b) DEFINITIONS.—In this section:

(1) MANAGED CARE COVERAGE.—The term ''managed care coverage'' means health coverage to the extent the coverage is provided through a managed care arrangement (as defined in paragraph (3)) that meets the applicable requirements of such section.

(2) PARTICIPATING PROVIDER.—The term ''participating provider'' means an entity or individual which provides, sells, or leases health care services as part of a provider network (as defined in paragraph (4)).

(3) MANAGED CARE ARRANGEMENT.—The term ''managed care arrangement'' means, with respect to a group health plan or under health insurance coverage, an arrangement under such plan or coverage under which providers agree to provide items and services covered under the arrangement to individuals covered under the plan or who have such coverage.

(4) PROVIDER NETWORK.—The term ''provider network'' means, with respect to a group health plan or health insurance coverage, providers who have entered into an agreement described in paragraph (3).

SEC. 15042. PREEMPTION OF STATE LAWS RESTRICTING UTILIZATION REVIEW PROGRAMS.

(a) IN GENERAL.—Effective January 1, 1997, no State law or regulation shall prohibit or regulate activities under a utilization review program (as defined in subsection (b)).

(b) UTILIZATION REVIEW PROGRAM DEFINED.—In this section, the term ''utilization review program'' means

a system of reviewing the medical necessity and appropriateness of patient services (which may include inpatient and outpatient services) using specified guidelines. Such a system may include preadmission certification, the application of practice guidelines, continued stay review, discharge planning, preauthorization of ambulatory procedures, and retrospective review.

(c) EXEMPTION OF LAWS PREVENTING DENIAL OF LIFESAVING MEDICAL TREATMENT PENDING TRANSFER TO ANOTHER HEALTH CARE PROVIDER.—Nothing in this subtitle shall be construed to invalidate any State law that has the effect of preventing involuntary denial of life-preserving medical treatment when such denial would cause the involuntary death of the patient pending transfer of the patient to a health care provider willing to provide such treatment.

Subtitle B—Provisions Relating to Regulatory Relief

PART 1—PROVISIONS RELATING TO PHYSICIAN FINANCIAL RELATIONSHIPS

SEC. 15101. REPEAL OF PROHIBITIONS BASED ON COMPENSATION ARRANGEMENTS.

(a) IN GENERAL.—Section 1877(a)(2) (42 U.S.C. 1395nn(a)(2)) is amended by striking ''is—'' and all that follows through ''equity,'' and inserting the following: ''is

(except as provided in subsection (c)) an ownership or investment interest in the entity through equity,''.

(b) CONFORMING AMENDMENTS.—Section 1877 (42 U.S.C. 1395nn) is amended as follows:

(1) In subsection (b)—

(A) in the heading, by striking ''TO BOTH OWNERSHIP AND COMPENSATION ARRANGEMENT PROVISIONS'' and inserting ''WHERE FINANCIAL RELATIONSHIP EXISTS''; and

(B) by redesignating paragraph (4) as paragraph (7).

(2) In subsection (c)—

(A) by amending the heading to read as follows: ''EXCEPTION FOR OWNERSHIP OR INVESTMENT INTEREST IN PUBLICLY TRADED SECURITIES AND MUTUAL FUNDS''; and

(B) in the matter preceding paragraph (1), by striking ''subsection (a)(2)(A)'' and inserting ''subsection (a)(2)''.

(3) In subsection (d)—

(A) by striking the matter preceding paragraph (1);

(B) in paragraph (3), by striking ''paragraph (1)'' and inserting ''paragraph (4)''; and

(C) by redesignating paragraphs (1), (2), and (3) as paragraphs (4), (5), and (6), and by transferring and inserting such paragraphs after paragraph (3) of subsection (b).

(4) By striking subsection (e).

(5) In subsection (f)(2), as amended by section 152(a) of the Social Security Act Amendments of 1994—

(A) in the matter preceding paragraph (1), by striking ''ownership, investment, and compensation'' and inserting ''ownership and investment'';

(B) in paragraph (2), by striking ''subsection (a)(2)(A)'' and all that follows through ''subsection (a)(2)(B)),'' and inserting ''subsection (a)(2),''; and

(C) in paragraph (2), by striking ''or who have such a compensation relationship with the entity''.

(6) In subsection (h)—

(A) by striking paragraphs (1), (2), and (3);

(B) in paragraph (4)(A), by striking clauses (iv) and (vi);

(C) in paragraph (4)(B), by striking ''RULES.—'' and all that follows through ''(ii) FACULTY'' and inserting ''RULES FOR FACULTY; and

(D) by adding at the end of paragraph (4) the following new subparagraph:

''(C) MEMBER OF A GROUP.—A physician is a 'member' of a group if the physician is an owner or a bona fide employee, or both, of the group.''.

SEC. 15102. REVISION OF DESIGNATED HEALTH SERVICES SUBJECT TO PROHIBITION.

(a) IN GENERAL.—Section 1877(h)(6) (42 U.S.C. 1395nn(h)(6)) is amended by striking subparagraphs (B) through (K) and inserting the following:

''(B) Items and services furnished by a community pharmacy (as defined in paragraph (1)).

''(C) Magnetic resonance imaging and computerized tomography services.

''(D) Outpatient physical therapy services.''.

(b) COMMUNITY PHARMACY DEFINED.—Section 1877(h) (42 U.S.C. 1395nn(h)), as amended by section

15101(b)(6), is amended by inserting before paragraph (4) the following new paragraph:

''(1) COMMUNITY PHARMACY.—The term 'community pharmacy' means any entity licensed or certified to dispense prescription drugs by the State in which the entity is located (including an entity which dispenses such drugs by mail order).''.

(c) CONFORMING AMENDMENTS.—

(1) Section 1877(b)(2) (42 U.S.C. 1395nn(b)(2)) is amended in the matter preceding subparagraph (A) by striking ''services'' and all that follows through ''supplies)—'' and inserting ''services—''.

(2) Section 1877(h)(5)(C) (42 U.S.C. 1395nn(h)(5)(C)) is amended—

(A) by striking '', a request by a radiologist for diagnostic radiology services, and a request by a radiation oncologist for radiation therapy,'' and inserting ''and a request by a radiologist for magnetic resonance imaging or for computerized tomography'', and

(B) by striking ''radiologist, or radiation oncologist'' and inserting ''or radiologist''.

SEC. 15103. DELAY IN IMPLEMENTATION UNTIL PROMULGATION OF REGULATIONS.

(a) IN GENERAL.—Section 13562(b) of OBRA–1993 (42 U.S.C. 1395nn note) is amended—

(1) in paragraph (1), by striking ''paragraph (2)'' and inserting ''paragraphs (2) and (3)''; and

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

''(3) PROMULGATION OF REGULATIONS.—Notwithstanding paragraphs (1) and (2), the amendments made by this section shall not apply to any referrals made before the effective date of final regulations promulgated by the Secretary of Health and Human Services to carry out such amendments.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall take effect as if included in the enactment of OBRA–1993.

SEC. 15104. EXCEPTIONS TO PROHIBITION.

(a) REVISIONS TO EXCEPTION FOR IN-OFFICE ANCILLARY SERVICES.—

(1) REPEAL OF SITE-OF-SERVICE REQUIREMENT.—Section 1877 (42 U.S.C. 1395nn) is amended—

(A) by amending subparagraph (A) of subsection (b)(2) to read as follows:

''(A) that are furnished personally by the referring physician, personally by a physician who is a member of the same group practice as the referring physician, or personally by individuals who are under the general supervision of the physician or of another physician in the group practice, and'', and

(B) by adding at the end of subsection (h) the following new paragraph:

''(7) GENERAL SUPERVISION.—An individual is considered to be under the 'general supervision' of a physician if the physician (or group practice of which the physician is a member) is legally responsible for the services performed by the individual and for ensuring that the individual meets licensure and certification requirements, if any, applicable under other provisions of law, regardless of whether or not the physician is physically present when the individual furnishes an item or service.''.

(2) CLARIFICATION OF TREATMENT OF PHYSICIAN OWNERS OF GROUP PRACTICE.—Section 1877(b)(2)(B) (42 U.S.C. 1395nn(b)(2)(B)) is amended by striking ''physician or such group practice'' and inserting ''physician, such group practice, or the physician owners of such group practice''.

(3) CONFORMING AMENDMENT.—Section 1877(b)(2) (42 U.S.C. 1395nn(b)(2)) is amended by amending the heading to read as follows: ''ANCILLARY SERVICES FURNISHED PERSONALLY OR THROUGH GROUP PRACTICE.—''.

(b) CLARIFICATION OF EXCEPTION FOR SERVICES FURNISHED IN A RURAL AREA.—Paragraph (5) of section 1877(b) (42 U.S.C. 1395nn(b)), as transferred by section 15101(b)(3)(C), is amended by striking ''substantially all'' and inserting ''not less than 75 percent''.

(c) REVISION OF EXCEPTION FOR CERTAIN MANAGED CARE ARRANGEMENTS.—Section 1877(b)(3) (42 U.S.C. 1395nn(b)(3)) is amended—

(1) in the heading by inserting ''MANAGED CARE ARRANGEMENTS'' after ''PREPAID PLANS'';

(2) in the matter preceding subparagraph (A), by striking ''organization—'' and inserting ''organization, directly or through contractual arrangements with other entities, to individuals enrolled with the organization—'';

(3) in subparagraph (A), by inserting ''or part C'' after ''section 1876'';

(4) by striking ''or'' at the end of subparagraph (C);

(5) by striking the period at the end of subparagraph (D) and inserting a comma; and

(6) by adding at the end the following new subparagraphs:

''(E) with a contract with a State to provide services under the State plan under title XIX (in accordance with section 1903(m)) or a State MediGrant plan under title XXI; or

''(F) which—

''(i) provides health care items or services directly or through one or more subsidiary entities or arranges for the provision of health care items or services substantially through the services of health care providers under contract with the organization, and

''(ii)(I) assumes financial risk for the provision of health services through mechanisms (such as capitation, risk pools, withholds, and per diem payments) or offers its network of contract health providers to an entity (including self-insured employers and indemnity plans) which assumes financial risk for the provision of such health services, or

"(II) has in effect a written agreement with the provider of services under which the provider is at significant financial risk (whether through a withhold, capitation, incentive pool, per diem payments, or similar risk sharing arrangement) for the cost or utilization of services that the provider is obligated to provide.".

(d) NEW EXCEPTION FOR SHARED FACILITY SERVICES.—

(1) IN GENERAL.—Section 1877(b) (42 U.S.C. 1395nn(b)), as amended by section 15101(b)(3)(C), is amended—

(A) by redesignating paragraphs (4) through (7) as paragraphs (5) through (8); and

(B) by inserting after paragraph (3) the following new paragraph:

"(4) SHARED FACILITY SERVICES.—In the case of a designated health service consisting of a shared facility service of a shared facility—

"(A) that is furnished—

"(i) personally by the referring physician who is a shared facility physician or personally by an individual directly em-

ployed or under the general supervision of such a physician,

''(ii) by a shared facility in a building in which the referring physician furnishes substantially all of the services of the physician that are unrelated to the furnishing of shared facility services, and

''(iii) to a patient of a shared facility physician; and

''(B) that is billed by the referring physician or a group practice of which the physician is a member.''.

(2) DEFINITIONS.—Section 1877(h) (42 U.S.C. 1395nn(h)), as amended by section 15101(b)(6) and section 15102(b), is amended by inserting after paragraph (1) the following new paragraph:

''(2) SHARED FACILITY RELATED DEFINITIONS.—

''(A) SHARED FACILITY SERVICE.—The term 'shared facility service' means, with respect to a shared facility, a designated health service furnished by the facility to patients of shared facility physicians.

''(B) SHARED FACILITY.—The term 'shared facility' means an entity that furnishes

shared facility services under a shared facility arrangement.

''(C) SHARED FACILITY PHYSICIAN.—The term 'shared facility physician' means, with respect to a shared facility, a physician (or a group practice of which the physician is a member) who has a financial relationship under a shared facility arrangement with the facility.

''(D) SHARED FACILITY ARRANGEMENT.—The term 'shared facility arrangement' means, with respect to the provision of shared facility services in a building, a financial arrangement—

''(i) which is only between physicians who are providing services (unrelated to shared facility services) in the same building,

''(ii) in which the overhead expenses of the facility are shared, in accordance with methods previously determined by the physicians in the arrangement, among the physicians in the arrangement, and

''(iii) which, in the case of a corporation, is wholly owned and controlled by shared facility physicians.''.

(e) NEW EXCEPTION FOR SERVICES FURNISHED IN COMMUNITIES WITH NO ALTERNATIVE PROVIDERS.—Section 1877(b) (42 U.S.C. 1395nn(b)), as amended by section 15101(b)(3)(C) and subsection (d)(1), is amended—

(1) by redesignating paragraphs (5) through (8) as paragraphs (6) through (9); and

(2) by inserting after paragraph (4) the following new paragraph:

''(5) NO ALTERNATIVE PROVIDERS IN AREA.—In the case of a designated health service furnished in any area with respect to which the Secretary determines that individuals residing in the area do not have reasonable access to such a designated health service for which subsection (a)(1) does not apply.''.

(f) NEW EXCEPTION FOR SERVICES FURNISHED IN AMBULATORY SURGICAL CENTERS.—Section 1877(b) (42 U.S.C. 1395nn(b)), as amended by section 15101(b)(3)(C), subsection (d)(1), and subsection (e)(1), is amended—

(1) by redesignating paragraphs (6) through (9) as paragraphs (7) through (10); and

(2) by inserting after paragraph (5) the following new paragraph:

"(6) SERVICES FURNISHED IN AMBULATORY SURGICAL CENTERS.—In the case of a designated health service furnished in an ambulatory surgical center described in section 1832(a)(2)(F)(i).".

(g) NEW EXCEPTION FOR SERVICES FURNISHED IN RENAL DIALYSIS FACILITIES.—Section 1877(b) (42 U.S.C. 1395nn(b)), as amended by section 15101(b)(3)(C), subsection (d)(1), subsection (e)(1), and subsection (f), is amended—

(1) by redesignating paragraphs (7) through (10) as paragraphs (8) through (11); and

(2) by inserting after paragraph (6) the following new paragraph:

"(7) SERVICES FURNISHED IN RENAL DIALYSIS FACILITIES.—In the case of a designated health service furnished in a renal dialysis facility under section 1881.".

(h) NEW EXCEPTION FOR SERVICES FURNISHED IN A HOSPICE.—Section 1877(b) (42 U.S.C. 1395nn(b)), as amended by section 15101(b)(3)(C), subsection (d)(1), subsection (e)(1), subsection (f), and subsection (g), is amended—

(1) by redesignating paragraphs (8) through (11) as paragraphs (9) through (12); and

(2) by inserting after paragraph (7) the following new paragraph:

''(8) SERVICES FURNISHED BY A HOSPICE PROGRAM.—In the case of a designated health service furnished by a hospice program under section 1861(dd)(2).''.

(i) NEW EXCEPTION FOR SERVICES FURNISHED IN A COMPREHENSIVE OUTPATIENT REHABILITATION FACILITY.—Section 1877(b) (42 U.S.C. 1395nn(b)), as amended by section 15101(b)(3)(C), subsection (d)(1), subsection (e)(1), subsection (f), subsection (g), and subsection (h), is amended—

(1) by redesignating paragraphs (9) through (12) as paragraphs (10) through (13); and

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

''(9) SERVICES FURNISHED IN A COMPREHENSIVE OUTPATIENT REHABILITATION FACILITY.—In the case of a designated health service furnished in a comprehensive outpatient rehabilitation facility (as defined in section 1861(cc)(2)).''.

(i) DEFINITION OF REFERRAL.—Section 1877(h)(5)(A) (42 U.S.C. 1395nn(h)(5)(A)) is amended—

(1) by striking ''an item or service'' and inserting ''a designated health service'', and

(2) by striking ''the item or service'' and inserting ''the designated health service''.

SEC. 15105. REPEAL OF REPORTING REQUIREMENTS.

Section 1877 (42 U.S.C. 1395nn) is amended—

(1) by striking subsection (f); and

(2) by striking subsection (g)(5).

SEC. 15106. PREEMPTION OF STATE LAW.

Section 1877 (42 U.S.C. 1395nn) is amended by adding at the end the following new subsection:

''(i) PREEMPTION OF STATE LAW.—This section preempts State law to the extent State law is inconsistent with this section.''.

SEC. 15107. EFFECTIVE DATE.

Except as provided in section 15103(b), the amendments made by this part shall apply to referrals made on or after August 14, 1995, regardless of whether or not regulations are promulgated to carry out such amendments.

PART 2—ANTITRUST REFORM

SEC. 15111. PUBLICATION OF ANTITRUST GUIDELINES ON ACTIVITIES OF HEALTH PLANS.

(a) IN GENERAL.—The Attorney General shall provide for the development and publication of explicit guide-

lines on the application of antitrust laws to the activities of health plans. The guidelines shall be designed to facilitate development and operation of plans, consistent with the antitrust laws.

(b) REVIEW PROCESS.—The Attorney General shall establish a review process under which the administrator or sponsor of a health plan (or organization that proposes to administer or sponsor a health plan) may submit a request to the Attorney General to obtain a prompt opinion (but in no event later than 90 days after the Attorney General receives the request) from the Department of Justice on the plan's conformity with the Federal antitrust laws.

SEC. 15112. ISSUANCE OF HEALTH CARE CERTIFICATES OF PUBLIC ADVANTAGE.

(a) ISSUANCE AND EFFECT OF CERTIFICATE.—The Attorney General, after consultation with the Secretary, shall issue in accordance with this section a certificate of public advantage to each eligible health care collaborative activity that complies with the requirements in effect under this section on or after the expiration of the 1-year period that begins on the date of the enactment of this Act (without regard to whether or not the Attorney General has promulgated regulations to carry out this section by such date). Such activity, and the parties to such activ-

ity, shall not be liable under any of the antitrust laws for conduct described in such certificate and engaged in by such activity if such conduct occurs while such certificate is in effect.

(b) REQUIREMENTS APPLICABLE TO ISSUANCE OF CERTIFICATES.—

(1) STANDARDS TO BE MET.—The Attorney General shall issue a certificate to an eligible health care collaborative activity if the Attorney General finds that—

(A) the benefits that are likely to result from carrying out the activity outweigh the reduction in competition (if any) that is likely to result from the activity, and

(B) such reduction in competition is necessary to obtain such benefits.

(2) FACTORS TO BE CONSIDERED.—

(A) WEIGHING OF BENEFITS AGAINST REDUCTION IN COMPETITION.—For purposes of making the finding described in paragraph (1)(A), the Attorney General shall consider whether the activity is likely—

(i) to maintain or to increase the quality of health care by providing new

services not currently offered in the relevant market,

(ii) to increase access to health care,

(iii) to achieve cost efficiencies that will be passed on to health care consumers, such as economies of scale, reduced transaction costs, and reduced administrative costs, that cannot be achieved by the provision of available services and facilities in the relevant market,

(iv) to preserve the operation of health care facilities located in underserved geographical areas,

(v) to improve utilization of health care resources, and

(vi) to reduce inefficient health care resource duplication.

(B) NECESSITY OF REDUCTION IN COMPETITION.—For purposes of making the finding described in paragraph (1)(B), the Attorney General shall consider—

(i) the ability of the providers of health care services that are (or likely to be) affected by the health care collaborative activity and the entities responsible

for making payments to such providers to negotiate societally optimal payment and service arrangements,

(ii) the effects of the health care collaborative activity on premiums and other charges imposed by the entities described in clause (i), and

(iii) the availability of equally efficient, less restrictive alternatives to achieve the benefits that are intended to be achieved by carrying out the activity.

(c) ESTABLISHMENT OF CRITERIA AND PROCEDURES.—Subject to subsections (d) and (e), not later than 1 year after the date of the enactment of this Act, the Attorney General and the Secretary shall establish jointly by rule the criteria and procedures applicable to the issuance of certificates under subsection (a). The rules shall specify the form and content of the application to be submitted to the Attorney General to request a certificate, the information required to be submitted in support of such application, the procedures applicable to denying and to revoking a certificate, and the procedures applicable to the administrative appeal (if such appeal is authorized by rule) of the denial and the revocation of a certificate. Such information may include the terms of the health care col-

1 laborative activity (in the case of an activity in existence
2 as of the time of the application) and implementation plan
3 for the collaborative activity.

4 (d) ELIGIBLE HEALTH CARE COLLABORATIVE AC-
5 TIVITY.—To be an eligible health care collaborative activ-
6 ity for purposes of this section, a health care collaborative
7 activity shall submit to the Attorney General an applica-
8 tion that complies with the rules in effect under subsection
9 (c) and that includes—

10 (1) an agreement by the parties to the activity
11 that the activity will not foreclose competition by en-
12 tering into contracts that prevent health care provid-
13 ers from providing health care in competition with
14 the activity,

15 (2) an agreement that the activity will submit
16 to the Attorney General annually a report that de-
17 scribes the operations of the activity and information
18 regarding the impact of the activity on health care
19 and on competition in health care, and

20 (3) an agreement that the parties to the activity
21 will notify the Attorney General and the Secretary of
22 the termination of the activity not later than 30
23 days after such termination occurs.

24 (e) REVIEW OF APPLICATIONS FOR CERTIFICATES.—
25 Not later than 90 days after an eligible health care col-

1 laborative activity submits to the Attorney General an ap-
2 plication that complies with the rules in effect under sub-
3 section (c) and with subsection (d), the Attorney General
4 shall issue or deny the issuance of such certificate. If, be-
5 fore the expiration of such 90-day period, the Attorney
6 General may extend the time for issuance for good cause.
7 (f) REVOCATION OF CERTIFICATE.—Whenever the
8 Attorney General finds that a health care collaborative ac-
9 tivity with respect to which a certificate is in effect does
10 not meet the standards specified in subsection (b), the At-
11 torney General shall revoke such certificate.
12 (g) WRITTEN REASONS; JUDICIAL REVIEW.—
13 (1) DENIAL AND REVOCATION OF CERTIFI-
14 CATES.—If the Attorney General denies an applica-
15 tion for a certificate or revokes a certificate, the At-
16 torney General shall include in the notice of denial
17 or revocation a statement of the reasons relied upon
18 for the denial or revocation of such certificate.
19 (2) JUDICIAL REVIEW.—
20 (A) AFTER ADMINISTRATIVE PROCEED-
21 ING.—(i) If the Attorney General denies an ap-
22 plication submitted or revokes a certificate is-
23 sued under this section after an opportunity for
24 hearing on the record, then any party to the
25 health care collaborative activity involved may

commence a civil action, not later than 60 days after receiving notice of the denial or revocation, in an appropriate district court of the United States for review of the record of such denial or revocation.

(ii) As part of the Attorney General's answer, the Attorney General shall file in such court a certified copy of the record on which such denial or revocation is based. The findings of fact of the Attorney General may be set aside only if found to be unsupported by substantial evidence in such record taken as a whole.

(B) DENIAL OR REVOCATION WITHOUT ADMINISTRATIVE PROCEEDING.—If the Attorney General denies an application submitted or revokes a certificate issued under this section without an opportunity for hearing on the record, then any party to the health care collaborative activity involved may commence a civil action, not later than 60 days after receiving notice of the denial or revocation, in an appropriate district court of the United States for de novo review of such denial or revocation.

(h) EXEMPTION.—A person shall not be liable under any of the antitrust laws for conduct necessary—

(1) to prepare, agree to prepare, or attempt to agree to prepare an application to request a certificate under this section, or

(2) to attempt to enter into any health care collaborative activity with respect to which such a certificate is in effect.

(i) DEFINITIONS.—In this section:

(1) The term ''certificate'' means a certificate of public advantage authorized to be issued under subsection (a).

(2) The term ''health care collaborative activity'' means an agreement (whether existing or proposed) between 2 or more providers of health care services that is entered into solely for the purpose of sharing in the provision and coordination of health care services and that involves substantial integration and financial risk-sharing between the parties, but does not include the exchanging of information, the entering into of any agreement, or the engagement in any other conduct that is not reasonably required to carry out such agreement.

(3) The term ''health care services'' includes services related to the delivery or administration of health care services.

(4) The term ''liable'' means liable for any civil or criminal violation of the antitrust laws.

(5) The term ''provider of health care services'' means any individual or entity that is engaged in the delivery of health care services in a State and that is required by State law or regulation to be licensed or certified by the State to engage in the delivery of such services in the State.

SEC. 15113. STUDY OF IMPACT ON COMPETITION.

The Attorney General, in consultation with the Chairman of the Federal Trade Commission, annually shall submit to the Congress a report as part of the annual budget oversight proceedings concerning the Antitrust Division of the Department of Justice. The report shall enable the Congress to determine how enforcement of antitrust laws is affecting the formation of efficient, cost-saving joint ventures and if the certificate of public advantage procedure set forth in section 15112 has resulted in undesirable reduction in competition in the health care marketplace. The report shall include an evaluation of the factors set forth in paragraphs (2)(A) and (2)(B) of section 15112(b).

SEC. 15114. ANTITRUST EXEMPTION.

The antitrust laws shall not apply with respect to—

(1) the merger of, or the attempt to merge, 2 or more hospitals,

(2) a contract entered into solely by 2 or more hospitals to allocate hospital services, or

(3) the attempt by only 2 or more hospitals to enter into a contract to allocate hospital services,

if each of such hospitals satisfies all of the requirements of section 15115 at the time such hospitals engage in the conduct described in paragraph (1), (2), or (3), as the case may be.

SEC. 15115. REQUIREMENTS.

The requirements referred to in section 15114 are as follows:

(1) The hospital is located outside of a city, or in a city that has less than 150,000 inhabitants, as determined in accordance with the most recent data available from the Bureau of the Census.

(2) In the most recently concluded calendar year, the hospital received more than 40 percent of its gross revenue from payments made under Federal programs.

(3) There is in effect with respect to the hospital a certificate issued by the Health Care Financing Administration specifying that such Administration has determined that Federal expenditures would

be reduced, consumer costs would not increase, and access to health care services would not be reduced, if the hospital and the other hospitals that requested such certificate merge, or allocate the hospital services specified in such request, as the case may be.

SEC. 15116. DEFINITION.

For purposes of this subtitle, the term 'antitrust laws' has the meaning given such term in subsection (a) of the first section of the Clayton Act (15 U.S.C. 12), except that such term includes section 5 of the Federal Trade Commission Act (15 U.S.C. 45) to the extent that such section 5 applies with respect to unfair methods of competition.

PART 3—MALPRACTICE REFORM

Subpart A—Uniform Standards for Malpractice Claims

SEC. 15121. APPLICABILITY.

Except as provided in section 15131, this subpart shall apply to any medical malpractice liability action brought in a Federal or State court, and to any medical malpractice claim subject to an alternative dispute resolution system, that is initiated on or after January 1, 1996.

SEC. 15122. REQUIREMENT FOR INITIAL RESOLUTION OF ACTION THROUGH ALTERNATIVE DISPUTE RESOLUTION.

(a) IN GENERAL.—

(1) STATE CASES.—A medical malpractice liability action may not be brought in any State court during a calendar year unless the medical malpractice liability claim that is the subject of the action has been initially resolved under an alternative dispute resolution system certified for the year by the Secretary under section 15132(a), or, in the case of a State in which such a system is not in effect for the year, under the alternative Federal system established under section 15132(b).

(2) FEDERAL DIVERSITY ACTIONS.—A medical malpractice liability action may not be brought in any Federal court under section 1332 of title 28, United States Code, during a calendar year unless the medical malpractice liability claim that is the subject of the action has been initially resolved under the alternative dispute resolution system referred to in paragraph (1) that applied in the State whose law applies in such action.

(3) CLAIMS AGAINST UNITED STATES.—

(A) ESTABLISHMENT OF PROCESS FOR CLAIMS.—The Attorney General shall establish

an alternative dispute resolution process for the resolution of tort claims consisting of medical malpractice liability claims brought against the United States under chapter 171 of title 28, United States Code. Under such process, the resolution of a claim shall occur after the completion of the administrative claim process applicable to the claim under section 2675 of such title.

(B) REQUIREMENT FOR INITIAL RESOLUTION UNDER PROCESS.—A medical malpractice liability action based on a medical malpractice liability claim described in subparagraph (A) may not be brought in any Federal court unless the claim has been initially resolved under the alternative dispute resolution process established by the Attorney General under such subparagraph.

(b) INITIAL RESOLUTION OF CLAIMS UNDER ADR.—For purposes of subsection (a), an action is ''initially resolved'' under an alternative dispute resolution system if—

(1) the ADR reaches a decision on whether the defendant is liable to the plaintiff for damages; and

(2) if the ADR determines that the defendant is liable, the ADR reaches a decision on the amount of damages assessed against the defendant.

(c) PROCEDURES FOR FILING ACTIONS.—

(1) NOTICE OF INTENT TO CONTEST DECISION.—Not later than 60 days after a decision is issued with respect to a medical malpractice liability claim under an alternative dispute resolution system, each party affected by the decision shall submit a sealed statement to a court of competent jurisdiction indicating whether or not the party intends to contest the decision.

(2) DEADLINE FOR FILING ACTION.—A medical malpractice liability action may not be brought by a party unless—

(A) the party has filed the notice of intent required by paragraph (1); and

(B) the party files the action in a court of competent jurisdiction not later than 90 days after the decision resolving the medical malpractice liability claim that is the subject of the action is issued under the applicable alternative dispute resolution system.

(3) COURT OF COMPETENT JURISDICTION.—For purposes of this subsection, the term ''court of competent jurisdiction'' means—

(A) with respect to actions filed in a State court, the appropriate State trial court; and

(B) with respect to actions filed in a Federal court, the appropriate United States district court.

(d) LEGAL EFFECT OF UNCONTESTED ADR DECISION.—The decision reached under an alternative dispute resolution system shall, for purposes of enforcement by a court of competent jurisdiction, have the same status in the court as the verdict of a medical malpractice liability action adjudicated in a State or Federal trial court. The previous sentence shall not apply to a decision that is contested by a party affected by the decision pursuant to subsection (c)(1).

SEC. 15123. OPTIONAL APPLICATION OF PRACTICE GUIDELINES.

(a) DEVELOPMENT AND CERTIFICATION OF GUIDELINES.—Each State may develop, for certification by the Secretary, a set of specialty clinical practice guidelines, based on recommended guidelines from national specialty societies, to be updated annually. In the absence of recommended guidelines from such societies, each State may

develop such guidelines based on such criteria as the State considers appropriate (including based on recommended guidelines developed by the Agency for Health Care Policy and Research).

(b) PROVISION OF HEALTH CARE UNDER GUIDELINES.—Notwithstanding any other provision of law, in any medical malpractice liability action arising from the conduct of a health care provider or health care professional, if such conduct was in accordance with a guideline developed by the State in which the conduct occurred and certified by the Secretary under subsection (a), the guideline—

(1) may be introduced by any party to the action (including a health care provider, health care professional, or patient); and

(2) if introduced, shall establish a rebuttable presumption that the conduct was in accordance with the appropriate standard of medical care, which may only be overcome by the presentation of clear and convincing evidence on behalf of the party against whom the presumption operates.

SEC. 15124. TREATMENT OF NONECONOMIC AND PUNITIVE DAMAGES.

(a) LIMITATION ON NONECONOMIC DAMAGES.—The total amount of noneconomic damages that may be award-

ed to a claimant and the members of the claimant's family for losses resulting from the injury which is the subject of a medical malpractice liability action may not exceed $250,000, regardless of the number of parties against whom the action is brought or the number of actions brought with respect to the injury.

(b) NO AWARD OF PUNITIVE DAMAGES AGAINST MANUFACTURER OF MEDICAL PRODUCT.—In the case of a medical malpractice liability action in which the plaintiff alleges a claim against the manufacturer of a medical product, no punitive or exemplary damages may be awarded against such manufacturer.

(c) JOINT AND SEVERAL LIABILITY FOR NONECONOMIC DAMAGES.—The liability of each defendant for noneconomic damages shall be several only and shall not be joint, and each defendant shall be liable only for the amount of noneconomic damages allocated to the defendant in direct proportion to the defendant's percentage of responsibility (as determined by the trier of fact).

(d) USE OF PUNITIVE DAMAGE AWARDS FOR OPERATION OF ADR SYSTEMS IN STATES.—

(1) IN GENERAL.—The total amount of any punitive damages awarded in a medical malpractice liability action shall be paid to the State in which the action is brought (or, in a case brought in Federal

court, in the State in which the health care services that caused the injury that is the subject of the action were provided), and shall be used by the State solely to implement and operate the State alternative dispute resolution system certified by the Secretary under section 15132 (except as provided in paragraph (2)).

(2) USE OF REMAINING AMOUNTS FOR PROVIDER LICENSING AND DISCIPLINARY ACTIVITIES.—If the amount of punitive damages paid to a State under paragraph (1) for a year is greater than the State's costs of implementing and operating the State alternative dispute resolution system during the year, the balance of such punitive damages paid to the State shall be used solely to carry out activities to assure the safety and quality of health care services provided in the State, including (but not limited to)—

(A) licensing or certifying health care professionals and health care providers in the State; and

(B) carrying out programs to reduce malpractice-related costs for providers volunteering to provide services in medically underserved areas.

(3) MAINTENANCE OF EFFORT.—A State shall use any amounts paid pursuant to paragraph (1) to supplement and not to replace amounts spent by the State for implementing and operating the State alternative dispute resolution system or carrying out the activities described in paragraph (2).

(e) DRUGS AND DEVICES.—

(1)(A) Punitive damages shall not be awarded against a manufacturer or product seller of a drug (as defined in section 201(g)(1) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321(g)(1)) or medical device (as defined in section 201(h) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321(h)) which caused the claimant's harm where—

(i) such drug or device was subject to premarket approval by the Food and Drug Administration with respect to the safety of the formulation or performance of the aspect of such drug or device which caused the claimant's harm or the adequacy of the packaging or labeling of such drug or device, and such drug was approved by the Food and Drug Administration; or

(ii) the drug is generally recognized as safe and effective pursuant to conditions established by the Food and Drug Administration and applicable regulations, including packaging and labeling regulations.

(B) Subparagraph (A) shall not apply in any case in which the defendant, before or after premarket approval of a drug or device—

(i) intentionally and wrongfully withheld from or misrepresented to the Food and Drug Administration information concerning such drug or device required to be submitted under the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 301 et seq.) or section 351 of the Public Health Service Act (42 U.S.C. 262) that is material and relevant to the harm suffered by the claimant, or

(ii) made an illegal payment to an official or employee of the Food and Drug Administration for the purpose of securing or maintaining approval of such drug or device.

(2) PACKAGING.—In a product liability action for harm which is alleged to relate to the adequacy of the packaging (or labeling relating to such packaging) of a drug which is required to have tamper-

resistant packaging under regulations of the Secretary of Health and Human Services (including labeling regulations related to such packaging), the manufacturer of the drug shall not be held liable for punitive damages unless the drug is found by the court by clear and convincing evidence to be substantially out of compliance with such regulations.

SEC. 15125. PERIODIC PAYMENTS FOR FUTURE LOSSES.

(a) IN GENERAL.—In any medical malpractice liability action in which the damages awarded for future economic loss exceeds $100,000, a defendant may not be required to pay such damages in a single, lump-sum payment, but may be permitted to make such payments on a periodic basis. The periods for such payments shall be determined by the court, based upon projections of when such expenses are likely to be incurred.

(b) WAIVER.—A court may waive the application of subsection (a) with respect to a defendant if the court determines that it is not in the best interests of the plaintiff to receive payments for damages on such a periodic basis.

SEC. 15126. TREATMENT OF ATTORNEY'S FEES AND OTHER COSTS.

(a) REQUIRING PARTY CONTESTING ADR RULING TO PAY ATTORNEY'S FEES AND OTHER COSTS.—

(1) IN GENERAL.—The court in a medical malpractice liability action shall require the party that (pursuant to section 15122(c)(1)) contested the ruling of the alternative dispute resolution system with respect to the medical malpractice liability claim that is the subject of the action to pay to the opposing party the costs incurred by the opposing party under the action, including attorney's fees, fees paid to expert witnesses, and other litigation expenses (but not including court costs, filing fees, or other expenses paid directly by the party to the court, or any fees or costs associated with the resolution of the claim under the alternative dispute resolution system), but only if—

(A) in the case of an action in which the party that contested the ruling is the claimant, the amount of damages awarded to the party under the action is less than the amount of damages awarded to the party under the ADR system; and

(B) in the case of an action in which the party that contested the ruling is the defendant, the amount of damages assessed against the party under the action is greater than the

amount of damages assessed under the ADR system.

(2) EXCEPTIONS.—Paragraph (1) shall not apply if—

(A) the party contesting the ruling made under the previous alternative dispute resolution system shows that—

(i) the ruling was procured by corruption, fraud, or undue means,

(ii) there was partiality or corruption under the system,

(iii) there was other misconduct under the system that materially prejudiced the party's rights, or

(iv) the ruling was based on an error of law;

(B) the party contesting the ruling made under the alternative dispute resolution system presents new evidence before the trier of fact that was not available for presentation under the ADR system;

(C) the medical malpractice liability action raised a novel issue of law; or

(D) the court finds that the application of such paragraph to a party would constitute an

undue hardship, and issues an order waiving or modifying the application of such paragraph that specifies the grounds for the court's decision.

(3) LIMIT ON ATTORNEYS' FEES PAID.—Attorneys' fees that are required to be paid under paragraph (1) by the contesting party shall not exceed the amount of the attorneys' fees incurred by the contesting party in the action. If the attorneys' fees of the contesting party are based on a contingency fee agreement, the amount of attorneys' fees for purposes of the preceding sentence shall not exceed the reasonable value of those services.

(4) RECORDS.—In order to receive attorneys' fees under paragraph (1), counsel of record in the medical malpractice liability action involved shall maintain accurate, complete records of hours worked on the action, regardless of the fee arrangement with the client involved.

(b) CONTINGENCY FEE DEFINED.—As used in this section, the term ''contingency fee'' means any fee for professional legal services which is, in whole or in part, contingent upon the recovery of any amount of damages, whether through judgment or settlement.

SEC. 15127. UNIFORM STATUTE OF LIMITATIONS.

(a) IN GENERAL.—Except as provided in subsection (b), no medical malpractice claim may be initiated after the expiration of the 2-year period that begins on the date on which the alleged injury that is the subject of such claim was discovered, but in no event may such a claim be initiated after the expiration of the 4-year period that begins on the date on which the alleged injury that is the subject of such claim occurred.

(b) EXCEPTION FOR MINORS.—In the case of an alleged injury suffered by a minor who has not attained 6 years of age, a medical malpractice claim may not be initiated after the expiration of the 2-year period that begins on the date on which the alleged injury that is the subject of such claim was discovered or should reasonably have been discovered, but in no event may such a claim be initiated after the date on which the minor attains 12 years of age.

SEC. 15128. SPECIAL PROVISION FOR CERTAIN OBSTETRIC SERVICES.

(a) IN GENERAL.—In the case of a medical malpractice claim relating to services provided during labor or the delivery of a baby, if the health care professional or health care provider against whom the claim is brought did not previously treat the claimant for the pregnancy, the trier of fact may not find that such professional or

provider committed malpractice and may not assess damages against such professional or provider unless the malpractice is proven by clear and convincing evidence.

(b) APPLICABILITY TO GROUP PRACTICES OR AGREEMENTS AMONG PROVIDERS.—For purposes of subsection (a), a health care professional shall be considered to have previously treated an individual for a pregnancy if the professional is a member of a group practice whose members previously treated the individual for the pregnancy or is providing services to the individual during labor or the delivery of a baby pursuant to an agreement with another professional.

SEC. 15129. JURISDICTION OF FEDERAL COURTS.

Nothing in this subpart shall be construed to establish any jurisdiction over any medical malpractice liability action in the district courts of the United States on the basis of sections 1331 or 1337 of title 28, United States Code.

SEC. 15130. PREEMPTION.

(a) IN GENERAL.—The provisions of this subpart shall preempt any State law to the extent such law is inconsistent with such provisions, except that the provisions of this subpart shall not preempt any State law that provides for defenses or places limitations on a person's liability in addition to those contained in this part, places great-

er limitations on the amount of attorneys' fees that can be collected, or otherwise imposes greater restrictions than those provided in this part.

(b) EFFECT ON SOVEREIGN IMMUNITY AND CHOICE OF LAW OR VENUE.—Nothing in this subpart shall be construed to—

(1) waive or affect any defense of sovereign immunity asserted by any State under any provision of law;

(2) waive or affect any defense of sovereign immunity asserted by the United States;

(3) affect the applicability of any provision of the Foreign Sovereign Immunities Act of 1976;

(4) preempt State choice-of-law rules with respect to claims brought by a foreign nation or a citizen of a foreign nation; or

(5) affect the right of any court to transfer venue or to apply the law of a foreign nation or to dismiss a claim of a foreign nation or of a citizen of a foreign nation on the ground in inconvenient forum.

Subpart B—Requirements for State Alternative Dispute Resolution Systems (ADR)

SEC. 15131. BASIC REQUIREMENTS.

(a) IN GENERAL.—A State's alternative dispute resolution system meets the requirements of this section if the system—

(1) applies to all medical malpractice liability claims under the jurisdiction of the courts of that State;

(2) requires that a written opinion resolving the dispute be issued not later than 6 months after the date by which each party against whom the claim is filed has received notice of the claim (other than in exceptional cases for which a longer period is required for the issuance of such an opinion), and that the opinion contain—

(A) findings of fact relating to the dispute, and

(B) a description of the costs incurred in resolving the dispute under the system (including any fees paid to the individuals hearing and resolving the claim), together with an appropriate assessment of the costs against any of the parties;

(3) requires individuals who hear and resolve claims under the system to meet such qualifications

as the State may require (in accordance with regulations of the Secretary);

(4) is approved by the State or by local governments in the State;

(5) with respect to a State system that consists of multiple dispute resolution procedures—

(A) permits the parties to a dispute to select the procedure to be used for the resolution of the dispute under the system, and

(B) if the parties do not agree on the procedure to be used for the resolution of the dispute, assigns a particular procedure to the parties;

(6) provides for the transmittal to the State agency responsible for monitoring or disciplining health care professionals and health care providers of any findings made under the system that such a professional or provider committed malpractice, unless, during the 90-day period beginning on the date the system resolves the claim against the professional or provider, the professional or provider brings an action contesting the decision made under the system; and

(7) provides for the regular transmittal to the Administrator for Health Care Policy and Research

of information on disputes resolved under the system, in a manner that assures that the identity of the parties to a dispute shall not be revealed.

(b) APPLICATION OF MALPRACTICE LIABILITY STANDARDS TO ALTERNATIVE DISPUTE RESOLUTION.—The provisions of subpart A (other than section 15122) shall apply with respect to claims brought under a State alternative dispute resolution system or the alternative Federal system in the same manner as such provisions apply with respect to medical malpractice liability actions brought in the State.

SEC. 15132. CERTIFICATION OF STATE SYSTEMS; APPLICABILITY OF ALTERNATIVE FEDERAL SYSTEM.

(a) CERTIFICATION.—

(1) IN GENERAL.—Not later than October 1 of each year (beginning with 1995), the Secretary, in consultation with the Attorney General, shall determine whether a State's alternative dispute resolution system meets the requirements of this subpart for the following calendar year.

(2) BASIS FOR CERTIFICATION.—The Secretary shall certify a State's alternative dispute resolution system under this subsection for a calendar year if the Secretary determines under paragraph (1) that the system meets the requirements of section 15131,

including the requirement described in section 15124 that punitive damages awarded under the system are paid to the State for the uses described in such section.

(b) APPLICABILITY OF ALTERNATIVE FEDERAL SYSTEM.—

(1) ESTABLISHMENT AND APPLICABILITY.—Not later than October 1, 1995, the Secretary, in consultation with the Attorney General, shall establish by rule an alternative Federal ADR system for the resolution of medical malpractice liability claims during a calendar year in States that do not have in effect an alternative dispute resolution system certified under subsection (a) for the year.

(2) REQUIREMENTS FOR SYSTEM.—Under the alternative Federal ADR system established under paragraph (1)—

(A) paragraphs (1), (2), (6), and (7) of section 15131(a) shall apply to claims brought under the system;

(B) if the system provides for the resolution of claims through arbitration, the claims brought under the system shall be heard and resolved by arbitrators appointed by the Sec-

retary in consultation with the Attorney General; and

(C) with respect to a State in which the system is in effect, the Secretary may (at the State's request) modify the system to take into account the existence of dispute resolution procedures in the State that affect the resolution of medical malpractice liability claims.

(3) TREATMENT OF STATES WITH ALTERNATIVE SYSTEM IN EFFECT.—If the alternative Federal ADR system established under this subsection is applied with respect to a State for a calendar year, the State shall make a payment to the United States (at such time and in such manner as the Secretary may require) in an amount equal to 110 percent of the costs incurred by the United States during the year as a result of the application of the system with respect to the State.

SEC. 15133. REPORTS ON IMPLEMENTATION AND EFFECTIVENESS OF ALTERNATIVE DISPUTE RESOLUTION SYSTEMS.

(a) IN GENERAL.—Not later than 5 years after the date of the enactment of this Act, the Secretary shall prepare and submit to the Congress a report describing and evaluating State alternative dispute resolution systems op-

erated pursuant to this subpart and the alternative Federal system established under section 15132(b).

(b) CONTENTS OF REPORT.—The Secretary shall include in the report prepared and submitted under subsection (a)—

(1) information on—

(A) the effect of the alternative dispute resolution systems on the cost of health care within each State,

(B) the impact of such systems on the access of individuals to health care within the State, and

(C) the effect of such systems on the quality of health care provided within the State; and

(2) to the extent that such report does not provide information on no-fault systems operated by States as alternative dispute resolution systems pursuant to this part, an analysis of the feasibility and desirability of establishing a system under which medical malpractice liability claims shall be resolved on a no-fault basis.

Subpart C—Definitions

SEC. 15141. DEFINITIONS.

As used in this part:

(1) ALTERNATIVE DISPUTE RESOLUTION SYSTEM.—The term ''alternative dispute resolution system'' means a system that is enacted or adopted by a State to resolve medical malpractice claims other than through a medical malpractice liability action.

(2) CLAIMANT.—The term ''claimant'' means any person who brings a health care liability action and, in the case of an individual who is deceased, incompetent, or a minor, the person on whose behalf such an action is brought.

(3) CLEAR AND CONVINCING EVIDENCE.—The term ''clear and convincing evidence'' is that measure or degree of proof that will produce in the mind of the trier of fact a firm belief or conviction as to the truth of the allegations sought to be established, except that such measure or degree of proof is more than that required under preponderance of the evidence, but less than that required for proof beyond a reasonable doubt.

(4) ECONOMIC DAMAGES.—The term ''economic damages'' means damages paid to compensate an individual for losses for hospital and other medical expenses, lost wages, lost employment, and other pecuniary losses.

(5) HEALTH CARE PROFESSIONAL.—The term ''health care professional'' means any individual who provides health care services in a State and who is required by State law or regulation to be licensed or certified by the State to provide such services in the State.

(6) HEALTH CARE PROVIDER.—The term ''health care provider'' means any organization or institution that is engaged in the delivery of health care services in a State that is required by State law or regulation to be licensed or certified by the State to engage in the delivery of such services in the State.

(7) INJURY.—The term ''injury'' means any illness, disease, or other harm that is the subject of a medical malpractice claim.

(8) MEDICAL MALPRACTICE LIABILITY ACTION.—The term ''medical malpractice liability action'' means any civil action brought pursuant to State law in which a plaintiff alleges a medical malpractice claim against a health care provider or health care professional, but does not include any action in which the plaintiff's sole allegation is an allegation of an intentional tort.

(9) MEDICAL MALPRACTICE CLAIM.—The term ''medical malpractice claim'' means any claim relating to the provision of (or the failure to provide) health care services or the use of a medical product, without regard to the theory of liability asserted, and includes any third-party claim, cross-claim, counterclaim, or contribution claim in a medical malpractice liability action.

(10) MEDICAL PRODUCT.—

(A) IN GENERAL.—The term ''medical product'' means, with respect to the allegation of a claimant, a drug (as defined in section 201(g)(1) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321(g)(1)) or a medical device (as defined in section 201(h) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321(h)) if—

(i) such drug or device was subject to premarket approval under section 505, 507, or 515 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355, 357, or 360e) or section 351 of the Public Health Service Act (42 U.S.C. 262) with respect to the safety of the formulation or performance of the aspect of such drug or de-

vice which is the subject of the claimant's allegation or the adequacy of the packaging or labeling of such drug or device, and such drug or device is approved by the Food and Drug Administration; or

(ii) the drug or device is generally recognized as safe and effective under regulations issued by the Secretary of Health and Human Services under section 201(p) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321(p)).

(B) EXCEPTION IN CASE OF MISREPRESENTATION OR FRAUD.—Notwithstanding subparagraph (A), the term ''medical product'' shall not include any product described in such subparagraph if the claimant shows that the product is approved by the Food and Drug Administration for marketing as a result of withheld information, misrepresentation, or an illegal payment by manufacturer of the product.

(11) NONECONOMIC DAMAGES.—The term ''noneconomic damages'' means damages paid to compensate an individual for losses for physical and emotional pain, suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of

enjoyment of life, loss of consortium, and other nonpecuniary losses, but does not include punitive damages.

(12) PUNITIVE DAMAGES.—The term ''punitive damages'' means compensation, in addition to compensation for actual harm suffered, that is awarded for the purpose of punishing a person for conduct deemed to be malicious, wanton, willful, or excessively reckless.

PART 4—PAYMENT AREAS FOR PHYSICIANS' SERVICES UNDER MEDICARE

SEC. 15151. MODIFICATION OF PAYMENT AREAS USED TO DETERMINE PAYMENTS FOR PHYSICIANS' SERVICES UNDER MEDICARE.

(a) IN GENERAL.—Section 1848(j)(2) (42 U.S.C. 1395w@4(j)(2)) is amended to read as follows:

''(2) FEE SCHEDULE AREA.—

''(A) GENERAL RULE.—Except as provided in subparagraph (B), the term 'fee schedule area' means, with respect to physicians' services furnished in a State, the State.

''(B) EXCEPTION FOR STATES WITH HIGHEST VARIATION AMONG AREAS.—In the case of the 15 States with the greatest variation in cost associated with physicians' services among var-

ious geographic areas of the State (as determined by the Secretary in accordance with such standards as the Secretary considers appropriate), the fee schedule area applicable with respect to physicians' services furnished in the State shall be a locality used under section 1842(b) for purposes of computing payment amounts for physicians' services, except that the Secretary shall revise the localities used under such section so that there are no more than 5 such localities in any State.''.

(b) BUDGET-NEUTRALITY REQUIREMENT.—The Secretary of Health and Human Services shall carry out the amendment made by subsection (a) in a manner which ensures that the aggregate amount of payment made for physicians' services under part B of the medicare program in any year does not exceed the aggregate amount of payment which would have been made for such services under part B during the year if the amendment were not in effect.

(c) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to physicians' services furnished on or after January 1, 1997.

Subtitle C—Medicare Payments to Health Care Providers

PART 1—PROVISIONS AFFECTING ALL PROVIDERS

SEC. 15201. ONE-YEAR FREEZE IN PAYMENTS TO PROVIDERS.

(a) FREEZE IN UPDATES.—

(1) IN GENERAL.—Notwithstanding any other provision of law, except as otherwise provided in paragraph (2), for purposes of determining the amount to be paid for an item or service under title XVIII of the Social Security Act, the percentage increase in any economic index by which a payment amount under title XVIII of the Social Security Act is required to be increased during fiscal year 1996 shall be deemed to be zero.

(2) EXCEPTIONS.—Paragraph (1) shall not apply—

(A) to payments for the operating costs of inpatient hospital services of a subsection (d) hospital (as defined in section 1886(d)(1)(B) of the Social Security Act); or

(B) to the determination of hospital-specific FTE resident amounts under section 1886(h) of such Act.

(b) ECONOMIC INDEX.— The term ''economic index'' includes—

(1) the hospital market basket index (described in section 1886(b)(3)(B)(iii) of the Social Security Act),

(2) the medicare economic index (referred to in the fourth sentence of section 1842(b)(3) of such Act),

(3) the consumer price index for all urban consumers (U.S. city average), and

(4) any other index used to adjust payment amounts under title XVIII of such Act.

(c) EXTENSION OF PAYMENT FREEZE FOR SNFS AND HHAS.—

(1) SKILLED NURSING FACILITIES.—

(A) NO CHANGE IN COST LIMITS.—Section 13503(a)(1) of OBRA–1993 is amended by striking ''1994 and 1995'' and inserting ''1994, 1995, and 1996''.

(B) DELAY IN UPDATES; NO CATCHUP.— The last sentence of section 1888(a) (42 U.S.C. 1395yy(a)) is amended—

(i) by striking ''1995'' and inserting ''1996'', and

(ii) by striking ''subsection.'' and inserting ''subsection (except that such updates may not take into account any changes in the routine service costs of skilled nursing facilities during cost reporting periods which began during fiscal year 1994, 1995, or 1996).''.

(C) PROSPECTIVE PAYMENTS.—Section 13505(b) of OBRA–1993 is amended by striking ''fiscal years 1994 and 1995'' and inserting ''fiscal years 1994, 1995, and 1996''.

(2) HOME HEALTH AGENCIES.—

(A) NO CHANGE IN COST LIMITS.—Section 13564(a)(1) of OBRA–1993 is amended by striking ''1996'' and inserting ''1997''.

(B) DELAY IN UPDATES; NO CATCHUP.—Section 1861(v)(1)(L)(iii) (42 U.S.C. 1395x(v)(1)(L)(iii)) is amended—

(i) by striking ''1996'' and inserting ''1997'', and

(ii) by adding at the end the following: ''In establishing limits under this subparagraph, the Secretary may not take into account any changes in the routine service costs of the provision of services

furnished by home health agencies with respect to cost reporting periods which began on or after July 1, 1994, and before July 1,1997.''.

PART 2—PROVISIONS AFFECTING DOCTORS

SEC. 15211. UPDATING FEES FOR PHYSICIANS' SERVICES.

(a) ESTABLISHMENT OF SINGLE, CUMULATIVE MVPS.— Section 1848(f) (42 U.S.C. 1395w–4(f)) is amended—

(1) in subparagraphs (A) and (C) of paragraph (1), by striking ''rates of increase for all physicians' services and for each category of such services'' each place it appears and inserting ''rate of increase for all physicians' services (and, in the case of fiscal years beginning before fiscal year 1996, for each category of such services)''; and

(2) in paragraph (2)—

(A) in subparagraph (A)—

(i) by striking ''IN GENERAL.—'' and inserting ''FISCAL YEARS 1991 THROUGH 1995.—'',

(ii) in the matter preceding clause (i), by striking ''a fiscal year (beginning with fiscal year 1991)'' and inserting ''fiscal years 1991 through 1995'', and

(iii) in the matter following clause (iv), by striking ''subparagraph (B)) and inserting ''subparagraph (C))'',

(B) by redesignating subparagraphs (B) and (C) as subparagraphs (C) and (D), and

(C) by inserting after subparagraph (A) the following:

''(B) FISCAL YEAR 1996 AND THEREAFTER.—Unless Congress otherwise provides, the performance standard rate of increase for all physicians' services for a fiscal year beginning with fiscal year 1996 shall be equal to the performance standard rate of increase determined under this paragraph for the previous fiscal year, increased by the product of—

''(i) 1 plus the Secretary's estimate of the weighted average percentage increase (divided by 100) in the fees for all physicians' services under this part for portions of calendar years included in the fiscal year involved,

''(ii) 1 plus the Secretary's estimate of the percentage increase or decrease (divided by 100) in the average number of individuals enrolled under this part (other

than HMO enrollees) from the previous fiscal year to the fiscal year involved,

''(iii) 1 plus the Secretary's estimate of the average annual percentage growth (divided by 100) in volume and intensity of all physicians' services under this part for the 5-fiscal-year-period ending with the preceding fiscal year, and

''(iv) 1 plus the Secretary's estimate of the percentage increase or decrease (divided by 100) in expenditures for all physicians' services in the fiscal year (compared with the previous fiscal year) that are estimated to result from changes in law or regulations affecting the percentage increase described in clause (i) and that is not taken into account in the percentage increase described in clause (i), minus 1, multiplied by 100, and reduced by the performance standard factor (specified in subparagraph (C)).''.

(b) ANNUAL UPDATE BASED ON CUMULATIVE PERFORMANCE.—

(1) IN GENERAL.—Section 1848(d)(3)(B) (42 U.S.C. 1395w–4(d)(3)(B)) is amended—

(A) in clause (i)—

(i) by striking ''IN GENERAL.—'' and inserting ''For 1992 through 1995'',

(ii) by striking ''for a year'' and inserting ''for each of the years 1992 through 1995'', and

(iii) by striking '', subject to clause (ii),'' and inserting ''subject to clause (iii),'';

(B) by redesignating clause (ii) as clause (iii); and

(C) by inserting after clause (i) the following:

''(ii) YEARS BEGINNING AFTER 1996.—

''(I) IN GENERAL.—The update for all physicians'' services for a year beginning after 1996 provided under subparagraph (A) shall, subject to clause (iii), be increased or decreased by the same percentage by which the cumulative percentage increase in actual expenditures for all physicians' services in the second previous fiscal year over the third previous fiscal

year, was less or greater, respectively, than the performance standard rate of increase (established under subsection (f)) for such services for the second previous fiscal year.

''(II) CUMULATIVE PERCENTAGE INCREASE DEFINED.—In subclause (I), the 'cumulative percentage increase in actual expenditures' for a year shall be equal to the product of the adjusted increases for each year beginning with 1995 up to and including the year involved, minus 1 and multiplied by 100. In the previous sentence, the 'adjusted increase' for a year is equal to 1 plus the percentage increase in actual expenditures for the year (over the preceding year).''.

(3) ESTABLISHMENT OF CONVERSION FACTOR FOR 1996.—Section 1848(d)(1) (42 U.S.C. 1395w–4(d)(1)) is amended—

(A) by redesignating subparagraph (C) as subparagraph (D); and

(B) by inserting after subparagraph (B) the following new subparagraph:

"(C) SPECIAL RULE FOR 1996.—For 1996, the conversion factor under this subsection shall be $36.40 for all physicians' services.".

(c) ESTABLISHING UPPER LIMIT ON MVPS REWARDS.—

(1) IN GENERAL.—Clause (iii) of section 1848(d)(3)(B), as redesignated by subsection (b)(1)(B), is amended by striking "a decrease" and inserting "an increase or decrease".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to physicians' services furnished on or after January 1, 1996.

SEC. 15212. USE OF REAL GDP TO ADJUST FOR VOLUME AND INTENSITY.

Section 1848(f)(2)(B)(iii) (42 U.S.C. 1395w–4(f)(2)(B)(iii)), as added by section 15211(a)(2)(C), is amended to read as follows:

"(iii) 1 plus the average per capita growth in the real gross domestic product (divided by 100) for the 5-fiscal-year period ending with the previous fiscal year (increased by 1.5 percentage points for the category of services consisting of primary care services), and".

PART 3—PROVISIONS AFFECTING HOSPITALS

SEC. 15221. REDUCTION IN UPDATE FOR INPATIENT HOSPITAL SERVICES.

(a) PPS HOSPITALS.—Section 1886(b)(3)(B)(i) (42 U.S.C. 1395ww(b)(3)(B)(i)) is amended—

(1) by amending subclause (XII) to read as follows:

''(XII) for each of the fiscal years 1997 through 2002, the market basket percentage increase minus 0.5 percentage point for hospitals in a rural area, and the market basket percentage increase minus 1.5 percentage points for all other hospitals, and''; and

(2) in subclause (XIII), by striking ''1998'' and inserting ''2003''.

(b) PPS-EXEMPT HOSPITALS.—

(1) IN GENERAL.—Section 1886(b)(3)(B)(ii) (42 U.S.C. 1395ww(b)(3)(B)(ii)) is amended—

(A) in subclause (V)—

(i) by striking ''through 1997'' and inserting ''through 1996'', and

(ii) by striking ''and'' at the end;

(B) by redesignating subclause (VI) as subclause (VII); and

(C) by inserting after subclause (V) the following new subclause:

''(VI) fiscal years 1997 through 2002, is the market basket percentage increase minus 1.0 percentage point, and''.

(2) CONFORMING AMENDMENT.—Section 1886(b)(3)(B) (42 U.S.C. 1395ww(b)(3)(B)) is amended by striking clause (v).

SEC. 15222. ELIMINATION OF FORMULA-DRIVEN OVERPAYMENTS FOR CERTAIN OUTPATIENT HOSPITAL SERVICES.

(a) AMBULATORY SURGICAL CENTER PROCEDURES.—Section 1833(i)(3)(B)(i)(II) (42 U.S.C. 1395l(i)(3)(B)(i)(II)) is amended—

(1) by striking ''of 80 percent''; and

(2) by striking the period at the end and inserting the following: '', less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A).''.

(b) RADIOLOGY SERVICES AND DIAGNOSTIC PROCEDURES.—Section 1833(n)(1)(B)(i)(II) (42 U.S.C. 1395l(n)(1)(B)(i)(II)) is amended—

(1) by striking ''of 80 percent''; and

(2) by striking the period at the end and inserting the following: '', less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A).''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished during portions of cost reporting periods occurring on or after July 1, 1994.

SEC. 15223. ESTABLISHMENT OF PROSPECTIVE PAYMENT SYSTEM FOR OUTPATIENT SERVICES.

(a) IN GENERAL.—Section 1833(a)(2)(B) (42 U.S.C. 1395l(a)(2)(B)) is amended by striking ''section 1886)—'' and all that follows and inserting the following: ''section 1886), an amount equal to a prospectively determined payment rate established by the Secretary that provides for payments for such items and services to be based upon a national rate adjusted to take into account the relative costs of furnishing such items and services in various geographic areas, except that for items and services furnished during cost reporting periods (or portions thereof) in years beginning with 1996, such amount shall be equal to 95 percent of the amount that would otherwise have been determined;''.

(b) ESTABLISHMENT OF PROSPECTIVE PAYMENT SYSTEM.—Not later than July 1, 1995, the Secretary of Health and Human Services shall establish the prospective payment system for hospital outpatient services necessary to carry out section 1833(a)(2)(B) of the Social Security Act (as amended by subsection (a)).

(c) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to items and services furnished on or after January 1, 1996.

SEC. 15224. REDUCTION IN MEDICARE PAYMENTS TO HOSPITALS FOR INPATIENT CAPITAL-RELATED COSTS.

(a) PPS HOSPITALS.—Section 1886(g)(1)(A) (42 U.S.C. 1395ww(g)(1)(A)) is amended by striking ''1995'' and inserting ''1996''.

(b) REDUCTION IN BASE PAYMENT RATES FOR PPS HOSPITALS.—Section 1886(g)(1)(A) (42 U.S.C. 1395ww(g)(1)(A)) is amended by adding at the end the following new sentence: ''In addition to the reduction described in the preceding sentence, for discharges occurring after September 30, 1995, the Secretary shall reduce by 7.47 percent the unadjusted standard Federal capital payment rate (as described in 42 CFR 412.308(c), as in effect on the date of the enactment of the Omnibus Budget Reconciliation Act of 1995) and shall reduce by 8.27 percent the unadjusted hospital-specific rate (as described in 42 CFR 412.328(e)(1), as in effect on the date of the enactment of the Omnibus Budget Reconciliation Act of 1995).''.

(c) PPS-EXEMPT HOSPITALS.—Section 1861(v)(1) (42 U.S.C. 1395x(v)(1)) is amended by adding at the end the following:

> ''(T) Such regulations shall provide that, in determining the amount of the payments that may be made under this title with respect to the capital-related costs of inpatient hospital services furnished by a hospital that is not a subsection (d) hospital (as defined in section 1886(d)(1)(B)) or a subsection (d) Puerto Rico hospital (as defined in section 1886(d)(9)(A)), the Secretary shall reduce the amounts of such payments otherwise established under this title by 10 percent for payments attributable to portions of cost reporting periods occurring during fiscal year 1996.''.

SEC. 15225. MORATORIUM ON PPS EXEMPTION FOR LONG-TERM CARE HOSPITALS.

(a) IN GENERAL.—Section 1886(d)(1)(B)(iv) (42 U.S.C. 1395ww(d)(1)(B)(iv)) is amended by striking ''Secretary)'' and inserting ''Secretary on or before September 30, 1995)''.

(b) RECOMMENDATIONS ON APPROPRIATE STANDARDS FOR LONG-TERM CARE HOSPITALS.—Not later than 1 year after the date of the enactment of this Act,

the Secretary of Health and Human Services shall submit to Congress recommendations for modifications to the standards used by the Secretary to determine whether a hospital (including a distinct part of another hospital) is classified as a long-term care hospital for purposes of determining the amount of payment to the hospital under part A of the medicare program for the operating costs of inpatient hospital services.

SEC. 15226. ELIMINATION OF CERTAIN ADDITIONAL PAYMENTS FOR OUTLIER CASES.

(a) INDIRECT MEDICAL EDUCATION.—Section 1886(d)(5)(B)(i)(I) (42 U.S.C. 1395ww(d)(5)(B)(i)(I)) is amended—

(1) by striking ''the sum of''; and

(2) by striking ''and the amount paid to the hospital under subparagraph (A)''.

(b) DISPROPORTIONATE SHARE ADJUSTMENTS.—Section 1886(d)(5)(F)(ii)(I) (42 U.S.C. 1395ww(d)(5)(F)(ii)(I)) is amended—

(1) by striking ''the sum of''; and

(2) by striking ''and the amount paid to the hospital under subparagraph (A) for that discharge''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to discharges occurring on or after October 1, 1995.

PART 4—PROVISIONS AFFECTING OTHER PROVIDERS.

SEC. 15231. REVISION OF PAYMENT METHODOLOGY FOR HOME HEALTH SERVICES.

(a) ADDITIONS TO COST LIMITS.—Section 1861(v)(1)(L) (42 U.S.C. 1395x(v)(1)(L)) is amended by adding at the end the following new clauses:

> ''(iv) For services furnished by home health agencies for cost reporting periods beginning on or after October 1, 1996, the Secretary shall provide for an interim system of limits. Payment shall be the lower of—
>
> > ''(I) costs determined under the preceding provisions of this subparagraph, or
> >
> > ''(II) an agency-specific per beneficiary annual limit calculated from the agency's 12-month cost reporting period ending on or after January 1, 1994 and on or before December 31, 1994 based on reasonable costs (in-

cluding non-routine medical supplies), updated by the home health market basket index. The per beneficiary limitation shall be multiplied by the agency's unduplicated census count of Medicare patients for the year subject to the limitation. The limitation shall represent total Medicare reasonable costs divided by the unduplicated census count of Medicare patients.

''(v) For services furnished by home health agencies for cost reporting periods beginning on or after October 1, 1996, the following rules shall apply:

''(I) For new providers and those providers without a 12-month cost reporting period ending in calendar year 1994, the per beneficiary limit shall be equal to the mean of these limits (or the Secretary's best estimates thereof) applied to home health agencies as determined by the Secretary. Home health agencies that have altered their corporate structure or

name may not be considered new providers for payment purposes.

''(II) For beneficiaries who use services furnished by more than one home health agency, the per beneficiary limitation shall be pro-rated among agencies.

''(vi) Home health agencies whose cost or utilization experience is below 125 percent of the mean national or census region aggregate per beneficiary cost or utilization experience for 1994, or best estimates thereof, and whose year-end reasonable costs are below the agency-specific per beneficiary limit, shall receive payment equal to 50 percent of the difference between the agency's reasonable costs and its limit for fiscal years 1996, 1997, 1998, and 1999. Such payments may not exceed 5 percent of an agency's aggregate Medicare reasonable cost in a year.

''(vii) Effective January 1, 1997, or as soon as feasible, the Secretary shall modify the agency specific per beneficiary annual limit described in clause (iv) to pro-

vide for regional or national variations in utilization. For purposes of determining payment under clause (iv), the limit shall be calculated through a blend of 75 percent of the agency-specific cost or utilization experience in 1994 with 25 percent of the national or census region cost or utilization experience in 1994, or the Secretary's best estimates thereof.''.

(b) USE OF INTERIM FINAL REGULATIONS.—The Secretary shall implement the payment limits described in section 1861(v)(1)(L)(iv) of the Social Security Act by publishing in the Federal Register a notice of interim final payment limits by August 1, 1996 and allowing for a period of public comments thereon. Payments subject to these limits will be effective for cost reporting periods beginning on or after October 1, 1996, without the necessity for consideration of comments received, but the Secretary shall, by Federal Register notice, affirm or modify the limits after considering those comments.

(c) STUDIES.—The Secretary shall expand research on a prospective payment system for home health agencies that shall tie prospective payments to an episode of care, including an intensive effort to develop a reliable case mix adjuster that explains a significant amount of the

variances in costs. The Secretary shall develop such a system for implementation in fiscal year 2000.

(d) PAYMENTS DETERMINED ON PROSPECTIVE BASIS.—Title XVIII is amended by adding at the end the following new section:

''PROSPECTIVE PAYMENT FOR HOME HEALTH SERVICES

''SEC. 1893. (a) Notwithstanding section 1861(v), the Secretary shall, for cost reporting periods beginning on or after fiscal year 2000, provide for payments for home health services in accordance with a prospective payment system, which pays home health agencies on a per episode basis, established by the Secretary.

''(b) Such a system shall include the following:

''(1) Per episode rates under the system shall be 15 percent less than those that would otherwise occur under fiscal year 2000 Medicare expenditures for home health services.

''(2) All services covered and paid on a reasonable cost basis under the Medicare home health benefit as of the date of the enactment of the Medicare Enhancement Act of 1995, including medical supplies, shall be subject to the per episode amount. In defining an episode of care, the Secretary shall consider an appropriate length of time for an episode the use of services and the number of visits provided within an episode, potential changes in the mix of

services provided within an episode and their cost, and a general system design that will provide for continued access to quality services. The per episode amount shall be based on the most current audited cost report data available to the Secretary.

''(c) The Secretary shall employ an appropriate case mix adjuster that explains a significant amount of the variation in cost.

''(d) The episode payment amount shall be adjusted annually by the home health market basket index. The labor portion of the episode amount shall be adjusted for geographic differences in labor-related costs based on the most current hospital wage index.

''(e) The Secretary may designate a payment provision for outliers, recognizing the need to adjust payments due to unusual variations in the type or amount of medically necessary care.

''(f) A home health agency shall be responsible for coordinating all care for a beneficiary. If a beneficiary elects to transfer to, or receive services from, another home health agency within an episode period, the episode payment shall be pro-rated between home health agencies.''.

SEC. 15232. LIMITATION OF HOME HEALTH COVERAGE UNDER PART A.

(a) IN GENERAL.—Section 1812(a)(3) (42 U.S.C. 1395d(a)(3)) is amended by striking the semicolon and inserting ''for up to 150 days during any spell of illness;''.

(b) CONFORMING AMENDMENT.—Section 1812(b) (42 U.S.C. 1395d(b)) is amended—

(1) by striking ''or'' at the end of paragraph (2),

(2) by striking the period at the end of paragraph (3) and inserting ''; or'', and

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

''(4) home health services furnished to the individual during such spell after such services have been furnished to the individual for 150 days during such spell.''.

(3) EXCLUSION OF ADDITIONAL PART B COSTS FROM DETERMINATION OF PART B MONTHLY PREMIUM.—Section 1839(a) (42 U.S.C. 1395r(a)) is amended—

(A) in the second sentence of paragraph (1), by striking ''enrollees.'' and inserting ''enrollees (except as provided in paragraph (5)).''; and

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

''(5) In estimating the benefits and administrative costs which will be payable from the Federal Supplementary Medical Insurance Trust Fund for a year (beginning with 1996), the Secretary shall exclude an estimate of any benefits and costs attributable to home health services for which payment would have been made under part A during the year but for paragraph (4) of section 1812(b).''.

(c) EFFECTIVE DATE.—The amendments made by this subsection shall apply to spells of illness beginning on or after October 1, 1995.

SEC. 15233. REDUCTION IN FEE SCHEDULE FOR DURABLE MEDICAL EQUIPMENT.

(a) IN GENERAL.—

(1) FREEZE IN UPDATE FOR COVERED ITEMS.—Section 1834(a)(14) (42 U.S.C. 1395m(a)(14)) is amended—

(A) by striking ''and'' at the end of subparagraph (A);

(B) in subparagraph (B)—

(i) by striking ''a subsequent year'' and inserting ''1993, 1994, and 1995'', and

(ii) by striking the period at the end and inserting ''; and''; and

(C) by adding at the end the following:

''(C) for each of the years 1996 through 1998, 0 percent; and

''(D) for a subsequent year, the percentage increase in the consumer price index for all urban consumers (U.S. urban average) for the 12-month period ending with June of the previous year.''.

(2) UPDATE FOR ORTHOTICS AND PROSTHETICS.—Section 1834(h)(4)(A)(iii) (42 U.S.C. 1395m(h)(4)(A)(iii)) is amended by striking ''1994 and 1995'' and inserting ''each of the years 1994 through 1998''.

(b) OXYGEN AND OXYGEN EQUIPMENT.—Section 1834(a)(9)(C) (42 U.S.C. 1395m(a)(9)(C)) is amended—

(1) by striking ''and'' at the end of clause (iii);

(2) in clause (iv)—

(A) by striking ''a subsequent year'' and inserting ''1993, 1994, and 1995'', and

(B) by striking the period at the end and inserting ''; and''; and

(3) by adding at the end the following new clause:

"(v) in 1996 and each subsequent year, is 90 percent of the national limited monthly payment rate computed under subparagraph (B) for the item for the year.".

SEC. 15234. NURSING HOME BILLING.

(a) PAYMENTS FOR ROUTINE SERVICE COSTS.—

(1) CLARIFICATION OF DEFINITION OF ROUTINE SERVICE COSTS.—Section 1888 (42 U.S.C. 1395yy) is amended by adding at the end the following new subsection:

"(e) For purposes of this section, the 'routine service costs' of a skilled nursing facility are all costs which are attributable to nursing services, room and board, administrative costs, other overhead costs, and all other ancillary services (including supplies and equipment), excluding costs attributable to covered non-routine services subject to payment limits under section 1888A.".

(2) CONFORMING AMENDMENT.—Section 1888 (42 U.S.C. 1395yy) is amended in the heading by inserting "AND CERTAIN ANCILLARY" after "SERVICE".

(b) INCENTIVES FOR COST-EFFECTIVE MANAGEMENT OF COVERED NON-ROUTINE SERVICES.—

(1) IN GENERAL.—Title XVIII is amended by inserting after section 1888 the following new section:

''INCENTIVES FOR COST-EFFECTIVE MANAGEMENT OF COVERED NON-ROUTINE SERVICES OF SKILLED NURSING FACILITIES

''SEC. 1888A. (a) DEFINITIONS.—For purposes of this section:

''(1) COVERED NON-ROUTINE SERVICES.—The term 'covered non-routine services' means post-hospital extended care services consisting of any of the following:

''(A) Physical or occupational therapy or speech-language pathology services, or respiratory therapy.

''(B) Prescription drugs.

''(C) Complex medical equipment.

''(D) Intravenous therapy and solutions (including enteral and parenteral nutrients, supplies, and equipment).

''(E) Radiation therapy.

''(F) Diagnostic services, including laboratory, radiology (including computerized tomography services and imaging services), and pulmonary services.

"(2) SNF MARKET BASKET PERCENTAGE INCREASE.—The term 'SNF market basket percentage increase' for a fiscal year means a percentage equal to the percentage increase in routine service cost limits for the year under section 1888(a).

"(3) STAY.—The term 'stay' means, with respect to an individual who is a resident of a skilled nursing facility, a period of continuous days during which the facility provides extended care services for which payment may be made under this title to the individual during the individual's spell of illness.

"(b) NEW PAYMENT METHOD FOR COVERED NON-ROUTINE SERVICES.—

"(1) IN GENERAL.—Subject to subsection (c), a skilled nursing facility shall receive interim payments under this title for covered non-routine services furnished to an individual during a cost reporting period beginning during a fiscal year (after fiscal year 1996) in an amount equal to the reasonable cost of providing such services in accordance with section 1861(v). The Secretary may adjust such payments if the Secretary determines (on the basis of such estimated information as the Secretary considers appropriate) that payments to the facility under this paragraph for a cost reporting period would

substantially exceed the cost reporting period limit determined under subsection (c)(1)(B).

''(2) RESPONSIBILITY OF SKILLED NURSING FACILITY TO MANAGE BILLINGS.—

''(A) CLARIFICATION RELATING TO PART A BILLING.—In the case of a covered non-routine service furnished to an individual who (at the time the service is furnished) is a resident of a skilled nursing facility who is entitled to coverage under section 1812(a)(2) for such service, the skilled nursing facility shall submit a claim for payment under this title for such service under part A (without regard to whether or not the item or service was furnished by the facility, by others under arrangement with them made by the facility, under any other contracting or consulting arrangement, or otherwise).

''(B) PART B BILLING.—In the case of a covered non-routine service furnished to an individual who (at the time the service is furnished) is a resident of a skilled nursing facility who is not entitled to coverage under section 1812(a)(2) for such service but is entitled to coverage under part B for such service, the skilled nursing facility shall submit a claim for

payment under this title for such service under part B (without regard to whether or not the item or service was furnished by the facility, by others under arrangement with them made by the facility, under any other contracting or consulting arrangement, or otherwise).

''(C) MAINTAINING RECORDS ON SERVICES FURNISHED TO RESIDENTS.—Each skilled nursing facility receiving payments for extended care services under this title shall document on the facility's cost report all covered non-routine services furnished to all residents of the facility to whom the facility provided extended care services for which payment was made under part A during a fiscal year (beginning with fiscal year 1996) (without regard to whether or not the services were furnished by the facility, by others under arrangement with them made by the facility, under any other contracting or consulting arrangement, or otherwise).

''(c) RECONCILIATION OF AMOUNTS.—

''(1) LIMIT BASED ON PER STAY LIMIT AND NUMBER OF STAYS.—

''(A) IN GENERAL.—If a skilled nursing facility has received aggregate payments under

subsection (b) for covered non-routine services during a cost reporting period beginning during a fiscal year in excess of an amount equal to the cost reporting period limit determined under subparagraph (B), the Secretary shall reduce the payments made to the facility with respect to such services for cost reporting periods beginning during the following fiscal year in an amount equal to such excess. The Secretary shall reduce payments under this subparagraph at such times and in such manner during a fiscal year as the Secretary finds necessary to meet the requirement of this subparagraph.

''(B) COST REPORTING PERIOD LIMIT.—The cost reporting period limit determined under this subparagraph is an amount equal to the product of—

''(i) the per stay limit applicable to the facility under subsection (d) for the period; and

''(ii) the number of stays beginning during the period for which payment was made to the facility for such services.

''(C) PROSPECTIVE REDUCTION IN PAYMENTS.—In addition to the process for reduc-

ing payments described in subparagraph (A), the Secretary may reduce payments made to a facility under this section during a cost reporting period if the Secretary determines (on the basis of such estimated information as the Secretary considers appropriate) that payments to the facility under this section for the period will substantially exceed the cost reporting period limit for the period determined under this paragraph.

''(2) INCENTIVE PAYMENTS.—

''(A) IN GENERAL.—If a skilled nursing facility has received aggregate payments under subsection (b) for covered non-routine services during a cost reporting period beginning during a fiscal year in an amount that is less than the amount determined under paragraph (1)(B), the Secretary shall pay the skilled nursing facility in the following fiscal year an incentive payment equal to 50 percent of the difference between such amounts, except that the incentive payment may not exceed 5 percent of the aggregate payments made to the facility under subsection (b) for the previous fiscal year (without regard to subparagraph (B)).

"(B) INSTALLMENT INCENTIVE PAYMENTS.—The Secretary may make installment payments during a fiscal year to a skilled nursing facility based on the estimated incentive payment that the facility would be eligible to receive with respect to such fiscal year.

"(d) DETERMINATION OF FACILITY PER STAY LIMIT.—

"(1) LIMIT FOR FISCAL YEAR 1997.—

"(A) IN GENERAL.—Except as provided in subparagraph (B), the Secretary shall establish separate per stay limits for hospital-based and freestanding skilled nursing facilities for the 12-month cost reporting period beginning during fiscal year 1997 that are equal to the sum of—

"(i) 50 percent of the facility-specific stay amount for the facility (as determined under subsection (e)) for the last 12-month cost reporting period ending on or before September 30, 1994, increased (in a compounded manner) by the SNF market basket percentage increase for fiscal years 1995 through 1997; and

"(ii) 50 percent of the average of all facility-specific stay amounts for all hos-

pital-based facilities or all freestanding facilities (whichever is applicable) during the cost reporting period described in clause (i), increased (in a compounded manner) by the SNF market basket percentage increase for fiscal years 1995 through 1997.

''(B) FACILITIES NOT HAVING 1994 COST REPORTING PERIOD.—In the case of a skilled nursing facility for which payments were not made under this title for covered non-routine services for the last 12-month cost reporting period ending on or before September 30, 1994, the per stay limit for the 12-month cost reporting period beginning during fiscal year 1997 shall be twice the amount determined under subparagraph (A)(ii).

''(2) LIMIT FOR SUBSEQUENT FISCAL YEARS.—The per stay limit for a skilled nursing facility for a 12-month cost reporting period beginning during a fiscal year after fiscal year 1997 is equal to the per stay limit established under this subsection for the 12-month cost reporting period beginning during the previous fiscal year, increased by the SNF market basket percentage increase for such subsequent fiscal year minus 2 percentage points.

"(3) REBASING OF AMOUNTS.—

"(A) IN GENERAL.—The Secretary shall provide for an update to the facility-specific amounts used to determine the per stay limits under this subsection for cost reporting periods beginning on or after October 1, 1999, and every 2 years thereafter.

"(B) TREATMENT OF FACILITIES NOT HAVING REBASED COST REPORTING PERIODS.—Paragraph (1)(B) shall apply with respect to a skilled nursing facility for which payments were not made under this title for covered non-routine services for the 12-month cost reporting period used by the Secretary to update facility-specific amounts under subparagraph (A) in the same manner as such paragraph applies with respect to a facility for which payments were not made under this title for covered non-routine services for the last 12-month cost reporting period ending on or before September 30, 1994.

"(e) DETERMINATION OF FACILITY-SPECIFIC STAY AMOUNTS.—The 'facility-specific stay amount' for a skilled nursing facility for a cost reporting period is the sum of—

"(1) the average amount of payments made to the facility under part A during the period which are attributable to covered non-routine services furnished during a stay (as determined on a per diem basis); and

"(2) the Secretary's best estimate of the average amount of payments made under part B during the period for covered non-routine services furnished to all residents of the facility to whom the facility provided extended care services for which payment was made under part A during the period (without regard to whether or not the services were furnished by the facility, by others under arrangement with them made by the facility, under any other contracting or consulting arrangement, or otherwise), as estimated by the Secretary.

"(f) INTENSIVE NURSING OR THERAPY NEEDS.—

"(1) IN GENERAL.—In applying subsection (b) to covered non-routine services furnished during a stay beginning during a cost reporting period beginning during a fiscal year (beginning with fiscal years after fiscal year 1997) to a resident of a skilled nursing facility who requires intensive nursing or therapy services, the per stay limit for such resident shall be the per stay limit developed under para-

graph (2) instead of the per stay limit determined under subsection (d)(1)(A).

''(2) PER STAY LIMIT FOR INTENSIVE NEED RESIDENTS.—Not later than June 30, 1997, the Secretary, after consultation with the Medicare Payment Review Commission and skilled nursing facility experts, shall develop and publish a per stay limit for residents of a skilled nursing facility who require intensive nursing or therapy services.

''(3) BUDGET NEUTRALITY.—The Secretary shall adjust payments under subsection (b) in a manner that ensures that total payments for covered non-routine services under this section are not greater or less than total payments for such services would have been but for the application of paragraph (1).

''(g) SPECIAL TREATMENT FOR SMALL SKILLED NURSING FACILITIES.—This section shall not apply with respect to a skilled nursing facility for which payment is made for routine service costs during a cost reporting period on the basis of prospective payments under section 1888(d).

''(h) EXCEPTIONS AND ADJUSTMENTS TO LIMITS.—

''(1) IN GENERAL.—The Secretary may make exceptions and adjustments to the cost reporting

limits applicable to a skilled nursing facility under subsection (c)(1)(B) for a cost reporting period, except that the total amount of any additional payments made under this section for covered non-routine services during the cost reporting period as a result of such exceptions and adjustments may not exceed 5 percent of the aggregate payments made to all skilled nursing facilities for covered non-routine services during the cost reporting period (determined without regard to this paragraph).

''(2) BUDGET NEUTRALITY.—The Secretary shall adjust payments under subsection (b) in a manner that ensures that total payments for covered non-routine services under this section are not greater or less than total payments for such services would have been but for the application of paragraph (1).

''(i) SPECIAL RULE FOR X-RAY SERVICES.—Before furnishing a covered non-routine service consisting of an X-ray service for which payment may be made under part A or part B to a resident, a skilled nursing facility shall consider whether furnishing the service through a provider of portable X-ray service services would be appropriate, taking into account the cost effectiveness of the service and the convenience to the resident.''.

(2) CONFORMING AMENDMENT.—Section 1814(b) (42 U.S.C. 1395f(b)) is amended in the matter preceding paragraph (1) by striking ''1813 and 1886'' and inserting ''1813, 1886, 1888, and 1888A''.

SEC. 15235. FREEZE IN PAYMENTS FOR CLINICAL DIAGNOSTIC LABORATORY TESTS.

Section 1833(h)(2)(A)(ii)(IV) (42 U.S.C. 1395l(h)(2)(A)(ii)(IV)) is amended by striking ''1994 and 1995'' and inserting ''1994 through 1998''.

PART 5—GRADUATE MEDICAL EDUCATION AND TEACHING HOSPITALS

SEC. 15241. TEACHING HOSPITAL AND GRADUATE MEDICAL EDUCATION TRUST FUND.

(a) TEACHING HOSPITAL AND GRADUATE MEDICAL EDUCATION TRUST FUND.—The Social Security Act (42 U.S.C. 300 et seq.) is amended by adding at the end the following title:

''TITLE XXI—TEACHING HOSPITAL AND GRADUATE MEDICAL EDUCATION TRUST FUND

''PART A—ESTABLISHMENT OF FUND

''SEC. 2101. ESTABLISHMENT OF FUND.

''(a) IN GENERAL.—There is established in the Treasury of the United States a fund to be known as the Teaching Hospital and Graduate Medical Education Trust

Fund (in this title referred to as the 'Fund'), consisting of amounts transferred to the Fund under subsection (c), amounts appropriated to the Fund pursuant to subsections (d) and (e)(3), and such gifts and bequests as may be deposited in the Fund pursuant to subsection (f). Amounts in the Fund are available until expended.

''(b) EXPENDITURES FROM FUND.—Amounts in the Fund are available to the Secretary for making payments under section 2111.

''(c) TRANSFERS TO FUND.—

''(1) IN GENERAL.—From the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, the Secretary shall, for fiscal year 1996 and each subsequent fiscal year, transfer to the Fund an amount determined by the Secretary for the fiscal year involved in accordance with paragraph (2).

''(2) DETERMINATION OF AMOUNTS.—For purposes of paragraph (1), the amount determined under this paragraph for a fiscal year is an estimate by the Secretary of an amount equal to 75 percent of the difference between—

''(A) the nationwide total of the amounts that would have been paid under sections 1855

and 1876 during the year but for the operation of section 1855(b)(2)(B)(ii); and

''(B) the nationwide total of the amounts paid under such sections during the year.

''(3) ALLOCATION BETWEEN MEDICARE TRUST FUNDS.—In providing for a transfer under paragraph (1) for a fiscal year, the Secretary shall provide for an allocation of the amounts involved between part A and part B of title XVIII (and the trust funds established under the respective parts) as reasonably reflects the proportion of payments for the indirect costs of medical education and direct graduate medical education costs of hospitals associated with the provision of services under each respective part.

''(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Fund such sums as may be necessary for each of the fiscal years 1996 through 2002.

''(e) INVESTMENT.—

''(1) IN GENERAL.—The Secretary of the Treasury shall invest such amounts of the Fund as such Secretary determines are not required to meet current withdrawals from the Fund. Such investments may be made only in interest-bearing obliga-

tions of the United States. For such purpose, such obligations may be acquired on original issue at the issue price, or by purchase of outstanding obligations at the market price.

''(2) SALE OF OBLIGATIONS.—Any obligation acquired by the Fund may be sold by the Secretary of the Treasury at the market price.

''(3) AVAILABILITY OF INCOME.—Any interest derived from obligations acquired by the Fund, and proceeds from any sale or redemption of such obligations, are hereby appropriated to the Fund.

''(f) ACCEPTANCE OF GIFTS AND BEQUESTS.—The Fund may accept on behalf of the United States money gifts and bequests made unconditionally to the Fund for the benefit of the Fund or any activity financed through the Fund.

''PART B—PAYMENTS TO TEACHING HOSPITALS

''SEC. 2111. FORMULA PAYMENTS TO TEACHING HOSPITALS.

''(a) IN GENERAL.—In the case of each teaching hospital that in accordance with subsection (b) submits to the Secretary a payment document for fiscal year 1996 or any subsequent fiscal year, the Secretary shall make payments for the year to the teaching hospital for the direct and indirect costs of operating approved medical residency

training programs. Such payments shall be made from the Fund, and shall be made in accordance with a formula established by the Secretary.

''(b) PAYMENT DOCUMENT.—For purposes of subsection (a), a payment document is a document containing such information as may be necessary for the Secretary to make payments under such subsection to a teaching hospital for a fiscal year. The document is submitted in accordance with this subsection if the document is submitted not later than the date specified by the Secretary, and the document is in such form and is made in such manner as the Secretary may require. The Secretary may require that information under this subsection be submitted to the Secretary in periodic reports.''.

(b) NATIONAL ADVISORY COUNCIL ON POSTGRADUATE MEDICAL EDUCATION.—

(1) IN GENERAL.—There is established within the Department of Health and Human Services an advisory council to be known as the National Advisory Council on Postgraduate Medical Education (in this title referred to as the ''Council'').

(2) DUTIES.—The council shall provide advice to the Secretary on appropriate policies for making payments for the support of postgraduate medical education in order to assure an adequate supply of

physicians trained in various specialities, consistent with the health care needs of the United States.

(3) COMPOSITION.—

(A) IN GENERAL.—The Secretary shall appoint to the Council 15 individuals who are not officers or employees of the United States. Such individuals shall include not less than 1 individual from each of the following categories of individuals or entities:

(i) Organizations representing consumers of health care services.

(ii) Physicians who are faculty members of medical schools, or who supervise approved physician training programs.

(iii) Physicians in private practice who are not physicians described in clause (ii).

(iv) Practitioners in public health.

(v) Advanced-practice nurses.

(vi) Other health professionals who are not physicians.

(vii) Medical schools.

(viii) Teaching hospitals.

(ix) The Accreditation Council on Graduate Medical Education.

(x) The American Board of Medical Specialities.

(xi) The Council on Postdoctoral Training of the American Osteopathic Association.

(xii) The Council on Podiatric Medical Education of the American Podiatric Medical Association.

(B) REQUIREMENTS REGARDING REPRESENTATIVE MEMBERSHIP.—To the greatest extent feasible, the membership of the Council shall represent the various geographic regions of the United States, shall reflect the racial, ethnic, and gender composition of the population of the United States, and shall be broadly representative of medical schools and teaching hospitals in the United States.

(C) EX OFFICIO MEMBERS; OTHER FEDERAL OFFICERS OR EMPLOYEES.—The membership of the Council shall include individuals designated by the Secretary to serve as members of the Council from among Federal officers or employees who are appointed by the President, or by the Secretary (or by other Federal officers who are appointed by the President with

the advice and consent of the Senate). Individuals designated under the preceding sentence shall include each of the following officials (or a designee of the official):

(i) The Secretary of Health and Human Services.

(ii) The Secretary of Veterans Affairs.

(iii) The Secretary of Defense.

(4) CHAIR.—The Secretary shall, from among members of the council appointed under paragraph (3)(A), designate an individual to serve as the chair of the council.

(5) TERMINATION.—The Council terminates December 31, 1999.

(c) REMOVE MEDICAL EDUCATION AND DISPROPORTIONATE SHARE HOSPITAL PAYMENTS FROM CALCULATION OF ADJUSTED AVERAGE PER CAPITA COST.—For provision removing medical education and disproportionate share hospital payments from calculation of payment amounts for organizations paid on a capitated basis, see section 1855(b)(2)(B)(ii).

(2) PAYMENTS TO HOSPITALS OF AMOUNTS ATTRIBUTABLE TO DSH.—Section 1886 (42 U.S.C. 1395ww) is amended by adding at the end the following new subsection:

"(j)(1) In addition to amounts paid under subsection (d)(5)(F), the Secretary is authorized to pay hospitals which are eligible for such payments for a fiscal year supplemental amounts that do not exceed the limit provided for in paragraph (2).

"(2) The sum of the aggregate amounts paid pursuant to paragraph (1) for a fiscal year shall not exceed the Secretary's estimate of 75 percent of the amount of reductions in payments under section 1855 that are attributable to the operation of subsection (b)(2)(B)(ii) of such section. ".

SEC. 15242. REDUCTION IN PAYMENT ADJUSTMENTS FOR INDIRECT MEDICAL EDUCATION.

(a) MODIFICATION REGARDING 5.6 PERCENT.—Section 1886(d)(5)(B)(ii) (42 U.S.C. 1395ww(d)(5)(B)(ii)) is amended—

(1) by striking "on or after October 1, 1988," and inserting "on or after October 1, 1999,"; and

(2) by striking "1.89" and inserting "1.38".

(b) SPECIAL RULE REGARDING FISCAL YEARS 1996 THROUGH 1998; MODIFICATION REGARDING 6 PERCENT.—Section 1886(d)(5)(B)(ii), as amended by paragraph (1), is amended by adding at the end the following: "In the case of discharges occurring on or after October 1, 1995, and before October 1, 1999, the preceding sen-

tence applies to the same extent and in the same manner as the sentence applies to discharges occurring on or after October 1, 1999, except that the term '1.38' is deemed to be 1.48.''.

Subtitle D—Provisions Relating to Medicare Beneficiaries

SEC. 15301. EXTENDING MEDICARE PART B PREMIUM.

Section 1839(e) (42 U.S.C. 1395r(e)) is amended—

(1) in paragraph (1)(A), by striking ''January 1999 shall be an amount equal to 50 percent'' and inserting ''January 2003 shall be an amount equal to 56 percent'', and

(2) in paragraph (2) by striking ''1998'' and inserting ''2002''.

SEC. 15302. RELATING MEDICARE PART B PREMIUM TO INCOME FOR CERTAIN HIGH INCOME INDIVIDUALS.

(a) INCREASE IN PREMIUM.—

(1) IN GENERAL.—Section 1839 (42 U.S.C. 1395r) is amended by adding at the end the following:

''(h)(1) Notwithstanding the previous subsections of this section, in the case of an individual whose modified adjusted gross income in a taxable year ending with or within a calendar year (as reported by the individual under

section 1894(a)) is equal to or exceeds the sum of the threshold amount described in paragraph (4) and $25,000, the amount of the monthly premium for the calendar year shall be increased by an amount such that the total monthly premium (determined without regard to subsection (b)) is equal to 200 percent of the monthly actuarial rate for enrollees age 65 and over as determined under subsection (a)(1) for that calendar year. The preceding sentence shall not apply to any individual whose threshold amount is zero.

''(2) Notwithstanding the previous subsections of this section, in the case of an individual not described in paragraph (1) whose modified adjusted gross income in a taxable year ending with or within a calendar year (as reported by the individual under section 1894(a)) exceeds the threshold amount described in paragraph (4), the amount of the monthly premium for the calendar year shall be increased by an amount which bears the same ratio to the amount of the increase determined under paragraph (1) as such excess bears to $25,000. The preceding sentence shall not apply to any individual whose threshold amount is zero.

''(3) Using information provided by the Secretary of the Treasury under section 6103(l)(14) of the Internal Revenue Code of 1986, the Secretary shall determine the

actual modified adjusted gross income of individuals enrolled in this part during a taxable year and adjust the monthly premium applicable to an individual during a calendar year to take into account any overpayments or underpayments in the premium during the previous calendar year resulting from the application of this subsection.

''(4) In this subsection and section 1813(c), the term 'threshold amount' means—

''(A) except as otherwise provided in this paragraph, $75,000,

''(B) $100,000 in the case of an individual who files a joint return under section 6013 of the Internal Revenue Code of 1986, and

''(C) zero in the case of an individual who—

''(i) is married at the close of the taxable year (as determined under section 7703 of the Internal Revenue Code of 1986) but does not file a joint return for such year, and

''(ii) does not live apart from the individual's spouse at all times during the taxable year.''.

(2) CONFORMING AMENDMENT.—Section 1839(f) (42 U.S.C. 1395r(f)) is amended by striking ''if an individual'' and inserting the following: ''if an individual (other than an individual subject to an in-

crease in the monthly premium under this section pursuant to subsection (h))''.

(3) EFFECTIVE DATE.—The amendments made by paragraphs (1) and (2) shall apply to the monthly premium under section 1839 of the Social Security Act for months beginning after February 1996 in taxable years beginning after December 31, 1995.

(b) REPORTING REQUIREMENT FOR BENEFICIARIES.—Title XVIII, as amended by section 15231(d), is further amended by adding at the end the following:

''REPORT TO SECRETARY ON ESTIMATED MODIFIED ADJUSTED GROSS INCOME

''SEC. 1894. (a) IN GENERAL.—

''(1) INDIVIDUALS COVERED THROUGHOUT YEAR.—Not later than November 1 of each year (beginning with 1996), each individual enrolled under part B shall submit to the Secretary (in such form and manner as the Secretary may require, in consultation with the Secretary of the Treasury) an estimate of the individual's modified adjusted gross income anticipated for the taxable year ending with or within the following calendar year, to be used (subject to section 1839(h)(3)) to determine whether the individual is to be subject to an increase in the

monthly part B premium under section 1839(h) for such following calendar year.

''(2) SPECIAL RULE FOR FIRST YEAR OF COVERAGE.—For the first year in which an individual is enrolled under part B, the individual shall submit to the Secretary (at such time and in such form and manner as the Secretary may require, in consultation with the Secretary of the Treasury) an estimate of the individual's modified adjusted gross income anticipated for the taxable year ending with December 31 of such year, to be used to determine whether the individual is to be subject to an increase in the monthly part B premium under section 1839(h) for such year.

''(b) SPECIAL RULE FOR 1996.—Not later than 60 days after the date of the enactment of this section, each individual described in subsection (a) shall submit to the Secretary an estimate of the individual's modified adjusted gross income for the taxable year ending December 1995, to be used to determine (subject to section 1839(h)(3)) whether the individual is to be subject to an increase in the monthly part B premium under section 1839(h) during 1996.

''(c) MODIFIED ADJUSTED GROSS INCOME DEFINED.—In subsection (a), the term 'modified adjusted

gross income' means, with respect to an individual for a taxable year, the individual's adjusted gross income under the Internal Revenue Code of 1986, determined without regard to sections 931 or 933 of such Code.''.

(c) DISCLOSURE OF CERTAIN TAX INFORMATION BY SECRETARY OF TREASURY.—

(1) IN GENERAL.—Subsection (l) of section 6103 of the Internal Revenue Code of 1986 (relating to confidentiality and disclosure of returns and return information) is amended by adding at the end thereof the following new paragraph:

''(14) DISCLOSURE OF RETURN INFORMATION TO MEANS-TEST MEDICARE.—

''(A) IN GENERAL.—The Secretary shall, upon written request from the Administrator of the Health Care Financing Administration, disclose to the officers and employees of such Administration return information necessary to determine the modified adjusted gross income (as defined in section 1894(c) of the Social Security Act) of any medicare beneficiary (as defined in paragraph (12)(E)), to be used to determine whether the beneficiary is to be subject to an increase in the monthly part B premium under section 1839(g) of such Act.

"(B) RESTRICTION ON USE OF DISCLOSED INFORMATION.—Any officer or employee of the Health Care Financing Administration receiving return information under subparagraph (A) shall use such information only for purposes of, and to the extent necessary in, establishing the modified adjusted gross income (as so defined) of any medicare beneficiary (as so defined)."

(2) CONFORMING AMENDMENTS.—Paragraphs (3)(A) and (4) of section 6103(p) of such Code are each amended by striking "or (13)" each place it appears and inserting "(13), or (14)".

(3) EFFECTIVE DATE.—The amendments made by paragraphs (1) and (2) shall apply with respect to information for taxable years beginning after December 31, 1995.

SEC. 15303. EXPANDED COVERAGE OF PREVENTIVE BENEFITS.

(a) PROVIDING ANNUAL SCREENING MAMMOGRAPHY FOR WOMEN OVER AGE 49.—Section 1834(c)(2)(A) (42 U.S.C. 1395m(c)(2)(A)) is amended—

(1) in clause (iv), by striking "but under 65 years of age,"; and

(2) by striking clause (v).

(b) COVERAGE OF SCREENING PAP SMEAR AND PELVIC EXAMS.—

(1) COVERAGE OF PELVIC EXAM; INCREASING FREQUENCY OF COVERAGE OF PAP SMEAR.—Section 1861(nn) (42 U.S.C. 1395x(nn)) is amended—

(A) in the heading, by striking ''Smear'' and inserting ''Smear; Screening Pelvic Exam'';

(B) by striking ''(nn)'' and inserting ''(nn)(1)'';

(C) by striking ''3 years'' and all that follows and inserting ''3 years, or during the preceding year in the case of a woman described in paragraph (3).''; and

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

''(2) The term 'screening pelvic exam' means an pelvic examination provided to a woman if the woman involved has not had such an examination during the preceding 3 years, or during the preceding year in the case of a woman described in paragraph (3), and includes a clinical breast examination.

''(3) A woman described in this paragraph is a woman who—

''(A) is of childbearing age and has not had a test described in this subsection during each of the

preceding 3 years that did not indicate the presence of cervical cancer; or

''(B) is at high risk of developing cervical cancer (as determined pursuant to factors identified by the Secretary).''.

(2) WAIVER OF DEDUCTIBLE.—The first sentence of section 1833(b) (42 U.S.C. 1395l(b)), as amended by subsection (a)(2), is amended—

(A) by striking ''and (5)'' and inserting ''(5)''; and

(B) by striking the period at the end and inserting the following: '', and (6) such deductible shall not apply with respect to screening pap smear and screening pelvic exam (as described in section 1861(nn)).''.

(3) CONFORMING AMENDMENTS.—(A) Section 1861(s)(14) (42 U.S.C. 1395x(s)(14)) is amended by inserting ''and screening pelvic exam'' after ''screening pap smear''.

(B) Section 1862(a)(1)(F) (42 U.S.C. 1395y(a)(1)(F)) is amended by inserting ''and screening pelvic exam'' after ''screening pap smear''.

(c) COVERAGE OF COLORECTAL SCREENING.—

(1) IN GENERAL.—Section 1834 (42 U.S.C. 1395m) is amended by inserting after subsection (c) the following new subsection:

''(d) FREQUENCY AND PAYMENT LIMITS FOR SCREENING FECAL-OCCULT BLOOD TESTS, SCREENING FLEXIBLE SIGMOIDOSCOPIES, AND SCREENING COLONOSCOPY.—

''(1) FREQUENCY LIMITS FOR SCREENING FECAL-OCCULT BLOOD TESTS.—Subject to revision by the Secretary under paragraph (4), no payment may be made under this part for a screening fecal-occult blood test provided to an individual for the purpose of early detection of colon cancer if the test is performed—

''(A) in the case of an individual under 65 years of age, more frequently than is provided in a periodicity schedule established by the Secretary for purposes of this subparagraph; or

''(B) in the case of any other individual, within the 11 months following the month in which a previous screening fecal-occult blood test was performed.

''(2) SCREENING FLEXIBLE SIGMOIDOSCOPIES.—

"(A) PAYMENT AMOUNT.—The Secretary shall establish a payment amount under section 1848 with respect to screening flexible sigmoidoscopies provided for the purpose of early detection of colon cancer that is consistent with payment amounts under such section for similar or related services, except that such payment amount shall be established without regard to subsection (a)(2)(A) of such section.

"(B) FREQUENCY LIMITS.—Subject to revision by the Secretary under paragraph (4), no payment may be made under this part for a screening flexible sigmoidoscopy provided to an individual for the purpose of early detection of colon cancer if the procedure is performed—

"(i) in the case of an individual under 65 years of age, more frequently than is provided in a periodicity schedule established by the Secretary for purposes of this subparagraph; or

"(ii) in the case of any other individual, within the 59 months following the month in which a previous screening flexible sigmoidoscopy was performed.

"(3) SCREENING COLONOSCOPY FOR INDIVIDUALS AT HIGH RISK FOR COLORECTAL CANCER.—

"(A) PAYMENT AMOUNT.—The Secretary shall establish a payment amount under section 1848 with respect to screening colonoscopy for individuals at high risk for colorectal cancer (as determined in accordance with criteria established by the Secretary) provided for the purpose of early detection of colon cancer that is consistent with payment amounts under such section for similar or related services, except that such payment amount shall be established without regard to subsection (a)(2)(A) of such section.

"(B) FREQUENCY LIMIT.—Subject to revision by the Secretary under paragraph (4), no payment may be made under this part for a screening colonoscopy for individuals at high risk for colorectal cancer provided to an individual for the purpose of early detection of colon cancer if the procedure is performed within the 47 months following the month in which a previous screening colonoscopy was performed.

"(C) FACTORS CONSIDERED IN ESTABLISHING CRITERIA FOR DETERMINING INDIVID-

UALS AT HIGH RISK.—In establishing criteria for determining whether an individual is at high risk for colorectal cancer for purposes of this paragraph, the Secretary shall take into consideration family history, prior experience of cancer, a history of chronic digestive disease condition, and the presence of any appropriate recognized gene markers for colorectal cancer.

''(4) REVISION OF FREQUENCY.—

''(A) REVIEW.—The Secretary shall review periodically the appropriate frequency for performing screening fecal-occult blood tests, screening flexible sigmoidoscopies, and screening colonoscopy based on age and such other factors as the Secretary believes to be pertinent.

''(B) REVISION OF FREQUENCY.—The Secretary, taking into consideration the review made under clause (i), may revise from time to time the frequency with which such tests and procedures may be paid for under this subsection.''.

(2) CONFORMING AMENDMENTS.—(A) Paragraphs (1)(D) and (2)(D) of section 1833(a) (42 U.S.C. 1395l(a)) are each amended by striking

''subsection (h)(1),'' and inserting ''subsection (h)(1) or section 1834(d)(1),''.

(B) Clauses (i) and (ii) of section 1848(a)(2)(A) (42 U.S.C. 1395w–4(a)(2)(A)) are each amended by striking ''a service'' and inserting ''a service (other than a screening flexible sigmoidoscopy provided to an individual for the purpose of early detection of colon cancer or a screening colonoscopy provided to an individual at high risk for colorectal cancer for the purpose of early detection of colon cancer)''.

(C) Section 1862(a) (42 U.S.C. 1395y(a)) is amended—

(i) in paragraph (1)—

(I) in subparagraph (E), by striking ''and'' at the end;

(II) in subparagraph (F), by striking the semicolon at the end and inserting '', and''; and

(III) by adding at the end the following new subparagraph:

''(G) in the case of screening fecal-occult blood tests, screening flexible sigmoidoscopies, and screening colonoscopy provided for the purpose of early detection of colon cancer, which are performed more

frequently than is covered under section 1834(d);''; and

(ii) in paragraph (7), by striking ''paragraph (1)(B) or under paragraph (1)(F)'' and inserting ''subparagraphs (B), (F), or (G) of paragraph (1)''.

(d) PROSTATE CANCER SCREENING TESTS.—

(1) IN GENERAL.—Section 1861(s)(2) (42 U.S.C. 1395x(s)(2)) is amended—

(A) by striking ''and'' at the end of subparagraph (N) and subparagraph (O); and

(B) by inserting after subparagraph (O) the following new subparagraph:

''(P) prostate cancer screening tests (as defined in subsection (oo)); and''.

(2) TESTS DESCRIBED.—Section 1861 (42 U.S.C. 1395x) is amended by adding at the end the following new subsection:

''Prostate Cancer Screening Tests

''(oo) The term 'prostate cancer screening test' means a test that consists of a digital rectal examination or a prostate-specific antigen blood test (or both) provided for the purpose of early detection of prostate cancer to a man over 40 years of age who has not had such a test during the preceding year.''.

(3) PAYMENT FOR PROSTATE-SPECIFIC ANTIGEN BLOOD TEST UNDER CLINICAL DIAGNOSTIC LABORATORY TEST FEE SCHEDULES.—Section 1833(h)(1)(A) (42 U.S.C. 1395l(h)(1)(A)) is amended by inserting after ''laboratory tests'' the following: ''(including prostate cancer screening tests under section 1861(oo) consisting of prostate-specific antigen blood tests)''.

(4) CONFORMING AMENDMENT.—Section 1862(a) (42 U.S.C. 1395y(a)), as amended by subsection (c)(3)(C), is amended—

(A) in paragraph (1)—

(i) in subparagraph (F), by striking ''and'' at the end,

(ii) in subparagraph (G), by striking the semicolon at the end and inserting '', and'', and

(iii) by adding at the end the following new subparagraph:

''(H) in the case of prostate cancer screening test (as defined in section 1861(oo)) provided for the purpose of early detection of prostate cancer, which are performed more frequently than is covered under such section;''; and

(B) in paragraph (7), by striking ''or (G)'' and inserting ''(G), or (H)''.

(e) DIABETES SCREENING BENEFITS.—

(1) DIABETES OUTPATIENT SELF-MANAGEMENT TRAINING SERVICES.—

(A) IN GENERAL.—Section 1861(s)(2) (42 U.S.C. 1395x(s)(2)), as amended by subsection (d)(1), is amended—

(i) by striking ''and'' at the end of subparagraph (N);

(ii) by striking ''and'' at the end of subparagraph (O); and

(iii) by inserting after subparagraph (O) the following new subparagraph:

''(P) diabetes outpatient self-management training services (as defined in subsection (pp)); and''.

(B) DEFINITION.—Section 1861 (42 U.S.C. 1395x), as amended by subsection (d)(2), is amended by adding at the end the following new subsection:

''DIABETES OUTPATIENT SELF-MANAGEMENT TRAINING SERVICES

''(pp)(1) The term 'diabetes outpatient self-management training services' means educational and training services furnished to an individual with diabetes by or under arrangements with a certified provider (as described

in paragraph (2)(A)) in an outpatient setting by an individual or entity who meets the quality standards described in paragraph (2)(B), but only if the physician who is managing the individual's diabetic condition certifies that such services are needed under a comprehensive plan of care related to the individual's diabetic condition to provide the individual with necessary skills and knowledge (including skills related to the self-administration of injectable drugs) to participate in the management of the individual's condition.

''(2) In paragraph (1)—

''(A) a 'certified provider' is an individual or entity that, in addition to providing diabetes outpatient self-management training services, provides other items or services for which payment may be made under this title; and

''(B) an individual or entity meets the quality standards described in this paragraph if the individual or entity meets quality standards established by the Secretary, except that the individual or entity shall be deemed to have met such standards if the individual or entity meets applicable standards originally established by the National Diabetes Advisory Board and subsequently revised by organizations who participated in the establishment of standards

by such Board, or is recognized by the American Diabetes Association as meeting standards for furnishing the services.''.

(C) CONSULTATION WITH ORGANIZATIONS IN ESTABLISHING PAYMENT AMOUNTS FOR SERVICES PROVIDED BY PHYSICIANS.—In establishing payment amounts under section 1848(a) of the Social Security Act for physicians' services consisting of diabetes outpatient self-management training services, the Secretary of Health and Human Services shall consult with appropriate organizations, including the American Diabetes Association, in determining the relative value for such services under section 1848(c)(2) of such Act.

(2) BLOOD-TESTING STRIPS FOR INDIVIDUALS WITH DIABETES.—

(A) INCLUDING STRIPS AS DURABLE MEDICAL EQUIPMENT.—Section 1861(n) (42 U.S.C. 1395x(n)) is amended by striking the semicolon in the first sentence and inserting the following: '', and includes blood-testing strips for individuals with diabetes without regard to whether the individual has Type I or Type II diabetes (as determined under standards established by

the Secretary in consultation with the American Diabetes Association);''.

(2) PAYMENT FOR STRIPS BASED ON METHODOLOGY FOR INEXPENSIVE AND ROUTINELY PURCHASED EQUIPMENT.—Section 1834(a)(2)(A) (42 U.S.C. 1395m(a)(2)(A)) is amended—

(A) by striking ''or'' at the end of clause (ii);

(B) by adding ''or'' at the end of clause (iii); and

(C) by inserting after clause (iii) the following new clause:

''(iv) which is a blood-testing strip for an individual with diabetes,''.

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after January 1, 1996.

Subtitle E—Medicare Fraud Reduction

SEC. 15401. INCREASING BENEFICIARY AWARENESS OF FRAUD AND ABUSE.

(a) BENEFICIARY OUTREACH EFFORTS.—The Secretary of Health and Human Services (acting through the Administrator of the Health Care Financing Administration and the Inspector General of the Department of

Health and Human Services) shall make ongoing efforts (through public service announcements, publications, and other appropriate methods) to alert individuals entitled to benefits under the medicare program of the existence of fraud and abuse committed against the program and the costs to the program of such fraud and abuse, and of the existence of the toll-free telephone line operated by the Secretary to receive information on fraud and abuse committed against the program.

(b) CLARIFICATION OF REQUIREMENT TO PROVIDE EXPLANATION OF MEDICARE BENEFITS.—The Secretary shall provide an explanation of benefits under the medicare program with respect to each item or service for which payment may be made under the program which is furnished to an individual, without regard to whether or not a deductible or coinsurance may be imposed against the individual with respect to the item or service.

(c) PROVIDER OUTREACH EFFORTS; PUBLICATION OF FRAUD ALERTS.—

(1) SPECIAL FRAUD ALERTS.—

(A) IN GENERAL.—

(i) REQUEST FOR SPECIAL FRAUD ALERTS.—Any person may present, at any time, a request to the Secretary to issue and publish a special fraud alert.

(ii) SPECIAL FRAUD ALERT DEFINED.—In this section, a ''special fraud alert'' is a notice which informs the public of practices which the Secretary considers to be suspect or of particular concern under the medicare program or a State health care program (as defined in section 1128(h) of the Social Security Act).

(B) ISSUANCE AND PUBLICATION OF SPECIAL FRAUD ALERTS.—

(i) INVESTIGATION.—Upon receipt of a request for a special fraud alert under subparagraph (A), the Secretary shall investigate the subject matter of the request to determine whether a special fraud alert should be issued. If appropriate, the Secretary (in consultation with the Attorney General) shall issue a special fraud alert in response to the request. All special fraud alerts issued pursuant to this subparagraph shall be published in the Federal Register.

(ii) CRITERIA FOR ISSUANCE.—In determining whether to issue a special fraud

alert upon a request under subparagraph (A), the Secretary may consider—

(I) whether and to what extent the practices that would be identified in the special fraud alert may result in any of the consequences described in subparagraph (C); and

(II) the extent and frequency of the conduct that would be identified in the special fraud alert.

(C) CONSEQUENCES DESCRIBED.—The consequences described in this subparagraph are as follows:

(i) An increase or decrease in access to health care services.

(ii) An increase or decrease in the quality of health care services.

(iii) An increase or decrease in patient freedom of choice among health care providers.

(iv) An increase or decrease in competition among health care providers.

(v) An increase or decrease in the cost to health care programs of the Federal Government.

(vi) An increase or decrease in the potential overutilization of health care services.

(vii) Any other factors the Secretary deems appropriate in the interest of preventing fraud and abuse in health care programs of the Federal Government.

(2) PUBLICATION OF ALL HCFA FRAUD ALERTS IN FEDERAL REGISTER.—Each notice issued by the Health Care Financing Administration which informs the public of practices which the Secretary considers to be suspect or of particular concern under the medicare program or a State health care program (as defined in section 1128(h) of the Social Security Act) shall be published in the Federal Register, without regard to whether or not the notice is issued by a regional office of the Health Care Financing Administration.

SEC. 15402. BENEFICIARY INCENTIVES TO REPORT FRAUD AND ABUSE.

(a) PROGRAM TO COLLECT INFORMATION ON FRAUD AND ABUSE.—

(1) ESTABLISHMENT OF PROGRAM.—Not later than 3 months after the date of the enactment of this Act, the Secretary shall establish a program

under which the Secretary shall encourage individuals to report to the Secretary information on individuals and entities who are engaging or who have engaged in acts or omissions which constitute grounds for the imposition of a sanction under section 1128, section 1128A, or section 1128B of the Social Security Act, or who have otherwise engaged in fraud and abuse against the medicare program.

(2) PAYMENT OF PORTION OF AMOUNTS COLLECTED.—If an individual reports information to the Secretary under the program established under paragraph (1) which serves as the basis for the collection by the Secretary or the Attorney General of any amount of at least $100 (other than any amount paid as a penalty under section 1128B of the Social Security Act), the Secretary may pay a portion of the amount collected to the individual (under procedures similar to those applicable under section 7623 of the Internal Revenue Code of 1986 to payments to individuals providing information on violations of such Code).

(b) PROGRAM TO COLLECT INFORMATION ON PROGRAM EFFICIENCY.—

(1) ESTABLISHMENT OF PROGRAM.—Not later than 3 months after the date of the enactment of

this Act, the Secretary shall establish a program under which the Secretary shall encourage individuals to submit to the Secretary suggestions on methods to improve the efficiency of the medicare program.

(2) PAYMENT OF PORTION OF PROGRAM SAVINGS.—If an individual submits a suggestion to the Secretary under the program established under paragraph (1) which is adopted by the Secretary and which results in savings to the program, the Secretary may make a payment to the individual of such amount as the Secretary considers appropriate.

SEC. 15403. ELIMINATION OF HOME HEALTH OVERPAYMENTS.

(a) REQUIRING BILLING AND PAYMENT TO BE BASED ON SITE WHERE SERVICE FURNISHED.—Section 1891 (42 U.S.C. 1395bbb) is amended by adding at the end the following new subsection:

''(g) A home health agency shall submit claims for payment for home health services under this title only on the basis of the geographic location at which the service is furnished.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to services furnished during cost reporting periods beginning on or after October 1, 1995.

SEC. 15404. SKILLED NURSING FACILITIES.

(a) CLARIFICATION OF TREATMENT OF HOSPITAL TRANSFERS.—Section 1886(d)(5)(I) (42 U.S.C. 1395ww(d)(5)(I)) is amended by adding at the end the following new clause:

''(iii) In making adjustments under clause (i) for transfer cases, the Secretary shall treat as a transfer any transfer to a hospital (without regard to whether or not the hospital is a subsection (d) hospital), a unit thereof, or a skilled nursing facility.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to discharges occurring on or after October 1, 1995.

SEC. 15405. DIRECT SPENDING FOR ANTI-FRAUD ACTIVITIES UNDER MEDICARE.

(a) ESTABLISHMENT OF MEDICARE INTEGRITY PROGRAM.—Title XVIII, as amended by section 15231(d) and section 15302(b), is further amended by adding at the end the following new section:

''MEDICARE INTEGRITY PROGRAM

''SEC. 1895. (a) ESTABLISHMENT OF PROGRAM.—There is hereby established the Medicare Integrity Program (hereafter in this section referred to as the 'Program') under which the Secretary shall promote the integrity of the medicare program by entering into contracts

in accordance with this section with eligible private entities to carry out the activities described in subsection (b).

''(b) ACTIVITIES DESCRIBED.—The activities described in this subsection are as follows:

''(1) Review of activities of providers of services or other individuals and entities furnishing items and services for which payment may be made under this title (including skilled nursing facilities and home health agencies), including medical and utilization review and fraud review (employing similar standards, processes, and technologies used by private health plans, including equipment and software technologies which surpass the capability of the equipment and technologies used in the review of claims under this title as of the date of the enactment of this section).

''(2) Audit of cost reports.

''(3) Determinations as to whether payment should not be, or should not have been, made under this title by reason of section 1862(b), and recovery of payments that should not have been made.

''(4) Education of providers of services, beneficiaries, and other persons with respect to payment integrity and benefit quality assurance issues.

"(c) ELIGIBILITY OF ENTITIES.—An entity is eligible to enter into a contract under the Program to carry out any of the activities described in subsection (b) if—

"(1) the entity has demonstrated capability to carry out such activities;

"(2) in carrying out such activities, the entity agrees to cooperate with the Inspector General of the Department of Health and Human Services, the Attorney General of the United States, and other law enforcement agencies, as appropriate, in the investigation and deterrence of fraud and abuse in relation to this title and in other cases arising out of such activities;

"(3) the entity's financial holdings, interests, or relationships will not interfere with its ability to perform the functions to be required by the contract in an effective and impartial manner; and

"(4) the entity meets such other requirements as the Secretary may impose.

"(d) PROCESS FOR ENTERING INTO CONTRACTS.—The Secretary shall enter into contracts under the Program in accordance with such procedures as the Secretary may by regulation establish, except that such procedures shall include the following:

"(1) The Secretary shall determine the appropriate number of separate contracts which are necessary to carry out the Program and the appropriate times at which the Secretary shall enter into such contracts.

"(2) The provisions of section 1153(e)(1) shall apply to contracts and contracting authority under this section, except that competitive procedures must be used when entering into new contracts under this section, or at any other time considered appropriate by the Secretary.

"(3) A contract under this section may be renewed without regard to any provision of law requiring competition if the contractor has met or exceeded the performance requirements established in the current contract.

"(e) LIMITATION ON CONTRACTOR LIABILITY.—The Secretary shall by regulation provide for the limitation of a contractor's liability for actions taken to carry out a contract under the Program, and such regulation shall, to the extent the Secretary finds appropriate, employ the same or comparable standards and other substantive and procedural provisions as are contained in section 1157.

"(f) TRANSFER OF AMOUNTS TO MEDICARE ANTI-FRAUD AND ABUSE TRUST FUND.—For each fiscal year,

the Secretary shall transfer from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund to the Medicare Anti-Fraud and Abuse Trust Fund under subsection (g) such amounts as are necessary to carry out the activities described in subsection (b). Such transfer shall be in an allocation as reasonably reflects the proportion of such expenditures associated with part A and part B.

''(g) MEDICARE ANTI-FRAUD AND ABUSE TRUST FUND.—

''(1) ESTABLISHMENT.—

''(A) IN GENERAL.—There is hereby established in the Treasury of the United States the Anti-Fraud and Abuse Trust Fund (hereafter in this subsection referred to as the 'Trust Fund'). The Trust Fund shall consist of such gifts and bequests as may be made as provided in subparagraph (B) and such amounts as may be deposited in the Trust Fund as provided in subsection (f).

''(B) AUTHORIZATION TO ACCEPT GIFTS AND BEQUESTS.—The Trust Fund is authorized to accept on behalf of the United States money gifts and bequests made unconditionally to the Trust Fund, for the benefit of the Trust

Fund or any activity financed through the Trust Fund.

''(2) INVESTMENT.—

''(A) IN GENERAL.—The Secretary of the Treasury shall invest such amounts of the Fund as such Secretary determines are not required to meet current withdrawals from the Fund in government account serial securities.

''(B) USE OF INCOME.—Any interest derived from investments under subparagraph (A) shall be credited to the Fund.

''(3) DIRECT APPROPRIATION OF FUNDS TO CARRY OUT PROGRAM.—

''(A) IN GENERAL.—There are appropriated from the Trust Fund for each fiscal year such amounts as are necessary to carry out the Medicare Integrity Program under this section, subject to subparagraph (B).

''(B) AMOUNTS SPECIFIED.—The amount appropriated under subparagraph (A) for a fiscal year is as follows:

''(i) For fiscal year 1996, such amount shall be not less than $430,000,000 and not more than $440,000,000.

"(ii) For fiscal year 1997, such amount shall be not less than $490,000,000 and not more than $500,000,000.

"(iii) For fiscal year 1998, such amount shall be not less than $550,000,000 and not more than $560,000,000.

"(iv) For fiscal year 1999, such amount shall be not less than $620,000,000 and not more than $630,000,000.

"(v) For fiscal year 2000, such amount shall be not less than $670,000,000 and not more than $680,000,000.

"(vi) For fiscal year 2001, such amount shall be not less than $690,000,000 and not more than $700,000,000.

"(vii) For fiscal year 2002, such amount shall be not less than $710,000,000 and not more than $720,000,000.

"(4) ANNUAL REPORT.—The Secretary shall submit an annual report to Congress on the amount of revenue which is generated and disbursed by the Trust Fund in each fiscal year.".

(b) ELIMINATION OF FI AND CARRIER RESPONSIBILITY FOR CARRYING OUT ACTIVITIES SUBJECT TO PROGRAM.—

(1) RESPONSIBILITIES OF FISCAL INTERMEDIARIES UNDER PART A.—Section 1816 (42 U.S.C. 1395h) is amended by adding at the end the following new subsection:

"(l) No agency or organization may carry out (or receive payment for carrying out) any activity pursuant to an agreement under this section to the extent that the activity is carried out pursuant to a contract under the Medicare Integrity Program under section 1895.".

(2) RESPONSIBILITIES OF CARRIERS UNDER PART B.—Section 1842(c) (42 U.S.C. 1395u(c)) is amended by adding at the end the following new paragraph:

"(6) No carrier may carry out (or receive payment for carrying out) any activity pursuant to a contract under this subsection to the extent that the activity is carried out pursuant to a contract under the Medicare Integrity Program under section 1895.".

(c) DIRECT SPENDING FOR MEDICARE-RELATED ACTIVITIES OF INSPECTOR GENERAL.—Section 1895, as added by subsection (a), is amended by adding at the end the following new subsection:

''(h) DIRECT SPENDING FOR MEDICARE-RELATED ACTIVITIES OF INSPECTOR GENERAL.—

''(1) IN GENERAL.—There are appropriated from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund to the Inspector General of the Department of Health and Human Services for each fiscal year such amounts as are necessary to enable the Inspector General to carry out activities relating to the medicare program (as described in paragraph (2)), subject to paragraph (3).

''(2) ACTIVITIES DESCRIBED.—The activities described in this paragraph are as follows:

''(A) Prosecuting medicare-related matters through criminal, civil, and administrative proceedings.

''(B) Conducting investigations relating to the medicare program.

''(C) Performing financial and performance audits of programs and operations relating to the medicare program.

"(D) Performing inspections and other evaluations relating to the medicare program.

"(E) Conducting provider and conumer education activities regarding the requirements of this title.

"(3) AMOUNTS SPECIFIED.—The amount appropriated under paragraph (1) for a fiscal year is as follows:

"(A) For fiscal year 1996, such amount shall be $130,000,000.

"(B) For fiscal year 1997, such amount shall be $181,000,000.

"(C) For fiscal year 1998, such amount shall be $204,000,000.

"(D) For each subsequent fiscal year, the amount appropriated for the previous fiscal year, increased by the percentage increase in aggregate expenditures under this title for the fiscal year involved over the previous fiscal year.

"(4) ALLOCATION OF PAYMENTS AMONG TRUST FUNDS.—The appropriations made under paragraph (1) shall be in an allocation as reasonably reflects the proportion of such expenditures associated with part A and part B.".

SEC. 15406. FRAUD REDUCTION DEMONSTRATION PROJECT.

(a) IN GENERAL.—Not later than July 1, 1996, the Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall establish not less than three demonstration projects under which organizations with a contract under section 1816 or section 1842 of the Social Security Act—

(1) identify practitioners and providers whose patterns of providing care to beneficiaries enrolled under title XVIII of the Social Security Act are consistently outside the norm for other practitioners or providers of the same category, class, or type, and

(2) experiment with ways of identifying fraudulent claims submitted to the program established under such title before they are paid.

(b) DURATION OF PROJECTS.—Each project established under subsection (a) shall last for at least 18 months and shall focus on those categories, classes, or types of providers and practitioners that have been identified by the Inspector General of the Department of Health and Human Services as having a high incidence of fraud and abuse.

(c) REPORT.—Not later than July 1, 1997, the Secretary shall report to the Congress on the demonstration projects established under subsection (a), and shall include

in the report an assessment of the effectiveness of, and any recommended legislative changes based on, the projects.

SEC. 15407. REPORT ON COMPETITIVE PRICING.

Not later than 1 year after the date of the enactment of this Act, the Secretary of Health and Human Services (acting through the Administrator of the Health Care Financing Administration) shall submit to Congress a report recommending legislative changes to the medicare program to enable the prices paid for items and services under the medicare program to be established on a more competitive basis.

Subtitle F—Improving Access to Health Care

PART 1—IMPROVING ACCESS TO HEALTH CARE IN RURAL AREAS

SEC. 15501. COMMUNITY RURAL HEALTH NETWORK GRANTS.

(a) ASSISTANCE FOR DEVELOPMENT OF ACCESS PLANS FOR CHRONICALLY UNDERSERVED AREAS.—

(1) AVAILABILITY OF FINANCIAL ASSISTANCE TO IMPLEMENT ACTION PLANS TO INCREASE ACCESS.—

(A) IN GENERAL.—The Secretary shall provide grants (in amounts determined in ac-

cordance with subparagraph (C)) over a 3-year period to an eligible State for the development of plans to increase access to health care services during such period for residents of areas in the State that are designated as chronically underserved areas in accordance with paragraph (2).

(B) ELIGIBILITY REQUIREMENTS.—A State is eligible to receive grants under this section if the State submits to the Secretary (at such time and in such form as the Secretary may require) assurances that the State has developed (or is in the process of developing) a plan to increase the access of residents of a chronically underserved area to health care services that meets the requirements of paragraph (3), together with such other information and assurances as the Secretary may require.

(C) AMOUNT OF ASSISTANCE.—

(i) IN GENERAL.—Subject to clause (ii), the amount of assistance provided to a State under this subsection with respect to any plan during a 3-year period shall be equal to—

(I) for the first year of the period, an amount equal to 100 percent of the amounts expended by the State during the year to implement the plan described in subparagraph (A) (as reported to the Secretary in accordance with such requirements as the Secretary may impose);

(II) for the second year of the period, an amount equal to 50 percent of the amounts expended by the State during the year to implement the plan; and

(III) for the third year of the period, an amount equal to 33 percent of the amounts expended by the State during the year to implement the plan.

(ii) AGGREGATE PER PLAN LIMIT.—The amount of assistance provided to a State under this paragraph with respect to any plan may not exceed $100,000 during any year of the 3-year period for which the State receives assistance.

(2) DESIGNATION OF AREAS.—

(A) DESIGNATION BY GOVERNOR.—In accordance with the guidelines developed under subparagraph (B), the Governor of a State may designate an area in the State as a chronically underserved area for purposes of this section upon the request of a local official of the area or upon the Governor's initiative.

(B) GUIDELINES FOR DESIGNATION.—

(i) DEVELOPMENT BY SECRETARY.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall develop guidelines for the designation of areas as chronically underserved areas under this subsection.

(ii) FACTORS CONSIDERED IN DEVELOPMENT OF GUIDELINES.—In developing guidelines under subparagraph (A), the Secretary shall consider the following factors:

(I) Whether the area (or a significant portion of the area)—

(aa) is designated as a health professional shortage area (under section 332(a) of the Public Health Service Act), or meets

the criteria for designation as such an area; or

(bb) was previously designated as such an area or previously met such criteria for an extended period prior to the designation of the area under this subsection (in accordance with criteria established by the Secretary).

(II) The availability and adequacy of health care providers and facilities for residents of the area.

(III) The extent to which the availability of assistance under other Federal and State programs has failed to alleviate the lack of access to health care services for residents of the area.

(IV) The percentage of residents of the area whose income is at or below the poverty level.

(V) The percentage of residents of the area who are age 65 or older.

(VI) The existence of cultural or geographic barriers to access to health care services in the area, including weather conditions.

(C) REVIEW BY SECRETARY.—No designation under subparagraph (A) shall take effect under this subsection unless the Secretary—

(i) has been notified of the proposed designation; and

(ii) has not, within 60 days after the date of receipt of the notice, disapproved the designation.

(D) PERIOD OF DESIGNATION.—A designation under this subsection shall be effective during a period specified by the Governor of not longer than 3 years. The Governor may extend the designation for additional 3-year periods, except that a State may not receive assistance under paragraph (1)(C) for amounts expended during any such additional periods.

(3) REQUIREMENTS FOR STATE ACCESS PLANS.—A State plan to increase the access of residents of chronically underserved areas to health care services meets the requirements of this subsection if the Secretary finds that the plan was developed with

the participation of health care providers and facilities and residents of the area that is the subject of the plan, together with such other requirements as the Secretary may impose.

(4) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated for assistance under this subsection $10,000,000 for each of the first 3 fiscal years beginning after the date on which the Secretary develops guidelines for the designation of areas as chronically underserved areas under paragraph (2)(B).

(b) TECHNICAL ASSISTANCE GRANTS FOR NETWORKS.—

(1) IN GENERAL.—The Secretary shall make funds available under this subsection to provide technical assistance (including information regarding eligibility for other Federal programs) and advice for entities described in paragraph (2) seeking to establish or enhance a community rural health network in an underserved rural area.

(2) ENTITIES ELIGIBLE TO RECEIVE FUNDS.—The following entities are eligible to receive funds for technical assistance under this subsection:

(A) An entity receiving a grant under subsection (c).

(B) A State or unit of local government.

(C) An entity providing health care services (including health professional education services) in the area involved.

(3) USE OF FUNDS.—

(A) IN GENERAL.—Funds made available under this subsection may be used—

(i) for planning a community rural health network and the submission of the plan for the network to the Secretary under subsection (c)(3) (subject to the limitation described in subparagraph (B));

(ii) to provide assistance in conducting community-based needs and prioritization, identifying existing regional health resources, and developing networks, utilizing existing local providers and facilities where appropriate;

(iii) to provide advice on obtaining the proper balance of primary and secondary facilities for the population served by the network;

(iv) to provide assistance in coordinating arrangements for tertiary care;

(v) to provide assistance in recruitment and retention of health care professionals;

(vi) to provide assistance in coordinating the delivery of emergency services with the provision of other health care services in the area served by the network;

(vii) to provide assistance in coordinating arrangements for mental health and substance abuse treatment services; and

(viii) to provide information regarding the area or proposed network's eligibility for Federal and State assistance for health care-related activities, together with information on funds available through private sources.

(B) LIMITATION ON AMOUNT AVAILABLE FOR DEVELOPMENT OF NETWORK.—The amount of financial assistance available for activities described in subparagraph (A) may not exceed $50,000 and may not be available for a period of time exceeding 1 year.

(4) USE OF RURAL HEALTH OFFICES.—In carrying out this subsection with respect to entities in rural areas, the Secretary shall make funds available

through the State offices of rural health or through appropriate entities designated by such offices.

(5) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated $10,000,000 for each of fiscal years 1996 through 2000 to carry out this section. Amounts appropriated under this subsection shall be available until expended.

(c) DEVELOPMENT GRANTS FOR NETWORKS.—

(1) IN GENERAL.—The Secretary shall provide financial assistance to eligible entities for the purpose of providing for the development and implementation of community rural health networks (as defined in subsection (d)). In providing such assistance, the Secretary shall give priority to eligible entities that will carry out such purpose in States that have developed a plan under subsection (a).

(2) ELIGIBLE ENTITIES.—

(A) IN GENERAL.—An entity is eligible to receive financial assistance under this subsection only if the entity meets the requirements of clauses (i) through (iii) as follows:

(i) The entity—

(I) is based in a rural area;

(II) is described in subparagraph (B), (C), or (D) of subsection (b)(2);or

(III) is a hospital-affiliated primary care center (as defined in subsection (d)).

(ii) The entity is undertaking to develop and implement a community rural health network in one or more underserved rural areas (as defined in subsection (d)) with the active participation of at least 3 health care providers or facilities in the area.

(iii) The entity has consulted with the local governments of the area to be served by the network and with individuals who reside in the area.

(B) COORDINATION WITH PROVIDERS OUTSIDE OF AREA PERMITTED.—Nothing in this subsection shall be construed as preventing an entity that coordinates the delivery of services in an underserved rural area with an entity outside the area from qualifying for financial assistance under this section, or as preventing an entity consisting of a consortia of members lo-

cated in adjoining States from qualifying for such assistance.

(C) PERMITTING ENTITIES NOT RECEIVING FUNDING FOR DEVELOPMENT OF PLAN TO RECEIVE FUNDING FOR IMPLEMENTATION.—An entity that is eligible to receive financial assistance under this subsection may receive assistance to carry out activities described in paragraph (3)(A)(ii) notwithstanding that the entity does not receive assistance to carry out activities described in paragraph (c)(A)(i).

(3) USE OF FUNDS.—

(A) IN GENERAL.—Financial assistance made available to eligible entities under this subsection may be used only—

(ii) for the development of a community health network and the submission of the plan for the network to the Secretary; and

(ii) after the Secretary approves the plan for the network, for activities to implement the network, including (but not limited to)—

(I) establishing information systems, including telecommunications,

(II) recruiting health care providers,

(III) providing services to enable individuals to have access to health care services, including transportation and language interpretation services (including interpretation services for the hearing-impaired), and

(IV) establishing and operating a community health advisor program described in subparagraph (B).

(B) COMMUNITY HEALTH ADVISOR PROGRAM.—

(i) PROGRAM DESCRIBED.—In subparagraph (A), a ''community health advisor program'' is a program under which community health advisors carry out the following activities:

(I) Collaborating efforts with health care providers and related entities to facilitate the provision of health services and health-related social services.

(II) Providing public education on health promotion and disease pre-

vention and efforts to facilitate the use of available health services and health-related social services.

(III) Providing health-related counseling.

(IV) Making referrals for available health services and health-related social services.

(V) Improving the ability of individuals to use health services and health-related social services under Federal, State, and local programs through assisting individuals in establishing eligibility under the programs.

(VI) Providing outreach services to inform the community of the availability of the services provided under the program.

(ii) COMMUNITY HEALTH ADVISOR DEFINED.—In clause (i), the term ''community health advisor'' means, with respect to a community health advisor program, an individual—

(I) who has demonstrated the capacity to carry out one or more of the

activities carried out under the program; and

(II) who, for not less than one year, has been a resident of the community in which the program is to be operated.

(C) LIMITATIONS ON ACTIVITIES FUNDED.—Financial assistance made available under this subsection may not be used for any of the following:

(i) For a telecommunications system unless such system is coordinated with, and does not duplicate, a system existing in the area.

(ii) For construction or remodeling of health care facilities.

(D) LIMITATION ON AMOUNT AVAILABLE FOR DEVELOPMENT OF NETWORK.—The amount of financial assistance available for activities described in subparagraph (A)(i) may not exceed $50,000 and may not be made available for a period of time exceeding 1 year.

(4) APPLICATION.—

(A) IN GENERAL.—No financial assistance shall be provided under this section to an entity

unless the entity has submitted to the Secretary, in a time and manner specified by the Secretary, and had approved by the Secretary an application.

(B) INFORMATION TO BE INCLUDED.—Each such application shall include—

(i) a description of the community rural health network, including service area and capacity, and

(ii) a description of how the proposed network will utilize existing health care facilities in a manner that avoids unnecessary duplication.

(5) AUTHORIZATION OF APPROPRIATIONS.—

(A) IN GENERAL.—There are authorized to be appropriated $100,000,000 for each of fiscal years 1996 through 2000 to carry out this subsection. Amounts appropriated under this subsection shall be available until expended.

(B) ANNUAL LIMIT ON ASSISTANCE TO GRANTEE.—The amount of financial assistance provided to an entity under this subsection during a year may not exceed $250,000.

(d) DEFINITIONS.—

(1) IN GENERAL.—

(A) COMMUNITY RURAL HEALTH NETWORK.—For purposes of this section, the term ''community rural health network'' means a formal cooperative arrangement between participating hospitals, physicians, and other health care providers which—

(i) is located in an underserved rural area;

(ii) furnishes health care services to individuals residing in the area; and

(iii) is governed by a board of directors selected by participating health care providers and residents of the area.

(B) HOSPITAL-AFFILIATED PRIMARY CARE CENTER.—

(i) IN GENERAL.—For purposes of this section, the term ''hospital-affiliated primary care center'' means a distinct administrative unit of a community hospital (as defined in clause (ii)) meeting the following requirement:

(I) The unit is located in, or adjacent to, the hospital.

(II) The unit delivers primary health services, as defined in para-

graph (1) of section 330(b) of the Public Health Service Act to a catchment area determined by the hospital and approved by the Secretary.

(III) The unit provides referrals to providers of supplemental health services, as defined in paragraph (2) of such section.

(IV) The services of the unit are delivered through a primary care group practice (as defined in clause (iii)).

(V) To the extent practicable, primary health services in the community hospital are delivered only through the unit.

(VI) Qualified personnel trained in triage are placed in the unit, the emergency room, and the outpatient department to screen and direct patients to the appropriate location for care.

(VII) Each patient of the unit has an identified member of the group

practice responsible for continuous management of the patient, including emergency services and referrals of the patients for inpatient or outpatient services.

(VIII) To the extent practicable, excess facilities and equipment in or owned by the community hospital are covered for use in the unit.

(IX) The unit and the hospital avoid unnecessary duplication of facilities and equipment, except that the unit may install appropriate support equipment for routine primary health services.

(X) The unit is maintained as a separate and distinct cost and revenue center for accounting purposes.

(XI) The unit is operated in accordance with all of the requirements specified for community health centers in section 330(e)(3) of the Public Health Service Act (other than clause (vii).

(XII) The hospital has an advisory committee that—

(aa) is composed of individuals a majority of whom are health consumers in the catchment area of the hospital; and

(bb) meets at least 6 times a year to review the operations of the primary care center and develop recommendations to the governing board of the hospital about the operation of the center and the types of services to be provided.

(XIII) The unit maintains an information program for its patients that fully discloses—

(aa) the covered professional services and referral capabilities offered by the unit; and

(bb) the method by which patients of the unit may resolve grievances about billing for cov-

ered professional services and the quality of such services.

(ii) COMMUNITY HOSPITAL.—For purposes of this section, the term ''community hospital'' means a public general hospital, owned and operated by a State, county or local unit of government, or a private community hospital that—

(i) has less than 50 beds; and

(ii) primarily serves—

(I) a medically underserved population, as defined in section 330(b)(3) of the Public Health Service Act; or

(II) a health professional shortage area, as defined in section 332(a)(1) of such Act.

(iii) PRIMARY CARE GROUP PRACTICE.—For purposes of this section, the term ''primary care group practice'' means any combination of 3 or more primary care physicians who are—

(I) organized to provide primary health services in a manner that is consistent with the needs of the population served;

(II) located in, or adjacent to, the community hospital;

(III) who have admitting privileges at the community hospital; and

(IV)(aa) who are salaried by the hospital such that a majority of the members of the group practice is full time in the primary care center; or

(bb) who are organized into a legal entity (partnership, corporation, or professional association) that has a contract approved by the Secretary with the community hospital to provide primary health services.

(2) OTHER DEFINITIONS.—For purposes of this section:

(A) The term ''rural area'' has the meaning given such term in section 1886(d)(2)(D) of the Social Security Act.

(B) The term ''Secretary'' means the Secretary of Health and Human Services.

(C) The term ''State'' means each of the several States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa.

(D) The term ''underserved rural area'' means a rural area designated—

(i) as a health professional shortage area under section 332(a) of the Public Health Service Act; or

(ii) as a chronically underserved area under subsection (a).

SEC. 15502. PROVIDER INCENTIVES.

(a) ADDITIONAL PAYMENTS UNDER MEDICARE FOR PHYSICIANS' SERVICES FURNISHED IN SHORTAGE AREAS.—

(1) INCREASE IN AMOUNT OF ADDITIONAL PAYMENT.—Section 1833(m) (42 U.S.C. 1395l(m)) is amended by striking ''10 percent'' and inserting ''20 percent''.

(2) RESTRICTION TO PRIMARY CARE SERVICES.—Section 1833(m) (42 U.S.C. 1395l(m)) is amended by inserting after ''physicians' services'' the following: ''consisting of primary care services (as defined in section 1842(i)(4))''.

(3) EXTENSION OF PAYMENT FOR FORMER SHORTAGE AREAS.—

(A) IN GENERAL.—Section 1833(m) (42 U.S.C. 1395l(m)) is amended by striking ''area,'' and inserting ''area (or, in the case of

an area for which the designation as a health professional shortage area under such section is withdrawn, in the case of physicians' services furnished to such an individual during the 3-year period beginning on the effective date of the withdrawal of such designation),''.

(B) EFFECTIVE DATE.—The amendment made by subparagraph (A) shall apply to physicians' services furnished in an area for which the designation as a health professional shortage area under section 332(a)(1)(A) of the Public Health Service Act is withdrawn on or after January 1, 1996.

(4) REQUIRING CARRIERS TO REPORT ON SERVICES PROVIDED.—Section 1842(b)(3) (42 U.S.C. 1395u(b)(3)) is amended—

(A) by striking ''and'' at the end of subparagraph (I); and

(B) by inserting after subparagraph (I) the following new subparagraph:

''(J) will provide information to the Secretary not later than 30 days after the end of the contract year on the types of providers to whom the carrier made additional payments during the year for certain physicians' services pursuant to section

1833(m), together with a description of the services furnished by such providers during the year; and''.

(5) STUDY.—

(A) IN GENERAL.—The Secretary of Health and Human Services shall conduct a study analyzing the effectiveness of the provision of additional payments under part B of the medicare program for physicians' services provided in health professional shortage areas in recruiting and retaining physicians to provide services in such areas.

(B) REPORT.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall submit to Congress a report on the study conducted under subparagraph (A), and shall include in the report such recommendations as the Secretary considers appropriate.

(6) EFFECTIVE DATE.—The amendments made by paragraphs (1), (2), and (4) shall apply to physicians' services furnished on or after January 1, 1996.

(b) DEVELOPMENT OF MODEL STATE SCOPE OF PRACTICE LAW.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall develop and publish a model

law that may be adopted by States to increase the access of individuals residing in underserved rural areas to health care services by expanding the services which non-physician health care professionals may provide in such areas.

(2) DEADLINE.—The Secretary shall publish the model law developed under paragraph (1) not later than 1 year after the date of the enactment of this Act.

SEC. 8503. MODIFICATIONS TO THE NATIONAL HEALTH SERVICE CORPS.

(a) NATIONAL HEALTH SERVICE CORPS LOAN REPAYMENTS EXCLUDED FROM GROSS INCOME.—

(1) IN GENERAL.—Part III of subchapter B of chapter 1 of the Internal Revenue Code of 1986 (relating to items 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. NATIONAL HEALTH SERVICE CORPS LOAN REPAYMENTS.

''(a) GENERAL RULE.—Gross income shall not include any qualified loan repayment.

''(b) QUALIFIED LOAN REPAYMENT.—For purposes of this section, the term 'qualified loan repayment' means

any payment made on behalf of the taxpayer by the National Health Service Corps Loan Repayment Program under section 338B(g) of the Public Health Service Act.''.

(2) CONFORMING AMENDMENT.—Paragraph (3) of section 338B(g) of the Public Health Service Act is amended by striking ''Federal, State, or local'' and inserting ''State or local''.

(3) CLERICAL AMENDMENT.—The table of sections for part III of subchapter B of chapter 1 of the Internal Revenue Code of 1986 is amended by striking the item relating to section 137 and inserting the following:

''Sec. 137. National Health Service Corps loan repayments.
''Sec. 138. Cross references to other Acts.''.

(4) EFFECTIVE DATE.—The amendments made by this subsection shall apply to payments made under section 338B(g) of the Public Health Service Act after the date of the enactment of this Act.

(b) STUDY REGARDING DESIGNATION AS HEALTH PROFESSIONAL SHORTAGE AREA; ALLOCATION OF CORPS MEMBERS AMONG SHORTAGE AREAS.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this subsection referred to as the ''Secretary'') shall conduct a study for the purpose of determining the following:

(A) With respect to the designation of health professional shortage areas under subpart II of part D of title III of the Public Health Service Act—

(i) whether the statutory and administrative criteria for the designation of such areas should be modified to ensure that all areas with significant shortages of health professionals receive such a designation; and

(ii) if so, the recommendations of the Secretary for modifications in the criteria.

(B) With respect to the assignment of members of the National Health Service Corps under such subpart—

(i) whether the statutory and administrative criteria for the assignment of Corps members should be modified in order to ensure that the members are equitably allocated among health professional shortage areas; and

(ii) if so, the recommendations of the Secretary for modifications in the criteria.

(2) REPORT.—Not later than May 1, 1996, the Secretary shall complete the study required in para-

graph (1) and submit to the Congress a report describing the findings made in the study.

(c) OTHER PROVISIONS REGARDING NATIONAL HEALTH SERVICE CORPS.—

(1) PRIORITY IN ASSIGNMENT OF CORPS MEMBERS; COMMUNITY RURAL HEALTH NETWORKS.—Section 333A(a)(1)(B) of the Public Health Service Act (42 U.S.C. 254f–1(a)(1)(B)) is amended—

(A) in clause (iii), by striking ''and'' after the semicolon at the end;

(B) in clause (iv), by adding ''and'' after the semicolon at the end; and

(B) by adding at the end the following clause:

''(v) is a participant in a community rural health network, as defined in section 15501 of the Medicare Preservation Act of 1995.''.

(2) ALLOCATION FOR PARTICIPATION OF NURSES IN SCHOLARSHIP PROGRAM.—Section 338H(b)(2) of the Public Health Service Act (42 U.S.C. 254q(b)(2)) is amended by adding at the end the following subparagraph:

''(C) Of the amounts appropriated under paragraph (1) for fiscal year 1996 and subse-

quent fiscal years, the Secretary shall reserve such amounts as may be necessary to ensure that, of the aggregate number of individuals who are participants in the Scholarship Program, the total number who are being educated as nurses or are serving as nurses, respectively, is increased to 20 percent.''.

SEC. 15504. CREATION OF HOSPITAL-AFFILIATED PRIMARY CARE CENTERS.

Section 330 of the Public Health Service Act (42 U.S.C. 254c) is amended by adding at the end the following subsection:

''(l) Of the amounts appropriated under subsection (g)(1)(A) for a fiscal year, the Secretary shall reserve not less than 10 percent, and not more than 20 percent, for the establishment and operation of hospital-affiliated primary care centers, as defined in section 15504 of the Medicare Preservation Act of 1995.''.

SEC. 15505. ESTABLISHMENT OF RURAL EMERGENCY ACCESS CARE HOSPITALS.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—Section 1861 (42 U.S.C. 1395x) is amended by adding at the end the following new subsection:

''Rural Emergency Access Care Hospital; Rural Emergency Access Care Hospital Services

''(oo)(1) The term 'rural emergency access care hospital' means, for a fiscal year, a facility with respect to which the Secretary finds the following:

''(A) The facility is located in a rural area (as defined in section 1886(d)(2)(D)).

''(B) The facility was a hospital under this title at any time during the 5-year period that ends on the date of the enactment of this subsection.

''(C) The facility is in danger of closing due to low inpatient utilization rates and operating losses, and the closure of the facility would limit the access to emergency services of individuals residing in the facility's service area.

''(D) The facility has entered into (or plans to enter into) an agreement with a hospital with a participation agreement in effect under section 1866(a), and under such agreement the hospital shall accept patients transferred to the hospital from the facility and receive data from and transmit data to the facility.

''(E) There is a practitioner who is qualified to provide advanced cardiac life support services (as de-

termined by the State in which the facility is located) on-site at the facility on a 24-hour basis.

''(F) A physician is available on-call to provide emergency medical services on a 24-hour basis.

''(G) The facility meets such staffing requirements as would apply under section 1861(e) to a hospital located in a rural area, except that—

''(i) the facility need not meet hospital standards relating to the number of hours during a day, or days during a week, in which the facility must be open, except insofar as the facility is required to provide emergency care on a 24-hour basis under subparagraphs (E) and (F); and

''(ii) the facility may provide any services otherwise required to be provided by a full-time, on-site dietitian, pharmacist, laboratory technician, medical technologist, or radiological technologist on a part-time, off-site basis.

''(H) The facility meets the requirements applicable to clinics and facilities under subparagraphs (C) through (J) of paragraph (2) of section 1861(aa) and of clauses (ii) and (iv) of the second sentence of such paragraph (or, in the case of the requirements of subparagraph (E), (F), or (J) of

such paragraph, would meet the requirements if any reference in such subparagraph to a 'nurse practitioner' or to 'nurse practitioners' were deemed to be a reference to a 'nurse practitioner or nurse' or to 'nurse practitioners or nurses'); except that in determining whether a facility meets the requirements of this subparagraph, subparagraphs (E) and (F) of that paragraph shall be applied as if any reference to a 'physician' is a reference to a physician as defined in section 1861(r)(1).

''(2) The term 'rural emergency access care hospital services' means the following services provided by a rural emergency access care hospital and furnished to an individual over a continuous period not to exceed 24 hours (except that such services may be furnished over a longer period in the case of an individual who is unable to leave the hospital because of inclement weather):

''(A) An appropriate medical screening examination (as described in section 1867(a)).

''(B) Necessary stabilizing examination and treatment services for an emergency medical condition and labor (as described in section 1867(b)).''.

(2) REQUIRING RURAL EMERGENCY ACCESS CARE HOSPITALS TO MEET HOSPITAL ANTI-DUMPING REQUIREMENTS.—Section 1867(e)(5) (42 U.S.C.

1395dd(e)(5)) is amended by striking ''1861(mm)(1))'' and inserting ''1861(mm)(1)) and a rural emergency access care hospital (as defined in section 1861(oo)(1))''.

(b) COVERAGE AND PAYMENT UNDER PART B.—

(1) COVERAGE UNDER PART B.—Section 1832(a)(2) (42 U.S.C. 1395k(a)(2)) is amended—

(A) by striking ''and'' at the end of subparagraph (I);

(B) by striking the period at the end of subparagraph (J) and inserting ''; and''; and

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

''(K) rural emergency access care hospital services (as defined in section 1861(oo)(2)).''.

(2) PAYMENT BASED ON PAYMENT FOR OUTPATIENT RURAL PRIMARY CARE HOSPITAL SERVICES.—

(A) IN GENERAL.—Section 1833(a)(6) (42 U.S.C. 1395l(a)(6)) is amended by striking ''services,'' and inserting ''services and rural emergency access care hospital services,''.

(B) PAYMENT METHODOLOGY DESCRIBED.—Section 1834(g) (42 U.S.C. 1395m(g)) is amended—

(i) in the heading, by striking ''SERVICES'' and inserting ''SERVICES AND RURAL EMERGENCY ACCESS CARE HOSPITAL SERVICES''; and

(ii) by adding at the end the following new sentence: ''The amount of payment for rural emergency access care hospital services provided during a year shall be determined using the applicable method provided under this subsection for determining payment for outpatient rural primary care hospital services during the year.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to fiscal years beginning on or after October 1, 1995.

SEC. 15506. MEDICAL EDUCATION.

(a) STATE AND CONSORTIUM DEMONSTRATION PROJECTS.—

(1) IN GENERAL.—

(A) PARTICIPATION OF STATES AND CONSORTIA.—The Secretary shall establish and conduct a demonstration project to increase the number and percentage of medical students entering primary care practice relative to those entering nonprimary care practice under which

the Secretary shall make payments in accordance with paragraph (4)—

(i) to not more than 10 States for the purpose of testing and evaluating mechanisms to meet the goals described in subsection (b); and

(ii) to not more than 10 health care training consortia for the purpose of testing and evaluating mechanisms to meet such goals.

(B) EXCLUSION OF CONSORTIA IN PARTICIPATING STATES.—A consortia may not receive payments under the demonstration project under subparagraph (A)(ii) if any of its members is located in a State receiving payments under the project under subparagraph (A)(i).

(2) APPLICATIONS.—

(A) IN GENERAL.—Each State and consortium desiring to conduct a demonstration project under this subsection shall prepare and submit to the Secretary an application, at such time, in such manner, and containing such information as the Secretary may require to assure that the State or consortium will meet the goals described in subsection (b). In the case

of an application of a State, the application shall include—

(i) information demonstrating that the State has consulted with interested parties with respect to the project, including State medical associations, State hospital associations, and medical schools located in the State;

(ii) an assurance that no hospital conducting an approved medical residency training program in the State will lose more than 10 percent of such hospital's approved medical residency positions in any year as a result of the project; and

(iii) an explanation of a plan for evaluating the impact of the project in the State.

(B) APPROVAL OF APPLICATIONS.—A State or consortium that submits an application under subparagraph (A) may begin a demonstration project under this subsection—

(i) upon approval of such application by the Secretary; or

(ii) at the end of the 60-day period beginning on the date such application is

submitted, unless the Secretary denies the application during such period.

(C) NOTICE AND COMMENT.—A State or consortium shall issue a public notice on the date it submits an application under subparagraph (A) which contains a general description of the proposed demonstration project. Any interested party may comment on the proposed demonstration project to the State or consortium or the Secretary during the 30-day period beginning on the date the public notice is issued.

(3) SPECIFIC REQUIREMENTS FOR PARTICIPANTS.—

(A) REQUIREMENTS FOR STATES.—Each State participating in the demonstration project under this section shall use the payments provided under paragraph (4) to test and evaluate either of the following mechanisms to increase the number and percentage of medical students entering primary care practice relative to those entering nonprimary care practice:

(i) USE OF ALTERNATIVE WEIGHTING FACTORS.—

(I) IN GENERAL.—The State may make payments to hospitals in the State for direct graduate medical education costs in amounts determined under the methodology provided under section 1886(h) of the Social Security Act, except that the State shall apply weighting factors that are different than the weighting factors otherwise set forth in section 1886(h)(4)(C) of the Social Security Act.

(II) USE OF PAYMENTS FOR PRIMARY CARE RESIDENTS.—In applying different weighting factors under subclause (I), the State shall ensure that the amount of payment made to hospitals for costs attributable to primary care residents shall be greater than the amount that would have been paid to hospitals for costs attributable to such residents if the State had applied the weighting factors otherwise set forth in section 1886(h)(4)(C) of the Social Security Act.

(ii) PAYMENTS FOR MEDICAL EDUCATION THROUGH CONSORTIUM.—The State may make payments for graduate medical education costs through payments to a health care training consortium (or through any entity identified by such a consortium as appropriate for receiving payments on behalf of the consortium) that is established in the State but that is not otherwise participating in the demonstration project.

(B) REQUIREMENTS FOR CONSORTIUM.—

(i) IN GENERAL.—In the case of a consortium participating in the demonstration project under this section, the Secretary shall make payments for graduate medical education costs through a health care training consortium whose members provide medical residency training (or through any entity identified by such a consortium as appropriate for receiving payments on behalf of the consortium).

(ii) USE OF PAYMENTS.—

(I) IN GENERAL.—Each consortium receiving payments under clause

(i) shall use such funds to conduct activities which test and evaluate mechanisms to increase the number and percentage of medical students entering primary care practice relative to those entering nonprimary care practice, and may use such funds for the operation of the consortium.

(II) PAYMENTS TO PARTICIPATING PROGRAMS.—The consortium shall ensure that the majority of the payments received under clause (i) are directed to consortium members for primary care residency programs, and shall designate for each resident assigned to the consortium a hospital operating an approved medical residency training program for purposes of enabling the Secretary to calculate the consortium's payment amount under the project. Such hospital shall be the hospital where the resident receives the majority of the resident's hospital-based, nonambulatory training experience.

(4) ALLOCATION OF PORTION OF MEDICARE GME PAYMENTS FOR ACTIVITIES UNDER PROJECT.—Notwithstanding any provision of title XVIII of the Social Security Act, the following rules apply with respect to each State and each health care training consortium participating in the demonstration project established under this subsection during a year:

(A) In the case of a State—

(i) the Secretary shall reduce the amount of each payment made to hospitals in the State during the year for direct graduate medical education costs under section 1886(h) of the Social Security Act by 3 percent; and

(ii) the Secretary shall pay the State an amount equal to the Secretary's estimate of the sum of the reductions made during the year under clause (i) (as adjusted by the Secretary in subsequent years for over- or under-estimations in the amount estimated under this subparagraph in previous years).

(B) In the case of a consortium—

(i) the Secretary shall reduce the amount of each payment made to hospitals who are members of the consortium during the year for direct graduate medical education costs under section 1886(h) of the Social Security Act by 3 percent; and

(ii) the Secretary shall pay the consortium an amount equal to the Secretary's estimate of the sum of the reductions made during the year under clause (i) (as adjusted by the Secretary in subsequent years for over- or under-estimations in the amount estimated under this subparagraph in previous years).

(5) ADDITIONAL GRANT FOR PLANNING AND EVALUATION.—

(A) IN GENERAL.—The Secretary may award grants to States and consortia participating in the demonstration project under this subsection for the purpose of planning and evaluating such projects. A State or consortia may conduct such planning and evaluation activities or contract with a private entity to conduct such activities. Each State and consortia desiring to receive a grant under this subparagraph

shall prepare and submit to the Secretary an application, at such time, in such manner, and containing such information as the Secretary may require.

(B) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated for grants under this subparagraph $250,000 for fiscal year 1996, and $100,000 for each of the fiscal years 1997 through 2001.

(6) DURATION.—A demonstration project under this subsection shall be conducted for a period not to exceed 5 years. The Secretary may terminate a project if the Secretary determines that the State or consortium conducting the project is not in substantial compliance with the terms of the application approved by the Secretary.

(7) EVALUATIONS AND REPORTS.—

(A) EVALUATIONS.—Each State or consortium participating in the demonstration project shall submit to the Secretary a final evaluation within 360 days of the termination of the State or consortium's participation and such interim evaluations as the Secretary may require.

(B) REPORTS TO CONGRESS.—Not later than 360 days after the first demonstration

project under this section begins, and annually thereafter for each year in which such a project is conducted, the Secretary shall submit a report to Congress which evaluates the effectiveness of the State and consortium activities conducted under such projects and includes any legislative recommendations determined appropriate by the Secretary.

(8) MAINTENANCE OF EFFORT.—Any funds available for the activities covered by a demonstration project under this section shall supplement, and shall not supplant, funds that are expended for similar purposes under any State, regional, or local program.

(b) GOALS FOR PROJECTS.—The goals referred to in this subsection for a State or consortium participating in the demonstration project under this section are as follows:

(1) The training of an equal number of physician and nonphysician primary care providers.

(2) The recruiting of residents for graduate medical education training programs who received a portion of undergraduate training in a rural area.

(3) The allocation of not less than 50 percent of the training spent in a graduate medical residency

training program at sites at which acute care inpatient hospital services are not furnished.

(4) The rotation of residents in approved medical residency training programs among practices that serve residents of rural areas.

(5) The development of a plan under which, after a 5-year transition period, not less than 50 percent of the residents who begin an initial residency period in an approved medical residency training program shall be primary care residents.

(c) DEFINITIONS.—In this section:

(1) APPROVED MEDICAL RESIDENCY TRAINING PROGRAM.—The term ''approved medical residency training program'' has the meaning given such term in section 1886(h)(5)(A) of the Social Security Act.

(2) HEALTH CARE TRAINING CONSORTIUM.—The term ''health care training consortium'' means a State, regional, or local entity consisting of at least one of each of the following:

(A) A hospital operating an approved medical residency training program at which residents receive training at ambulatory training sites located in rural areas.

(B) A school of medicine or osteopathic medicine.

(C) A school of allied health or a program for the training of physician assistants (as such terms are defined in section 799 of the Public Health Service Act).

(D) A school of nursing (as defined in section 853 of the Public Health Service Act).

(3) PRIMARY CARE.—The term ''primary care'' means family practice, general internal medicine, general pediatrics, and obstetrics and gynecology.

(4) RESIDENT.—The term ''resident'' has the meaning given such term in section 1886(h)(5)(H) of the Social Security Act.

(5) RURAL AREA.—The term ''rural area'' has the meaning given such term in section 1886(d)(2)(D) of the Social Security Act.

SEC. 15507. TELEMEDICINE PAYMENT METHODOLOGY.

The Secretary of Health and Human Services shall establish a methodology for making payments under part B of the medicare program for telemedicine services furnished on an emergency basis to individuals residing in an area designated as a health professional shortage area (under section 332(a) of the Public Health Service Act).

SEC. 15508. DEMONSTRATION PROJECT TO INCREASE CHOICE IN RURAL AREAS.

The Secretary of Health and Human Services (acting through the Administrator of the Health Care Financing Administration) shall conduct a demonstration project to assess the advantages and disadvantages of requiring Medicare Choice organizations under part C of title XVIII of the Social Security Act (as added by section 15002(a)) to market Medicare Choice products in certain underserved areas which are near the standard service area for such products.

PART 2—MEDICARE SUBVENTION

SEC. 15511. MEDICARE PROGRAM PAYMENTS FOR HEALTH CARE SERVICES PROVIDED IN THE MILITARY HEALTH SERVICES SYSTEM.

(a) PAYMENTS UNDER MEDICARE RISK CONTRACTS PROGRAM.—

(1) CURRENT PROGRAM.—Section 1876 (42 U.S.C. 1395mm) is amended by adding at the end the following new subsection:

''(k) Notwithstanding any other provision of this section, a managed health care plan established by the Secretary of Defense under chapter 55 of title 10, United States Code, shall be considered an eligible organization under this section, and the Secretary shall make payments to such a managed health care plan during a year on be-

half of any individuals entitled to benefits under this title who are enrolled in such a managed health care plan during the year. Such payments shall be made in the same amounts and under similar terms and conditions under which the Secretary makes payments to other eligible organizations with risk sharing contracts under this section.''.

(2) MEDICARE CHOICE PROGRAM.—Section 1855, as inserted by section 15002(a), by adding at the end the following new subsection:

''(h) PAYMENTS TO MILITARY PROGRAM.—Notwithstanding any other provision of this section, a managed health care plan established by the Secretary of Defense under chapter 55 of title 10, United States Code, shall be considered a Medicare Choice organization under this part, and the Secretary shall make payments to such a managed health care plan during a year on behalf of any individuals entitled to benefits under this title who are enrolled in such a managed health care plan during the year. Such payments shall be made in the same amounts and under similar terms and conditions under which the Secretary makes payments to other Medicare Choice organizations with contracts in effect under this part.''.

(b) TEMPORARY PROVISION FOR WAIVER OF PART B PREMIUM PENALTY.—Section 1839 (42 U.S.C. 1395r)

is amended by adding at the end the following new subsection:

''(h) The premium increase required by subsection (b) shall not apply with respect to a person who is enrolled with a managed care plan that is established by the Secretary of Defense under chapter 55 of title 10, United States Code, and is recognized as an eligible organization pursuant to section 1855(h) or section 1876(k), if such person first enrolled in such plan prior to January 1, 1998.''.

(c) PAYMENTS UNDER PART A OF MEDICARE.—Section 1814(c) (42 U.S.C. 1395f(c)) is amended—

(1) by redesignating the current matter as paragraph (1); and

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

''(2) Paragraph (1) shall not apply to services provided by facilities of the uniformed services pursuant to chapter 55 of title 10, United States Code, and subject to the provisions of section 1095 of such title. With respect to such services, payments under this title shall be made without regard to whether the beneficiary under this title has paid the deductible and copayments amounts generally required by this title.''.

(d) PAYMENTS UNDER PART B OF MEDICARE.—Section 1835(d) (42 U.S.C. 1395n(d)) is amended—

(1) by redesignating the current matter as paragraph (1); and

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

''(2) Paragraph (1) shall not apply to services provided by facilities of the uniformed services pursuant to chapter 55 of title 10, United States Code, and subject to the provisions of section 1095 of such title. With respect to such services, payments under this title shall be made without regard to whether the beneficiary under this title has paid the deductible and copayments amounts generally required by this title.''.

(e) CONFORMING AMENDMENTS TO THE THIRD PARTY COLLECTION PROGRAM FOR MILITARY MEDICAL FACILITIES.—(1) Section 1095(d) of title 10, United States Code, is amended—

(A) by striking ''XVIII or''; and

(B) by striking ''1395'' and inserting ''1396''.

(2) Section 1095(h)(2) of such title is amended by inserting after ''includes'' the following: ''plans administered under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.),''.

(f) EFFECTIVE DATE.—The amendments made by this section shall take effect at the end of the 30-day period beginning on the date of the enactment of this Act.

Subtitle G—Other Provisions

SEC. 15601. EXTENSION AND EXPANSION OF EXISTING SECONDARY PAYER REQUIREMENTS.

(a) DATA MATCH.—

(1) Section 1862(b)(5)(C) (42 U.S.C. 1395y(b)(5)(C)) is amended by striking clause (iii).

(2) Section 6103(l)(12) of the Internal Revenue Code of 1986 is amended by striking subparagraph (F).

(b) APPLICATION TO DISABLED INDIVIDUALS IN LARGE GROUP HEALTH PLANS.—

(1) IN GENERAL.—Section 1862(b)(1)(B) (42 U.S.C. 1395y(b)(1)(B)) is amended—

(A) in clause (i), by striking ''clause (iv)'' and inserting ''clause (iii)'',

(B) by striking clause (iii), and

(C) by redesignating clause (iv) as clause (iii).

(2) CONFORMING AMENDMENTS.—Paragraphs (1) through (3) of section 1837(i) (42 U.S.C. 1395p(i)) and the second sentence of section 1839(b) (42 U.S.C. 1395r(b)) are each amended by

striking ''1862(b)(1)(B)(iv)'' each place it appears and inserting ''1862(b)(1)(B)(iii)''.

(c) EXPANSION OF PERIOD OF APPLICATION TO INDIVIDUALS WITH END STAGE RENAL DISEASE.—Section 1862(b)(1)(C) (42 U.S.C. 1395y(b)(1)(C)) is amended—

(1) in the first sentence, by striking ''12-month'' each place it appears and inserting ''24-month'', and

(2) by striking the second sentence.

SEC. 15602. CLARIFICATION OF MEDICARE COVERAGE OF ITEMS AND SERVICES ASSOCIATED WITH CERTAIN MEDICAL DEVICES APPROVED FOR INVESTIGATIONAL USE.

(a) COVERAGE.—Nothing in title XVIII of the Social Security Act may be construed to prohibit coverage under part A or part B of the medicare program of items and services associated with the use of a medical device in the furnishing of inpatient or outpatient hospital services (including outpatient diagnostic imaging services) for which payment may be made under the program solely on the grounds that the device is not an approved device, if—

(1) the device is an investigational device; and

(2) the device is used instead of either an approved device or a covered procedure.

(b) CLARIFICATION OF PAYMENT AMOUNT.—Notwithstanding any other provision of title XVIII of the Social Security Act, the amount of payment made under the medicare program for any item or service associated with the use of an investigational device in the furnishing of inpatient or outpatient hospital services (including outpatient diagnostic imaging services) for which payment may be made under the program may not exceed the amount of the payment which would have been made under the program for the item or service if the item or service were associated with the use of an approved device or a covered procedure.

(c) DEFINITIONS.—In this section—

(1) the term ''approved device'' means a medical device (or devices) which has been approved for marketing under pre-market approval under the Federal Food, Drug, and Cosmetic Act or cleared for marketing under a 510(k) notice under such Act; and

(2) the term ''investigational device'' means—

(A) a medical device or devices (other than a device described in paragraph (1)) approved for investigational use under section 520(g) of the Federal Food, Drug, and Cosmetic Act, or

(B) a product authorized for use under section 505(i) of the Federal Food, Drug, and Cosmetic Act which includes the use of a medical device (or devices) or an investigational combination product under section 503(g) of such Act which includes a device (or devices) authorized for use under section 505(i) of such Act.

SEC. 15603. ADDITIONAL EXCLUSION FROM COVERAGE.

(a) IN GENERAL.—Section 1862(a) (42 U.S.C. 1395y(a)) is amended—

(1) by striking ''or'' at the end of paragraph (14),

(2) by striking the period at the end of paragraph (15) and inserting ''; or'', and

(3) by inserting after paragraph (15) the following new paragraph:

''(16) where such expenses are for items or services, or to assist in the purchase, in whole or in part, of health benefit coverage that includes items or services, for the purpose of causing, or assisting in causing, the death, suicide, euthanasia, or mercy killing of a person.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to payment for items and serv-

ices furnished on or after the date of the enactment of this Act.

Subtitle H—Monitoring Achievement of Medicare Reform Goals

SEC. 15701. ESTABLISHMENT OF BUDGETARY AND PROGRAM GOALS.

(a) IN GENERAL.—The Secretary shall establish program budgetary and program goals for the medicare program consistent with this section.

(b) BUDGETARY GOALS.—The budgetary goal is to restrict total outlays under the medicare program as follows:

(1) For fiscal year 1996, $____.

(2) For fiscal year 1997, $____.

(3) For fiscal year 1998, $____.

(4) For fiscal year 1999, $____.

(5) For fiscal year 2000, $____.

(6) For fiscal year 2001, $____.

(7) For fiscal year 2002, $____.

(c) PROGRAM GOALS.—The program goals shall be consistent with the following:

(1) There should be an equitable distribution of funds between per beneficiary spending on payments to Medicare Choice organizations under part C of the medicare program and on payments to providers

on a fee-for-service basis under parts A and B of the program.

(2) Payments to Medicare Choice organizations should be established in a manner that promotes the availability of Medicare Choice products in all regions of the country and that permits such organizations to offer adequate coverage.

SEC. 15702. MEDICARE REFORM COMMISSION.

(a) ESTABLISHMENT.—There is established a commission to be known as the Medicare Reform Commission (in this section referred to as the ''Commission'').

(b) DUTIES.—

(1) IN GENERAL.—The Commission shall examine how the medicare program has met the budgetary and program goals established under section 15701.

(2) PERIODIC REPORTS.—

(A) IN GENERAL.—The Commission shall issue a report on April 1, 1998, and on March 1 of every third subsequent year, on the status of the medicare program in relation to the budgetary and program goals specified in section 15601.

(B) CONTENTS.—Each report shall include the following information about the medicare

program in the most recent fiscal year and projects for the succeeding 3 fiscal years:

(i) The actuarial value of the traditional medicare benefit package.

(ii) The projected rate of growth of outlays under the traditional medicare program.

(iii) The ability of Medicare Choice organizations to offer an adequate benefit package under part C of the medicare program.

(iv) The extent of Medicare Choice products made available to medicare beneficiaries in the different regions of the country.

(3) RECOMMENDATIONS.—

(A) IN GENERAL.—If a report under paragraph (2) finds that any of the following problems exists, the Commission shall include recommendations to respond to the problem:

(i) The actuarial value of the traditional medicare benefit package exceeds the payment rate under the Medicare Choice program.

(ii) The rate of growth of the traditional medicare program under parts A and B is projected to result in medicare outlays exceeding the outlay targets specified in section 15701.

(iii) The payments under the Medicare Choice program are not sufficient to allow contractors to provide an adequate benefit package.

(iv) The selection of Medicare Choice products are limited or not available in parts of the country.

(B) TYPES OF RECOMMENDATIONS.—The recommendations provided under subparagraph (A) may include—

(i) in response to the problem described in subparagraph (A)(ii), reduction in payments to providers under parts A and B or an increase in cost sharing by beneficiaries; and

(ii) in response to the problems described in subparagraphs (A)(iii) and (A)(iv), an adjustment to payment rates to Medicare Choice organizations.

Such recommendations may not include any change that is inconsistent with attaining the outlay targets specified under section 15701.

(4) PRESIDENTIAL RESPONSE.—If the Commission reports under this subsection that the goals established in section 15701 are not met (or projects that such goals will not be met during a 3-year period), the President shall submit to Congress, within 90 days after the date of submission of the report, specific legislative recommendations to correct the problem. Such recommendations may include those described in paragraph (3)(B) and may not include any change that is inconsistent with attaining the outlay targets specified under section 15701.

(5) CONGRESSIONAL CONSIDERATION.—

(A) IN GENERAL.—The President's recommendations submitted under paragraph (4) shall not apply unless a joint resolution (described in subparagraph (B)) approving such recommendations is enacted, in accordance with the provisions of subparagraph (C), before the end of the 60-day period beginning on the date on which a report containing such recommendations is submitted by the President under paragraph (4). For purposes of applying the preced-

ing sentence and subparagraphs (B) and (C), the days on which either House of Congress is not in session because of an adjournment of more than three days to a day certain shall be excluded in the computation of a period.

(B) JOINT RESOLUTION OF APPROVAL.—A joint resolution described in this subparagraph means only a joint resolution which is introduced within the 10-day period beginning on the date on which the report described in subparagraph (A) is submitted and—

(i) which does not have a preamble;

(ii) the matter after the resolving clause of which is as follows: ''That Congress approves the recommendations of the President under section 15702(b)(4) of the Medicare Preservation Act, as submitted by the President on _____.'', the blank space being filled in with the appropriate date; and

(iii) the title of which is as follows: ''Joint resolution approving Presidential recommendations submitted under section 15702(b)(4) of the Medicare Preservation Act, as submitted by the President on

_____.'', the blank space being filled in with the appropriate date.

(C) PROCEDURES FOR CONSIDERATION OF RESOLUTION OF APPROVAL.—Subject to subparagraph (D), the provisions of section 2908 (other than subsection (a)) of the Defense Base Closure and Realignment Act of 1990 shall apply to the consideration of a joint resolution described in subparagraph (B) in the same manner as such provisions apply to a joint resolution described in section 2908(a) of such Act.

(D) SPECIAL RULES.—For purposes of applying subparagraph (C) with respect to such provisions—

(i) any reference to the Committee on Armed Services of the House of Representatives shall be deemed a reference to the Committee on Ways and Means and any reference to the Committee on Armed Services of the Senate shall be deemed a reference to the Committee on Finance of the Senate; and

(ii) any reference to the date on which the President transmits a report shall be deemed a reference to the date on which

the President submits the recommendations under paragraph (4).

(c) MEMBERSHIP.—

(1) APPOINTMENT.—The Commission shall be composed of 5 members appointed by the President, of which 4 of whom are appointed from a list (of at least 5 nominees) submitted by each of the following:

(A) The Speaker of the House of Representatives.

(B) The Minority Leader of the House of Representatives.

(C) The Majority Leader of the Senate.

(D) The Minority Leader of the Senate.

(2) CHAIRMAN AND VICE CHAIRMAN.—The Commission shall elect a Chairman and Vice Chairman from among its members.

(3) VACANCIES.—Any vacancy in the membership of the Commission shall be filled in the manner in which the original appointment was made and shall not affect the power of the remaining members to execute the duties of the Commission.

(4) QUORUM.—A quorum shall consist of 3 members of the Commission, except that 2 members may conduct a hearing under subsection (e).

(5) MEETINGS.—The Commission shall meet at the call of its Chairman or a majority of its members.

(6) COMPENSATION AND REIMBURSEMENT OF EXPENSES.—Members of the Commission are not entitled to receive compensation for service on the Commission. Members may be reimbursed for travel, subsistence, and other necessary expenses incurred in carrying out the duties of the Commission.

(d) STAFF AND CONSULTANTS.—

(1) STAFF.—The Commission may appoint and determine the compensation of such staff as may be necessary to carry out the duties of the Commission. Such appointments and compensation may be made without regard to the provisions of title 5, United States Code, that govern appointments in the competitive services, and the provisions of chapter 51 and subchapter III of chapter 53 of such title that relate to classifications and the General Schedule pay rates.

(2) CONSULTANTS.—The Commission may procure such temporary and intermittent services of consultants under section 3109(b) of title 5, United States Code, as the Commission determines to be necessary to carry out the duties of the Commission.

(e) POWERS.—

(1) HEARINGS AND OTHER ACTIVITIES.—For the purpose of carrying out its duties, the Commission may hold such hearings and undertake such other activities as the Commission determines to be necessary to carry out its duties.

(2) STUDIES BY GAO.—Upon the request of the Commission, the Comptroller General shall conduct such studies or investigations as the Commission determines to be necessary to carry out its duties.

(3) COST ESTIMATES BY CONGRESSIONAL BUDGET OFFICE.—

(A) Upon the request of the Commission, the Director of the Congressional Budget Office shall provide to the Commission such cost estimates as the Commission determines to be necessary to carry out its duties.

(B) The Commission shall reimburse the Director of the Congressional Budget Office for expenses relating to the employment in the office of the Director of such additional staff as may be necessary for the Director to comply with requests by the Commission under subparagraph (A).

(4) DETAIL OF FEDERAL EMPLOYEES.—Upon the request of the Commission, the head of any Federal agency is authorized to detail, without reimbursement, any of the personnel of such agency to the Commission to assist the Commission in carrying out its duties. Any such detail shall not interrupt or otherwise affect the civil service status or privileges of the Federal employee.

(5) TECHNICAL ASSISTANCE.—Upon the request of the Commission, the head of a Federal agency shall provide such technical assistance to the Commission as the Commission determines to be necessary to carry out its duties.

(6) USE OF MAILS.—The Commission may use the United States mails in the same manner and under the same conditions as Federal agencies and shall, for purposes of the frank, be considered a commission of Congress as described in section 3215 of title 39, United States Code.

(7) OBTAINING INFORMATION.—The Commission may secure directly from any Federal agency information necessary to enable it to carry out its duties, if the information may be disclosed under section 552 of title 5, United States Code. Upon request of the Chairman of the Commission, the head

of such agency shall furnish such information to the Commission. In particular, the Administrator of the Health Care Financing Administration and the Director of the Office of Management and Budget shall provide the Commission with access to data for the conduct of its work.

(8) ADMINISTRATIVE SUPPORT SERVICES.—Upon the request of the Commission, the Administrator of General Services shall provide to the Commission on a reimbursable basis such administrative support services as the Commission may request.

(9) ACCEPTANCE OF DONATIONS.—The Commission may accept, use, and dispose of gifts or donations of services or property.

(10) PRINTING.—For purposes of costs relating to printing and binding, including the cost of personnel detailed from the Government Printing Office, the Commission shall be deemed to be a committee of the Congress.

(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out this section. Amounts appropriated to carry out this section shall remain available until expended.

Subtitle I—Lock-Box Provisions for Medicare Part B Savings from Growth Reductions

SEC. 15801. ESTABLISHMENT OF MEDICARE GROWTH REDUCTION TRUST FUND FOR PART B SAVINGS.

Part B of title XVIII is amended by inserting after section 1841 the following new section:

''MEDICARE GROWTH REDUCTION TRUST FUND

''SEC. 1841A. (a)(1) There is hereby created on the books of the Treasury of the United States a trust fund to be known as the 'Federal Medicare Growth Reduction Trust Fund' (in this section referred to as the 'Trust Fund'). The Trust Fund shall consist of such gifts and bequests as may be made as provided in section 201(i)(1) and amounts appropriated under paragraph (2).

''(2) There are hereby appropriated to the Trust Fund amounts equivalent to 100 percent of the Secretary's estimate of the reductions in expenditures under this part that are attributable to the Medicare Preservation Act of 1995. The amounts appropriated by the preceding sentence shall be transferred from time to time (not less frequently than monthly) from the general fund in the Treasury to the Trust Fund.

''(3)(A) Subject to subparagraph (B), with respect to monies transferred to the Trust Fund, no transfers, au-

thorizations of appropriations, or appropriations are permitted.

''(B) Beginning with fiscal year 2003, the Secretary may expend funds in the Trust Fund to carry out this title, but only to the extent provided by Congress in advance through a specific amendment to this section.

''(b) The provisions of subsections (b) through (e) of section 1841 shall apply to the Trust Fund in the same manner as they apply to the Federal Supplementary Medical Insurance Trust Fund, except that the Board of Trustees and Managing Trustee of the Trust Fund shall be composed of the members of the Board of Trustees and the Managing Trustee, respectively, of the Federal Supplementary Medical Insurance Trust Fund.''.

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