

105TH CONGRESS }
1st Session

HOUSE OF REPRESENTATIVES

{ REPORT
105-149

BALANCED BUDGET ACT OF 1997

R E P O R T

OF THE

COMMITTEE ON THE BUDGET
HOUSE OF REPRESENTATIVES

TO ACCOMPANY

H.R. 2015

A BILL TO PROVIDE FOR RECONCILIATION PURSUANT TO SUB-
SECTIONS (b)(1) AND (c) OF SECTION 105 OF THE CONCURRENT
RESOLUTION ON THE BUDGET FOR FISCAL YEAR 1998

together with

ADDITIONAL AND MINORITY VIEWS



JUNE 24, 1997.—Committed to the Committee of the Whole House on
the State of the Union and ordered to be printed

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PROVIDING FOR RECONCILIATION PURSUANT TO SUBSECTIONS (b)(1) AND (c) OF SECTION 105 OF THE CONCURRENT RESOLUTION ON THE BUDGET FOR FISCAL YEAR 1998

JUNE 24, 1997.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. KASICH, from the Committee on the Budget,
submitted the following

R E P O R T

together with

ADDITIONAL AND MINORITY VIEWS

[To accompany H.R. 2015]

[Including cost estimate of the Congressional Budget Office]

The Committee on the Budget, to whom reconciliation recommendations were submitted pursuant to subsections (b)(1) and (c) of section 105 of House Concurrent Resolution 84, the concurrent resolution on the budget for fiscal year 1998, having considered the same, reports favorably thereon without amendment and recommends that the bill do pass.

SECTION 1. SHORT TITLE.

This Act may be cited as the “Balanced Budget Act of 1997”.

SEC. 2. TABLE OF CONTENTS.

Title I—Committee on Agriculture.
Title II—Committee on Banking and Financial Services.
Title III—Committee on Commerce—NonMedicare.
Title IV—Committee on Commerce—Medicare.
Title V—Committee on Education and the Workforce.
Title VI—Committee on Government Reform and Oversight.
Title VII—Committee on Transportation and Infrastructure.
Title VIII—Committee on Veterans’ Affairs.

Title IX—Committee on Ways and Means—NonMedicare.
 Title X—Committee on Ways and Means—Medicare.

TITLE I—COMMITTEE ON AGRICULTURE

SEC. 1001. EXEMPTION.

Section 6(o) of the Food Stamp Act of 1977 (7 U.S.C. 2015(o)) is amended—

(1) in paragraph (2)(D), by striking “or (5)” and inserting “(5), or (6)”;

(2) by redesignating paragraphs (5) and (6) as paragraphs (6) and (7), respectively; and

(3) by inserting after paragraph (4) the following new paragraph:

“(5) 15-PERCENT EXEMPTION.—

“(A) DEFINITIONS.—In this paragraph:

“(i) CASELOAD.—The term ‘caseload’ means the average monthly number of individuals receiving food stamps during the 12-month period ending the preceding June 30.

“(ii) COVERED INDIVIDUAL.—The term ‘covered individual’ means a food stamp recipient, or an individual denied eligibility for food stamp benefits solely due to paragraph (2), who—

“(I) is not eligible for an exception under paragraph (3);

“(II) does not reside in an area covered by a waiver granted under paragraph (4);

“(III) is not complying with subparagraph (A), (B), or (C) of paragraph (2);

“(IV) is not in the first 3 months of eligibility under paragraph (2); and

“(V) is not receiving benefits under paragraph (6).

“(B) GENERAL RULE.—Subject to subparagraphs (C) through (F), a State agency may provide an exemption from the requirements of paragraph (2) for covered individuals.

“(C) FISCAL YEAR 1998.—Subject to subparagraph (E), for fiscal year 1998, a State agency may provide a number of exemptions such that the average monthly number of the exemptions in effect during the fiscal year does not exceed 15 percent of the number of covered individuals in the State in fiscal year 1998, as estimated by the Secretary, based on the survey conducted to carry out section 16(c) for fiscal year 1996 and such other factors as the Secretary considers appropriate due to the timing and limitations of the survey.

“(D) SUBSEQUENT FISCAL YEARS.—Subject to subparagraphs (E) and (F), for fiscal year 1999 and each subsequent fiscal year, a State agency may provide a number of exemptions such that the average monthly number of the

exemptions in effect during the fiscal year does not exceed 15 percent of the number of covered individuals in the State, as estimated by the Secretary under subparagraph (C), adjusted by the Secretary to reflect changes in the State's caseload and the Secretary's estimate of changes in the proportion of food stamp recipients covered by waivers granted under paragraph (4).

“(E) CASELOAD ADJUSTMENTS.—The Secretary shall adjust the number of individuals estimated for a State under subparagraph (C) or (D) during a fiscal year if the number of food stamp recipients in the State varies by a significant number from the caseload, as determined by the Secretary.

“(F) EXEMPTION ADJUSTMENTS.—During fiscal year 1999 and each subsequent fiscal year, the Secretary shall increase or decrease the number of individuals who may be granted an exemption by a State agency to the extent that the average monthly number of exemptions in effect in the State for the preceding fiscal year is greater or less than the average monthly number of exemptions estimated for the State agency during such preceding fiscal year.

“(G) REPORTING REQUIREMENT.—A State agency shall submit such reports to the Secretary as the Secretary determines are necessary to ensure compliance with this paragraph.”

SEC. 1002. ADDITIONAL FUNDING FOR EMPLOYMENT AND TRAINING.

(a) IN GENERAL.—Section 16(h) of the Food Stamp Act of 1977 (7 U.S.C. 2025(h)) is amended—

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

“(1) IN GENERAL.—

“(A) AMOUNTS.—To carry out employment and training programs, the Secretary shall reserve for allocation to State agencies, to remain available until expended, from funds made available for each fiscal year under section 18(a)(1) the amount of—

“(i) for fiscal year 1996, \$75,000,000;

“(ii) for fiscal year 1997, \$79,000,000;

“(iii) for fiscal year 1998, \$221,000,000;

“(iv) for fiscal year 1999, \$224,000,000;

“(v) for fiscal year 2000, \$226,000,000;

“(vi) for fiscal year 2001, \$228,000,000; and

“(vii) for fiscal year 2002, \$210,000,000.

“(B) LIMITATIONS.—The Secretary shall ensure that—

“(i) the funds provided in this subparagraph shall not be used for food stamp recipients who receive benefits under a State program funded under part A of title IV of the Social Security Act (42 U.S.C. 601 et seq.); and

“(ii) not less than 75 percent of the funds provided in this subparagraph shall be used by a State agency for the employment and training of food stamp recipients not excepted by section 6(o)(3).

“(C) ALLOCATION.—

“(i) ALLOCATION FORMULA.—The Secretary shall allocate the amounts reserved under subparagraph (A) among the State agencies using a reasonable formula, as determined and adjusted by the Secretary each fiscal year, to reflect changes in each State’s caseload (as defined in section 6(o)(5)(A)) that reflects the proportion of food stamp recipients who reside in each State—

“(I) who are not eligible for an exception under section 6(o)(3); and

“(II) who do not reside in an area subject to the waiver granted by the Secretary under section 6(o)(4), if the State agency does not provide employment and training services in the area to food stamp recipients not excepted by section 6(o)(3).

“(ii) REPORTING REQUIREMENT.—A State agency shall submit such reports to the Secretary as the Secretary determines are necessary to ensure compliance with this paragraph.”; and

“(D) REALLOCATION.—

“(i) NOTIFICATION.—A State agency shall promptly notify the Secretary if the State agency determines that it will not expend all of the funds allocated to it under subparagraph (B).

“(ii) REALLOCATION.—On notification under clause (i), the Secretary shall reallocate the funds that the State agency will not expend as the Secretary considers appropriate and equitable.

“(E) MINIMUM ALLOCATION.—Notwithstanding subparagraphs (A) through (C), the Secretary shall ensure that each State agency operating an employment and training program shall receive not less than \$50,000 for each fiscal year.

“(F) MAINTENANCE OF EFFORT.—To receive the additional funding under subparagraph (A), as provided by the amendment made by section 1002 of the Balanced Budget Act of 1997, a State agency shall maintain the expenditures of the State agency for employment and training programs and workfare programs for any fiscal year under paragraph (2), and administrative expenses under section 20(g)(1), at a level that is not less than the level of the expenditures by the State agency to carry out the programs for fiscal year 1996.”;

(2) by redesignating paragraphs (2) through (5) as paragraphs (3) through (6), respectively;

(3) by inserting after paragraph (1) the following new paragraph:

“(2) REPORT TO CONGRESS ON ADDITIONAL FUNDING.—Beginning one year after the date of the enactment of this paragraph, the Secretary shall submit an annual report to the Committee on Agriculture of the House of Representatives and the Committee on Agriculture, Nutrition, and Forestry of the Senate regarding whether the additional funding provided under paragraph (1)(A) has been utilized by State agencies to

increase the number of work slots in their employment and training programs and workfare for recipients subject to section 6(o) in the most efficient and effective manner.”; and

(4) in paragraph (3) (as so redesignated), by striking “paragraph (3)” and inserting “paragraph (4)”.

(b) **CONFORMING AMENDMENTS.**—(1) Subsection (b)(1)(B)(iv)(III)(hh) of section 17 of the Food Stamp Act of 1977 (7 U.S.C. 2026) is amended by striking “(h)(2), or (h)(3) of section 16” and inserting “(h)(3), or (h)(4) of section 16”.

(2) Subsection (d)(1)(B)(ii) of section 22 of such Act (7 U.S.C. 2031) is amended by striking “(h)(2), and (h)(3) of section 16” and inserting “(h)(3), and (h)(4) of section 16”.

SEC. 1003. AUTHORIZING USE OF NONGOVERNMENTAL PERSONNEL IN MAKING DETERMINATIONS OF ELIGIBILITY FOR BENEFITS UNDER THE FOOD STAMP PROGRAM.

(a) **IN GENERAL.**—Notwithstanding any other provision of law, no provision of law shall be construed as preventing any State (as defined in section 3(m) of the Food Stamp Act of 1977 (7 U.S.C. 2012(m))) from allowing eligibility determinations described in subsection (b) to be made by an entity that is not a State or local government, or by an individual who is not an employee of a State or local government, which meets such qualifications as the State determines. For purposes of any Federal law, such determinations shall be considered to be made by the State and by a State agency.

(b) **ELIGIBILITY DETERMINATIONS.**—An eligibility determination described in this subsection is a determination of eligibility of individuals or households to receive benefits under the food stamp program as defined in section 3(h) of the Food Stamp Act of 1977 (7 U.S.C. 2012(h)).

(c) **CONSTRUCTION.**—Nothing in this section shall be construed as affecting—

(1) the conditions for eligibility for benefits (including any conditions relating to income or resources);

(2) the rights to challenge determinations regarding eligibility or rights to benefits; and

(3) determinations regarding quality control or error rates.

TITLE II—COMMITTEE ON BANKING AND FINANCIAL SERVICES

SEC. 2001. TABLE OF CONTENTS.

The table of contents for this title is as follows:

TITLE II—COMMITTEE ON BANKING AND FINANCIAL SERVICES

Sec. 2001. Table of contents.

Sec. 2002. Extension of foreclosure avoidance and borrower assistance provisions for FHA single family housing mortgage insurance program.

Sec. 2003. Adjustment of maximum monthly rents for certain dwelling units in new construction and substantial or moderate rehabilitation projects assisted under section 8 rental assistance program.

Sec. 2004. Adjustment of maximum monthly rents for non-turnover dwelling units assisted under section 8 rental assistance program.

SEC. 2002. EXTENSION OF FORECLOSURE AVOIDANCE AND BORROWER ASSISTANCE PROVISIONS FOR FHA SINGLE FAMILY HOUSING MORTGAGE INSURANCE PROGRAM.

Section 407 of The Balanced Budget Downpayment Act, I (12 U.S.C. 1710 note) is amended—

- (1) in subsection (c)—
 - (A) by striking “only”; and
 - (B) by inserting “, on, or after” after “before”; and
- (2) by striking subsection (e).

SEC. 2003. ADJUSTMENT OF MAXIMUM MONTHLY RENTS FOR CERTAIN DWELLING UNITS IN NEW CONSTRUCTION AND SUBSTANTIAL OR MODERATE REHABILITATION PROJECTS ASSISTED UNDER SECTION 8 RENTAL ASSISTANCE PROGRAM.

The third sentence of section 8(c)(2)(A) of the United States Housing Act of 1937 (42 U.S.C. 1437f(c)(2)(A)) is amended by inserting before the period at the end the following: “, and during fiscal year 1999 and thereafter”.

SEC. 2004. ADJUSTMENT OF MAXIMUM MONTHLY RENTS FOR NON-TURNOVER DWELLING UNITS ASSISTED UNDER SECTION 8 RENTAL ASSISTANCE PROGRAM.

The last sentence of section 8(c)(2)(A) of the United States Housing Act of 1937 is amended by inserting before the period at the end the following: “, and during fiscal year 1999 and thereafter”.

TITLE III—COMMITTEE ON COMMERCE—NONMEDICARE

Subtitle A—Nuclear Regulatory Commission Annual Charges

SEC. 3001. NUCLEAR REGULATORY COMMISSION ANNUAL CHARGES.

Section 6101(a)(3) of the Omnibus Budget Reconciliation Act of 1990 (42 U.S.C. 2214(a)(3)) is amended by striking “September 30, 1998” and inserting “September 30, 2002”.

Subtitle B—Lease of Excess Strategic Petroleum Reserve Capacity

SEC. 3101. LEASE OF EXCESS STRATEGIC PETROLEUM RESERVE CAPACITY.

(a) AMENDMENT.—Part B of title I of the Energy Policy and Conservation Act (42 U.S.C. 6231 et seq.) is amended by adding at the end the following:

“USE OF UNDERUTILIZED FACILITIES

“SEC. 168. (a) AUTHORITY.—Notwithstanding any other provision of this title, the Secretary, by lease or otherwise, for any term and under such other conditions as the Secretary considers necessary or appropriate, may store in underutilized Strategic Petroleum Reserve facilities petroleum product owned by a foreign government or its representative. Petroleum products stored under this section

are not part of the Strategic Petroleum Reserve and may be exported without license from the United States.

“(b) PROTECTION OF FACILITIES.—All agreements entered into pursuant to subsection (a) shall contain provisions providing for fees to fully compensate the United States for all costs of storage and removals of petroleum products, including the cost of replacement facilities necessitated as a result of any withdrawals.

“(c) ACCESS TO STORED OIL.—The Secretary shall ensure that agreements to store petroleum products for foreign governments or their representatives do not affect the ability of the United States to withdraw, distribute, or sell petroleum from the Strategic Petroleum Reserve in response to an energy emergency or to the obligations of the United States under the Agreement on an International Energy Program.

“(d) AVAILABILITY OF FUNDS.—Funds collected through the leasing of Strategic Petroleum Reserve facilities authorized by subsection (a) after September 30, 2002, shall be used by the Secretary of Energy without further appropriation for the purchase of oil for, and operation and maintenance costs of, the Strategic Petroleum Reserve.”.

(b) TABLE OF CONTENTS AMENDMENT.—The table of contents of part B of title I of the Energy Policy and Conservation Act is amended by adding at the end the following:

“Sec. 168. Use of underutilized facilities.”.

Subtitle C—Sale of DOE Assets

SEC. 3201. SALE OF DOE SURPLUS URANIUM ASSETS.

(a) IN GENERAL.—The Secretary of Energy shall, during the period fiscal year 1999 through fiscal year 2002, sell 3.2 million pounds per year of natural and low-enriched uranium that the President has determined is not necessary for national security needs. Such sales shall be—

- (1) made for delivery after January 1, 1999;
- (2) subject to a determination, for the period fiscal year 1999 through fiscal year 2002, by the Secretary under section 3112(d)(2)(B) of the USEC Privatization Act (42 U.S.C. 2297h–10(d)(2)(B)); and
- (3) made at a price not less than the fair market value of the uranium and in a manner that maximizes proceeds to the Treasury.

The Secretary shall receive the proceeds from such sale in the period fiscal year 1999 through fiscal year 2002 and shall deposit such proceeds in the General Fund of the Treasury.

(b) COSTS.—The costs of making the sales required by subsection (a) shall be covered by the unobligated balances of appropriations of the Department of Energy.

Subtitle D—Communications

SEC. 3301. SPECTRUM AUCTIONS.

(a) EXTENSION AND EXPANSION OF AUCTION AUTHORITY.—

(1) AMENDMENTS.—Section 309(j) of the Communications Act of 1934 (47 U.S.C. 309(j)) is amended—

(A) by striking paragraphs (1) and (2) and inserting in lieu thereof the following:

“(1) GENERAL AUTHORITY.—If, consistent with the obligations described in paragraph (6)(E), mutually exclusive applications are accepted for any initial license or construction permit which will involve an exclusive use of the electromagnetic spectrum, then the Commission shall grant such license or permit to a qualified applicant through a system of competitive bidding that meets the requirements of this subsection.

“(2) EXEMPTIONS.—The competitive bidding authority granted by this subsection shall not apply to licenses or construction permits issued by the Commission—

“(A) that, as the result of the Commission carrying out the obligations described in paragraph (6)(E), are not mutually exclusive;

“(B) for public safety radio services, including private internal radio services used by non-Government entities, that—

“(i) protect the safety of life, health, or property; and

“(ii) are not made commercially available to the public;

“(C) for initial licenses or construction permits assigned by the Commission to existing terrestrial broadcast licensees for new terrestrial digital television services; or

“(D) for public telecommunications services, as defined in section 397(14) of the Communications Act of 1934 (47 U.S.C. 397(14)), when the license application is for channels reserved for noncommercial use.”;

(B) in paragraph (3)—

(i) by inserting after the second sentence the following new sentence: “The Commission shall, directly or by contract, provide for the design and conduct (for purposes of testing) of competitive bidding using a contingent combinatorial bidding system that permits prospective bidders to bid on combinations or groups of licenses in a single bid and to enter multiple alternative bids within a single bidding round.”;

(ii) by striking “and” at the end of subparagraph (C);

(iii) by striking the period at the end of subparagraph (D) and inserting “; and”; and

(iv) by adding at the end the following new subparagraph:

“(E) ensuring that, in the scheduling of any competitive bidding under this subsection, an adequate period is allowed—

“(i) before issuance of bidding rules, to permit notice and comment on proposed auction procedures; and

“(ii) after issuance of bidding rules, to ensure that interested parties have a sufficient time to develop business plans, assess market conditions, and evaluate the availability of equipment for the relevant services.”;

(C) in paragraph (8)—

(i) by striking subparagraph (B); and

(ii) by redesignating subparagraph (C) as subparagraph (B);

(D) in paragraph (11), by striking “1998” and inserting “2002”; and

(E) in paragraph (13)(F), by striking “September 30, 1998” and inserting “the date of enactment of the Balanced Budget Act of 1997”.

(2) CONFORMING AMENDMENT.—Subsection (i) of section 309 of the Communications Act of 1934 (47 U.S.C. 309(i)) is repealed.

(3) EFFECTIVE DATE.—The amendment made by paragraph (1)(A) shall not apply with respect to any license or permit for which the Federal Communications Commission has accepted mutually exclusive applications on or before the date of enactment of this Act.

(b) COMMISSION OBLIGATION TO MAKE ADDITIONAL SPECTRUM AVAILABLE BY AUCTION.—

(1) IN GENERAL.—The Federal Communications Commission shall complete all actions necessary to permit the assignment, by September 30, 2002, by competitive bidding pursuant to section 309(j) of the Communications Act of 1934 (47 U.S.C. 309(j)) of licenses for the use of bands of frequencies that—

(A) individually span not less than 25 megahertz, unless a combination of smaller bands can, notwithstanding the provisions of paragraph (7) of such section, reasonably be expected to produce greater receipts;

(B) in the aggregate span not less than 100 megahertz;

(C) are located below 3 gigahertz;

(D) have not, as of the date of enactment of this Act—

(i) been designated by Commission regulation for assignment pursuant to such section;

(ii) been identified by the Secretary of Commerce pursuant to section 113 of the National Telecommunications and Information Administration Organization Act;

(iii) been allocated for Federal Government use pursuant to section 305 of the Communications Act of 1934 (47 U.S.C. 305);

(iv) been designated in section 3303 of this Act; or

(v) been allocated for unlicensed use pursuant to part 15 of the Commission’s regulations (47 C.F.R. Part 15), if the competitive bidding for licenses would interfere with operation of end-user products permitted under such regulations; and

(E) notwithstanding section 115(b)(1)(B) of the National Telecommunications and Information Administration Organization Act (47 U.S.C. 925(b)(1)(B)) or any proposal pursuant to such section, include frequencies at 1,710–1,755 megahertz.

(2) CRITERIA FOR REASSIGNMENT.—In making available bands of frequencies for competitive bidding pursuant to paragraph (1), the Commission shall—

- (A) seek to promote the most efficient use of the spectrum;
 - (B) take into account the cost to incumbent licensees of relocating existing uses to other bands of frequencies or other means of communication; and
 - (C) comply with the requirements of international agreements concerning spectrum allocations.
- (3) NOTIFICATION TO NTIA.—The Commission shall notify the Secretary of Commerce if—
- (A) the Commission is not able to provide for the effective relocation of incumbent licensees to bands of frequencies that are available to the Commission for assignment; and
 - (B) the Commission has identified bands of frequencies that are—
 - (i) suitable for the relocation of such licensees; and
 - (ii) allocated for Federal Government use, but that could be reallocated pursuant to part B of the National Telecommunications and Information Administration Organization Act (as amended by this Act).
- (4) PROTECTION OF SPACE RESEARCH USES.—The licenses assigned pursuant to paragraph (1) shall require licensees to avoid interference with communications in space research and earth exploration-satellite services authorized under notes 750A and US90 to section 2.106 of the regulations of the Federal Communications Commission (47 C.F.R. 2.106) as in effect on the date of enactment of this Act.
- (c) IDENTIFICATION AND REALLOCATION OF FREQUENCIES.—The National Telecommunications and Information Administration Organization Act (47 U.S.C. 901 et seq.) is amended—
- (1) in section 113, by adding at the end the following new subsection:
 - “(f) ADDITIONAL REALLOCATION REPORT.—If the Secretary receives a notice from the Commission pursuant to section 3301(b)(3) of the Balanced Budget Act of 1997, the Secretary shall prepare and submit to the President, the Commission, and the Congress a report recommending for reallocation for use other than by Federal Government stations under section 305 of the 1934 Act (47 U.S.C. 305), bands of frequencies that are suitable for the uses identified in the Commission’s notice. The Commission shall, not later than one year after receipt of such report, prepare, submit to the President and the Congress, and implement, a plan for the immediate allocation and assignment of such frequencies under the 1934 Act to incumbent licensees described in section 3301(b)(3) of the Balanced Budget Act of 1997.”; and
 - (2) in section 114(a)(1), by striking “(a) or (d)(1)” and inserting “(a), (d)(1), or (f)”.
- (d) IDENTIFICATION AND REALLOCATION OF AUCTIONABLE FREQUENCIES.—The National Telecommunications and Information Administration Organization Act (47 U.S.C. 901 et seq.) is amended—
- (1) in section 113(b)—
 - (A) by striking the heading of paragraph (1) and inserting “INITIAL REALLOCATION REPORT”;

(B) by inserting “in the first report required by subsection (a)” after “recommend for reallocation” in paragraph (1);

(C) by inserting “or (3)” after “paragraph (1)” each place it appears in paragraph (2); and

(D) by inserting after paragraph (2) the following new paragraph:

“(3) SECOND REALLOCATION REPORT.—In accordance with the provisions of this section, the Secretary shall recommend for reallocation in the second report required by subsection (a), for use other than by Federal Government stations under section 305 of the 1934 Act (47 U.S.C. 305), a band or bands of frequencies that—

“(A) in the aggregate span not less than 20 megahertz;

“(B) individually span not less than 20 megahertz, unless a combination of smaller bands can reasonably be expected to produce greater receipts;

“(C) are located below 3 gigahertz; and

“(D) meet the criteria specified in paragraphs (1) through (5) of subsection (a).”; and

(2) in section 115—

(A) in subsection (b), by striking “the report required by section 113(a)” and inserting “the initial reallocation report required by section 113(a).”; and

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

“(c) ALLOCATION AND ASSIGNMENT OF FREQUENCIES IDENTIFIED IN THE SECOND REALLOCATION REPORT.—With respect to the frequencies made available for reallocation pursuant to section 113(b)(3), the Commission shall, not later than one year after receipt of the second reallocation report required by such section, prepare, submit to the President and the Congress, and implement, a plan for the immediate allocation and assignment under the 1934 Act of all such frequencies in accordance with section 309(j) of such Act.”.

(e) MINIMUM RECOVERY FOR PUBLIC REQUIRED.—

(1) METHODOLOGY TO SECURE MINIMUM AMOUNTS REQUIRED.—In establishing, pursuant to section 309(j)(3) of the Communications Act of 1934 (47 U.S.C. 309(j)(3)), a competitive bidding methodology with respect to the frequencies required to be assigned by competitive bidding under subsection (b) of this section and section 115(c) of the National Telecommunications and Information Administration Organization Act (47 U.S.C. 925(c)), the Commission shall establish procedures that are designed to secure winning bids totaling not less than two-thirds of \$7,500,000,000.

(2) AUTHORITY.—In establishing such methodology, the Commission is authorized—

(A) to partition the total required to be obtained under paragraph (1) among separate competitive bidding proceedings, or among separate bands, regions, or markets;

(B) to void any such separated competitive bidding proceeding that fails to obtain the partitioned subtotal that pertains to that proceeding; and

(C) to prescribe minimum bids or other bidding requirements to obtain such total or subtotal.

(3) **LICENSES WITHHELD.**—Notwithstanding any other requirement of this section, or the amendments made by this section, the Commission shall refrain from conducting any competitive bidding pursuant to the methodology established pursuant to this subsection unless the Commission determines that such methodology will secure winning bids totaling not less than two-thirds of \$7,500,000,000.

(4) **AUTHORITY TO REBID AT A LATER TIME TO SECURE STATUTORY OBJECTIVES.**—Nothing in paragraph (2) or (3) shall preclude or limit the Commission from assigning the frequencies described in paragraph (1) by competitive bidding at such later date (than the date required by this section) as the Commission determines, in its discretion, will better attain the objectives of recovering for the public a fair portion of the value of the public spectrum resource and avoiding unjust enrichment.

SEC. 3302. AUCTION OF RECAPTURED BROADCAST TELEVISION SPECTRUM.

Section 309(j) of the Communications Act of 1934 (47 U.S.C. 309(j)) is amended by adding at the end the following new paragraph:

“(14) **AUCTION OF RECAPTURED BROADCAST TELEVISION SPECTRUM.**—

“(A) **LIMITATIONS ON TERMS OF TERRESTRIAL TELEVISION BROADCAST LICENSES.**—A television license that authorizes analog television services may not be renewed to authorize such service for a period that extends beyond December 31, 2006. The Commission shall grant by regulation an extension of such date to licensees in a market if the Commission determines that more than 5 percent of households in such market continue to rely exclusively on over-the-air terrestrial analog television signals.

“(B) **SPECTRUM REVERSION AND RESALE.**—

“(i) The Commission shall ensure that, when the authority to broadcast analog television services under a license expires pursuant to subparagraph (A), each licensee shall return spectrum according to the Commission’s direction and the Commission shall reclaim such spectrum.

“(ii) Licensees for new services occupying spectrum reclaimed pursuant to clause (i) shall be selected in accordance with this subsection. The Commission shall start such selection process by July 1, 2001, with payment pursuant to rules established by the Commission under this subsection.

“(C) **MINIMUM RECOVERY FOR PUBLIC REQUIRED.**—

“(i) **METHODOLOGY TO SECURE MINIMUM AMOUNTS REQUIRED.**—In establishing, pursuant to section 309(j)(3) of the Communications Act of 1934 (47 U.S.C. 309(j)(3)), a competitive bidding methodology with respect to the frequencies required to be assigned by competitive bidding under subparagraph (B) of this paragraph, the Commission shall establish procedures

that are designed to secure winning bids totaling not less than two-thirds of \$4,000,000,000.

“(ii) AUTHORITY.—In establishing such methodology, the Commission is authorized—

“(I) to partition the total required to be obtained under clause (i) among separate competitive bidding proceedings, or among separate bands, regions, or markets;

“(II) to void any such separated competitive bidding proceeding that fails to obtain the partitioned subtotal that pertains to that proceeding; and

“(III) to prescribe minimum bids or other bidding requirements to obtain such aggregate total.

“(iii) LICENSES WITHHELD.—Notwithstanding any other requirement of this paragraph, the Commission shall refrain from conducting any competitive bidding pursuant to the methodology established pursuant to this subparagraph unless the Commission determines that such methodology will secure winning bids totaling not less than two-thirds of \$4,000,000,000.

“(iv) AUTHORITY TO REBID AT A LATER TIME TO SECURE STATUTORY OBJECTIVES.—Nothing in clause (ii) or (iii) shall preclude or limit the Commission from assigning the frequencies described in clause (i) by competitive bidding at such later date (than the date required by this paragraph) as the Commission determines, in its discretion, will better attain the objectives of recovering for the public a fair portion of the value of the public spectrum resource and avoiding unjust enrichment.

“(D) CERTAIN LIMITATIONS ON QUALIFIED BIDDERS PROHIBITED.—In prescribing any regulations relating to the qualification of bidders for spectrum reclaimed pursuant to subparagraph (B)(i), the Commission shall not—

“(i) preclude any party from being a qualified bidder for spectrum that is allocated for any use that includes digital television service on the basis of—

“(I) the Commission’s duopoly rule (47 C.F.R. 73.3555(b)); or

“(II) the Commission’s newspaper cross-ownership rule (47 C.F.R. 73.3555(d)); or

“(ii) apply either such rule to preclude such a party that is a successful bidder in a competitive bidding for such spectrum from using such spectrum for digital television service.

“(E) DEFINITIONS.—As used in this paragraph:

“(i) The term ‘digital television service’ means television service provided using digital technology to enhance audio quality and video resolution, as further defined in the Memorandum Opinion, Report, and Order of the Commission entitled ‘Advanced Television Systems and Their Impact Upon the Existing Television Service’, MM Docket No. 87–268 and any subse-

quent Commission proceedings dealing with digital television.

“(ii) The term ‘analog television service’ means service provided pursuant to the transmission standards prescribed by the Commission in section 73.682(a) of its regulation (47 CFR 73.682(a)).”.

SEC. 3303. ALLOCATION AND ASSIGNMENT OF NEW PUBLIC SAFETY AND COMMERCIAL LICENSES.

(a) **IN GENERAL.**—The Federal Communications Commission shall, not later than January 1, 1998, allocate on a national, regional, or market basis, from radio spectrum between 746 megahertz and 806 megahertz—

(1) 24 megahertz of that spectrum for public safety services according to the terms and conditions established by the Commission, unless the Commission determines that the needs for public safety services can be met in particular areas with allocations of less than 24 megahertz; and

(2) the remainder of that spectrum for commercial purposes to be assigned by competitive bidding in accordance with section 309(j).

(b) **ASSIGNMENT.**—The Commission shall—

(1) assign the licenses for public safety created pursuant to subsection (a) no later than March 31, 1998; and

(2) commence competitive bidding for the commercial licenses created pursuant to subsection (a) no later than July 1, 2001.

(c) **LICENSING OF UNUSED FREQUENCIES FOR PUBLIC SAFETY RADIO SERVICES.**—

(1) **USE OF UNUSED CHANNELS FOR PUBLIC SAFETY.**—It shall be the policy of the Commission, notwithstanding any other provision of this Act or any other law, to waive whatever licensee eligibility and other requirements (including bidding requirements) are applicable in order to permit the use of unassigned frequencies for public safety purposes by a State or local governmental agency upon a showing that—

(A) no other existing satisfactory public safety channel is immediately available to satisfy the requested use;

(B) the proposed use is technically feasible without causing harmful interference to existing stations in the frequency band entitled to protection from such interference under the rules of the Commission; and

(C) use of the channel for public safety purposes is consistent with other existing public safety channel allocations in the geographic area of proposed use.

(2) **APPLICABILITY.**—Paragraph (1) shall apply to any application that is pending before the Federal Communications Commission, or that is not finally determined under either section 402 or 405 of the Communications Act of 1934 (47 U.S.C. 402, 405) on May 15, 1997, or that is filed after such date.

(d) **CONDITIONS ON LICENSES.**—With respect to public safety and commercial licenses granted pursuant to this subsection, the Commission shall—

(1) establish interference limits at the boundaries of the spectrum block and service area;

(2) establish any additional technical restrictions necessary to protect full-service analog television service and digital television service during a transition to digital television service; and

(3) permit public safety and commercial licensees—

(A) to aggregate multiple licenses to create larger spectrum blocks and service areas; and

(B) to disaggregate or partition licenses to create smaller spectrum blocks or service areas.

(e) MINIMUM RECOVERY FOR PUBLIC REQUIRED.—

(1) METHODOLOGY TO SECURE MINIMUM AMOUNTS REQUIRED.—In establishing, pursuant to section 309(j)(3) of the Communications Act of 1934 (47 U.S.C. 309(j)(3)), a competitive bidding methodology with respect to the frequencies required to be assigned by competitive bidding under this section, the Commission shall establish procedures that are designed to secure winning bids totaling not less than two-thirds of \$1,900,000,000.

(2) AUTHORITY.—In establishing such methodology, the Commission is authorized—

(A) to partition the total required to be obtained under paragraph (1) among separate competitive bidding proceedings, or among separate bands, regions, or markets;

(B) to void any such separated competitive bidding proceeding that fails to obtain the partitioned subtotal that pertains to that proceeding; and

(C) to prescribe minimum bids or other bidding requirements to obtain such total or subtotal.

(3) LICENSES WITHHELD.—Notwithstanding any other requirement of this section, the Commission shall refrain from conducting any competitive bidding pursuant to the methodology established pursuant to this subsection unless the Commission determines that such methodology will secure winning bids totaling not less than two-thirds of \$1,900,000,000.

(4) AUTHORITY TO REBID AT A LATER TIME TO SECURE STATUTORY OBJECTIVES.—Nothing in paragraph (2) or (3) shall preclude or limit the Commission from assigning the frequencies described in paragraph (1) by competitive bidding at such later date (than the date required by this section) as the Commission determines, in its discretion, will better attain the objectives of recovering for the public a fair portion of the value of the public spectrum resource and avoiding unjust enrichment.

(f) PROTECTION OF QUALIFYING LOW-POWER STATIONS.—Prior to making any allocation or assignment under this section the Commission shall assure that each qualifying low-power television station is assigned a frequency below 746 megahertz to permit the continued operation of such station.

(g) DEFINITIONS.—For purposes of this section:

(1) COMMISSION.—The term “Commission” means the Federal Communications Commission.

(2) DIGITAL TELEVISION SERVICE.—The term “digital television service” means television service provided using digital technology to enhance audio quality and video resolution, as further defined in the Memorandum Opinion, Report, and

Order of the Commission entitled ‘Advanced Television Systems and Their Impact Upon the Existing Television Service’, MM Docket No. 87–268 and any subsequent Commission proceedings dealing with digital television.

(3) ANALOG TELEVISION SERVICE.—The term “analog television service” means services provided pursuant to the transmission standards prescribed by the Commission in section 73.682(a) of its regulation (47 CFR 73.682(a)).

(4) PUBLIC SAFETY SERVICES.—The term “public safety services” means services—

(A) the sole or principal purpose of which is to protect the safety of life, health, or property;

(B) that are provided—

(i) by State or local government entities; or

(ii) by nongovernmental, private organizations that are authorized by a governmental entity whose primary mission is the provision of such services; and

(C) that are not made commercially available to the public by the provider.

(5) SERVICE AREA.—The term “service area” means the geographic area over which a licensee may provide service and is protected from interference.

(6) SPECTRUM BLOCK.—The term “spectrum block” means the range of frequencies over which the apparatus licensed by the Commission is authorized to transmit signals.

(7) QUALIFYING LOW-POWER TELEVISION STATIONS.—A station is a qualifying low-power television station if—

(A) during the 90 days preceding the date of enactment of this Act—

(i) such station broadcast a minimum of 18 hours per day;

(ii) such station broadcast an average of at least 3 hours per week of programming that was produced within the community of license of such station; and

(iii) such station was in compliance with the requirements applicable to low-power television stations; or

(B) the Commission determines that the public interest, convenience, and necessity would be served by treating the station as a qualifying low-power television station for purposes of this section.

SEC. 3304. INQUIRY REQUIRED.

The Federal Communications Commission shall, not later than July 1, 1997, initiate the inquiry required by section 309(j)(12) of the Communications Act of 1934 (47 U.S.C. 309(j)(12)) for the purposes of collecting the information required for its report under each of subparagraphs (A) through (E) of such section, and shall keep the Congress fully and currently informed with respect to the progress of such inquiry.

Subtitle E—Medicaid

SEC. 3400. TABLE OF CONTENTS OF SUBTITLE; REFERENCES.

(a) TABLE OF CONTENTS OF SUBTITLE.—The table of contents of this subtitle is as follows:

Sec. 3400. Table of contents of subtitle; references.

CHAPTER 1—STATE FLEXIBILITY

SUBCHAPTER A—USE OF MANAGED CARE

- Sec. 3401. State options to provide benefits through managed care entities.
- Sec. 3402. Elimination of 75:25 restriction on risk contracts.
- Sec. 3403. Primary care case management services as State option without need for waiver.
- Sec. 3404. Change in threshold amount for contracts requiring Secretary's prior approval.
- Sec. 3405. Determination of hospital stay.

SUBCHAPTER B—PAYMENT METHODOLOGY

- Sec. 3411. Flexibility in payment methods for hospital, nursing facility, and ICF/MR services; flexibility for home health.
- Sec. 3412. Payment for Federally qualified health center services.
- Sec. 3413. Treatment of State taxes imposed on certain hospitals that provide free care.

SUBCHAPTER C—ELIGIBILITY

- Sec. 3421. State option of continuous eligibility for 12 months; clarification of State option to cover children.
- Sec. 3422. Payment of home-health-related medicare part B premium amount for certain low-income individuals.
- Sec. 3423. Penalty for fraudulent eligibility.
- Sec. 3424. Treatment of certain settlement payments.

SUBCHAPTER D—PROGRAMS OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)

- Sec. 3431. Establishment of PACE program as medicaid State option.
- Sec. 3432. Coverage of PACE under the medicare program.
- Sec. 3433. Effective date; transition.
- Sec. 3434. Study and reports.

SUBCHAPTER E—BENEFITS

- Sec. 3441. Elimination of requirement to pay for private insurance.
- Sec. 3442. Permitting same copayments in health maintenance organizations as in fee-for-service.
- Sec. 3443. Physician qualification requirements.
- Sec. 3444. Elimination of requirement of prior institutionalization with respect to habilitation services furnished under a waiver for home or community-based services.
- Sec. 3445. Benefits for services of physician assistants.
- Sec. 3446. Study and report on actuarial value of EPSDT benefit.

SUBCHAPTER F—ADMINISTRATION

- Sec. 3451. Elimination of duplicative inspection of care requirements for ICFS/MR and mental hospitals.
- Sec. 3452. Alternative sanctions for noncompliant ICFS/MR.
- Sec. 3453. Modification of MMIS requirements.
- Sec. 3454. Facilitating imposition of State alternative remedies on noncompliant nursing facilities.
- Sec. 3455. Medically accepted indication.
- Sec. 3456. Continuation of State-wide section 1115 medicaid waivers.
- Sec. 3457. Authorizing administrative streamlining and privatizing modifications under the medicaid program.
- Sec. 3458. Extension of moratorium.

CHAPTER 2—QUALITY ASSURANCE

- Sec. 3461. Requirements to ensure quality of and access to care under managed care plans.
- Sec. 3462. Solvency standards for certain health maintenance organizations.
- Sec. 3463. Application of prudent layperson standard for emergency medical condition and prohibition of gag rule restrictions.
- Sec. 3464. Additional fraud and abuse protections in managed care.
- Sec. 3465. Grievances under managed care plans.
- Sec. 3466. Standards relating to access to obstetrical and gynecological services under managed care plans.

CHAPTER 3—FEDERAL PAYMENTS

- Sec. 3471. Reforming disproportionate share payments under State medicaid programs.
- Sec. 3472. Additional funding for State emergency health services furnished to undocumented aliens.

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

CHAPTER 1—STATE FLEXIBILITY**Subchapter A—Use of Managed Care****SEC. 3401. STATE OPTIONS TO PROVIDE BENEFITS THROUGH MANAGED CARE ENTITIES.**

(a) IN GENERAL.—Section 1915(a) (42 U.S.C. 1396n(a)) is amended—

- (1) by striking “or” at the end of paragraph (1),
- (2) by striking the period at the end of paragraph (2) and inserting “; or”, and

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

“(3) requires individuals, other than special needs children (as defined in subsection (i)), eligible for medical assistance for items or services under the State plan to enroll with an entity that provides or arranges for services for enrollees under a contract pursuant to section 1903(m), or with a primary care case manager (as defined in section 1905(t)(2)) (or restricts the number of provider agreements with those entities under the State plan, consistent with quality of care), if—

“(A) the State permits an individual to choose the manager or managed care entity from among the managed care organizations and primary care case providers who meet the requirements of this title;

“(B)(i) individuals are permitted to choose between at least 2 of those entities, or 2 of the managers, or an entity and a manager, each of which has sufficient capacity to provide services to enrollees; or

“(ii) with respect to a rural area—

“(I) individuals who are required to enroll with a single entity are afforded the option to obtain covered services by an alternative provider; and

“(II) an individual who is offered no alternative to a single entity or manager is given a choice between at least two providers within the entity or through the manager;

“(C) no individual who is an Indian (as defined in section 4 of the Indian Health Care Improvement Act of 1976) is required to enroll in any entity that is not one of the following (and only if such entity is participating under the plan): the Indian Health Service, an Indian health program operated by an Indian tribe or tribal organization pursuant to a contract, grant, cooperative agreement, or compact with the Indian Health Service pursuant to the Indian Self-Determination Act (25 U.S.C. 450 et seq.), or an urban Indian health program operated by an urban Indian organization pursuant to a grant or contract with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.);

“(D) the State restricts those individuals from changing their enrollment without cause for periods no longer than six months (and permits enrollees to change enrollment for cause at any time);

“(E) the restrictions do not apply to providers of family planning services (as defined in section 1905(a)(4)(C)) and are not conditions for payment of medicare cost sharing pursuant to section 1905(p)(3); and

“(F) prior to establishing an enrollment requirement under this paragraph, the State agency provides for public notice and comment pursuant to requirements established by the Secretary.”

(b) SPECIAL NEEDS CHILDREN DEFINED.—Section 1915 (42 U.S.C. 1396n) is amended by adding at the end the following:

“(i) For purposes of subsection (a)(3), the term ‘special needs child’ means an individual under 19 years of age who—

“(1) is eligible for supplemental security income under title XVI,

“(2) is described in section 501(a)(1)(D),

“(3) is described in section 1902(e)(3), or

“(4) is in foster care or otherwise in an out-of-home placement.”

(c) CONFORMING AMENDMENT TO RISK-BASED ARRANGEMENTS.—Section 1903(m)(2) (42 U.S.C. 1396b(m)(2)) is amended—

(1) in paragraph (A)(vi)—

(A) by striking “(I) except as provided under subparagraph (F),”; and

(B) by striking all that follows “to terminate such enrollment” and inserting “in accordance with the provisions of subparagraph (F),”; and

(2) in subparagraph (F)—

(A) by striking “In the case of—” and all that follows through “a State plan” and inserting “A State plan”, and

(B) by striking “(A)(vi)(I)” and inserting “(A)(vi)”.

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

SEC. 3402. ELIMINATION OF 75:25 RESTRICTION ON RISK CONTRACTS.

(a) 75 PERCENT LIMIT ON MEDICARE AND MEDICAID ENROLLMENT.—

(1) IN GENERAL.—Section 1903(m)(2)(A) (42 U.S.C. 1396b(m)(2)(A)) is amended by striking clause (ii).

(2) CONFORMING AMENDMENTS.—Section 1903(m)(2) (42 U.S.C. 1396b(m)(2)) is amended—

(A) by striking subparagraphs (C), (D), and (E); and
(B) in subparagraph (G), by striking “clauses (i) and (ii)” and inserting “clause (i)”.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) take effect on the date of the enactment of this Act.

SEC. 3403. PRIMARY CARE CASE MANAGEMENT SERVICES AS STATE OPTION WITHOUT NEED FOR WAIVER.

(a) OPTIONAL COVERAGE AS PART OF MEDICAL ASSISTANCE.—Section 1905(a) (42 U.S.C. 1396d(a)) is amended—

(1) by striking “and” at the end of paragraph (24);

(2) by redesignating paragraph (25) as paragraph (26) and by striking the period at the end of such paragraph and inserting a comma; and

(3) by inserting after paragraph (24) the following new paragraph:

“(25) primary care case management services (as defined in subsection (t)); and”.

(b) PRIMARY CARE CASE MANAGEMENT SERVICES DEFINED.—Section 1905 (42 U.S.C. 1396d) is amended by adding at the end the following new subsection:

“(t)(1) The term ‘primary care case management services’ means case-management related services (including coordination and monitoring of health care services) provided by a primary care case manager under a primary care case management contract.

“(2)(A) The term ‘primary care case manager’ means, with respect to a primary care case management contract, a provider described in subparagraph (B).

“(B) A provider described in this subparagraph is a provider that provides primary care case management services under contract and is—

“(i) a physician, a physician group practice, or an entity employing or having other arrangements with physicians; or

“(ii) at State option—

“(I) a nurse practitioner (as described in section 1905(a)(21));

“(II) a certified nurse-midwife (as defined in section 1861(gg)); or

“(III) a physician assistant (as defined in section 1861(aa)(5)).

“(3) The term ‘primary care case management contract’ means a contract with a State agency under which a primary care case manager undertakes to locate, coordinate and monitor covered primary care (and such other covered services as may be specified under the contract) to all individuals enrolled with the primary care case manager, and which provides for—

“(A) reasonable and adequate hours of operation, including 24-hour availability of information, referral, and treatment with respect to medical emergencies;

“(B) restriction of enrollment to individuals residing sufficiently near a service delivery site of the entity to be able to reach that site within a reasonable time using available and affordable modes of transportation;

“(C) employment of, or contracts or other arrangements with, sufficient numbers of physicians and other appropriate health care professionals to ensure that services under the contract can be furnished to enrollees promptly and without compromise to quality of care;

“(D) a prohibition on discrimination on the basis of health status or requirements for health services in enrollment, disenrollment, or reenrollment of individuals eligible for medical assistance under this title; and

“(E) a right for an enrollee to terminate enrollment without cause during the first month of each enrollment period, which period shall not exceed six months in duration, and to terminate enrollment at any time for cause.

“(4) For purposes of this subsection, the term ‘primary care’ includes all health care services customarily provided in accordance with State licensure and certification laws and regulations, and all laboratory services customarily provided by or through, a general practitioner, family medicine physician, internal medicine physician, obstetrician/gynecologist, or pediatrician.”

(c) CONFORMING AMENDMENTS.—Section 1902 (42 U.S.C. 1396a) is amended—

(1) in subsection (a)(10)(C)(iv), by striking “(24)” and inserting “(25)”, and

(2) in subsection (j), by striking “(25)” and inserting “(26)”.

(d) EFFECTIVE DATE.—The amendments made by this section apply to primary care case management services furnished on or after October 1, 1997.

SEC. 3404. CHANGE IN THRESHOLD AMOUNT FOR CONTRACTS REQUIRING SECRETARY'S PRIOR APPROVAL.

(a) IN GENERAL.—Section 1903(m)(2)(A)(iii) (42 U.S.C. 1396b(m)(2)(A)(iii)) is amended by striking “\$100,000” and inserting “\$1,000,000 for 1998 and, for a subsequent year, the amount established under this clause for the previous year increased by the percentage increase in the consumer price index for all urban consumers over the previous year”.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to contracts entered into or renewed on or after the date of the enactment of this Act.

SEC. 3405. DETERMINATION OF HOSPITAL STAY.

(a) IN GENERAL.—Title XIX, as amended by section 3431(a), is amended—

(1) by redesignating section 1933 as section 1934, and

(2) by inserting after section 1932 the following new section:

“DETERMINATION OF HOSPITAL STAY

“SEC. 1933. (a) IN GENERAL.—A Medicaid health plan shall cover the length of an inpatient hospital stay under this title as determined by the attending physician (or other attending health care provider to the extent permitted under State law) in consultation with the patient to be medically appropriate.

“(b) CONSTRUCTION.—Nothing in this title shall be construed—

“(1) as requiring the provision of inpatient coverage if the attending physician (or other attending health care provider to

the extent permitted under State law) and patient determine that a shorter period of hospital stay is medically appropriate, or

“(2) as affecting the application of deductibles and coinsurance.”.

(b) **EFFECTIVE DATE.**—The amendments made by subsection (a) shall apply to discharges occurring on or after 6 months after the date of the enactment of this Act.

Subchapter B—Payment Methodology

SEC. 3411. FLEXIBILITY IN PAYMENT METHODS FOR HOSPITAL, NURSING FACILITY, AND ICF/MR SERVICES; FLEXIBILITY FOR HOME HEALTH.

(a) **REPEAL OF BOREN REQUIREMENTS.**—Section 1902(a)(13) (42 U.S.C. 1396a(a)) is amended—

(1) by amending subparagraphs (A) and (B) to read as follows:

“(A) for a public process for determination of rates of payment under the plan for hospital services, nursing facility services, and services of intermediate care facilities for the mentally retarded under which—

“(i) proposed rates are published, and providers, beneficiaries and their representatives, and other concerned State residents are given a reasonable opportunity for review and comment on the proposed rates;

“(ii) final rates are published, together with justifications, and

“(iii) in the case of hospitals, take into account (in a manner consistent with section 1923) the situation of hospitals which serve a disproportionate number of low income patients with special needs;

“(B) that the State shall provide assurances satisfactory to the Secretary that the average level of payments under the plan for nursing facility services (as determined on an aggregate per resident-day basis) and the level of payments under the plan for inpatient hospital services (as determined on an aggregate hospital payment basis) furnished during the 18-month period beginning October 1, 1997, is not less than the average level of payments that would be made under the plan during such 18-month period for such respective services (determined on such basis) based on rates or payment basis in effect as of May 1, 1997;” and

(2) by striking subparagraph (C).

(b) **REPEAL OF REQUIREMENTS RELATING TO HOME HEALTH SERVICES.**—Such section is further amended—

(1) by adding “and” at the end of subparagraph (D),

(2) by striking “and” at the end of subparagraph (E), and

(3) by striking subparagraph (F).

(c) **EFFECTIVE DATE.**—The amendments made by this section shall apply to payment for items and services furnished on or after the date of the enactment of this Act.

SEC. 3412. PAYMENT FOR CENTER AND CLINIC SERVICES.

(a) PHASE-OUT OF PAYMENT BASED ON REASONABLE COSTS.—Section 1902(a)(13)(E) (42 U.S.C. 1396a(a)(13)(E)) is amended by inserting “(or 95 percent for services furnished during fiscal year 2000, 90 percent for service furnished during fiscal year 2001, and 85 percent for services furnished during fiscal year 2002)” after “100 percent”.

(b) TRANSITIONAL SUPPLEMENTAL PAYMENT FOR SERVICES FURNISHED UNDER CERTAIN MANAGED CARE CONTRACTS.—

(1) IN GENERAL.—Section 1902(a)(13)(E) is further amended—

(A) by inserting “(i)” after “(E)”, and

(B) by inserting before the semicolon at the end the following: “and (ii) in carrying out clause (i) in the case of services furnished by a federally qualified health center or a rural health clinic pursuant to a contract between the center and a health maintenance organization under section 1903(m), for payment by the State of a supplemental payment equal to the amount (if any) by which the amount determined under clause (i) exceeds the amount of the payments provided under such contract”.

(2) CONFORMING AMENDMENT TO MANAGED CARE CONTRACT REQUIREMENT.—Clause (ix) of section 1903(m)(2)(A) (42 U.S.C. 1396b(m)(2)(A)) is amended to read as follows:

“(ix) such contract provides, in the case of an entity that has entered into a contract for the provision of services with a federally qualified health center or a rural health clinic, that the entity shall provide payment that is not less than the level and amount of payment which the entity would make for the services if the services were furnished by a provider which is not a federally qualified health center or a rural health clinic;”.

(3) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after October 1, 1997.

(c) END OF TRANSITIONAL PAYMENT RULES.—Effective for services furnished on or after October 1, 2002—

(1) subparagraph (E) of section 1902(a)(13) (42 U.S.C. 1396a(a)(13)) is repealed, and

(2) clause (ix) of section 1903(m)(2)(A) (42 U.S.C. 1396b(m)(2)(A)) is repealed.

(d) FLEXIBILITY IN COVERAGE OF NON-FREESTANDING LOOK-ALIKES.—

(1) IN GENERAL.—Section 1905(l)(2)(B)(iii) (42 U.S.C. 1396d(l)(2)(B)(iii)) is amended by inserting “and is not other than an entity that is owned, controlled, or operated by another provider” after “such a grant”.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to service furnished on and after the date of the enactment of this Act.

(e) GAO REPORT.—By not later than February 1, 2001, the Comptroller General shall submit to Congress a report on the impact of the amendments made by this section on access to health care for medicaid beneficiaries and the uninsured served at health centers and rural health clinics and the ability of health centers

and rural health clinics to become integrated in a managed care system.

SEC. 3413. TREATMENT OF STATE TAXES IMPOSED ON CERTAIN HOSPITALS THAT PROVIDE FREE CARE.

(a) EXCEPTION FROM TAX DOES NOT DISQUALIFY AS BROAD-BASED TAX.—Section 1903(w)(3) (42 U.S.C. 1396b(w)(3)) is amended—

(1) in subparagraph (B), by striking “and (E)” and inserting “(E), and (F)”, and

(2) by adding at the end the following:

“(F) In no case shall a tax not qualify as a broad-based health care related tax under this paragraph because it does not apply to a hospital that is exempt from taxation under section 501(c)(3) of the Internal Revenue Code of 1986 and that does not accept payment under the State plan under this title or under title XVIII.”.

(b) REDUCTION IN FEDERAL FINANCIAL PARTICIPATION IN CASE OF IMPOSITION OF TAX.—Section 1903(b) (42 U.S.C. 1396b(b)) is amended by adding at the end the following:

“(4) Notwithstanding the preceding provisions of this section, the amount determined under subsection (a)(1) for any State shall be decreased in a quarter by the amount of any health care related taxes (described in section 1902(w)(3)(A)) that are imposed on a hospital described in subsection (w)(3)(F) in that quarter.”.

(c) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to taxes imposed before, on, or after the date of the enactment of this Act and the amendment made by subsection (b) shall apply to taxes imposed on or after such date.

Subchapter C—Eligibility

SEC. 3421. STATE OPTION OF CONTINUOUS ELIGIBILITY FOR 12 MONTHS; CLARIFICATION OF STATE OPTION TO COVER CHILDREN.

(a) CONTINUOUS ELIGIBILITY OPTION.—Section 1902(e) (42 U.S.C. 1396a(e)) is amended by adding at the end the following new paragraph:

“(12) At the option of the State, the plan may provide that an individual who is under an age specified by the State (not to exceed 19 years of age) and who is determined to be eligible for benefits under a State plan approved under this title under subsection (a)(10)(A) shall remain eligible for those benefits until the earlier of—

“(A) the end of a period (not to exceed 12 months) following the determination; or

“(B) the time that the individual exceeds that age.”.

(b) CLARIFICATION OF STATE OPTION TO COVER ALL CHILDREN UNDER 19 YEARS OF AGE.—Section 1902(l)(1)(D) (42 U.S.C. 1396a(l)(1)(D)) is amended by inserting “(or, at the option of a State, after any earlier date)” after “children born after September 30, 1983”.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to medical assistance for items and services furnished on or after October 1, 1997.

SEC. 3422. PAYMENT OF HOME-HEALTH-RELATED MEDICARE PART B PREMIUM AMOUNT FOR CERTAIN LOW-INCOME INDIVIDUALS.

(a) **ELIGIBILITY.**—Section 1902(a)(10)(E) (42 U.S.C. 1396a(a)(10)(E)) is amended—

- (1) by striking “and” at the end of clause (ii), and
- (2) by inserting after clause (iii) the following:

“(iv) subject to section 1905(p)(4), for making medical assistance available for the portion of medicare cost sharing described in section 1905(p)(3)(A)(ii), that is attributable to the application under section 1839(a)(5) of section 1833(d)(2) for individuals who would be described in clause (iii) but for the fact that their income exceeds 120 percent, but is less than 175 percent, of the official poverty line (referred to in section 1905(p)(2)) for a family of the size involved.”

(b) **100 PERCENT FEDERAL PAYMENT.**—The third sentence of section 1905(b) (42 U.S.C. 1396d(b)) is amended by inserting “and with respect to amounts expended for medical assistance described in section 1902(a)(10)(E)(iv) for individuals described in such section” before the period at the end.

SEC. 3423. PENALTY FOR FRAUDULENT ELIGIBILITY.

Section 1128B(a) (42 U.S.C. 1320a–7b(a)), as amended by section 217 of the Health Insurance Portability and Accountability Act of 1996, is amended—

- (1) by amending paragraph (6) to read as follows:

“(6) for a fee knowingly and willfully counsels or assists an individual to dispose of assets (including by any transfer in trust) in order for the individual to become eligible for medical assistance under a State plan under title XIX, if disposing of the assets results in the imposition of a period of ineligibility for such assistance under section 1917(c),”; and

- (2) in clause (ii) of the matter following such paragraph, by striking “failure, or conversion by any other person” and inserting “failure, conversion, or provision of counsel or assistance by any other person”.

SEC. 3424. TREATMENT OF CERTAIN SETTLEMENT PAYMENTS.

Notwithstanding any other provision of law, the payments made from any fund established pursuant to the settlement in the case of *In re Factor VIII or IX Concentrate Blood Products Litigation*, MDL–986, no. 93–C7452 (N.D. Ill.) shall not be considered income or resources in determining eligibility for, or the amount of benefits under, a State plan of medical assistance approved under title XIX of the Social Security Act.

Subchapter D—Programs of All-inclusive Care for the Elderly (PACE)

SEC. 3431. ESTABLISHMENT OF PACE PROGRAM AS MEDICAID STATE OPTION.

(a) **IN GENERAL.**—Title XIX is amended—

- (1) in section 1905(a) (42 U.S.C. 1396d(a)), as amended by section 3403(a)—
 - (A) by striking “and” at the end of paragraph (25);

(B) by redesignating paragraph (26) as paragraph (27);
and

(C) by inserting after paragraph (25) the following new paragraph:

“(26) services furnished under a PACE program under section 1932 to PACE program eligible individuals enrolled under the program under such section; and”;

(2) by redesignating section 1932 as section 1933; and

(3) by inserting after section 1931 the following new section:

“PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)

“SEC. 1932. (a) OPTION.—

“(1) IN GENERAL.—A State may elect to provide medical assistance under this section with respect to PACE program services to PACE program eligible individuals who are eligible for medical assistance under the State plan and who are enrolled in a PACE program under a PACE program agreement. Such individuals need not be eligible for benefits under part A, or enrolled under part B, of title XVIII to be eligible to enroll under this section. In the case of an individual enrolled with a PACE program pursuant to such an election—

“(A) the individual shall receive benefits under the plan solely through such program, and

“(B) the PACE provider shall receive payment in accordance with the PACE program agreement for provision of such benefits.

A State may limit through its PACE program agreement the number of individuals who may be enrolled in a PACE program under the State plan.

“(2) PACE PROGRAM DEFINED.—For purposes of this section and section 1894, the term ‘PACE program’ means a program of all-inclusive care for the elderly that meets the following requirements:

“(A) OPERATION.—The entity operating the program is a PACE provider (as defined in paragraph (3)).

“(B) COMPREHENSIVE BENEFITS.—The program provides comprehensive health care services to PACE program eligible individuals in accordance with the PACE program agreement and regulations under this section.

“(C) TRANSITION.—In the case of an individual who is enrolled under the program under this section and whose enrollment ceases for any reason (including the individual no longer qualifies as a PACE program eligible individual, the termination of a PACE program agreement, or otherwise), the program provides assistance to the individual in obtaining necessary transitional care through appropriate referrals and making the individual’s medical records available to new providers.

“(3) PACE PROVIDER DEFINED.—

“(A) IN GENERAL.—For purposes of this section, the term ‘PACE provider’ means an entity that—

“(i) subject to subparagraph (B), is (or is a distinct part of) a public entity or a private, nonprofit entity

organized for charitable purposes under section 501(c)(3) of the Internal Revenue Code of 1986, and

“(ii) has entered into a PACE program agreement with respect to its operation of a PACE program.

“(B) TREATMENT OF PRIVATE, FOR-PROFIT PROVIDERS.— Clause (i) of subparagraph (A) shall not apply—

“(i) to entities subject to a demonstration project waiver under subsection (h); and

“(ii) after the date the report under section 4014(b) of the Balanced Budget Act of 1997 is submitted, unless the Secretary determines that any of the findings described in subparagraph (A), (B), (C) or (D) of paragraph (2) of such section are true.

“(4) PACE PROGRAM AGREEMENT DEFINED.—For purposes of this section, the term ‘PACE program agreement’ means, with respect to a PACE provider, an agreement, consistent with this section, section 1894 (if applicable), and regulations promulgated to carry out such sections, between the PACE provider, the Secretary, and a State administering agency for the operation of a PACE program by the provider under such sections.

“(5) PACE PROGRAM ELIGIBLE INDIVIDUAL DEFINED.—For purposes of this section, the term ‘PACE program eligible individual’ means, with respect to a PACE program, an individual who—

“(A) is 55 years of age or older;

“(B) subject to subsection (c)(4), is determined under subsection (c) to require the level of care required under the State medicaid plan for coverage of nursing facility services;

“(C) resides in the service area of the PACE program; and

“(D) meets such other eligibility conditions as may be imposed under the PACE program agreement for the program under subsection (e)(2)(A)(ii).

“(6) PACE PROTOCOL.—For purposes of this section, the term ‘PACE protocol’ means the Protocol for the Program of All-inclusive Care for the Elderly (PACE), as published by On Lok, Inc., as of April 14, 1995.

“(7) PACE DEMONSTRATION WAIVER PROGRAM DEFINED.—For purposes of this section, the term ‘PACE demonstration waiver program’ means a demonstration program under either of the following sections (as in effect before the date of their repeal):

“(A) Section 603(c) of the Social Security Amendments of 1983 (Public Law 98–21), as extended by section 9220 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99–272).

“(B) Section 9412(b) of the Omnibus Budget Reconciliation Act of 1986 (Public Law 99–509).

“(8) STATE ADMINISTERING AGENCY DEFINED.—For purposes of this section, the term ‘State administering agency’ means, with respect to the operation of a PACE program in a State, the agency of that State (which may be the single agency responsible for administration of the State plan under this title

in the State) responsible for administering PACE program agreements under this section and section 1894 in the State.

“(9) TRIAL PERIOD DEFINED.—

“(A) IN GENERAL.—For purposes of this section, the term ‘trial period’ means, with respect to a PACE program operated by a PACE provider under a PACE program agreement, the first 3 contract years under such agreement with respect to such program.

“(B) TREATMENT OF ENTITIES PREVIOUSLY OPERATING PACE DEMONSTRATION WAIVER PROGRAMS.—Each contract year (including a year occurring before the effective date of this section) during which an entity has operated a PACE demonstration waiver program shall be counted under subparagraph (A) as a contract year during which the entity operated a PACE program as a PACE provider under a PACE program agreement.

“(10) REGULATIONS.—For purposes of this section, the term ‘regulations’ refers to interim final or final regulations promulgated under subsection (f) to carry out this section and section 1894.

“(b) SCOPE OF BENEFITS; BENEFICIARY SAFEGUARDS.—

“(1) IN GENERAL.—Under a PACE program agreement, a PACE provider shall—

“(A) provide to PACE program eligible individuals, regardless of source of payment and directly or under contracts with other entities, at a minimum—

“(i) all items and services covered under title XVIII (for individuals enrolled under section 1894) and all items and services covered under this title, but without any limitation or condition as to amount, duration, or scope and without application of deductibles, copayments, coinsurance, or other cost-sharing that would otherwise apply under such title or this title, respectively; and

“(ii) all additional items and services specified in regulations, based upon those required under the PACE protocol;

“(B) provide such enrollees access to necessary covered items and services 24 hours per day, every day of the year;

“(C) provide services to such enrollees through a comprehensive, multidisciplinary health and social services delivery system which integrates acute and long-term care services pursuant to regulations; and

“(D) specify the covered items and services that will not be provided directly by the entity, and to arrange for delivery of those items and services through contracts meeting the requirements of regulations.

“(2) QUALITY ASSURANCE; PATIENT SAFEGUARDS.—The PACE program agreement shall require the PACE provider to have in effect at a minimum—

“(A) a written plan of quality assurance and improvement, and procedures implementing such plan, in accordance with regulations, and

“(B) written safeguards of the rights of enrolled participants (including a patient bill of rights and procedures for grievances and appeals) in accordance with regulations and with other requirements of this title and Federal and State law designed for the protection of patients.

“(c) ELIGIBILITY DETERMINATIONS.—

“(1) IN GENERAL.—The determination of whether an individual is a PACE program eligible individual—

“(A) shall be made under and in accordance with the PACE program agreement, and

“(B) who is entitled to medical assistance under this title, shall be made (or who is not so entitled, may be made) by the State administering agency.

“(2) CONDITION.—An individual is not a PACE program eligible individual (with respect to payment under this section) unless the individual’s health status has been determined, in accordance with regulations, to be comparable to the health status of individuals who have participated in the PACE demonstration waiver programs. Such determination shall be based upon information on health status and related indicators (such as medical diagnoses and measures of activities of daily living, instrumental activities of daily living, and cognitive impairment) that are part of a uniform minimum data set collected by PACE providers on potential eligible individuals.

“(3) ANNUAL ELIGIBILITY RECERTIFICATIONS.—

“(A) IN GENERAL.—Subject to subparagraph (B), the determination described in subsection (a)(5)(B) for an individual shall be reevaluated at least once a year.

“(B) EXCEPTION.—The requirement of annual reevaluation under subparagraph (A) may be waived during a period in accordance with regulations in those cases where the State administering agency determines that there is no reasonable expectation of improvement or significant change in an individual’s condition during the period because of the advanced age, severity of the advanced age, severity of chronic condition, or degree of impairment of functional capacity of the individual involved.

“(4) CONTINUATION OF ELIGIBILITY.—An individual who is a PACE program eligible individual may be deemed to continue to be such an individual notwithstanding a determination that the individual no longer meets the requirement of subsection (a)(5)(B) if, in accordance with regulations, in the absence of continued coverage under a PACE program the individual reasonably would be expected to meet such requirement within the succeeding 6-month period.

“(5) ENROLLMENT; DISENROLLMENT.—The enrollment and disenrollment of PACE program eligible individuals in a PACE program shall be pursuant to regulations and the PACE program agreement and shall permit enrollees to voluntarily disenroll without cause at any time.

“(d) PAYMENTS TO PACE PROVIDERS ON A CAPITATED BASIS.—

“(1) IN GENERAL.—In the case of a PACE provider with a PACE program agreement under this section, except as provided in this subsection or by regulations, the State shall make

prospective monthly payments of a capitation amount for each PACE program eligible individual enrolled under the agreement under this section.

“(2) CAPITATION AMOUNT.—The capitation amount to be applied under this subsection for a provider for a contract year shall be an amount specified in the PACE program agreement for the year. Such amount shall be an amount, specified under the PACE agreement, which is less than the amount that would otherwise have been made under the State plan if the individuals were not so enrolled and shall be adjusted to take into account the comparative frailty of PACE enrollees and such other factors as the Secretary determines to be appropriate. The payment under this section shall be in addition to any payment made under section 1894 for individuals who are enrolled in a PACE program under such section.

“(e) PACE PROGRAM AGREEMENT.—

“(1) REQUIREMENT.—

“(A) IN GENERAL.—The Secretary, in close cooperation with the State administering agency, shall establish procedures for entering into, extending, and terminating PACE program agreements for the operation of PACE programs by entities that meet the requirements for a PACE provider under this section, section 1894, and regulations.

“(B) NUMERICAL LIMITATION.—

“(i) IN GENERAL.—The Secretary shall not permit the number of PACE providers with which agreements are in effect under this section or under section 9412(b) of the Omnibus Budget Reconciliation Act of 1986 to exceed—

“(I) 40 as of the date of the enactment of this section, or

“(II) as of each succeeding anniversary of such date, the numerical limitation under this subparagraph for the preceding year plus 20.

Subclause (II) shall apply without regard to the actual number of agreements in effect as of a previous anniversary date.

“(ii) TREATMENT OF CERTAIN PRIVATE, FOR-PROFIT PROVIDERS.—The numerical limitation in clause (i) shall not apply to a PACE provider that—

“(I) is operating under a demonstration project waiver under subsection (h), or

“(II) was operating under such a waiver and subsequently qualifies for PACE provider status pursuant to subsection (a)(3)(B)(ii).

“(2) SERVICE AREA AND ELIGIBILITY.—

“(A) IN GENERAL.—A PACE program agreement for a PACE program—

“(i) shall designate the service area of the program;

“(ii) may provide additional requirements for individuals to qualify as PACE program eligible individuals with respect to the program;

“(iii) shall be effective for a contract year, but may be extended for additional contract years in the ab-

sence of a notice by a party to terminate and is subject to termination by the Secretary and the State administering agency at any time for cause (as provided under the agreement);

“(iv) shall require a PACE provider to meet all applicable State and local laws and requirements; and

“(v) shall have such additional terms and conditions as the parties may agree to, consistent with this section and regulations.

“(B) SERVICE AREA OVERLAP.—In designating a service area under a PACE program agreement under subparagraph (A)(i), the Secretary (in consultation with the State administering agency) may exclude from designation an area that is already covered under another PACE program agreement, in order to avoid unnecessary duplication of services and avoid impairing the financial and service viability of an existing program.

“(3) DATA COLLECTION.—

“(A) IN GENERAL.—Under a PACE program agreement, the PACE provider shall—

“(i) collect data,

“(ii) maintain, and afford the Secretary and the State administering agency access to, the records relating to the program, including pertinent financial, medical, and personnel records, and

“(iii) make to the Secretary and the State administering agency reports that the Secretary finds (in consultation with State administering agencies) necessary to monitor the operation, cost, and effectiveness of the PACE program under this title and title XVIII.

“(B) REQUIREMENTS DURING TRIAL PERIOD.—During the first three years of operation of a PACE program (either under this section or under a PACE demonstration waiver program), the PACE provider shall provide such additional data as the Secretary specifies in regulations in order to perform the oversight required under paragraph (4)(A).

“(4) OVERSIGHT.—

“(A) ANNUAL, CLOSE OVERSIGHT DURING TRIAL PERIOD.—During the trial period (as defined in subsection (a)(9)) with respect to a PACE program operated by a PACE provider, the Secretary (in cooperation with the State administering agency) shall conduct a comprehensive annual review of the operation of the PACE program by the provider in order to assure compliance with the requirements of this section and regulations. Such a review shall include—

“(i) an on-site visit to the program site;

“(ii) comprehensive assessment of a provider’s fiscal soundness;

“(iii) comprehensive assessment of the provider’s capacity to provide all PACE services to all enrolled participants;

“(iv) detailed analysis of the entity’s substantial compliance with all significant requirements of this section and regulations; and

“(v) any other elements the Secretary or State agency considers necessary or appropriate.

“(B) CONTINUING OVERSIGHT.—After the trial period, the Secretary (in cooperation with the State administering agency) shall continue to conduct such review of the operation of PACE providers and PACE programs as may be appropriate, taking into account the performance level of a provider and compliance of a provider with all significant requirements of this section and regulations.

“(C) DISCLOSURE.—The results of reviews under this paragraph shall be reported promptly to the PACE provider, along with any recommendations for changes to the provider’s program, and shall be made available to the public upon request.

“(5) TERMINATION OF PACE PROVIDER AGREEMENTS.—

“(A) IN GENERAL.—Under regulations—

“(i) the Secretary or a State administering agency may terminate a PACE program agreement for cause, and

“(ii) a PACE provider may terminate such an agreement after appropriate notice to the Secretary, the State agency, and enrollees.

“(B) CAUSES FOR TERMINATION.—In accordance with regulations establishing procedures for termination of PACE program agreements, the Secretary or a State administering agency may terminate a PACE program agreement with a PACE provider for, among other reasons, the fact that—

“(i) the Secretary or State administering agency determines that—

“(I) there are significant deficiencies in the quality of care provided to enrolled participants; or

“(II) the provider has failed to comply substantially with conditions for a program or provider under this section or section 1894; and

“(ii) the entity has failed to develop and successfully initiate, within 30 days of the date of the receipt of written notice of such a determination, and continue implementation of a plan to correct the deficiencies.

“(C) TERMINATION AND TRANSITION PROCEDURES.—An entity whose PACE provider agreement is terminated under this paragraph shall implement the transition procedures required under subsection (a)(2)(C).

“(6) SECRETARY’S OVERSIGHT; ENFORCEMENT AUTHORITY.—

“(A) IN GENERAL.—Under regulations, if the Secretary determines (after consultation with the State administering agency) that a PACE provider is failing substantially to comply with the requirements of this section and regulations, the Secretary (and the State administering agency) may take any or all of the following actions:

“(i) Condition the continuation of the PACE program agreement upon timely execution of a corrective action plan.

“(ii) Withhold some or all further payments under the PACE program agreement under this section or section 1894 with respect to PACE program services furnished by such provider until the deficiencies have been corrected.

“(iii) Terminate such agreement.

“(B) APPLICATION OF INTERMEDIATE SANCTIONS.—Under regulations, the Secretary may provide for the application against a PACE provider of remedies described in section 1857(f)(2) (or, for periods before January 1, 1999, section 1876(i)(6)(B)) or 1903(m)(6)(B) in the case of violations by the provider of the type described in section 1857(f)(1) (or 1876(i)(6)(A) for such periods) or 1903(m)(6)(A), respectively (in relation to agreements, enrollees, and requirements under section 1894 or this section, respectively).

“(7) PROCEDURES FOR TERMINATION OR IMPOSITION OF SANCTIONS.—Under regulations, the provisions of section 1857(g) (or for periods before January 1, 1999, section 1876(i)(9)) shall apply to termination and sanctions respecting a PACE program agreement and PACE provider under this subsection in the same manner as they apply to a termination and sanctions with respect to a contract and a MedicarePlus organization under part C (or for such periods an eligible organization under section 1876).

“(8) TIMELY CONSIDERATION OF APPLICATIONS FOR PACE PROGRAM PROVIDER STATUS.—In considering an application for PACE provider program status, the application shall be deemed approved unless the Secretary, within 90 days after the date of the submission of the application to the Secretary, either denies such request in writing or informs the applicant in writing with respect to any additional information that is needed in order to make a final determination with respect to the application. After the date the Secretary receives such additional information, the application shall be deemed approved unless the Secretary, within 90 days of such date, denies such request.

“(f) REGULATIONS.—

“(1) IN GENERAL.—The Secretary shall issue interim final or final regulations to carry out this section and section 1894.

“(2) USE OF PACE PROTOCOL.—

“(A) IN GENERAL.—In issuing such regulations, the Secretary shall, to the extent consistent with the provisions of this section, incorporate the requirements applied to PACE demonstration waiver programs under the PACE protocol.

“(B) FLEXIBILITY.—The Secretary (in close consultation with State administering agencies) may modify or waive such provisions of the PACE protocol in order to provide for reasonable flexibility in adapting the PACE service delivery model to the needs of particular organizations (such as those in rural areas or those that may determine it appropriate to use non-staff physicians accordingly to State licensing law requirements) under this section and section 1932 where such flexibility is not inconsistent with and

would not impair the essential elements, objectives, and requirements of the this section, including—

“(i) the focus on frail elderly qualifying individuals who require the level of care provided in a nursing facility;

“(ii) the delivery of comprehensive, integrated acute and long-term care services;

“(iii) the interdisciplinary team approach to care management and service delivery;

“(iv) capitated, integrated financing that allows the provider to pool payments received from public and private programs and individuals; and

“(v) the assumption by the provider over time of full financial risk.

“(3) APPLICATION OF CERTAIN ADDITIONAL BENEFICIARY AND PROGRAM PROTECTIONS.—

“(A) IN GENERAL.—In issuing such regulations and subject to subparagraph (B), the Secretary may apply with respect to PACE programs, providers, and agreements such requirements of part C of title XVIII (or, for periods before January 1, 1999, section 1876) and section 1903(m) relating to protection of beneficiaries and program integrity as would apply to MedicarePlus organizations under such part C (or for such periods eligible organizations under risk-sharing contracts under section 1876) and to health maintenance organizations under prepaid capitation agreements under section 1903(m).

“(B) CONSIDERATIONS.—In issuing such regulations, the Secretary shall—

“(i) take into account the differences between populations served and benefits provided under this section and under part C of title XVIII (or, for periods before January 1, 1999, section 1876) and section 1903(m);

“(ii) not include any requirement that conflicts with carrying out PACE programs under this section; and

“(iii) not include any requirement restricting the proportion of enrollees who are eligible for benefits under this title or title XVIII.

“(g) WAIVERS OF REQUIREMENTS.—With respect to carrying out a PACE program under this section, the following requirements of this title (and regulations relating to such requirements) shall not apply:

“(1) Section 1902(a)(1), relating to any requirement that PACE programs or PACE program services be provided in all areas of a State.

“(2) Section 1902(a)(10), insofar as such section relates to comparability of services among different population groups.

“(3) Sections 1902(a)(23) and 1915(b)(4), relating to freedom of choice of providers under a PACE program.

“(4) Section 1903(m)(2)(A), insofar as it restricts a PACE provider from receiving prepaid capitation payments.

“(h) DEMONSTRATION PROJECT FOR FOR-PROFIT ENTITIES.—

“(1) IN GENERAL.—In order to demonstrate the operation of a PACE program by a private, for-profit entity, the Secretary

(in close consultation with State administering agencies) shall grant waivers from the requirement under subsection (a)(3) that a PACE provider may not be a for-profit, private entity.

“(2) SIMILAR TERMS AND CONDITIONS.—

“(A) IN GENERAL.—Except as provided under subparagraph (B), and paragraph (1), the terms and conditions for operation of a PACE program by a provider under this subsection shall be the same as those for PACE providers that are nonprofit, private organizations.

“(B) NUMERICAL LIMITATION.—The number of programs for which waivers are granted under this subsection shall not exceed 10. Programs with waivers granted under this subsection shall not be counted against the numerical limitation specified in subsection (e)(1)(B).

“(i) POST-ELIGIBILITY TREATMENT OF INCOME.—A State may provide for post-eligibility treatment of income for individuals enrolled in PACE programs under this section in the same manner as a State treats post-eligibility income for individuals receiving services under a waiver under section 1915(c).

“(j) MISCELLANEOUS PROVISIONS.—

“(1) CONSTRUCTION.—Nothing in this section or section 1894 shall be construed as preventing a PACE provider from entering into contracts with other governmental or nongovernmental payers for the care of PACE program eligible individuals who are not eligible for benefits under part A, or enrolled under part B, of title XVIII or eligible for medical assistance under this title.”

(b) CONFORMING AMENDMENTS.—

(1) Section 1902 (42 U.S.C. 1396a), as amended by section 3403(c), is amended—

(A) in subsection (a)(10)(C)(iv), by striking “(25)” and inserting “(26)”, and

(B) in subsection (j), by striking “(26)” and inserting “(27)”.

(2) Section 1924(a)(5) (42 U.S.C. 1396r–5(a)(5)) is amended—

(A) in the heading, by striking “FROM ORGANIZATIONS RECEIVING CERTAIN WAIVERS” and inserting “UNDER PACE PROGRAMS”, and

(B) by striking “from any organization” and all that follows and inserting “under a PACE demonstration waiver program (as defined in subsection (a)(7) of section 1932) or under a PACE program under section 1894.”.

(3) Section 1903(f)(4)(C) (42 U.S.C. 1396b(f)(4)(C)) is amended by inserting “or who is a PACE program eligible individual enrolled in a PACE program under section 1932,” after “section 1902(a)(10)(A),”.

SEC. 3432. COVERAGE OF PACE UNDER THE MEDICARE PROGRAM.

Title XVIII (42 U.S.C. 1395 et seq.) is amended by inserting after section 1894 the following new section:

“PAYMENTS TO, AND COVERAGE OF BENEFITS UNDER, PROGRAMS OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)

“SEC. 1894. (a) RECEIPT OF BENEFITS THROUGH ENROLLMENT IN PACE PROGRAM; DEFINITIONS FOR PACE PROGRAM RELATED TERMS.—

“(1) BENEFITS THROUGH ENROLLMENT IN A PACE PROGRAM.—

In accordance with this section, in the case of an individual who is entitled to benefits under part A or enrolled under part B and who is a PACE program eligible individual with respect to a PACE program offered by a PACE provider under a PACE program agreement—

“(A) the individual may enroll in the program under this section; and

“(B) so long as the individual is so enrolled and in accordance with regulations—

“(i) the individual shall receive benefits under this title solely through such program, and

“(ii) the PACE provider is entitled to payment under and in accordance with this section and such agreement for provision of such benefits.

“(2) APPLICATION OF DEFINITIONS.—The definitions of terms under section 1932(a) shall apply under this section in the same manner as they apply under section 1932.

“(b) APPLICATION OF MEDICAID TERMS AND CONDITIONS.—Except as provided in this section, the terms and conditions for the operation and participation of PACE program eligible individuals in PACE programs offered by PACE providers under PACE program agreements under section 1932 shall apply for purposes of this section.

“(c) PAYMENT.—

“(1) ADJUSTMENT IN PAYMENT AMOUNTS.—In the case of individuals enrolled in a PACE program under this section, the amount of payment under this section shall not be the amount calculated under section 1932(d)(2), but shall be an amount, specified under the PACE agreement, based upon payment rates established for purposes of payment under section 1854 (or, for periods before January 1, 1999, for purposes of risk-sharing contracts under section 1876) and shall be adjusted to take into account the comparative frailty of PACE enrollees and such other factors as the Secretary determines to be appropriate. Such amount under such an agreement shall be computed in a manner so that the total payment level for all PACE program eligible individuals enrolled under a program is less than the projected payment under this title for a comparable population not enrolled under a PACE program.

“(2) FORM.—The Secretary shall make prospective monthly payments of a capitation amount for each PACE program eligible individual enrolled under this section in the same manner and from the same sources as payments are made to a MedicarePlus organization under section 1854 (or, for periods beginning before January 1, 1999, to an eligible organization under a risk-sharing contract under section 1876). Such payments shall be subject to adjustment in the manner described

in section 1854(a)(2) or section 1876(a)(1)(E), as the case may be.

“(d) **WAIVERS OF REQUIREMENTS.**—With respect to carrying out a PACE program under this section, the following requirements of this title (and regulations relating to such requirements) are waived and shall not apply:

“(1) Section 1812, insofar as it limits coverage of institutional services.

“(2) Sections 1813, 1814, 1833, and 1886, insofar as such sections relate to rules for payment for benefits.

“(3) Sections 1814(a)(2)(B), 1814(a)(2)(C), and 1835(a)(2)(A), insofar as they limit coverage of extended care services or home health services.

“(4) Section 1861(i), insofar as it imposes a 3-day prior hospitalization requirement for coverage of extended care services.

“(5) Sections 1862(a)(1) and 1862(a)(9), insofar as they may prevent payment for PACE program services to individuals enrolled under PACE programs.”.

SEC. 3433. EFFECTIVE DATE; TRANSITION.

(a) **TIMELY ISSUANCE OF REGULATIONS; EFFECTIVE DATE.**—The Secretary of Health and Human Services shall promulgate regulations to carry out this subchapter in a timely manner. Such regulations shall be designed so that entities may establish and operate PACE programs under sections 1894 and 1932 for periods beginning not later than 1 year after the date of the enactment of this Act.

(b) **EXPANSION AND TRANSITION FOR PACE DEMONSTRATION PROJECT WAIVERS.**—

(1) **EXPANSION IN CURRENT NUMBER AND EXTENSION OF DEMONSTRATION PROJECTS.**—Section 9412(b) of the Omnibus Budget Reconciliation Act of 1986, as amended by section 4118(g) of the Omnibus Budget Reconciliation Act of 1987, is amended—

(A) in paragraph (1), by inserting before the period at the end the following: “, except that the Secretary shall grant waivers of such requirements to up to the applicable numerical limitation specified in section 1932(e)(1)(B) of the Social Security Act”; and

(B) in paragraph (2)—

(i) in subparagraph (A), by striking “, including permitting the organization to assume progressively (over the initial 3-year period of the waiver) the full financial risk”; and

(ii) in subparagraph (C), by adding at the end the following: “In granting further extensions, an organization shall not be required to provide for reporting of information which is only required because of the demonstration nature of the project.”.

(2) **ELIMINATION OF REPLICATION REQUIREMENT.**—Subparagraph (B) of paragraph (2) of such section shall not apply to waivers granted under such section after the date of the enactment of this Act.

(3) **TIMELY CONSIDERATION OF APPLICATIONS.**—In considering an application for waivers under such section before the effective date of repeals under subsection (c), subject to the numeri-

cal limitation under the amendment made by paragraph (1), the application shall be deemed approved unless the Secretary of Health and Human Services, within 90 days after the date of its submission to the Secretary, either denies such request in writing or informs the applicant in writing with respect to any additional information which is needed in order to make a final determination with respect to the application. After the date the Secretary receives such additional information, the application shall be deemed approved unless the Secretary, within 90 days of such date, denies such request.

(c) PRIORITY AND SPECIAL CONSIDERATION IN APPLICATION.—During the 3-year period beginning on the date of the enactment of this Act:

(1) PROVIDER STATUS.—The Secretary of Health and Human Services shall give priority, in processing applications of entities to qualify as PACE programs under section 1894 or 1932 of the Social Security Act—

(A) first, to entities that are operating a PACE demonstration waiver program (as defined in section 1932(a)(7) of such Act), and

(B) then entities that have applied to operate such a program as of May 1, 1997.

(2) NEW WAIVERS.—The Secretary shall give priority, in the awarding of additional waivers under section 9412(b) of the Omnibus Budget Reconciliation Act of 1986—

(A) to any entities that have applied for such waivers under such section as of May 1, 1997; and

(B) to any entity that, as of May 1, 1997, has formally contracted with a State to provide services for which payment is made on a capitated basis with an understanding that the entity was seeking to become a PACE provider.

(3) SPECIAL CONSIDERATION.—The Secretary shall give special consideration, in the processing of applications described in paragraph (1) and the awarding of waivers described in paragraph (2), to an entity which as of May 1, 1997 through formal activities (such as entering into contracts for feasibility studies) has indicated a specific intent to become a PACE provider.

(d) REPEAL OF CURRENT PACE DEMONSTRATION PROJECT WAIVER AUTHORITY.—

(1) IN GENERAL.—Subject to paragraphs (2) and (3), the following provisions of law are repealed:

(A) Section 603(c) of the Social Security Amendments of 1983 (Public Law 98–21).

(B) Section 9220 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99–272).

(C) Section 9412(b) of the Omnibus Budget Reconciliation Act of 1986 (Public Law 99–509).

(2) DELAY IN APPLICATION.—

(A) IN GENERAL.—Subject to subparagraph (B), the repeals made by paragraph (1) shall not apply to waivers granted before the initial effective date of regulations described in subsection (a).

(B) APPLICATION TO APPROVED WAIVERS.—Such repeals shall apply to waivers granted before such date only after

allowing such organizations a transition period (of up to 24 months) in order to permit sufficient time for an orderly transition from demonstration project authority to general authority provided under the amendments made by this subchapter.

(3) STATE OPTION.—A State may elect to maintain the PACE program which (as of the date of the enactment of this Act) were operating under the authority described in paragraph (1) without electing to use the authority under section 1932 of the Public Health Service Act.

SEC. 3434. STUDY AND REPORTS.

(a) STUDY.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in close consultation with State administering agencies, as defined in section 1932(a)(8) of the Social Security Act) shall conduct a study of the quality and cost of providing PACE program services under the medicare and medicaid programs under the amendments made by this subchapter.

(2) STUDY OF PRIVATE, FOR-PROFIT PROVIDERS.—Such study shall specifically compare the costs, quality, and access to services by entities that are private, for-profit entities operating under demonstration projects waivers granted under section 1932(h) of the Social Security Act with the costs, quality, and access to services of other PACE providers.

(b) REPORT.—

(1) IN GENERAL.—Not later than 4 years after the date of the enactment of this Act, the Secretary shall provide for a report to Congress on the impact of such amendments on quality and cost of services. The Secretary shall include in such report such recommendations for changes in the operation of such amendments as the Secretary deems appropriate.

(2) TREATMENT OF PRIVATE, FOR-PROFIT PROVIDERS.—The report shall include specific findings on whether any of the following findings is true:

(A) The number of covered lives enrolled with entities operating under demonstration project waivers under section 1932(h) of the Social Security Act is fewer than 800 (or such lesser number as the Secretary may find statistically sufficient to make determinations respecting findings described in the succeeding subparagraphs).

(B) The population enrolled with such entities is less frail than the population enrolled with other PACE providers.

(C) Access to or quality of care for individuals enrolled with such entities is lower than such access or quality for individuals enrolled with other PACE providers.

(D) The application of such section has resulted in an increase in expenditures under the medicare or medicaid programs above the expenditures that would have been made if such section did not apply.

(c) INFORMATION INCLUDED IN ANNUAL RECOMMENDATIONS.—The Medicare Payment Advisory Commission shall include in its annual report under section 1805(b)(1)(B) of the Social Security Act recommendations on the methodology and level of payments made

to PACE providers under section 1894(d) of such Act and on the treatment of private, for-profit entities as PACE providers.

Subchapter E—Benefits

SEC. 3441. ELIMINATION OF REQUIREMENT TO PAY FOR PRIVATE INSURANCE.

(a) REPEAL OF STATE PLAN PROVISION.—Section 1902(a)(25) (42 U.S.C. 1396a(a)(25)) is amended—

(1) by striking subparagraph (G); and

(2) by redesignating subparagraphs (H) and (I) as subparagraphs (G) and (H), respectively.

(b) MAKING PROVISION OPTIONAL.—Section 1906 (42 U.S.C. 1396e) is amended—

(1) in subsection (a)—

(A) by striking “For purposes of section 1902(a)(25)(G) and subject to subsection (d), each” and inserting “Each”,

(B) in paragraph (1), by striking “shall” and inserting “may”, and

(C) in paragraph (2), by striking “shall” and inserting “may”; and

(2) by striking subsection (d).

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

SEC. 3442. PERMITTING SAME COPAYMENTS IN HEALTH MAINTENANCE ORGANIZATIONS AS IN FEE-FOR-SERVICE.

(a) IN GENERAL.—Section 1916(a)(2)(D) (42 U.S.C. 1396o(a)(2)(D)) is amended by inserting “(at the option of the State)” after “section 1905(a)(4)(C), or”.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to cost sharing with respect to deductions, cost sharing and similar charges imposed for items and services furnished on or after the date of the enactment of this Act.

SEC. 3443. PHYSICIAN QUALIFICATION REQUIREMENTS.

(a) IN GENERAL.—Section 1903(i) (42 U.S.C. 1396b(i)) is amended by striking paragraph (12)

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to services furnished on or after the date of the enactment of this Act.

SEC. 3444. ELIMINATION OF REQUIREMENT OF PRIOR INSTITUTIONALIZATION WITH RESPECT TO HABILITATION SERVICES FURNISHED UNDER A WAIVER FOR HOME OR COMMUNITY-BASED SERVICES.

(a) IN GENERAL.—Section 1915(c)(5) (42 U.S.C. 1396n(c)(5)) is amended, in the matter preceding subparagraph (A), by striking “, with respect to individuals who receive such services after discharge from a nursing facility or intermediate care facility for the mentally retarded”.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) apply to services furnished on or after October 1, 1997.

SEC. 3445. BENEFITS FOR SERVICES OF PHYSICIAN ASSISTANTS.

(a) IN GENERAL.—Section 1905(a) (42 U.S.C. 1396d(a)), as amended by sections 3403(a) and 3431(a), is amended—

(1) by redesignating paragraphs (22) through (27) as paragraphs (23) through (28), and

(2) by inserting after paragraph (21) the following new paragraph:

“(22) services furnished by a physician assistant (as defined in section 1861(aa)(5)) which the assistant is legally authorized to perform under State law and with the supervision of a physician;”.

(b) CONFORMING AMENDMENTS.—Section 1902 (42 U.S.C. 1396a), as amended by sections 3403(c) and 3431(b)(1), is amended—

(1) in subsection (a)(10)(C)(iv), by striking “(26)” and inserting “(27)”, and

(2) in subsection (j), by striking “(27)” and inserting “(28)”.

SEC. 3446. STUDY AND REPORT ON ACTUARIAL VALUE OF EPSDT BENEFIT.

(a) STUDY.—The Secretary of Health and Human Services shall provide for a study on the actuarial value of the provision of early and periodic screening, diagnostic, and treatment services (as defined in section 1905(r) of the Social Security Act (42 U.S.C. 1396d(r))) under the medicaid program under title XIX of such Act. Such study shall include an examination of the portion of such value that is attributable to paragraph (5) of such section and to the second sentence of such section.

(b) REPORT.—By not later than 18 months after the date of the enactment of this Act, the Secretary shall submit a report to Congress on the results of the study under subsection (a).

Subchapter F—Administration

SEC. 3451. ELIMINATION OF DUPLICATIVE INSPECTION OF CARE REQUIREMENTS FOR ICFS/MR AND MENTAL HOSPITALS.

(a) MENTAL HOSPITALS.—Section 1902(a)(26) (42 U.S.C. 1396a(a)(26)) is amended—

(1) by striking “provide—

“(A) with respect to each patient” and inserting “provide, with respect to each patient”; and

(2) by striking subparagraphs (B) and (C).

(b) ICFS/MR.—Section 1902(a)(31) (42 U.S.C. 1396a(a)(31)) is amended—

(1) by striking “provide—

“(A) with respect to each patient” and inserting “provide, with respect to each patient”; and

(2) by striking subparagraphs (B) and (C).

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

SEC. 3452. ALTERNATIVE SANCTIONS FOR NONCOMPLIANT ICFS/MR.

(a) IN GENERAL.—Section 1902(i)(1)(B) (42 U.S.C. 1396a(i)(1)(B)) is amended by striking “provide” and inserting “establish alternative remedies if the State demonstrates to the Secretary’s satisfaction that the alternative remedies are effective in deterring non-compliance and correcting deficiencies, and may provide”.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) takes effect on the date of the enactment of this Act.

SEC. 3453. MODIFICATION OF MMIS REQUIREMENTS.

(a) IN GENERAL.—Section 1903(r) (42 U.S.C. 1396b(r)) is amended—

(1) by striking all that precedes paragraph (5) and inserting the following:

“(r)(1) In order to receive payments under subsection (a) for use of automated data systems in administration of the State plan under this title, a State must have in operation mechanized claims processing and information retrieval systems that meet the requirements of this subsection and that the Secretary has found—

“(A) is adequate to provide efficient, economical, and effective administration of such State plan;

“(B) is compatible with the claims processing and information retrieval systems used in the administration of title XVIII, and for this purpose—

“(i) has a uniform identification coding system for providers, other payees, and beneficiaries under this title or title XVIII;

“(ii) provides liaison between States and carriers and intermediaries with agreements under title XVIII to facilitate timely exchange of appropriate data; and

“(iii) provides for exchange of data between the States and the Secretary with respect to persons sanctioned under this title or title XVIII;

“(C) is capable of providing accurate and timely data;

“(D) is complying with the applicable provisions of part C of title XI;

“(E) is designed to receive provider claims in standard formats to the extent specified by the Secretary; and

“(F) effective for claims filed on or after January 1, 1999, provides for electronic transmission of claims data in the format specified by the Secretary and consistent with the Medicaid Statistical Information System (MSIS) (including detailed individual enrollee encounter data and other information that the Secretary may find necessary).”.

(2) in paragraph (5)—

(A) by striking subparagraph (B);

(B) by striking all that precedes clause (i) and inserting the following:

“(2) In order to meet the requirements of this paragraph, mechanized claims processing and information retrieval systems must meet the following requirements:”;

(C) in clause (iii), by striking “under paragraph (6)”; and

(D) by redesignating clauses (i) through (iii) as paragraphs (A) through (C); and

(3) by striking paragraphs (6), (7), and (8).

(b) CONFORMING AMENDMENTS.—Section 1902(a)(25)(A)(ii) (42 U.S.C. 1396a(a)(25)(A)(ii)) is amended by striking all that follows “shall” and inserting the following: “be integrated with, and be monitored as a part of the Secretary’s review of, the State’s mechanized claims processing and information retrieval system under section 1903(r);”.

(c) **EFFECTIVE DATE.**—Except as otherwise specifically provided, the amendments made by this section shall take effect on January 1, 1998.

SEC. 3454. FACILITATING IMPOSITION OF STATE ALTERNATIVE REMEDIES ON NONCOMPLIANT NURSING FACILITIES.

(a) **IN GENERAL.**—Section 1919(h)(3)(D) (42 U.S.C. 1396r(h)(3)(D)) is amended—

- (1) by inserting “and” at the end of clause (i);
- (2) by striking “, and” at the end of clause (ii) and inserting a period; and
- (3) by striking clause (iii).

(b) **EFFECTIVE DATE.**—The amendments made by subsection (a) take effect on the date of the enactment of this Act.

SEC. 3455. MEDICALLY ACCEPTED INDICATION.

Section 1927(g)(1)(B)(i) (42 U.S.C. 1396r-8(g)(1)(B)(i)) is amended—

- (1) by striking “and” at the end of subclause (II),
- (2) by redesignating subclause (III) as subclause (IV), and
- (3) by inserting after subclause (II) the following:
“(III) the DRUGDEX Information System; and”.

SEC. 3456. CONTINUATION OF STATE-WIDE SECTION 1115 MEDICAID WAIVERS.

(a) **IN GENERAL.**—Section 1115 (42 U.S.C. 1315) is amended by adding at the end the following new subsection:

“(e)(1) The provisions of this subsection shall apply to the extension of State-wide comprehensive demonstration project (in this subsection referred to as ‘waiver project’) for which a waiver of compliance with requirements of title XIX is granted under subsection (a).

“(2) Not earlier than 1 year before the date the waiver under subsection (a) with respect to a waiver project would otherwise expire, the chief executive officer of the State which is operating the project may submit to the Secretary a written request for an extension, of up to 3 years, of the project.

“(3) If the Secretary fails to respond to the request within 6 months after the date it is submitted, the request is deemed to have been granted.

“(4) If such a request is granted, the deadline for submittal of a final report under the waiver project is deemed to have been extended until the date that is 1 year after the date the waivers under subsection (a) with respect to the project would otherwise have expired.

“(5) The Secretary shall release an evaluation of each such project not later than 1 year after the date of receipt of the final report.

“(6) Subject to paragraphs (4) and (7), the extension of a waiver project under this subsection shall be on the same terms and conditions (including applicable terms and conditions relating to quality and access of services, budget neutrality, data and reporting requirements, and special population protections) that applied to the project before its extension under this subsection.

“(7) If an original condition of approval of a waiver project was that Federal expenditures under the project not exceed the Federal

expenditures that would otherwise have been made, the Secretary shall take such steps as may be necessary to assure that, in the extension of the project under this subsection, such condition continues to be met. In applying the previous sentence, the Secretary shall take into account the Secretary's best estimate of rates of change in expenditures at the time of the extension."

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to demonstration projects initially approved before, on, or after the date of the enactment of this Act.

SEC. 3457. AUTHORIZING ADMINISTRATIVE STREAMLINING AND PRIVATIZING MODIFICATIONS UNDER THE MEDICAID PROGRAM.

Section 1902 (42 U.S.C. 1396a) is amended by adding at the end the following:

"(aa)(1) Notwithstanding any other provision of law, no provision of law shall be construed as preventing any State from allowing determinations of eligibility to receive medical assistance under this title to be made by an entity that is not a State or local government, or by an individual who is not an employee of a State or local government, which meets such qualifications as the State determines. For purposes of any Federal law, such determinations shall be considered to be made by the State and by a State agency.

"(2) Nothing in this subsection shall be construed as affecting—

"(A) the conditions for eligibility for benefits (including any conditions relating to income or resources); and

"(B) the rights to challenge determinations regarding eligibility or rights to benefits; and

"(C) determinations regarding quality control or error rates."

SEC. 3458. EXTENSION OF MORATORIUM.

Section 6408(a)(3) of the Omnibus Budget Reconciliation Act of 1989, as amended by section 13642 of the Omnibus Budget Reconciliation Act of 1993, is amended by striking "December 31, 1995" and inserting "December 31, 2002".

CHAPTER 2—QUALITY ASSURANCE

SEC. 3461. REQUIREMENTS TO ENSURE QUALITY OF AND ACCESS TO CARE UNDER MANAGED CARE PLANS.

(a) STATE PLAN REQUIREMENT.—Section 1902(a) (42 U.S.C. 1396a(a)) is amended—

(1) in paragraph (62), by striking "; and" at the end and inserting a semicolon;

(2) by striking the period at the end of paragraph (63) and inserting "; and"; and

(3) by inserting after paragraph (63) the following new paragraph:

"(64) provide, with respect to all contracts described in section 1903(m)(2)(A) with an organization or provider, that—

"(A) the State agency develops and implements a quality assessment and improvement strategy, consistent with standards that the Secretary shall establish, in consultation with the States, and monitor and that do not preempt the application of stricter State standards, which includes—

“(i) standards for access to care so that covered services are available within reasonable timeframes and in a manner that ensures continuity of care and adequate primary care and, where applicable, specialized services capacity, including pediatric specialized services for special needs children (as defined in section 1915(i)); and

“(ii) procedures for monitoring and evaluating the quality and appropriateness of care and services to beneficiaries that reflect the full spectrum of populations enrolled under the contract and that include—

“(I) requirements for provision of quality assurance data to the State using the data and information set that the Secretary shall specify with respect to entities contracting under section 1876 or alternative data requirements approved by the Secretary;

“(II) regular and periodic examination of the scope and content of the quality improvement strategy; and

“(III) other aspects of care and service directly related to the improvement of quality of care (including grievance procedures and marketing and information standards); and

“(B) that adequate provision is made, consistent with standards that the Secretary shall specify and monitor, with respect to financial reporting under the contracts.”

(b) DEEMED COMPLIANCE.—Section 1903(m) (42 U.S.C. 1396b(m)) is amended by adding at the end the following:

“(7) DEEMED COMPLIANCE.—

“(A) MEDICARE ORGANIZATIONS.—At the option of a State, the requirements of the previous provisions of this subsection shall not apply with respect to a health maintenance organization if the organization is an eligible organization with a contract in effect under section 1876 or a MedicarePlus organization with a contract in effect under C of title XVIII.

“(B) PRIVATE ACCREDITATION.—

“(i) IN GENERAL.—At the option of a State, such requirements shall not apply with respect to a health maintenance organization if—

“(I) the organization is accredited by an organization meeting the requirements described in subparagraph (C); and

“(II) the standards and process under which the organization is accredited meet such requirements as are established under clause (ii), without regard to whether or not the time requirement of such clause is satisfied.

“(ii) STANDARDS AND PROCESS.—Not later than 180 days after the date of the enactment of this paragraph, the Secretary shall specify requirements for the standards and process under which a health maintenance organization is accredited by an organization meeting the requirements of subparagraph (C).

“(C) ACCREDITING ORGANIZATION.—An accrediting organization meets the requirements of this subparagraph if the organization—

“(i) is a private, nonprofit organization;

“(ii) exists for the primary purpose of accrediting managed care organizations or health care providers; and

“(iii) is independent of health care providers or associations of health care providers.”.

(c) APPLICATION TO MANAGED CARE ENTITIES.—Section 1903(m)(2)(A) (42 U.S.C. 1396b(m)(2)(A)) is amended—

(1) by striking “and” at the end of clause (x),

(2) by striking the period at the end of clause (xi) and inserting “; and”, and

(3) by adding at the end the following new clause:

“(xii) such contract provides for—

“(I) submitting to the State agency such information as may be necessary to monitor the care delivered to members,

“(II) maintenance of an internal quality assurance program consistent with section 1902(a)(64)(A), and meeting standards that the Secretary shall establish in regulations; and

“(III) providing effective procedures for hearing and resolving grievances between the entity and members enrolled with the organization under this subsection.”.

(d) APPLICATION TO PRIMARY CARE CASE MANAGEMENT CONTRACTS.—Section 1905(t)(3), as added by section 3403(b), is amended—

(1) by striking “and” at the end of subparagraph (D),

(2) by striking the period at the end of subparagraph (E) and inserting “; and”, and

(3) by adding at the end the following new subparagraph:

“(F) if payment is made to the organization on a prepaid capitated or other risk basis, compliance with the requirements of section 1903(m)(2)(A)(xii) in the same manner such requirements apply to a health maintenance organization under section 1903(m)(2)(A).”.

(e) EFFECTIVE DATE.—The amendments made by this section apply to agreements between a State agency and an organization entered into or renewed on or after January 1, 1999.

SEC. 3462. SOLVENCY STANDARDS FOR CERTAIN HEALTH MAINTENANCE ORGANIZATIONS.

(a) IN GENERAL.—Section 1903(m)(1) (42 U.S.C. 1396b(m)(1)) is amended—

(1) in subparagraph (A)(ii), by inserting “, meets the requirements of subparagraph (C)(i) (if applicable),” after “provision is satisfactory to the State”, and

(2) by adding at the end the following:

“(C)(i) Subject to clause (ii), a provision meets the requirements of this subparagraph for an organization if the organization meets solvency standards established by the State for private health maintenance organizations or is licensed or certified by the State as a risk-bearing entity.

“(ii) Clause (i) shall not apply to an organization if—

“(I) the organization is not responsible for the provision (directly or through arrangements with providers of services) of inpatient hospital services and physicians’ services;

“(II) the organization is a public entity;

“(III) the solvency of the organization is guaranteed by the State; or

“(IV) the organization is (or is controlled by) one or more federally-qualified health centers and meets solvency standards established by the State for such an organization.

For purposes of subclause (IV), the term ‘control’ means the possession, whether direct or indirect, of the power to direct or cause the direction of the management and policies of the organization through membership, board representation, or an ownership interest equal to or greater than 50.1 percent.”

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to contracts entered into or renewed on or after October 1, 1998.

(c) TRANSITION.—In the case of a health maintenance organization that as of the date of the enactment of this Act has entered into a contract with a State for the provision of medical assistance under title XIX under which the organization assumes full financial risk and is receiving capitation payments, the amendment made by subsection (a) shall not apply to such organization until 3 years after the date of the enactment of this Act.

SEC. 3463. APPLICATION OF PRUDENT LAYPERSON STANDARD FOR EMERGENCY MEDICAL CONDITION AND PROHIBITION OF GAG RULE RESTRICTIONS.

Section 1903(m) (42 U.S.C. 1396b(m)) is amended by adding at the end the following:

“(8)(A)(i) Each contract with a health maintenance organization under this subsection shall require the organization—

“(I) to provide coverage for emergency services (as defined in subparagraph (B)) without regard to prior authorization or the emergency care provider’s contractual relationship with the organization, and

“(II) to comply with guidelines established under section 1852(d)(2) (respecting coordination of post-stabilization care) in the same manner as such guidelines apply to MedicarePlus plans offered under part C of title XVIII.

“(B) In subparagraph (A)(i)(I), the term ‘emergency services’ means, with respect to an individual enrolled with an organization, covered inpatient and outpatient services that—

“(i) are furnished by a provider that is qualified to furnish such services under this title, and

“(ii) are needed to evaluate or stabilize an emergency medical condition (as defined in subparagraph (C)).

“(C) In subparagraph (B)(ii), the term ‘emergency medical condition’ means a medical condition manifesting itself by acute symptoms of sufficient severity such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in—

“(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,

“(ii) serious impairment to bodily functions, or

“(iii) serious dysfunction of any bodily organ or part.

“(9)(A) Subject to subparagraphs (B) and (C), under a contract under this subsection a health maintenance organization (in relation to an individual enrolled under the contract) shall not prohibit or otherwise restrict a covered health care professional (as defined in subparagraph (D)) from advising such an individual who is a patient of the professional about the health status of the individual or medical care or treatment for the individual’s condition or disease, regardless of whether benefits for such care or treatment are provided under the plan, if the professional is acting within the lawful scope of practice.

“(B) Subparagraph (A) shall not be construed as requiring a health maintenance organization to provide, reimburse for, or provide coverage of a counseling or referral service if the organization—

“(i) objects to the provision of such service on moral or religious grounds; and

“(ii) in the manner and through the written instrumentalities such organization deems appropriate, makes available information on its policies regarding such service to prospective enrollees before or during enrollment and to enrollees within 90 days after the date that the organization or plan adopts a change in policy regarding such a counseling or referral service.

“(C) Nothing in subparagraph (B) shall be construed to affect disclosure requirements under State law or under the Employee Retirement Income Security Act of 1974.

“(D) For purposes of this paragraph, the term ‘health care professional’ means a physician (as defined in section 1861(r)) or other health care professional if coverage for the professional’s services is provided under the contract under this subsection for the services of the professional. Such term includes a podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist and therapy assistant, speech-language pathologist, audiologist, registered or licensed practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified nurse-midwife), licensed certified social worker, registered respiratory therapist, and certified respiratory therapy technician.”

SEC. 3464. ADDITIONAL FRAUD AND ABUSE PROTECTIONS IN MANAGED CARE.

(a) PROTECTION AGAINST MARKETING ABUSES.—Section 1903(m) (42 U.S.C. 1396b(m)), as amended by section 3463, is amended—

(1) in paragraph (2)(A)(viii), by inserting “and compliance with the requirements of paragraphs (10) and (11)” after “of this subsection”, and

(2) by adding at the end the following:

“(10)(A)(i) A health maintenance organization with respect to activities under this subsection may not distribute directly or through

any agent or independent contractor marketing materials within any State—

“(I) without the prior approval of the State; and

“(II) that contain false or materially misleading information.

“(ii) In the process of reviewing and approving such materials, the State shall provide for consultation with a medical care advisory committee.

“(iii) The State may not enter into or renew a contract with a health maintenance organization for the provision of services to individuals enrolled under the State plan under this title if the State determines that the entity distributed directly or through any agent or independent contractor marketing materials in violation of clause (i)(II).

“(B) A health maintenance organization shall distribute marketing materials to the entire service area of such organization.

“(C) A health maintenance organization, or any agency of such organization, may not seek to influence an individual’s enrollment with the organization in conjunction with the sale of any other insurance.

“(D) Each health maintenance organization shall comply with such procedures and conditions as the Secretary prescribes in order to ensure that, before an individual is enrolled with the organization under this title, the individual is provided accurate oral and written and sufficient information to make an informed decision whether or not to enroll.

“(E) Each health maintenance organization shall not, directly or indirectly, conduct door-to-door, telephonic, or other ‘cold call’ marketing of enrollment under this title.”

(b) PROHIBITING AFFILIATIONS WITH INDIVIDUALS DEBARRED BY FEDERAL AGENCIES.—Section 1903(m) (42 U.S.C. 1396b(m)), as amended by section 3463 and subsection (a), is further amended by adding at the end the following:

“(11)(A) A health maintenance organization may not knowingly—

“(i) have a person described in subparagraph (C) as a director, officer, partner, or person with beneficial ownership of more than 5 percent of the organization equity; or

“(ii) have an employment, consulting, or other agreement with a person described in such subparagraph for the provision of items and services that are significant and material to the organization’s obligations under its contract with the State.

“(B) If a State finds that a health maintenance organization is not in compliance with clause (i) or (ii) of subparagraph (A), the State—

“(i) shall notify the Secretary of such noncompliance;

“(ii) may continue an existing agreement with the organization unless the Secretary (in consultation with the Inspector General of the Department of Health and Human Services) directs otherwise; and

“(iii) may not renew or otherwise extend the duration of an existing agreement with the organization unless the Secretary (in consultation with the Inspector General of the Department of Health and Human Services) provides to the State and to the Congress a written statement describing compelling reasons that exist for renewing or extending the agreement.

“(C) A person is described in this subparagraph if such person—

“(i) is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal acquisition regulation or from participating in nonprocurement activities under regulations issued pursuant to Executive Order 12549; or

“(ii) is an affiliate (within the meaning of the Federal acquisition regulation) of a person described in clause (i).”.

(c) APPLICATION OF STATE CONFLICT-OF-INTEREST SAFEGUARDS.—Section 1903(m)(2)(A) (42 U.S.C. 1396b(m)(2)(A)), as amended by section 3461(c), is amended—

(1) by striking “and” at the end of clause (xi),

(2) by striking the period at the end of clause (xii) and inserting “; and”, and

(3) by inserting after clause (xi) the following:

“(xiii) the State has in effect conflict-of-interest safeguards with respect to officers and employees of the State with responsibilities relating to contracts with such organizations and to any default enrollment process that are at least as effective as the Federal safeguards provided under section 27 of the Office of Federal Procurement Policy Act (41 U.S.C. 423), against conflicts of interest that apply with respect to Federal procurement officials with comparable responsibilities with respect to such contracts.”.

(d) LIMITATION ON AVAILABILITY OF FFP FOR USE OF ENROLLMENT BROKERS.—Section 1903(b) (42 U.S.C. 1396b(b)), as amended by section 3413(b), is amended by adding at the end the following:

“(5) Amounts expended by a State for the use an enrollment broker in marketing health maintenance organizations and other managed care entities to eligible individuals under this title shall be considered, for purposes of subsection (a)(7), to be necessary for the proper and efficient administration of the State plan but only if the following conditions are met with respect to the broker:

“(A) The broker is independent of any such entity and of any health care providers (whether or not any such provider participates in the State plan under this title) that provide coverage of services in the same State in which the broker is conducting enrollment activities.

“(B) No person who is an owner, employee, consultant, or has a contract with the broker either has any direct or indirect financial interest with such an entity or health care provider or has been excluded from participation in the program under this title or title XVIII or debarred by any Federal agency, or subject to a civil money penalty under this Act.”.

(e) EFFECTIVE DATE.—The amendments made by this section shall take effect on January 1, 1998.

SEC. 3465. GRIEVANCES UNDER MANAGED CARE PLANS.

Section 1903(m) (42 U.S.C. 1396b(m)) is amended—

(1) in paragraph (2)(A), as amended by sections 3461(c) and 3464(c),—

(A) by striking “and” at the end of clause (xii),

(B) by striking the period at the end of clause (xiii) and inserting “; and”, and

(C) by inserting after clause (xiii) the following new clause:

“(xiv) such contract provides for compliance of the organization with the grievance and appeals requirements described in paragraph (3).”; and

(2) by inserting after paragraph (2) the following new paragraph:

“(3)(A) An eligible organization must provide a meaningful and expedited procedure, which includes notice and hearing requirements, for resolving grievances between the organization (including any entity or individual through which the organization provides health care services) and members enrolled with the organization under this subsection. Under the procedure any member enrolled with the organization may at any time file orally or in writing a complaint to resolve grievances between the member and the organization before a board of appeals established under subparagraph (C).

“(B)(i) The organization must provide, in a timely manner, such an enrollee a notice of any denial of services in-network or denial of payment for out-of-network care or notice of termination or reduction of services.

“(ii) Such notice shall include the following:

“(I) A clear statement of the reason for the denial.

“(II) An explanation of the complaint process under subparagraph (C) which is available to the enrollee upon request.

“(III) An explanation of all other appeal rights available to all enrollees.

“(IV) A description of how to obtain supporting evidence for this hearing, including the patient’s medical records from the organization, as well as supporting affidavits from the attending health care providers.

“(C)(i) Each eligible organization shall establish a board of appeals to hear and make determinations on complaints by enrollees under this subsection concerning denials of coverage or payment for services (whether in-network or out-of-network) and the medical necessity and appropriateness of covered items and services.

“(ii) A board of appeals of an eligible organization shall consist of—

“(I) representatives of the organization, including physicians, nonphysicians, administrators, and enrollees;

“(II) consumers who are not enrollees; and

“(III) providers with expertise in the field of medicine which necessitates treatment.

“(iii) A board of appeals shall hear and resolve complaints within 30 days after the date the complaint is filed with the board.

“(D) Nothing in this paragraph may be construed to replace or supersede any appeals mechanism otherwise provided for an individual entitled to benefits under this title.”.

SEC. 3466. STANDARDS RELATING TO ACCESS TO OBSTETRICAL AND GYNECOLOGICAL SERVICES UNDER MANAGED CARE PLANS.

(a) IN GENERAL.—Section 1903(m)(2)(A) (42 U.S.C. 1396b(m)(2)(A)), as amended by sections 3461(c), 3464(c), and 3465(1), is amended—

- (1) by striking “and” at the end of clause (xiii),
- (2) by striking the period at the end of clause (xiv) and inserting “; and”, and
- (3) by inserting after clause (xiv) the following:
“(xv) the organization complies with the requirements of paragraph (12).”.

(b) REQUIREMENTS.—Section 1903(m) (42 U.S.C. 1396b(m)), as amended by sections 3463, 3464(a), and 3464(b), is amended by adding at the end the following new paragraph:

“(12)(A) If a health maintenance organization, under a contract under this subsection, requires or provides for an enrollee to designate a participating primary care provider—

“(i) the organization shall permit a female enrollee to designate an obstetrician-gynecologist who has agreed to be designated as such, as the enrollee’s primary care provider; and

“(ii) if such an enrollee has not designated such a provider as a primary care provider, the organization—

“(I) may not require prior authorization by the enrollee’s primary care provider or otherwise for coverage of obstetric and gynecologic care provided by a participating obstetrician-gynecologist, or a participating health care professional practicing in collaboration with the obstetrician-gynecologist and in accordance with State law, to the extent such care is otherwise covered, and

“(II) shall treat the ordering of other gynecologic care by such a participating physician as the prior authorization of the primary care provider with respect to such care under the contract.

“(B) Nothing in subparagraph (A)(ii)(II) shall waive any requirements of coverage relating to medical necessity or appropriateness with respect to coverage of gynecologic care so ordered.”.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to contracts entered into, renewed, or extended on or after January 1, 1998.

CHAPTER 3—FEDERAL PAYMENTS

SEC. 3471. REFORMING DISPROPORTIONATE SHARE PAYMENTS UNDER STATE MEDICAID PROGRAMS.

(a) DIRECT PAYMENT BY STATE.—Subsection (a)(1) of section 1923 (42 U.S.C. 1396r-4) is amended—

- (1) by striking “and” at the end of subparagraph (A),
- (2) by striking the period at the end of subparagraph (B) and inserting “, and”, and

(3) by adding at the end the following new subparagraph:

“(C) provides that payment adjustments under the plan under this section for services furnished by a hospital on or after October 1, 1997, for individuals entitled to benefits under the plan, and enrolled with an entity described in section 1903(m), under a primary care case management system (described in section 1905(t)), or other managed care plan—

“(i) are made directly to the hospital by the State, and

“(ii) are not used as part of, and are disregarded in determining the amount of, prepaid capitation paid under the State plan with respect to those services.”.

(b) ADJUSTMENT TO STATE DSH ALLOCATIONS.—

(1) IN GENERAL.—Subsection (f) of such section is amended—
 (A) in paragraph (2)(A), by inserting “and paragraph (5)” after “subparagraph (B)”, and

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

“(5) ADJUSTMENTS IN DSH ALLOTMENTS.—

“(A) ALLOTMENT FROZEN FOR STATES WITH VERY LOW DSH EXPENDITURES.—In the case of a State for which its State 1995 DSH spending did not exceed 1 percent of the total amount expenditures made under the State plan under this title for medical assistance during fiscal year 1995 (as reported by the State no later than January 1, 1997, on HCFA Form 64), the DSH allotment for each of fiscal years 1998 through 2002 is equal to its State 1995 DSH spending.

“(B) FULL REDUCTION FOR HIGH DSH STATES.—In the case of a State which was classified under this subsection as a high DSH State for fiscal year 1997, the DSH allotment for each of fiscal years 1998 through 2002 is equal to the State 1995 DSH spending reduced by the full reduction percentage (described in subparagraph (D)) for the fiscal year involved.

“(C) HALF-REDUCTION FOR OTHER STATES.—In the case of a State not described in subparagraph (A) or (B), the DSH allotment for each of fiscal years 1998 through 2002 is equal to the State 1995 DSH spending reduced by ½ of the full reduction percentage for the fiscal year involved.

“(D) FULL REDUCTION PERCENTAGE.—For purposes of this paragraph, the ‘full reduction percentage’ for—

“(i) fiscal year 1998 is 2 percent,

“(ii) fiscal year 1999 is 5 percent,

“(iii) fiscal year 2000 is 20 percent,

“(iv) fiscal year 2001 is 30 percent, and

“(v) fiscal year 2002 is 40 percent.

“(E) DEFINITIONS.— In this paragraph:

“(i) STATE.—The term ‘State’ means the 50 States and the District of Columbia.

“(ii) STATE 1995 DSH SPENDING.—The term ‘State 1995 DSH spending’ means, with respect to a State, the total amount of payment adjustments made under subsection (c) under the State plan during fiscal year 1995 as reported by the State no later than January 1, 1997, on HCFA Form 64.”.

(2) EFFECTIVE DATE.—The amendments made by paragraph

(1) shall apply to fiscal years beginning with fiscal year 1998.

(c) TRANSITION RULE.—Effective October 1, 1997, section 1923(g)(2)(A) of the Social Security Act (42 U.S.C. 1396r-4(g)(2)(A)) shall be applied to the State of California as though—

(1) “or that begins on or after October 1, 1997, and before October 1, 1999” were inserted in such section after “January 1, 1995”; and

(2) “(or 175 percent in the case of a State fiscal year that begins on or after October 1, 1997, and before October 1, 1999)” were inserted in such section after “200 percent”.

SEC. 3472. ADDITIONAL FUNDING FOR STATE EMERGENCY HEALTH SERVICES FURNISHED TO UNDOCUMENTED ALIENS.

(a) **TOTAL AMOUNT AVAILABLE FOR ALLOTMENT.**—There are available for allotments under this section for each of the 5 fiscal years (beginning with fiscal year 1998) \$20,000,000 for payments to certain States under this section.

(b) **STATE ALLOTMENT AMOUNT.**—

(1) **IN GENERAL.**—The Secretary of Health and Human Services shall compute an allotment for each fiscal year beginning with fiscal year 1998 and ending with fiscal year 2002 for each of the 12 States with the highest number of undocumented aliens. The amount of such allotment for each such State for a fiscal year shall bear the same ratio to the total amount available for allotments under subsection (a) for the fiscal year as the ratio of the number of undocumented aliens in the State in the fiscal year bears to the total of such numbers for all such States for such fiscal year. The amount of allotment to a State provided under this paragraph for a fiscal year that is not paid out under subsection (c) shall be available for payment during the subsequent fiscal year.

(2) **DETERMINATION.**—For purposes of paragraph (1), the number of undocumented aliens in a State under this section shall be determined based on estimates of the resident illegal alien population residing in each State prepared by the Statistics Division of the Immigration and Naturalization Service as of October 1992 (or as of such later date if such date is at least 1 year before the beginning of the fiscal year involved),

(c) **USE OF FUNDS.**—From the allotments made under subsection (b), the Secretary shall pay to each State amounts the State demonstrates were paid by the State (or by a political subdivision of the State) for emergency health services furnished to undocumented aliens.

(d) **STATE DEFINED.**—For purposes of this section, the term “State” includes the District of Columbia.

(e) **STATE ENTITLEMENT.**—This section constitutes budget authority in advance of appropriations Acts and represents the obligation of the Federal Government to provide for the payment to States of amounts provided under subsection (c).

Subtitle F—Child Health Assistance Program (CHAP)

SEC. 3501. SHORT TITLE OF SUBTITLE; TABLE OF CONTENTS OF SUBTITLE.

(a) **SHORT TITLE OF SUBTITLE.**—This subtitle may be cited as the “Child Health Assistance Program Act of 1997”.

(b) **TABLE OF CONTENTS OF SUBTITLE.**—The table of contents of this subtitle is as follows:

Sec. 3501. Short title of subtitle; table of contents.

Sec. 3502. Establishment of Child Health Assistance Program (CHAP).

“TITLE XXI—CHILD HEALTH ASSISTANCE PROGRAM

- “Sec. 2101. Purpose; State child health plans.
- “Sec. 2102. Contents of State child health plan.
- “Sec. 2103. Allotments.
- “Sec. 2104. Payments to States.
- “Sec. 2105. Process for submission, approval, and amendment of State child health plans.
- “Sec. 2106. Strategic objectives and performance goals; plan administration.
- “Sec. 2107. Annual reports; evaluations.
- “Sec. 2108. Definitions.
- Sec. 3503. Optional use of State child health assistance funds for enhanced medic-aid match for expanded medicaid eligibility.
- Sec. 3504. Medicaid presumptive eligibility for low-income children.

SEC. 3502. ESTABLISHMENT OF CHILD HEALTH ASSISTANCE PROGRAM (CHAP).

The Social Security Act is amended by adding at the end the following new title:

“TITLE XXI—CHILD HEALTH ASSISTANCE PROGRAM

“SEC. 2101. PURPOSE; STATE CHILD HEALTH PLANS.

“(a) PURPOSE.—The purpose of this title is to provide funds to States to enable them to implement plans to initiate and expand the provision of child health care assistance to uninsured, low-income children in an effective and efficient manner that is coordinated with other sources of coverage for children. Such assistance may be provided for obtaining creditable health coverage through methods specified in the plan, which may include any or all of the following:

“(1) Providing benefits under the State’s medicaid plan under title XIX.

“(2) Obtaining coverage under group health plans or group or individual health insurance coverage.

“(3) Direct purchase of services from providers.

“(4) Other methods specified under the plan.

“(b) STATE CHILD HEALTH PLAN REQUIRED.—A State is not eligible for payment under section 2104 unless the State has submitted to the Secretary under section 2105 a plan that—

“(1) sets forth how the State intends to use the funds provided under this title to provide child health assistance to needy children consistent with the provisions of this title, and

“(2) is approved under section 2105.

“(c) STATE ENTITLEMENT.—This title constitutes budget authority in advance of appropriations Acts and represents the obligation of the Federal Government to provide for the payment to States of amounts provided under section 2104.

“(d) EFFECTIVE DATE.—No State is eligible for payments under section 2104 for any calendar quarter beginning before October 1, 1997.

“SEC. 2102. CONTENTS OF STATE CHILD HEALTH PLAN.

“(a) GENERAL BACKGROUND AND DESCRIPTION.—A State child health plan shall include a description, consistent with the requirements of this title, of—

“(1) the extent to which, and manner in which, children in the State, including targeted low-income children and other classes of children classified by income and other relevant fac-

tors, currently have creditable health coverage (as defined in section 2108(c)(2));

“(2) current State efforts to provide or obtain creditable health coverage for uncovered children, including the steps the State is taking to identify and enroll all uncovered children who are eligible to participate in public health insurance programs and health insurance programs that involve public-private partnerships;

“(3) how the plan is designed to be coordinated with such efforts to increase coverage of children under creditable health coverage; and

“(4) how the plan will comply with subsection (c)(5).

“(b) GENERAL DESCRIPTION OF ELIGIBILITY STANDARDS AND METHODOLOGY.—

“(1) ELIGIBILITY STANDARDS.—

“(A) IN GENERAL.—The plan shall include a description of the standards used to determine the eligibility of targeted low-income children for child health assistance under the plan. Such standards may include (to the extent consistent with this title) those relating to the geographic areas to be served by the plan, age, income and resources (including any standards relating to spenddowns and disposition of resources), residency, disability status, immigration status, access to or coverage under other health coverage, and duration of eligibility. Such standards may not discriminate on the basis of diagnosis.

“(B) LIMITATIONS ON ELIGIBILITY STANDARDS.—Such eligibility standards—

“(i) shall, within any defined group of covered targeted low-income children, not cover such children with higher family income without covering children with a lower family income, and

“(ii) may not deny eligibility based on a child having a preexisting medical condition.

“(2) METHODOLOGY.—The plan shall include a description of methods of establishing and continuing eligibility and enrollment, including a methodology for computing family income that is consistent with the methodology used under section 1902(l)(3)(E).

“(3) ELIGIBILITY SCREENING; COORDINATION WITH OTHER HEALTH COVERAGE PROGRAMS.—The plan shall include a description of procedures to be used to ensure—

“(A) through both intake and followup screening, that only targeted low-income children are furnished child health assistance under the State child health plan;

“(B) that children found through the screening to be eligible for medical assistance under the State medicaid plan under title XIX are enrolled for such assistance under such plan;

“(C) that the insurance provided under the State child health plan does not substitute for coverage under group health plans; and

“(D) coordination with other public and private programs providing creditable coverage for low-income children.

“(4) NONENTITLEMENT.—Nothing in this title shall be construed as providing an individual with an entitlement to child health assistance under a State child health plan.

“(c) DESCRIPTION OF ASSISTANCE.—

“(1) IN GENERAL.—A State child health plan shall include a description of the child health assistance provided under the plan for targeted low-income children. The child health assistance provided to a targeted low-income child under the plan in the form described in paragraph (2) of section 2101(a) shall include benefits (in an amount, duration, and scope specified under the plan) for at least the following categories of services:

“(A) Inpatient and outpatient hospital services.

“(B) Physicians’ surgical and medical services.

“(C) Laboratory and x-ray services.

“(D) Well-baby and well-child care, including age-appropriate immunizations.

The previous sentence shall not apply to coverage under a group health plan if the benefits under such coverage for individuals under this title are no less than the benefits for other individuals similarly covered under the plan.

“(2) ITEMS.—The description shall include the following:

“(A) COST SHARING.—Subject to paragraph (3), the amount (if any) of premiums, deductibles, coinsurance, and other cost sharing imposed.

“(B) DELIVERY METHOD.—The State’s approach to delivery of child health assistance, including a general description of—

“(i) the use (or intended use) of different delivery methods, which may include the delivery methods used under the medicaid plan under title XIX, fee-for-service, managed care arrangements (such as capitated health care plans, case management, and case coordination), direct provision of health care services (such as through community health centers and disproportionate share hospitals), vouchers, and other delivery methods; and

“(ii) utilization control systems.

“(3) LIMITATIONS ON COST SHARING.—

“(A) NO COST SHARING ON PREVENTIVE BENEFITS.—The plan may not impose deductibles, coinsurance, or similar cost sharing with respect to benefits for preventive services.

“(B) SLIDING SCALE.—To the extent practicable, any premiums imposed under the plan shall be imposed on a sliding scale related to income and the plan may only vary premiums, deductibles, coinsurance, and other cost sharing based on the family income of targeted low-income children only in a manner that does not favor children from families with higher income over children from families with lower income.

“(4) RESTRICTION ON APPLICATION OF PREEXISTING CONDITION EXCLUSIONS.—

“(A) IN GENERAL.—Subject to subparagraph (B), the State child health plan shall not permit the imposition of

any preexisting condition exclusion for covered benefits under the plan.

“(B) GROUP HEALTH PLANS AND GROUP HEALTH INSURANCE COVERAGE.—If the State child health plan provides for benefits through payment for, or a contract with, a group health plan or group health insurance coverage, the plan may permit the imposition of a preexisting condition exclusion but only insofar as it is permitted under the applicable provisions of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 and title XXVII of the Public Health Service Act.

“(5) SPECIAL PROTECTION FOR CHILDREN WITH CHRONIC HEALTH CONDITIONS AND SPECIAL HEALTH CARE NEEDS.—In the case of a child who has a chronic condition, life-threatening condition, or combination of conditions that warrants medical specialty care and who is eligible for benefits under the plan with respect to such care, the State child health plan shall assure access to such care, including the use of a medical specialist as a primary care provider.

“(6) SECONDARY PAYMENT.—Nothing in this section shall be construed as preventing a State from denying benefits to an individual to the extent such benefits are available to the individual under another public or private health care insurance program.

“(7) TREATMENT OF CASH PAYMENTS.—Payments in the form of cash or vouchers provided as child health or other assistance under the State child health plan to parents, guardians or other caretakers of a targeted low-income child are not considered income for purpose of eligibility for, or benefits provided under, any means-tested Federal or Federally-assisted program.

“(d) OUTREACH AND COORDINATION.—A State child health plan shall include a description of the procedures to be used by the State to accomplish the following:

“(1) OUTREACH.—Outreach to families of children likely to be eligible for child health assistance under the plan or under other public or private health coverage programs to inform these families of the availability of, and to assist them in enrolling their children in, such a program.

“(2) COORDINATION WITH OTHER HEALTH INSURANCE PROGRAMS.—Coordination of the administration of the State program under this subtitle with other public and private health insurance programs.

“SEC. 2103. ALLOTMENTS.

“(a) TOTAL ALLOTMENT.—The total allotment that is available under this title for each fiscal year, beginning with fiscal year 1998, is \$2,880,000,000.

“(b) ALLOTMENTS TO 50 STATES AND DISTRICT OF COLUMBIA.—

“(1) IN GENERAL.—Subject to paragraphs (4) and (5), of the total allotment available under subsection (a) for a fiscal year, reduced by the amount of allotments made under subsection (c) for the fiscal year, the Secretary shall allot to each State (other than a State described in such subsection) with a State child

health plan approved under this title the same proportion as the ratio of—

“(A) the product of (i) the number of uncovered low-income children for the fiscal year in the State (as determined under paragraph (2)) and (ii) the State cost factor for that State (established under paragraph (3)); to

“(B) the sum of the products computed under subparagraph (A).

“(2) NUMBER OF UNCOVERED LOW-INCOME CHILDREN.—For the purposes of paragraph (1)(A)(i), the number of uncovered low-income children for a fiscal year in a State is equal to the arithmetic average of the number of low-income children (as defined in section 2108(c)(4)) with no health insurance coverage, as reported and defined in the 3 most recent March supplements to the Current Population Survey of the Bureau of the Census before the beginning of the fiscal year.

“(3) ADJUSTMENT FOR GEOGRAPHIC VARIATIONS IN HEALTH COSTS.—

“(A) IN GENERAL.—For purposes of paragraph (1)(A)(ii), the ‘State cost factor’ for a State for a fiscal year equal to the sum of—

“(i) 0.15, and

“(ii) 0.85 multiplied by the ratio of—

“(I) the annual average wages per employee for the State for such year (as determined under subparagraph (B)), to

“(II) the annual average wages per employee for the 50 States and the District of Columbia.

“(B) ANNUAL AVERAGE WAGES PER EMPLOYEE.—For purposes of subparagraph (A), the ‘annual average wages per employee’ for a State, or for all the States, for a fiscal year is equal to the average of the annual wages per employee for the State or for the 50 States and the District of Columbia for employees in the health services industry (SIC code 8000), as reported by the Bureau of Labor Statistics of the Department of Labor for each of the most recent 3 years before the beginning of the fiscal year involved.

“(4) FLOOR FOR STATES.—Subject to paragraph (5), in no case shall the amount of the allotment under this subsection for one of the 50 States or the District of Columbia for a year be less than \$2,000,000. To the extent that the application of the previous sentence results in an increase in the allotment to a State above the amount otherwise provided, the allotments for the other States and the District of Columbia under this subsection shall be decreased in a pro rata manner (but not below \$2,000,000) so that the total of such allotments in a fiscal year does not exceed the amount otherwise provided for allotment under paragraph (1) for that fiscal year.

“(5) OFFSET FOR EXPENDITURES UNDER MEDICAID PRESUMPTIVE ELIGIBILITY.—The amount of the allotment otherwise provided to a State under this subsection for a fiscal year shall be reduced by the amount of the payments made to the State under section 1903(a) for calendar quarters during such fiscal year that are attributable to provision of medical assistance to

a child during a presumptive eligibility period under section 1920A.

“(c) ALLOTMENTS TO TERRITORIES.—

“(1) IN GENERAL.—Subject to paragraph (3), of the total allotment under subsection (a) for a fiscal year, the Secretary shall allot 0.5 percent among each of the commonwealths and territories described in paragraph (4) in the same proportion as the percentage specified in paragraph (2) for such commonwealth or territory bears to the sum of such percentages for all such commonwealths or territories so described.

“(2) PERCENTAGE.—The percentage specified in this paragraph for—

“(A) Puerto Rico is 91.6 percent,

“(B) Guam is 3.5 percent,

“(C) Virgin Islands is 2.6 percent,

“(D) American Samoa is 1.2 percent, and

“(E) the Northern Mariana Islands is 1.1 percent.

“(3) FLOOR.—In no case shall the amount of the allotment to a commonwealth or territory under paragraph (1) for a fiscal year be less than \$100,000. To the extent that the application of the previous sentence results in an increase in the allotment to a commonwealth or territory above the amount otherwise provided, the allotments for the other commonwealths and territories under this subsection for the fiscal year shall be decreased (but not below \$100,000) in a pro rata manner so that the total of such allotments does not exceed the total amount otherwise provided for allotment under paragraph (1).

“(4) COMMONWEALTHS AND TERRITORIES.—A commonwealth or territory described in this paragraph is any of the following if it has a State child health plan approved under this title:

“(A) Puerto Rico.

“(B) Guam.

“(C) the Virgin Islands.

“(D) American Samoa.

“(E) the Northern Mariana Islands.

“(d) ADJUSTMENT FOR STATES USING ENHANCED MEDICAID MATCH.—In the case of a State that elects the increased medicaid matching option under section 1905(t), the amount of the State’s allotment under this section shall be reduced by the amount of additional payment made under section 1903 that is attributable to the increase in the Federal medical assistance percentage effected under such option.

“(e) 3-YEAR AVAILABILITY OF AMOUNTS ALLOTTED.—Amounts allotted to a State pursuant to this section for a fiscal year shall remain available for expenditure by the State through the end of the second succeeding fiscal year.

“SEC. 2104. PAYMENTS TO STATES.

“(a) IN GENERAL.—Subject to the succeeding provisions of this section, the Secretary shall pay to each State with a program approved under this title, from its allotment under section 2103 (as may be adjusted under section 2103(d)), an amount for each quarter up to 80 percent of expenditures under that program in the quarter for—

“(1) child health assistance for targeted low-income children;

“(2) health services initiatives for improving the health of children (including targeted low-income children and other low-income children);

“(3) expenditures for outreach activities as provided in section 2102(d)(1); and

“(4) other reasonable costs incurred by the State to administer the plan.

“(b) LIMITATION ON CERTAIN PAYMENTS FOR CERTAIN EXPENDITURES.—

“(1) IN GENERAL.—Funds provided to a State under this title shall only be used to carry out the purposes of this title.

“(2) LIMITATION ON EXPENDITURES NOT USED FOR ASSISTANCE.—Payment shall not be made under subsection (a) for expenditures for items described in paragraphs (2), (3), or (4) of subsection to the extent the total of such expenditures exceeds 15 percent of total expenditures under the plan for the period involved (including any in such total additional Federal medical assistance payments under section 1903(a)(1) that are attributable to an enhanced State medicaid match under section 1905(t)).

“(3) PURCHASE OF FAMILY COVERAGE.—The Secretary shall establish rules regarding the extent to which payment may be made under subsection (a)(1) for the purchase of family coverage under a group health plan or health insurance coverage that includes coverage of targeted low-income children. Under such rules such payment may be permitted, notwithstanding that a portion may be considered attributable to purchase of coverage for other family members, if the State demonstrates that purchase of such coverage is cost effective relative to the amounts that the State would have paid to obtain comparable coverage only of the targeted low-income children involved. In making such determination, there shall be taken into account the costs of providing coverage for medical assistance for children with similar actuarial characteristics under section 1902(l).

“(4) DENIAL OF PAYMENT FOR REDUCTION OF MEDICAID ELIGIBILITY STANDARDS.—No payment may be made under subsection (a) with respect to child health assistance provided under a State child health plan to a targeted low-income child if the child would be eligible for medical assistance under the State plan under title XIX (as such plan was in effect as of June 1, 1997) but for a change in the income or assets standards or methodology under such plan effected after such date.

“(5) DISALLOWANCES FOR EXCLUDED PROVIDERS.—

“(A) IN GENERAL.—Payment shall not be made to a State under subsection (a) for expenditures for items and services furnished—

“(i) by a provider who was excluded from participation under title V, XVIII, or XX or under this title pursuant to section 1128, 1128A, 1156, or 1842(j)(2), or

“(ii) under the medical direction or on the prescription of a physician who was so excluded, if the provider of the services knew or had reason to know of the exclusion.

“(B) EXCEPTION FOR EMERGENCY SERVICES.—Subparagraph (A) shall not apply to emergency items or services, not including hospital emergency room services.

“(6) USE OF NON-FEDERAL FUNDS FOR STATE MATCHING REQUIREMENT.—Amounts provided by the Federal Government, or services assisted or subsidized to any significant extent by the Federal Government, may not be included in determining the amount of non-Federal contributions required under subsection (a).

“(7) TREATMENT OF THIRD PARTY LIABILITY.—No payment shall be made to a State under this section for expenditures for child health assistance provided for a targeted low-income child under its plan to the extent that a private insurer (as defined by the Secretary by regulation and including a group health plan (as defined in section 607(1) of the Employee Retirement Income Security Act of 1974), a service benefit plan, and a health maintenance organization) would have been obligated to provide such assistance but for a provision of its insurance contract which has the effect of limiting or excluding such obligation because the individual is eligible for or is provided child health assistance under the plan.

“(8) SECONDARY PAYER PROVISIONS.—Except as otherwise provided by law, no payment shall be made to a State under this section for expenditures for child health assistance provided for a targeted low-income child under its plan to the extent that payment has been made or can reasonably be expected to be made promptly (as determined in accordance with regulations) under any other federally operated or financed health care insurance program, other than an insurance program operated or financed by the Indian Health Service, as identified by the Secretary. For purposes of this paragraph, rules similar to the rules for overpayments under section 1903(d)(2) shall apply.

“(9) LIMITATION ON PAYMENT FOR ABORTIONS.—

“(A) IN GENERAL.—Payment shall not be made to a State under this section for any amount expended under the State plan to pay for any abortion or to assist in the purchase, in whole or in part, of health benefit coverage that includes coverage of abortion.

“(B) EXCEPTION.—Subparagraph (A) shall not apply to an abortion—

“(i) if the pregnancy is the result of an act of rape or incest, or

“(ii) in the case where a woman suffers from a physical disorder, illness, or injury that would, as certified by a physician, place the woman in danger of death unless an abortion is performed.

“(c) ADVANCE PAYMENT; RETROSPECTIVE ADJUSTMENT.—The Secretary may make payments under this section for each quarter on the basis of advance estimates of expenditures submitted by the State and other investigation the Secretary may find necessary, and may reduce or increase the payments as necessary to adjust for any overpayment or underpayment for prior quarters.

“SEC. 2105. PROCESS FOR SUBMISSION, APPROVAL, AND AMENDMENT OF STATE CHILD HEALTH PLANS.

“(a) INITIAL PLAN.—

“(1) IN GENERAL.—As a condition of receiving funding under section 2104, a State shall submit to the Secretary a State child health plan that meets the applicable requirements of this title.

“(2) APPROVAL.—Except as the Secretary may provide under subsection (e), a State plan submitted under paragraph (1)—

“(A) shall be approved for purposes of this title, and

“(B) shall be effective beginning with a calendar quarter that is specified in the plan, but in no case earlier than the first calendar quarter that begins at least 60 days after the date the plan is submitted.

“(b) PLAN AMENDMENTS.—

“(1) IN GENERAL.—A State may amend, in whole or in part, its State child health plan at any time through transmittal of a plan amendment.

“(2) APPROVAL.—Except as the Secretary may provide under subsection (e), an amendment to a state plan submitted under paragraph (1)—

“(A) shall be approved for purposes of this title, and

“(B) shall be effective as provided in paragraph (3).

“(3) EFFECTIVE DATES FOR AMENDMENTS.—

“(A) IN GENERAL.—Subject to the succeeding provisions of this paragraph, an amendment to a State plan shall take effect on one or more effective dates specified in the amendment.

“(B) AMENDMENTS RELATING TO ELIGIBILITY OR BENEFITS.—

“(i) NOTICE REQUIREMENT.—Any plan amendment that eliminates or restricts eligibility or benefits under the plan may not take effect unless the State certifies that it has provided prior or contemporaneous public notice of the change, in a form and manner provided under applicable State law.

“(ii) TIMELY TRANSMITTAL.—Any plan amendment that eliminates or restricts eligibility or benefits under the plan shall not be effective for longer than a 60-day period unless the amendment has been transmitted to the Secretary before the end of such period.

“(C) OTHER AMENDMENTS.—Any plan amendment that is not described in subparagraph (C) becomes effective in a State fiscal year may not remain in effect after the end of such fiscal year (or, if later, the end of the 90-day period on which it becomes effective) unless the amendment has been transmitted to the Secretary.

“(c) DISAPPROVAL OF PLANS AND PLAN AMENDMENTS.—

“(1) PROMPT REVIEW OF PLAN SUBMITTALS.—The Secretary shall promptly review State plans and plan amendments submitted under this section to determine if they substantially comply with the requirements of this title.

“(2) 90-DAY APPROVAL DEADLINES.—A State plan or plan amendment is considered approved unless the Secretary noti-

fies the State in writing, within 90 days after receipt of the plan or amendment, that the plan or amendment is disapproved (and the reasons for disapproval) or that specified additional information is needed.

“(3) CORRECTION.—In the case of a disapproval of a plan or plan amendment, the Secretary shall provide a State with a reasonable opportunity for correction before taking financial sanctions against the State on the basis of such disapproval.

“(d) PROGRAM OPERATION.—

“(1) IN GENERAL.—The State shall conduct the program in accordance with the plan (and any amendments) approved under subsection (c) and with the requirements of this title.

“(2) VIOLATIONS.—The Secretary shall establish a process for enforcing requirements under this title. Such process shall provide for the withholding of funds in the case of substantial noncompliance with such requirements. In the case of an enforcement action against a State under this paragraph, the Secretary shall provide a State with a reasonable opportunity for correction before taking financial sanctions against the State on the basis of such an action.

“(e) CONTINUED APPROVAL.—An approved State child health plan shall continue in effect unless and until the State amends the plan under subsection (b) or the Secretary finds substantial noncompliance of the plan with the requirements of this title under subsection (d)(2).

“SEC. 2106. STRATEGIC OBJECTIVES AND PERFORMANCE GOALS; PLAN ADMINISTRATION.

“(a) STRATEGIC OBJECTIVES AND PERFORMANCE GOALS.—

“(1) DESCRIPTION.—A State child health plan shall include a description of—

“(A) the strategic objectives,

“(B) the performance goals, and

“(C) the performance measures,

the State has established for providing child health assistance to targeted low-income children under the plan and otherwise for maximizing health coverage for other low-income children and children generally in the State.

“(2) STRATEGIC OBJECTIVES.—Such plan shall identify specific strategic objectives relating to increasing the extent of creditable health coverage among targeted low-income children and other low-income children.

“(3) PERFORMANCE GOALS.—Such plan shall specify one or more performance goals for each such strategic objective so identified.

“(4) PERFORMANCE MEASURES.—Such plan shall describe how performance under the plan will be—

“(A) measured through objective, independently verifiable means, and

“(B) compared against performance goals, in order to determine the State’s performance under this title.

“(b) RECORDS, REPORTS, AUDITS, AND EVALUATION.—

“(1) DATA COLLECTION, RECORDS, AND REPORTS.—A State child health plan shall include an assurance that the State will collect the data, maintain the records, and furnish the reports

to the Secretary, at the times and in the standardized format the Secretary may require in order to enable the Secretary to monitor State program administration and compliance and to evaluate and compare the effectiveness of State plans under this title.

“(2) STATE ASSESSMENT AND STUDY.—A State child health plan shall include a description of the State’s plan for the annual assessments and reports under section 2107(a) and the evaluation required by section 2107(b).

“(3) AUDITS.—A State child health plan shall include an assurance that the State will afford the Secretary access to any records or information relating to the plan for the purposes of review or audit.

“(c) PROGRAM DEVELOPMENT PROCESS.—A State child health plan shall include a description of the process used to involve the public in the design and implementation of the plan and the method for ensuring ongoing public involvement.

“(d) PROGRAM BUDGET.—A State child health plan shall include a description of the budget for the plan. The description shall be updated periodically as necessary and shall include details on the planned use of funds and the sources of the non-Federal share of plan expenditures, including any requirements for cost sharing by beneficiaries.

“(e) APPLICATION OF CERTAIN GENERAL PROVISIONS.—The following sections in part A of title XI shall apply to States under this title in the same manner as they applied to a State under title XIX:

“(1) Section 1101(a)(1) (relating to definition of State).

“(2) Section 1116 (relating to administrative and judicial review), but only insofar as consistent with the provisions of part B.

“(3) Section 1124 (relating to disclosure of ownership and related information).

“(4) Section 1126 (relating to disclosure of information about certain convicted individuals).

“(5) Section 1128B(d) (relating to criminal penalties for certain additional charges).

“(6) Section 1132 (relating to periods within which claims must be filed).

“SEC. 2107. ANNUAL REPORTS; EVALUATIONS.

“(a) ANNUAL REPORT.—The State shall—

“(1) assess the operation of the State plan under this title in each fiscal year, including the progress made in reducing the number of uncovered low-income children; and

“(2) report to the Secretary, by January 1 following the end of the fiscal year, on the result of the assessment.

“(b) STATE EVALUATIONS.—

“(1) IN GENERAL.—By March 31, 2000, each State that has a State child health plan shall submit to the Secretary an evaluation that includes each of the following:

“(A) An assessment of the effectiveness of the State plan in increasing the number of children with creditable health coverage;

“(B) A description and analysis of the effectiveness of elements of the State plan, including—

“(i) the characteristics of the children and families assisted under the State plan including age of the children, family income, and the assisted child’s access to or coverage by other health insurance prior to the State plan and after eligibility for the State plan ends,

“(ii) the quality of health coverage provided including the types of benefits provided,

“(iii) the amount and level (payment of part or all of the premium) of assistance provided by the State,

“(iv) the service area of the State plan,

“(v) the time limits for coverage of a child under the State plan,

“(vi) the State’s choice of health insurance plans and other methods used for providing child health assistance, and

“(vii) the sources of non-Federal funding used in the State plan;

“(C) an assessment of the effectiveness of other public and private programs in the State in increasing the availability of affordable quality individual and family health insurance for children;

“(D) a review and assessment of State activities to coordinate the plan under this title with other public and private programs providing health care and health care financing, including Medicaid and maternal and child health services;

“(E) an analysis of changes and trends in the State that affect the provision of accessible, affordable, quality health insurance and health care to children;

“(F) a description of any plans the State has for improving the availability of health insurance and health care for children;

“(G) recommendations for improving the program under this title; and

“(H) any other matters the State and the Secretary consider appropriate.

“(2) REPORT OF THE SECRETARY.—The Secretary shall submit to the Congress and make available to the public by December 31, 2000, a report based on the evaluations submitted by States under paragraph (1), containing any conclusions and recommendations the Secretary considers appropriate.

“SEC. 2108. DEFINITIONS.

“(a) CHILD HEALTH ASSISTANCE.—For purposes of this title, the term ‘child health assistance’ means payment of part or all of the cost of any of the following, or assistance in the purchase, in whole or in part, of health benefit coverage that includes any of the following, for targeted low-income children (as defined in subsection (b)) as specified under the State plan:

“(1) Inpatient hospital services.

“(2) Outpatient hospital services.

“(3) Physician services.

“(4) Surgical services.

“(5) Clinic services (including health center services) and other ambulatory health care services.

“(6) Prescription drugs and biologicals and the administration of such drugs and biologicals, only if such drugs and biologicals are not furnished for the purpose of causing, or assisting in causing, the death, suicide, euthanasia, or mercy killing of a person.

“(7) Over-the-counter medications.

“(8) Laboratory and radiological services.

“(9) Prenatal care and pre-pregnancy family planning services and supplies.

“(10) Inpatient mental health services, including services furnished in a State-operated mental hospital and including residential or other 24-hour therapeutically planned structured services.

“(11) Outpatient mental health services, including services furnished in a State-operated mental hospital and including community-based services.

“(12) Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices).

“(13) Disposable medical supplies.

“(14) Home and community-based health care services and related supportive services (such as home health nursing services, home health aide services, personal care, assistance with activities of daily living, chore services, day care services, respite care services, training for family members, and minor modifications to the home).

“(15) Nursing care services (such as nurse practitioner services, nurse midwife services, advanced practice nurse services, private duty nursing care, pediatric nurse services, and respiratory care services) in a home, school, or other setting.

“(16) Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest.

“(17) Dental services.

“(18) Inpatient substance abuse treatment services and residential substance abuse treatment services.

“(19) Outpatient substance abuse treatment services.

“(20) Case management services.

“(21) Care coordination services.

“(22) Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders.

“(23) Hospice care.

“(24) Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services (whether in a facility, home, school, or other setting) if recognized by State law and only if the service is—

“(A) prescribed by or furnished by a physician or other licensed or registered practitioner within the scope of practice as defined by State law,

“(B) performed under the general supervision or at the direction of a physician, or

“(C) furnished by a health care facility that is operated by a State or local government or is licensed under State law and operating within the scope of the license.

“(25) Premiums for private health care insurance coverage.

“(26) Medical transportation.

“(27) Enabling services (such as transportation, translation, and outreach services) only if designed to increase the accessibility of primary and preventive health care services for eligible low-income individuals.

“(28) Any other health care services or items specified by the Secretary and not excluded under this section.

“(b) TARGETED LOW-INCOME CHILD DEFINED.—For purposes of this title—

“(1) IN GENERAL.—The term ‘targeted low-income child’ means a child—

“(A) who has been determined eligible by the State for child health assistance under the State plan;

“(B) whose family income (as determined under the State child health plan)—

“(i) exceeds the medicaid applicable income level (as defined in paragraph (2) and expressed as a percentage of the poverty line), but

“(ii) but does not exceed an income level that is 75 percentage points higher (as so expressed) than the medicaid applicable income level, or, if higher, 133 percent of the poverty line for a family of the size involved; and

“(C) who is not found to be eligible for medical assistance under title XIX or covered under a group health plan or under health insurance coverage (as such terms are defined in section 2791 of the Public Health Service Act).

Such term does not include a child who is an inmate of a public institution.

“(2) MEDICAID APPLICABLE INCOME LEVEL.—The term ‘medicaid applicable income level’ means, with respect to a child, the effective income level (expressed as a percent of the poverty line) that has been specified under the State plan under title XIX (including under a waiver authorized by the Secretary or under section 1902(r)(2)), as of June 1, 1997, for the child to be eligible for medical assistance under section 1902(1)(2) for the age of such child. In applying the previous sentence in the case of a child described in section 1902(1)(2)(D), such level shall be applied taking into account the expanded coverage effected among such children under such section with the passage of time.

“(c) ADDITIONAL DEFINITIONS.—For purposes of this title:

“(1) CHILD.—The term ‘child’ means an individual under 19 years of age.

“(2) CREDITABLE HEALTH COVERAGE.—The term ‘creditable health coverage’ has the meaning given the term ‘creditable coverage’ under section 2701(c) of the Public Health Service Act (42 U.S.C. 300gg(c)) and includes coverage (including the direct provision of services) provided to a targeted low-income child under this title.

“(3) GROUP HEALTH PLAN; HEALTH INSURANCE COVERAGE; ETC.—The terms ‘group health plan’, ‘group health insurance coverage’, and ‘health insurance coverage’ have the meanings

given such terms in section 2191 of the Public Health Service Act.

“(4) **LOW-INCOME.**—The term ‘low-income child’ means a child whose family income is below 200 percent of the poverty line for a family of the size involved.

“(5) **POVERTY LINE DEFINED.**—The term ‘poverty line’ has the meaning given such term in section 673(2) of the Community Services Block Grant Act (42 U.S.C. 9902(2)), including any revision required by such section.

“(6) **PREEXISTING CONDITION EXCLUSION.**—The term ‘preexisting condition exclusion’ has the meaning given such term in section 2701(b)(1)(A) of the Public Health Service Act (42 U.S.C. 300gg(b)(1)(A)).

“(7) **STATE CHILD HEALTH PLAN; PLAN.**—Unless the context otherwise requires, the terms ‘State child health plan’ and ‘plan’ mean a State child health plan approved under section 2105.

“(8) **UNCOVERED CHILD.**—The term ‘uncovered child’ means a child that does not have creditable health coverage.”.

(b) **CONFORMING AMENDMENTS.**—

(1) **DEFINITION OF STATE.**—Section 1101(a)(1) is amended—

(A) by striking “and XIX” and inserting “XIX, and XXI”, and

(B) by striking “title XIX” and inserting “titles XIX and XXI”.

SEC. 3503. OPTIONAL USE OF STATE CHILD HEALTH ASSISTANCE FUNDS FOR ENHANCED MEDICAID MATCH FOR EXPANDED MEDICAID ELIGIBILITY.

(a) **INCREASED FMAP FOR MEDICAL ASSISTANCE FOR EXPANDED COVERAGE OF TARGETED LOW-INCOME CHILDREN.**—Section 1905 of the Social Security Act (42 U.S.C. 1396d) is amended—

(1) in subsection (b), by adding at the end the following new sentence: “Notwithstanding the first sentence of this subsection, in the case of a State plan that meets the condition described in subsection (t)(1), with respect to expenditures for medical assistance for optional targeted low-income children described in subsection (t)(2), the Federal medical assistance percentage is equal to the enhanced medical assistance percentage described in subsection (t)(3).”; and

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

“(t)(1) The conditions described in this paragraph for a State plan are as follows:

“(A) The plan is not applying income and resource standards and methodologies for the purpose of determining eligibility of individuals under section 1902(1) that are more restrictive than those applied as of June 1, 1997, for the purpose of determining eligibility of individuals under such section.

“(B) The plan provides for such reporting of information about expenditures and payments attributable to the operation of this subsection as the Secretary deems necessary in order to carry out sections 2103(d) and 2104(b)(2).

“(C) The amount of the increased payments under section 1903(a) resulting from the application of this subsection does

not exceed the total amount of any allotment not otherwise expended by the State under section 2103 for the period involved.

“(2) For purposes of subsection (b), the term ‘optional targeted low-income child’ means a targeted low-income child described in section 2108(b)(1) who would not qualify for medical assistance under the State plan under this title based on such plan as in effect on June 1, 1997 (taking into account the process of individuals aging into eligibility under section 1902(l)(2)(D)).

“(3) The enhanced medical assistance percentage described in this paragraph for a State is equal to the Federal medical assistance percentage (as defined in the first sentence of subsection (b)) for the State increased by a number of percentage points equal to 30 percent of the number of percentage points by which (A) such Federal medical assistance percentage for the State, is less than (B) 100 percent.

“(4) Notwithstanding any other provision of this title, a State plan under this title may impose a limit on the number of optional targeted low-income children described in paragraph (2).”

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to medical assistance for items and services furnished on or after October 1, 1997.

SEC. 3504. MEDICAID PRESUMPTIVE ELIGIBILITY FOR LOW-INCOME CHILDREN.

(a) IN GENERAL.—Title XIX of the Social Security Act is amended by inserting after section 1920 the following new section:

“PRESUMPTIVE ELIGIBILITY FOR CHILDREN

“SEC. 1920A. (a) A State plan approved under section 1902 may provide for making medical assistance with respect to health care items and services covered under the State plan available to a child during a presumptive eligibility period.

“(b) For purposes of this section:

“(1) The term ‘child’ means an individual under 19 years of age.

“(2) The term ‘presumptive eligibility period’ means, with respect to a child, the period that—

“(A) begins with the date on which a qualified entity determines, on the basis of preliminary information, that the family income of the child does not exceed the applicable income level of eligibility under the State plan, and

“(B) ends with (and includes) the earlier of—

“(i) the day on which a determination is made with respect to the eligibility of the child for medical assistance under the State plan, or

“(ii) in the case of a child on whose behalf an application is not filed by the last day of the month following the month during which the entity makes the determination referred to in subparagraph (A), such last day.

“(3)(A) Subject to subparagraph (B), the term ‘qualified entity’ means any entity that—

“(i)(I) is eligible for payments under a State plan approved under this title and provides items and services described in subsection (a) or (II) is authorized to determine

eligibility of a child to participate in a Head Start program under the Head Start Act (42 U.S.C. 9821 et seq.), eligibility of a child to receive child care services for which financial assistance is provided under the Child Care and Development Block Grant Act of 1990 (42 U.S.C. 9858 et seq.), eligibility of an infant or child to receive assistance under the special supplemental nutrition program for women, infants, and children (WIC) under section 17 of the Child Nutrition Act of 1966 (42 U.S.C. 1786); and

“(ii) is determined by the State agency to be capable of making determinations of the type described in paragraph (1)(A).

“(B) The Secretary may issue regulations further limiting those entities that may become qualified entities in order to prevent fraud and abuse and for other reasons.

“(C) Nothing in this section shall be construed as preventing a State from limiting the classes of entities that may become qualified entities, consistent with any limitations imposed under subparagraph (B).

“(c)(1) The State agency shall provide qualified entities with—

“(A) such forms as are necessary for an application to be made on behalf of a child for medical assistance under the State plan, and

“(B) information on how to assist parents, guardians, and other persons in completing and filing such forms.

“(2) A qualified entity that determines under subsection (b)(1)(A) that a child is presumptively eligible for medical assistance under a State plan shall—

“(A) notify the State agency of the determination within 5 working days after the date on which determination is made, and

“(B) inform the parent or custodian of the child at the time the determination is made that an application for medical assistance under the State plan is required to be made by not later than the last day of the month following the month during which the determination is made.

“(3) In the case of a child who is determined by a qualified entity to be presumptively eligible for medical assistance under a State plan, the parent, guardian, or other person shall make application on behalf of the child for medical assistance under such plan by not later than the last day of the month following the month during which the determination is made, which application may be the application used for the receipt of medical assistance by individuals described in section 1902(l)(1).

“(d) Notwithstanding any other provision of this title, medical assistance for items and services described in subsection (a) that—

“(1) are furnished to a child—

“(A) during a presumptive eligibility period,

“(B) by a entity that is eligible for payments under the State plan; and

“(2) are included in the care and services covered by a State plan;

shall be treated as medical assistance provided by such plan for purposes of section 1903.”.

(b) CONFORMING AMENDMENTS.—(1) Section 1902(a)(47) of such Act (42 U.S.C. 1396a(a)(47)) is amended by inserting before the semicolon at the end the following: “and provide for making medical assistance for items and services described in subsection (a) of section 1920A available to children during a presumptive eligibility period in accordance with such section”.

(2) Section 1903(u)(1)(D)(v) of such Act (42 U.S.C. 1396b(u)(1)(D)(v)) of such Act is amended by inserting before the period at the end the following: “or for items and services described in subsection (a) of section 1920A provided to a child during a presumptive eligibility period under such section”.

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

TITLE IV—COMMITTEE ON COMMERCE—MEDICARE

SEC. 4000. AMENDMENTS TO SOCIAL SECURITY ACT AND REFERENCES TO OBRA; TABLE OF CONTENTS OF TITLE.

(a) 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.

(b) 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 OF TITLE.—The table of contents of this title is as follows:

Sec. 4000. Amendments to Social Security Act and references to OBRA; table of contents of title.

Subtitle A—MedicarePlus Program

CHAPTER 1—MEDICAREPLUS PROGRAM

SUBCHAPTER A—MEDICAREPLUS PROGRAM

Sec. 4001. Establishment of MedicarePlus program.

“PART C—MEDICAREPLUS PROGRAM

“Sec. 1851. Eligibility, election, and enrollment.

“Sec. 1852. Benefits and beneficiary protections.

“Sec. 1853. Payments to MedicarePlus organizations.

“Sec. 1854. Premiums.

“Sec. 1855. Organizational and financial requirements for MedicarePlus organizations; provider-sponsored organizations.

“Sec. 1856. Establishment of standards.

“Sec. 1857. Contracts with MedicarePlus organizations.

“Sec. 1859. Definitions; miscellaneous provisions.

Sec. 4002. Transitional rules for current medicare HMO program.

Sec. 4003. Conforming changes in medigap program.

SUBCHAPTER B—SPECIAL RULES FOR MEDICAREPLUS MEDICAL SAVINGS ACCOUNTS

Sec. 4006. MedicarePlus MSA.

SUBCHAPTER C—GME, IME, AND DSH PAYMENTS FOR MANAGED CARE ENROLLEES

Sec. 4008. Graduate medical education and indirect medical education payments for managed care enrollees.

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Subtitle A—MedicarePlus Program

CHAPTER 1—MEDICAREPLUS PROGRAM

Subchapter A—MedicarePlus Program

SEC. 4001. ESTABLISHMENT OF MEDICAREPLUS 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—MEDICAREPLUS PROGRAM

“ELIGIBILITY, ELECTION, AND ENROLLMENT

“SEC. 1851. (a) CHOICE OF MEDICARE BENEFITS THROUGH MEDICAREPLUS PLANS.—

“(1) IN GENERAL.—Subject to the provisions of this section, each MedicarePlus eligible individual (as defined in paragraph (3)) is entitled to elect to receive benefits under this title—

“(A) through the medicare fee-for-service program under parts A and B, or

“(B) through enrollment in a MedicarePlus plan under this part.

“(2) TYPES OF MEDICAREPLUS PLANS THAT MAY BE AVAILABLE.—A MedicarePlus plan may be any of the following types of plans of health insurance:

“(A) COORDINATED CARE PLANS.—Coordinated care plans which provide health care services, including health maintenance organization plans and preferred provider organization plans.

“(B) PLANS OFFERED BY PROVIDER-SPONSORED ORGANIZATION.—A MedicarePlus plan offered by a provider-sponsored organization, as defined in section 1855(e).

“(C) COMBINATION OF MSA PLAN AND CONTRIBUTIONS TO MEDICAREPLUS MSA.—An MSA plan, as defined in section 1859(b)(2), and a contribution into a MedicarePlus medical savings account (MSA).

“(3) MEDICAREPLUS ELIGIBLE INDIVIDUAL.—

“(A) IN GENERAL.—In this title, subject to subparagraph (B), the term ‘MedicarePlus eligible individual’ means an individual who is entitled to benefits under part A and enrolled under part B.

“(B) SPECIAL RULE FOR END-STAGE RENAL DISEASE.—Such term shall not include an individual medically determined to have end-stage renal disease, except that an individual who develops end-stage renal disease while enrolled in a MedicarePlus plan may continue to be enrolled in that plan.

“(b) SPECIAL RULES.—

“(1) RESIDENCE REQUIREMENT.—

“(A) IN GENERAL.—Except as the Secretary may otherwise provide, an individual is eligible to elect a MedicarePlus plan offered by a MedicarePlus organization only if the organization serves the geographic area in which the individual resides.

“(B) CONTINUATION OF ENROLLMENT PERMITTED.—Pursuant to rules specified by the Secretary, the Secretary shall provide that an individual may continue enrollment in a plan, notwithstanding that the individual no longer resides in the service area of the plan, so long as the plan provides benefits for enrollees located in the area in which the individual resides.

“(2) SPECIAL RULE FOR CERTAIN INDIVIDUALS COVERED UNDER FEHBP OR ELIGIBLE FOR VETERANS OR MILITARY HEALTH BENEFITS, VETERANS.—

“(A) FEHBP.—An individual who is enrolled in a health benefit plan under chapter 89 of title 5, United States Code, is not eligible to enroll in an MSA plan until such time as the Director of the Office of Management and Budget certifies to the Secretary that the Office of Personnel Management has adopted policies which will ensure that the enrollment of such individuals in such plans will not result in increased expenditures for the Federal Government for health benefit plans under such chapter.

“(B) VA AND DOD.—The Secretary may apply rules similar to the rules described in subparagraph (A) in the case of individuals who are eligible for health care benefits under chapter 55 of title 10, United States Code, or under chapter 17 of title 38 of such Code.

“(3) LIMITATION ON ELIGIBILITY OF QUALIFIED MEDICARE BENEFICIARIES AND OTHER MEDICAID BENEFICIARIES TO ENROLL IN AN MSA PLAN.—An individual who is a qualified medicare beneficiary (as defined in section 1905(p)(1)), a qualified disabled and working individual (described in section 1905(s)), an individual described in section 1902(a)(10)(E)(iii), or otherwise entitled to medicare cost-sharing under a State plan under title XIX is not eligible to enroll in an MSA plan.

“(4) COVERAGE UNDER MSA PLANS ON A DEMONSTRATION BASIS.—

“(A) IN GENERAL.—An individual is not eligible to enroll in an MSA plan under this part—

“(i) on or after January 1, 2003, unless the enrollment is the continuation of such an enrollment in effect as of such date; or

“(ii) as of any date if the number of such individuals so enrolled as of such date has reached 500,000.

Under rules established by the Secretary, an individual is not eligible to enroll (or continue enrollment) in an MSA plan for a year unless the individual provides assurances satisfactory to the Secretary that the individual will reside in the United States for at least 183 days during the year.

“(B) EVALUATION.—The Secretary shall regularly evaluate the impact of permitting enrollment in MSA plans under this part on selection (including adverse selection), use of preventive care, access to care, and the financial status of the Trust Funds under this title.

“(C) REPORTS.—The Secretary shall submit to Congress periodic reports on the numbers of individuals enrolled in such plans and on the evaluation being conducted under subparagraph (B). The Secretary shall submit such a report, by not later than March 1, 2002, on whether the time limitation under subparagraph (A)(i) should be extended or removed and whether to change the numerical limitation under subparagraph (A)(ii).

“(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) COORDINATION THROUGH MEDICAREPLUS ORGANIZATIONS.—

“(A) ENROLLMENT.—Such process shall permit an individual who wishes to elect a MedicarePlus plan offered by a MedicarePlus 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 MedicarePlus plan offered by a MedicarePlus organization and who wishes to terminate such election, to terminate such election through the filing of an appropriate election form with the organization.

“(3) 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 medicare fee-for-service program option.

“(ii) SEAMLESS CONTINUATION OF COVERAGE.—The Secretary may establish procedures under which an individual who is enrolled in a health plan (other than MedicarePlus plan) offered by a MedicarePlus organization at the time of the initial election period and who fails to elect to receive coverage other than through the organization is deemed to have elected the MedicarePlus plan offered by the organization (or, if the organization offers more than one such plan, such plan or plans as the Secretary identifies under such procedures).

“(B) CONTINUING PERIODS.—An individual who has made (or is 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 MedicarePlus plan is discontinued, if the individual had elected such plan at the time of the discontinuation.

“(d) PROVIDING INFORMATION TO PROMOTE INFORMED CHOICE.—

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

“(2) PROVISION OF NOTICE.—

“(A) OPEN SEASON NOTIFICATION.—At least 30 days before the beginning of each annual, coordinated election period (as defined in subsection (e)(3)(B)), the Secretary shall mail to each MedicarePlus eligible individual residing in an area the following:

“(i) GENERAL INFORMATION.—The general information described in paragraph (3).

“(ii) LIST OF PLANS AND COMPARISON OF PLAN OPTIONS.—A list identifying the MedicarePlus plans that are (or will be) available to residents of the area and information described in paragraph (4) concerning such plans. Such information shall be presented in a comparative form.

“(iii) MEDICAREPLUS MONTHLY CAPITATION RATE.—The amount of the monthly MedicarePlus capitation rate for the area.

“(iv) ADDITIONAL INFORMATION.—Any other information that the Secretary determines will assist the individual in making the election under this section.

The mailing of such information shall be coordinated with the mailing of any annual notice under section 1804.

“(B) NOTIFICATION TO NEWLY MEDICAREPLUS ELIGIBLE INDIVIDUALS.—To the extent practicable, the Secretary shall, not later than 2 months before the beginning of the initial MedicarePlus enrollment period for an individual described in subsection (e)(1), mail to the individual the information described in subparagraph (A).

“(C) FORM.—The information disseminated under this paragraph shall be written and formatted using language that is easily understandable by medicare beneficiaries.

“(D) PERIODIC UPDATING.—The information described in subparagraph (A) shall be updated on at least an annual basis to reflect changes in the availability of MedicarePlus plans and the benefits and monthly premiums (and net monthly premiums) for such plans.

“(3) GENERAL INFORMATION.—General information under this paragraph, with respect to coverage under this part during a year, shall include the following:

“(A) BENEFITS UNDER FEE-FOR-SERVICE PROGRAM OPTION.—A general description of the benefits covered (and not covered) under the medicare fee-for-service program under parts A and B, including—

“(i) covered items and services,

“(ii) beneficiary cost sharing, such as deductibles, co-insurance, and copayment amounts, and

“(iii) any beneficiary liability for balance billing.

“(B) PART B PREMIUM.—The part B premium rates that will be charged for part B coverage.

“(C) ELECTION PROCEDURES.—Information and instructions on how to exercise election options under this section.

“(D) RIGHTS.—The general description of procedural rights (including grievance and appeals procedures) of beneficiaries under the medicare fee-for-service program and the MedicarePlus program and right to be protected against discrimination based on health status-related factors under section 1852(b).

“(E) INFORMATION ON MEDIGAP AND MEDICARE SELECT.—A general description of the benefits, enrollment rights, and other requirements applicable to medicare supplemental policies under section 1882 and provisions relating to medicare select policies described in section 1882(t).

“(F) POTENTIAL FOR CONTRACT TERMINATION.—The fact that a MedicarePlus organization may terminate or refuse to renew its contract under this part and the effect the termination or nonrenewal of its contract may have on individuals enrolled with the MedicarePlus plan under this part.

“(4) INFORMATION COMPARING PLAN OPTIONS.—Information under this paragraph, with respect to a MedicarePlus plan for a year, shall include the following:

“(A) BENEFITS.—The benefits covered (and not covered) under the plan, including—

“(i) covered items and services beyond those provided under the medicare fee-for-service program,

“(ii) any beneficiary cost sharing,

“(iii) any maximum limitations on out-of-pocket expenses,

“(iv) in the case of an MSA plan, differences in cost sharing under such a plan compared to under other MedicarePlus plans,

“(v) the use of provider networks and the restriction on payments for services furnished other than by other through the organization,

“(vi) the organization’s coverage of emergency and urgently needed care,

“(vii) the appeal and grievance rights of enrollees,

“(viii) number of grievances and appeals, and information on their disposition in the aggregate,

“(ix) procedures used by the organization to control utilization of services and expenditures, and

“(x) any exclusions in the types of providers participating in the plan’s network.

“(B) PREMIUMS.—The monthly premium (and net monthly premium), if any, for the plan.

“(C) SERVICE AREA.—The service area of the plan.

“(D) QUALITY AND PERFORMANCE.—To the extent available, plan quality and performance indicators for the benefits under the plan (and how they compare to such indicators under the medicare fee-for-service program under parts A and B in the area involved), including—

“(i) disenrollment rates for medicare enrollees electing to receive benefits through the plan for the previous 2 years (excluding disenrollment due to death or moving outside the plan’s service area),

“(ii) information on medicare enrollee satisfaction,

“(iii) information on health outcomes, and

“(iv) the recent record regarding compliance of the plan with requirements of this part (as determined by the Secretary).

“(E) SUPPLEMENTAL BENEFITS OPTIONS.—Whether the organization offering the plan offers optional supplemental benefits and the terms and conditions (including premiums) for such coverage.

“(5) MAINTAINING A TOLL-FREE NUMBER AND INTERNET SITE.—The Secretary shall maintain a toll-free number for inquiries regarding MedicarePlus options and the operation of this part in all areas in which MedicarePlus plans are offered and an Internet site through which individuals may electronically obtain information on such options and MedicarePlus plans.

“(6) USE OF NONFEDERAL ENTITIES.—The Secretary may enter into contracts with non-Federal entities to carry out activities under this subsection.

“(7) PROVISION OF INFORMATION.—A MedicarePlus organization shall provide the Secretary with such information on the organization and each MedicarePlus plan it offers as may be required for the preparation of the information referred to in paragraph (2)(A).

“(e) COVERAGE ELECTION PERIODS.—

“(1) INITIAL CHOICE UPON ELIGIBILITY TO MAKE ELECTION IF MEDICAREPLUS PLANS AVAILABLE TO INDIVIDUAL.—If, at the time an individual first becomes entitled to benefits under part A and enrolled under part B, there is one or more MedicarePlus plans offered in the area in which the individual resides, 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 such time. Such period shall be specified in a manner so that, in the case of an individual who elects a MedicarePlus plan during the period, coverage under the plan becomes effective as of the first date on which the individual may receive such coverage.

“(2) OPEN ENROLLMENT AND DISENROLLMENT OPPORTUNITIES.—Subject to paragraph (5)—

“(A) CONTINUOUS OPEN ENROLLMENT AND DISENROLLMENT THROUGH 2000.—At any time during 1998, 1999, and 2000, a MedicarePlus eligible individual may change the election under subsection (a)(1).

“(B) CONTINUOUS OPEN ENROLLMENT AND DISENROLLMENT FOR FIRST 6 MONTHS DURING 2001.—

“(i) IN GENERAL.—Subject to clause (ii), at any time during the first 6 months of 2001, or, if the individual first becomes a MedicarePlus eligible individual during 2001, during the first 6 months during 2001 in which the individual is a MedicarePlus eligible individual may change the election under subsection (a)(1).

“(ii) LIMITATION OF ONE CHANGE PER YEAR.—An individual may exercise the right under clause (i) only once during 2001. The limitation under this clause shall not apply to changes in elections effected during an annual, coordinated election period under paragraph (3) or during a special enrollment period under paragraph (4).

“(C) CONTINUOUS OPEN ENROLLMENT AND DISENROLLMENT FOR FIRST 3 MONTHS IN SUBSEQUENT YEARS.—

“(i) IN GENERAL.—Subject to clause (ii), at any time during the first 3 months of a year after 2001, or, if the individual first becomes a MedicarePlus eligible individual during a year after 2001, during the first 3 months of such year in which the individual is a MedicarePlus eligible individual, a MedicarePlus eligible individual may change the election under subsection (a)(1).

“(ii) LIMITATION OF ONE CHANGE PER YEAR.—An individual may exercise the right under clause (i) only once a year. The limitation under this clause shall not apply to changes in elections effected during an annual, coordinated election period under paragraph (3) or during a special enrollment period under paragraph (4).

“(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 an annual, coordinated election period.

“(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 2001), the month of October before such year.

“(C) MEDICAREPLUS HEALTH FAIRS.—In the month of October of each year (beginning with 1998), the Secretary shall provide for a nationally coordinated educational and publicity campaign to inform MedicarePlus eligible individuals about MedicarePlus plans and the election process provided under this section.

“(4) SPECIAL ELECTION PERIODS.—Effective as of January 1, 2001, an individual may discontinue an election of a MedicarePlus plan offered by a MedicarePlus organization other than during an annual, coordinated election period and make a new election under this section if—

“(A) the organization’s or plan’s certification under this part has been terminated or the organization has terminated or otherwise discontinued providing the plan;

“(B) the individual is no longer eligible to elect the plan 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 the individual’s enrollment on the basis described in clause (i) or (ii) of subsection (g)(3)(B));

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

“(i) the organization offering the plan substantially violated a material provision of the organization’s contract under this part in relation to the individual (including the failure to provide an enrollee on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide such covered care in accordance with applicable quality standards); or

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

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

“(5) SPECIAL RULES FOR MSA PLANS.—Notwithstanding the preceding provisions of this subsection, an individual—

“(A) may elect an MSA plan only during—

“(i) an initial open enrollment period described in paragraph (1),

“(ii) an annual, coordinated election period described in paragraph (3)(B), or

“(iii) the months of October 1998 and October 1999; and

“(B) may not discontinue an election of an MSA plan except during the periods described in clause (ii) or (iii) of subparagraph (A) and under paragraph (4).

“(f) EFFECTIVENESS OF ELECTIONS AND CHANGES OF ELECTIONS.—

“(1) DURING INITIAL COVERAGE ELECTION PERIOD.—An election of coverage made during the initial coverage election period under subsection (e)(1) 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 CONTINUOUS OPEN ENROLLMENT PERIODS.—An election or change of coverage made under subsection (e)(2) shall take effect with the first day of the first calendar month following the date on which the election is made.

“(3) ANNUAL, COORDINATED ELECTION PERIOD.—An election or change 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 or change of coverage made during any other period under subsection (e)(4) 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) GUARANTEED ISSUE AND RENEWAL.—

“(1) IN GENERAL.—Except as provided in this subsection, a MedicarePlus organization shall provide that at any time during which elections are accepted under this section with respect to a MedicarePlus plan 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 MedicarePlus organization, in relation to a MedicarePlus plan it offers, has a capacity limit and the number of MedicarePlus eligible individuals who elect the plan under this section exceeds the capacity limit, the organization may limit the election of individuals of the plan under this section but only if priority in election is provided—

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

“(B) then to other such individuals in such a manner that does not discriminate, on a basis described in section 1852(b), among the individuals (who seek to elect the plan).

The preceding sentence shall not apply if it would result in the enrollment of enrollees substantially nonrepresentative, as de-

terminated in accordance with regulations of the Secretary, of the medicare population in the service area of the plan.

“(3) LIMITATION ON TERMINATION OF ELECTION.—

“(A) IN GENERAL.—Subject to subparagraph (B), a MedicarePlus organization may not for any reason terminate the election of any individual under this section for a MedicarePlus plan it offers.

“(B) BASIS FOR TERMINATION OF ELECTION.—A MedicarePlus organization may terminate an individual’s election under this section with respect to a MedicarePlus plan it offers if—

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

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

“(iii) the plan is terminated with respect to all individuals under this part in the area in which the individual resides.

“(C) CONSEQUENCE OF TERMINATION.—

“(i) TERMINATIONS FOR CAUSE.—Any individual whose election is terminated under clause (i) or (ii) of subparagraph (B) is deemed to have elected the medicare fee-for-service program option described in subsection (a)(1)(A).

“(ii) TERMINATION BASED ON PLAN TERMINATION OR SERVICE AREA REDUCTION.—Any individual whose election is terminated under subparagraph (B)(iii) shall have a special election period under subsection (e)(4)(A) in which to change coverage to coverage under another MedicarePlus plan. Such an individual who fails to make an election during such period is deemed to have chosen to change coverage to the medicare fee-for-service program option described in subsection (a)(1)(A).

“(D) ORGANIZATION OBLIGATION WITH RESPECT TO ELECTION FORMS.—Pursuant to a contract under section 1857, each MedicarePlus organization receiving an election form under subsection (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.

“(h) APPROVAL OF MARKETING MATERIAL AND APPLICATION FORMS.—

“(1) SUBMISSION.—No marketing material or application form may be distributed by a MedicarePlus organization to (or for the use of) MedicarePlus eligible individuals unless—

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

“(B) the Secretary has not disapproved the distribution of such material or form.

“(2) REVIEW.—The standards established under section 1856 shall include guidelines for the review of all such material or form submitted and under such guidelines the Secretary shall disapprove (or later require the correction of) such material or form if the material or form is materially inaccurate or misleading or otherwise makes a material misrepresentation.

“(3) DEEMED APPROVAL (1-STOP SHOPPING).—In the case of material or form 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 material or form under paragraph (1)(B) with respect to a MedicarePlus plan in an area, the Secretary is deemed not to have disapproved such distribution in all other areas covered by the plan and organization except to the extent that such material or form is specific only to an area involved.

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

“(i) EFFECT OF ELECTION OF MEDICAREPLUS PLAN OPTION.—Subject to sections 1852(a)(5), 1857(f)(2), and 1857(g)—

“(1) payments under a contract with a MedicarePlus organization under section 1853(a) with respect to an individual electing a MedicarePlus plan offered by the organization 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, and

“(2) subject to subsections (e) and (f) of section 1853, only the MedicarePlus organization shall be entitled to receive payments from the Secretary under this title for services furnished to the individual.

“BENEFITS AND BENEFICIARY PROTECTIONS

“SEC. 1852. (a) BASIC BENEFITS.—

“(1) IN GENERAL.—Except as provided in section 1859(b)(2) for MSA plans, each MedicarePlus plan shall provide to members enrolled under this part, through providers and other persons that meet the applicable requirements of this title and part A of title XI—

“(A) those items and services for which benefits are available under parts A and B to individuals residing in the area served by the plan, and

“(B) additional benefits required under section 1854(f)(1)(A).

“(2) SATISFACTION OF REQUIREMENT.—A MedicarePlus plan (other than an MSA plan) offered by a MedicarePlus organization satisfies paragraph (1)(A), with respect to benefits for items and services furnished other than through a provider that has a contract with the organization offering the plan, if

the plan provides (in addition to any cost sharing provided for under the plan) for at least the total dollar amount of payment for such items and services as would otherwise be authorized under parts A and B (including any balance billing permitted under such parts).

“(3) SUPPLEMENTAL BENEFITS.—

“(A) BENEFITS INCLUDED SUBJECT TO SECRETARY’S APPROVAL.—Each MedicarePlus organization may provide to individuals enrolled under this part (without affording those individuals an option to decline the coverage) supplemental health care benefits that the Secretary may approve. The Secretary shall approve any such supplemental benefits unless the Secretary determines that including such supplemental benefits would substantially discourage enrollment by MedicarePlus eligible individuals with the organization.

“(B) AT ENROLLEES’ OPTION.—A MedicarePlus organization may provide to individuals enrolled under this part (other than under an MSA plan) supplemental health care benefits that the individuals may elect, at their option, to have covered.

“(4) ORGANIZATION AS SECONDARY PAYER.—Notwithstanding any other provision of law, a MedicarePlus organization may (in the case of the provision of items and services to an individual under a MedicarePlus plan 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 a law, plan, 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.

“(5) NATIONAL COVERAGE DETERMINATIONS.—If there is a national coverage determination made in the period beginning on the date of an announcement under section 1853(b) and ending on the date of the next announcement under such section and the Secretary projects that the determination will result in a significant change in the costs to a MedicarePlus organization of providing the benefits that are the subject of such national coverage determination and that such change in costs was not incorporated in the determination of the annual MedicarePlus capitation rate under section 1853 included in the announcement made at the beginning of such period—

“(A) such determination shall not apply to contracts under this part until the first contract year that begins after the end of such period, and

“(B) if such coverage determination provides for coverage of additional benefits or coverage under additional circumstances, section 1851(i) shall not apply to payment for such additional benefits or benefits provided under such additional circumstances until the first contract year that begins after the end of such period,

unless otherwise required by law.

“(b) ANTIDISCRIMINATION.—

“(1) IN GENERAL.—A MedicarePlus organization may not deny, limit, or condition the coverage or provision of benefits under this part, for individuals permitted to be enrolled with the organization under this part, based on any health status-related factor described in section 2702(a)(1) of the Public Health Service Act.

“(2) CONSTRUCTION.—Paragraph (1) shall not be construed as requiring a MedicarePlus organization to enroll individuals who are determined to have end-stage renal disease, except as provided under section 1851(a)(3)(B).

“(c) DETAILED DESCRIPTION OF PLAN PROVISIONS.—A MedicarePlus organization shall disclose, in clear, accurate, and standardized form to each enrollee with a MedicarePlus plan offered by the organization under this part at the time of enrollment and at least annually thereafter, the following information regarding such plan:

“(1) SERVICE AREA.—The plan’s service area.

“(2) BENEFITS.—Benefits offered (and not offered) under the plan offered, including information described in section 1851(d)(3)(A) and exclusions from coverage and, if it is an MSA plan, a comparison of benefits under such a plan with benefits under other MedicarePlus plans.

“(3) ACCESS.—The number, mix, and distribution of plan providers and any point-of-service option (including the supplemental premium for such option).

“(4) OUT-OF-AREA COVERAGE.—Out-of-area coverage provided by the plan.

“(5) EMERGENCY COVERAGE.—Coverage of emergency services and urgently needed care, including—

“(A) the appropriate use of emergency services, including use of the 911 telephone system or its local equivalent in emergency situations and an explanation of what constitutes an emergency situation;

“(B) the process and procedures of the plan for obtaining emergency services; and

“(C) the locations of (i) emergency departments, and (ii) other settings, in which plan physicians and hospitals provide emergency services and post-stabilization care..

“(6) SUPPLEMENTAL BENEFITS.—Supplemental benefits available from the organization offering the plan, including—

“(A) whether the supplemental benefits are optional,

“(B) the supplemental benefits covered, and

“(C) the premium price for the supplemental benefits.

“(7) PRIOR AUTHORIZATION RULES.—Rules regarding prior authorization or other review requirements that could result in nonpayment.

“(8) PLAN GRIEVANCE AND APPEALS PROCEDURES.—Any appeal or grievance rights and procedures.

“(9) QUALITY ASSURANCE PROGRAM.—A description of the organization’s quality assurance program under subsection (e).

“(d) ACCESS TO SERVICES.—

“(1) IN GENERAL.—A MedicarePlus organization offering a MedicarePlus plan may select the providers from whom the benefits under the plan are provided so long as—

“(A) the organization makes such benefits available and accessible to each individual electing the plan within the plan service area with reasonable promptness and in a manner which assures continuity in the provision of benefits;

“(B) when medically necessary in the opinion of the treating health care provider the organization makes such benefits available and accessible 24 hours a day and 7 days a week;

“(C) the plan 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 in the opinion of the treating health care provider and immediately required because of an unforeseen illness, injury, or condition, and it was not reasonable given the circumstances to obtain the services through the organization,

“(ii) the services were renal dialysis services and were provided other than through the organization because the individual was temporarily out of the plan’s service area, or

“(iii) the services are maintenance care or post-stabilization care covered under the guidelines established under paragraph (2);

“(D) the organization provides access to appropriate providers, including credentialed specialists, for treatment and services when such treatment and services are determined to be medically necessary in the professional opinion of the treating health care provider, in consultation with the individual; and

“(E) coverage is provided for emergency services (as defined in paragraph (3)) without regard to prior authorization or the emergency care provider’s contractual relationship with the organization.

“(2) GUIDELINES RESPECTING COORDINATION OF POST-STABILIZATION CARE.—A MedicarePlus plan shall comply with such guidelines as the Secretary may prescribe relating to promoting efficient and timely coordination of appropriate maintenance and post-stabilization care of an enrollee after the enrollee has been determined to be stable under section 1867.

“(3) DEFINITION OF EMERGENCY SERVICES.—In this subsection—

“(A) IN GENERAL.—The term ‘emergency services’ means, with respect to an individual enrolled with an organization, covered inpatient and outpatient services that—

“(i) are furnished by a provider that is qualified to furnish such services under this title, and

“(ii) are needed to evaluate or stabilize an emergency medical condition (as defined in subparagraph (B)).

“(B) EMERGENCY MEDICAL CONDITION BASED ON PRUDENT LAYPERSON.—The term ‘emergency medical condition’ means a medical condition manifesting itself by acute symptoms of sufficient severity such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in—

“(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,

“(ii) serious impairment to bodily functions, or

“(iii) serious dysfunction of any bodily organ or part.

“(4) DETERMINATION OF HOSPITAL LENGTH OF STAY.—

“(A) IN GENERAL.—A MedicarePlus organization shall cover the length of an inpatient hospital stay under this part as determined by the attending physician (or other attending health care provider to the extent permitted under State law) in consultation with the patient to be medically appropriate.

“(B) CONSTRUCTION.—Nothing in this paragraph shall be construed—

“(i) as requiring the provision of inpatient coverage if the attending physician (or other attending health care provider to the extent permitted under State law) and patient determine that a shorter period of hospital stay is medically appropriate, or

“(ii) as affecting the application of deductibles and coinsurance.

“(e) QUALITY ASSURANCE PROGRAM.—

“(1) IN GENERAL.—Each MedicarePlus organization must have arrangements, consistent with any regulation, for an ongoing quality assurance program for health care services it provides to individuals enrolled with MedicarePlus plans of the organization.

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

“(A) stress health outcomes and provide for the collection, analysis, and reporting of data (in accordance with a quality measurement system that the Secretary recognizes) that will permit measurement of outcomes and other indices of the quality of MedicarePlus plans and organizations;

“(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) monitor and evaluate high volume and high risk services and the care of acute and chronic conditions;

“(E) evaluate the continuity and coordination of care that enrollees receive;

“(F) have mechanisms to detect both underutilization and overutilization of services;

“(G) after identifying areas for improvement, establish or alter practice parameters;

“(H) take action to improve quality and assesses the effectiveness of such action through systematic followup;

“(I) make 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) be evaluated on an ongoing basis as to its effectiveness;

“(K) include measures of consumer satisfaction; and

“(L) provide the Secretary with such access to information collected as may be appropriate to monitor and ensure the quality of care provided under this part.

“(3) EXTERNAL REVIEW.—Each MedicarePlus organization shall, for each MedicarePlus plan it operates, have an agreement with an independent quality review and improvement organization approved by the Secretary to perform functions of the type described in sections 1154(a)(4)(B) and 1154(a)(14) with respect to services furnished by MedicarePlus plans for which payment is made under this title.

“(4) TREATMENT OF ACCREDITATION.—The Secretary shall provide that a MedicarePlus organization is deemed to meet requirements of paragraphs (1) through (3) of this subsection and subsection (h) (relating to confidentiality and accuracy of enrollee records) if the organization is accredited (and periodically reaccredited) by a private organization under a process that the Secretary has determined assures that the organization, as a condition of accreditation, applies and enforces standards with respect to the requirements involved that are no less stringent than the standards established under section 1856 to carry out the respective requirements.

“(f) COVERAGE DETERMINATIONS.—

“(1) DECISIONS ON NONEMERGENCY CARE.—A MedicarePlus organization shall make determinations regarding authorization requests for nonemergency care on a timely basis, depending on the urgency of the situation. The organization shall provide notice of any coverage denial, which notice shall include a statement of the reasons for the denial and a description of the grievance and appeals processes available.

“(2) RECONSIDERATIONS.—

“(A) IN GENERAL.—Subject to subsection (g)(4), a reconsideration of a determination of an organization denying coverage shall be made within 30 days of the date of receipt of medical information, but not later than 60 days after the date of the determination.

“(B) PHYSICIAN DECISION ON CERTAIN RECONSIDERATIONS.—A reconsideration relating to a determination to deny coverage based on a lack of medical necessity shall

be made only by a physician with appropriate expertise in the field of medicine which necessitates treatment who is other than a physician involved in the initial determination.

“(g) GRIEVANCES AND APPEALS.—

“(1) GRIEVANCE MECHANISM.—Each MedicarePlus 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 with MedicarePlus plans of the organization under this part.

“(2) APPEALS.—An enrollee with a MedicarePlus plan of a MedicarePlus 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 paragraph, 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) INDEPENDENT REVIEW OF COVERAGE DENIALS.—The Secretary shall contract with an independent, outside entity to review and resolve in a timely manner reconsiderations that affirm denial of coverage.

“(4) EXPEDITED DETERMINATIONS AND RECONSIDERATIONS.—

“(A) RECEIPT OF REQUESTS.—An enrollee in a MedicarePlus plan may request, either in writing or orally, an expedited determination or reconsideration by the MedicarePlus organization regarding a matter described in paragraph (2). The organization shall also permit the acceptance of such requests by physicians.

“(B) ORGANIZATION PROCEDURES.—

“(i) IN GENERAL.—The MedicarePlus organization shall maintain procedures for expediting organization determinations and reconsiderations when, upon request of an enrollee, the organization determines that the application of normal time frames for making a determination (or a reconsideration involving a determination) could seriously jeopardize the life or health of the enrollee or the enrollee’s ability to regain maximum function.

“(ii) TIMELY RESPONSE.—In an urgent case described in clause (i), the organization shall notify the enrollee (and the physician involved, as appropriate) of the de-

termination (or determination on the reconsideration) as expeditiously as the enrollee's health condition requires, but not later than 72 hours (or 24 hours in the case of a reconsideration) of the time of receipt of the request for the determination or reconsideration (or receipt of the information necessary to make the determination or reconsideration), or such longer period as the Secretary may permit in specified cases.

“(iii) SECRETARIAL REPORT.—The Secretary shall annually report publicly on the number and disposition of denials and appeals within each MedicarePlus organization, and those reviewed and resolved by the independent entities under this subsection.

“(h) CONFIDENTIALITY AND ACCURACY OF ENROLLEE RECORDS.—Each MedicarePlus organization shall establish procedures—

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

“(2) to maintain accurate and timely medical records and other health information for enrollees, and

“(3) to assure timely access of enrollees to their medical information.

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

“(j) RULES REGARDING PHYSICIAN PARTICIPATION.—

“(1) PROCEDURES.—Each MedicarePlus organization shall establish reasonable procedures relating to the participation (under an agreement between a physician and the organization) of physicians under MedicarePlus plans 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 such adverse decisions, including the presentation of information and views of the physician regarding such decision.

“(2) CONSULTATION IN MEDICAL POLICIES.—A MedicarePlus 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) PROHIBITING INTERFERENCE WITH PROVIDER ADVICE TO ENROLLEES.—

“(A) IN GENERAL.—Subject to subparagraphs (B) and (C), a MedicarePlus organization (in relation to an individual enrolled under a MedicarePlus plan offered by the organization under this part) shall not prohibit or otherwise restrict a covered health care professional (as defined in subparagraph (D)) from advising such an individual who is a patient of the professional about the health status of the individual or medical care or treatment for the individual's condition or disease, regardless of whether benefits for

such care or treatment are provided under the plan, if the professional is acting within the lawful scope of practice.

“(B) CONSCIENCE PROTECTION.—Subparagraph (A) shall not be construed as requiring a MedicarePlus plan to provide, reimburse for, or provide coverage of a counseling or referral service if the MedicarePlus organization offering the plan—

“(i) objects to the provision of such service on moral or religious grounds; and

“(ii) in the manner and through the written instrumentalities such MedicarePlus organization deems appropriate, makes available information on its policies regarding such service to prospective enrollees before or during enrollment and to enrollees within 90 days after the date that the organization or plan adopts a change in policy regarding such a counseling or referral service.

“(C) CONSTRUCTION.—Nothing in subparagraph (B) shall be construed to affect disclosure requirements under State law or under the Employee Retirement Income Security Act of 1974.

“(D) HEALTH CARE PROFESSIONAL DEFINED.—For purposes of this paragraph, the term ‘health care professional’ means a physician (as defined in section 1861(r)) or other health care professional if coverage for the professional’s services is provided under the MedicarePlus plan for the services of the professional. Such term includes a podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist and therapy assistant, speech-language pathologist, audiologist, registered or licensed practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified nurse-midwife), licensed certified social worker, registered respiratory therapist, and certified respiratory therapy technician.

“(4) LIMITATIONS ON HEALTH CARE PROVIDER INCENTIVE PLANS.—

“(A) IN GENERAL.—No MedicarePlus organization may operate any health care provider 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 health care provider or health care provider 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 health care provider or health care provider group at substantial financial risk (as determined by the Secretary) for services not provided by the health care provider or health care provider group, the organization—

“(I) provides stop-loss protection for the health care provider or group that is adequate and appro-

appropriate, based on standards developed by the Secretary that take into account the number of health care providers 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 health care provider or 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) HEALTH CARE PROVIDER INCENTIVE PLAN DEFINED.—In this paragraph, the term ‘health care provider incentive plan’ means any compensation arrangement between a MedicarePlus organization and a health care provider or health care provider 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.

“(C) HEALTH CARE PROVIDER DEFINED.—For the purposes of this paragraph, the term ‘health care provider’ has the meaning given the term ‘health care professional’ in paragraph (3)(D).

“(5) LIMITATION ON PROVIDER INDEMNIFICATION.—A MedicarePlus organization may not provide (directly or indirectly) for a provider (or group of providers) to indemnify the organization against any liability resulting from a civil action brought for any damage caused to an enrollee with a MedicarePlus plan of the organization under this part by the organization’s denial of medically necessary care.

“(6) LIMITATION ON NON-COMPETE CLAUSE.—A MedicarePlus organization may not (directly or indirectly) seek to enforce any contractual provision which prevents a provider whose contractual obligations to the organization for the provision of services through the organization have ended from joining or forming any competing MedicarePlus organization that is a provider-sponsored organization in the same area.

“(k) TREATMENT OF SERVICES FURNISHED BY CERTAIN PROVIDERS.—A physician or other entity (other than a provider of services) that does not have a contract establishing payment amounts for services furnished to an individual enrolled under this part with a MedicarePlus organization shall accept as payment in full for covered services under this title that are furnished to such an individual the amounts that the physician or other entity could collect if the individual were not so enrolled. Any penalty or other provision of law that applies to such a payment with respect to an individual entitled to benefits under this title (but not enrolled with a

MedicarePlus organization under this part) also applies with respect to an individual so enrolled.

“(l) DISCLOSURE OF USE OF DSH AND TEACHING HOSPITALS.—Each MedicarePlus organization shall provide the Secretary with information on—

“(1) the extent to which the organization provides inpatient and outpatient hospital benefits under this part—

“(A) through the use of hospitals that are eligible for additional payments under section 1886(d)(5)(F)(i) (relating to so-called DSH hospitals), or

“(B) through the use of teaching hospitals that receive payments under section 1886(h); and

“(2) the extent to which differences between payment rates to different hospitals reflect the disproportionate share percentage of low-income patients and the presence of medical residency training programs in those hospitals.

“(m) OUT-OF-NETWORK ACCESS.—If an organization offers to members enrolled under this section one plan which provides for coverage of services covered under parts A and B primarily through providers and other persons who are members of a network of providers and other persons who have entered into a contract with the organization to provide such services, nothing in this section shall be construed as preventing the organization from offering such members (at the time of enrollment) another plan which provides for coverage of such items which are not furnished through such network providers.

“(n) NON-PREEMPTION OF STATE LAW.—A State may establish or enforce requirements with respect to beneficiary protections in this section, but only if such requirements are more stringent than the requirements established under this section.

“(o) NONDISCRIMINATION IN SELECTION OF NETWORK HEALTH PROFESSIONALS.—

“(1) IN GENERAL.—A MedicarePlus organization offering a MedicarePlus plan offering network coverage shall not discriminate in selecting the members of its health professional network (or in establishing the terms and conditions for membership in such network) on the basis of the race, national origin, gender, age, or disability (other than a disability that impairs the ability of an individual to provide health care services or that may threaten the health of enrollees) of the health professional.

“(2) APPROPRIATE RANGE OF SERVICES.—A MedicarePlus organization shall not deny any health care professionals, based solely on the license or certification as applicable under State law, the ability to participate in providing covered health care services, or be reimbursed or indemnified by a network plan for providing such services under this part.

“(3) DEFINITIONS.—For purposes of this subsection:

“(A) NETWORK.—The term ‘network’ means, with respect to a MedicarePlus organization offering a MedicarePlus plan, the participating health professionals and providers through whom the organization provides health care items and services to enrollees.

“(B) NETWORK COVERAGE.—The term ‘network coverage’ means a MedicarePlus plan offered by a MedicarePlus organization that provides or arranges for the provision of health care items and services to enrollees through participating health professionals and providers.

“(C) PARTICIPATING.—The term ‘participating’ means, with respect to a health professional or provider, a health professional or provider that provides health care items and services to enrollees under network coverage under an agreement with the MedicarePlus organization offering the coverage.

“(p) SPECIAL RULE FOR UNRESTRICTED FEE-FOR-SERVICE MSA PLANS.—Subsections (j)(1) and (k) shall not apply to a MedicarePlus organization with respect to an MSA plan it offers if the plan does not limit the providers through whom benefits may be obtained under the plan.

“PAYMENTS TO MEDICAREPLUS ORGANIZATIONS

“SEC. 1853. (a) PAYMENTS TO ORGANIZATIONS.—

“(1) MONTHLY PAYMENTS.—

“(A) IN GENERAL.—Under a contract under section 1857 and subject to subsections (e) and (f), the Secretary shall make monthly payments under this section in advance to each MedicarePlus organization, with respect to coverage of an individual under this part in a MedicarePlus payment area for a month, in an amount equal to $\frac{1}{12}$ of the annual MedicarePlus capitation rate (as calculated under subsection (c)) with respect to that individual for that area, adjusted for such risk factors as age, disability status, gender, institutional status, 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 factors, if such changes will improve the determination of actuarial equivalence.

“(B) SPECIAL RULE FOR END-STAGE RENAL DISEASE.—The Secretary shall establish separate rates of payment to a MedicarePlus organization with respect to classes of individuals determined to have end-stage renal disease and enrolled in a MedicarePlus plan of the organization. Such rates of payment shall be actuarially equivalent to rates paid to other enrollees in the MedicarePlus payment area (or such other area as specified by the Secretary). In accordance with regulations, the Secretary shall provide for the application of the seventh sentence of section 1881(b)(7) to payments under this section covering the provision of renal dialysis treatment in the same manner as such sentence applies to composite rate payments described in such sentence.

“(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 MedicarePlus organization under a plan 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 information required to be disclosed under section 1852(c) at the time the individual enrolled with the organization.

“(3) ESTABLISHMENT OF RISK ADJUSTMENT FACTORS.—

“(A) REPORT.—The Secretary shall develop, and submit to Congress by not later than October 1, 1999, a report on a method of risk adjustment of payment rates under this section that accounts for variations in per capita costs based on health status. Such report shall include an evaluation of such method by an outside, independent actuary of the actuarial soundness of the proposal.

“(B) DATA COLLECTION.—In order to carry out this paragraph, the Secretary shall require MedicarePlus organizations (and eligible organizations with risk-sharing contracts under section 1876) to submit, for periods beginning on or after January 1, 1998, data regarding inpatient hospital services and other services and other information the Secretary deems necessary.

“(C) INITIAL IMPLEMENTATION.—The Secretary shall first provide for implementation of a risk adjustment methodology that accounts for variations in per capita costs based on health status and other demographic factors for payments by no later than January 1, 2000.

“(b) ANNUAL ANNOUNCEMENT OF PAYMENT RATES.—

“(1) ANNUAL ANNOUNCEMENT.—The Secretary shall annually determine, and shall announce (in a manner intended to provide notice to interested parties) not later than August 1 before the calendar year concerned—

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

“(B) the risk and other factors to be used in adjusting such rates under subsection (a)(1)(A) for payments for months in that year.

“(2) ADVANCE NOTICE OF METHODOLOGICAL CHANGES.—At least 45 days before making the announcement under para-

graph (1) for a year, the Secretary shall provide for notice to MedicarePlus organizations of proposed changes to be made in the methodology from the methodology and assumptions used in the previous announcement and shall provide such organizations an opportunity to comment on such proposed changes.

“(3) EXPLANATION OF ASSUMPTIONS.—In each announcement made under paragraph (1), the Secretary shall include an explanation of the assumptions and changes in methodology used in the announcement in sufficient detail so that MedicarePlus organizations can compute monthly adjusted MedicarePlus capitation rates for individuals in each MedicarePlus payment area which is in whole or in part within the service area of such an organization.

“(c) CALCULATION OF ANNUAL MEDICAREPLUS CAPITATION RATES.—

“(1) IN GENERAL.—For purposes of this part, each annual MedicarePlus capitation rate, for a MedicarePlus payment area for a contract year consisting of a calendar year, is equal to the largest of the amounts specified in the following subparagraphs (A), (B), or (C):

“(A) BLENDED CAPITATION RATE.—The sum of—

“(i) area-specific percentage for the year (as specified under paragraph (2) for the year) of the annual area-specific MedicarePlus capitation rate for the year for the MedicarePlus payment area, as determined under paragraph (3), and

“(ii) national percentage (as specified under paragraph (2) for the year) of the input-price-adjusted annual national MedicarePlus capitation rate for the year, as determined under paragraph (4),

multiplied by the payment adjustment factors described in subparagraphs (A) and (B) of paragraph (5).

“(B) MINIMUM AMOUNT.—12 multiplied by the following amount:

“(i) For 1998, \$350 (but not to exceed, in the case of an area outside the 50 States and the District of Columbia, 150 percent of the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) for the area).

“(ii) For a succeeding year, the minimum amount specified in this clause (or clause (i)) for the preceding year increased by the national per capita MedicarePlus growth percentage, specified under paragraph (6) for that succeeding year.

“(C) MINIMUM PERCENTAGE INCREASE.—

“(i) For 1998, the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) for the MedicarePlus payment area.

“(ii) For 1999 and 2000, 101 percent of the annual MedicarePlus capitation rate under this paragraph for the area for the previous year.

“(iii) For a subsequent year, 102 percent of the annual MedicarePlus capitation rate under this paragraph for the area for the previous year.

“(2) AREA-SPECIFIC AND NATIONAL PERCENTAGES.—For purposes of paragraph (1)(A)—

“(A) for 1998, the ‘area-specific percentage’ is 90 percent and the ‘national percentage’ is 10 percent,

“(B) for 1999, the ‘area-specific percentage’ is 85 percent and the ‘national percentage’ is 15 percent,

“(C) for 2000, the ‘area-specific percentage’ is 80 percent and the ‘national percentage’ is 20 percent,

“(D) for 2001, the ‘area-specific percentage’ is 75 percent and the ‘national percentage’ is 25 percent, and

“(E) for a year after 2001, the ‘area-specific percentage’ is 70 percent and the ‘national percentage’ is 30 percent.

“(3) ANNUAL AREA-SPECIFIC MEDICAREPLUS CAPITATION RATE.—

“(A) IN GENERAL.—For purposes of paragraph (1)(A), subject to subparagraph (B), the annual area-specific MedicarePlus capitation rate for a MedicarePlus payment area—

“(i) for 1998 is the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) for the area, increased by the national per capita MedicarePlus growth percentage for 1998 (as defined in paragraph (6)); or

“(ii) for a subsequent year is the annual area-specific MedicarePlus capitation rate for the previous year determined under this paragraph for the area, increased by the national per capita MedicarePlus growth percentage for such subsequent year.

“(B) REMOVAL OF MEDICAL EDUCATION AND DISPROPORTIONATE SHARE HOSPITAL PAYMENTS FROM CALCULATION OF ADJUSTED AVERAGE PER CAPITA COST.—

“(i) IN GENERAL.—In determining the area-specific MedicarePlus capitation rate under subparagraph (A), for a year (beginning with 1998), the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) shall be adjusted to exclude from the rate the applicable percent (specified in clause (ii)) of the payment adjustments described in subparagraph (C).

“(ii) APPLICABLE PERCENT.—For purposes of clause (i), the applicable percent for—

“(I) 1998 is 20 percent,

“(II) 1999 is 40 percent,

“(III) 2000 is 60 percent,

“(IV) 2001 is 80 percent, and

“(V) a succeeding year is 100 percent.

“(C) PAYMENT ADJUSTMENT.—The payment adjustments described in this subparagraph are payment adjustments which the Secretary estimates were payable during 1997—

“(i) under section 1886(d)(5)(F) for hospitals serving a disproportionate share of low-income patients,

“(ii) for the indirect costs of medical education under section 1886(d)(5)(B), and

“(iii) for direct graduate medical education costs under section 1886(h), multiplied by a ratio (estimated by the Secretary) of total payments under subsection (h) and section 1858 in 1998 to payments under such subsection and payments under such section in such year for hospitals not reimbursed under section 1814(b)(3).

“(4) INPUT-PRICE-ADJUSTED ANNUAL NATIONAL MEDICAREPLUS CAPITATION RATE.—

“(A) IN GENERAL.—For purposes of paragraph (1)(A), the input-price-adjusted annual national MedicarePlus capitation rate for a MedicarePlus 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 service) of—

“(i) the national standardized annual MedicarePlus 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 ANNUAL MEDICAREPLUS CAPITATION RATE.—In subparagraph (A)(i), the ‘national standardized annual MedicarePlus capitation rate’ for a year is equal to—

“(i) the sum (for all MedicarePlus payment areas) of the product of—

“(I) the annual area-specific MedicarePlus capitation rate for that year for the area under paragraph (3), and

“(II) the average number of medicare beneficiaries residing in that area in the year, multiplied by the average of the risk factor weights used to adjust payments under subsection (a)(1)(A) for such beneficiaries in such area; divided by

“(ii) the sum of the products described in clause (i)(II) for all areas for that year.

“(C) SPECIAL RULES FOR 1998.—In applying this paragraph for 1998—

“(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)—

“(I) for part A services shall be the ratio (expressed as a percentage) of the national average annual per capita rate of payment for part A for

1997 to the total national average annual per capita rate of payment for parts A and B for 1997, and

“(II) for part B services shall be 100 percent minus the ratio described in subclause (I);

“(iii) for 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, 40 percent shall be adjusted by the index described in clause (iii); and

“(v) the index values shall be computed based only on the beneficiary population who are 65 years of age or older and who are not determined to have end stage renal disease.

The Secretary may continue to apply the rules described in this subparagraph (or similar rules) for 1999.

“(5) PAYMENT ADJUSTMENT BUDGET NEUTRALITY FACTORS.—

For purposes of paragraph (1)(A)—

“(A) BLENDED RATE PAYMENT ADJUSTMENT FACTOR.—For each year, the Secretary shall compute a blended rate payment adjustment factor such that, not taking into account subparagraphs (B) and (C) of paragraph (1) and the application of the payment adjustment factor described in subparagraph (B) but taking into account paragraph (7), the aggregate of the payments that would be made under this part is equal to the aggregate payments that would have been made under this part (not taking into account such subparagraphs and such other adjustment factor) if the area-specific percentage under paragraph (1) for the year had been 100 percent and the national percentage had been 0 percent.

“(B) FLOOR-AND-MINIMUM-UPDATE PAYMENT ADJUSTMENT FACTOR.—For each year, the Secretary shall compute a floor-and-minimum-update payment adjustment factor so that, taking into account the application of the blended rate payment adjustment factor under subparagraph (A) and subparagraphs (B) and (C) of paragraph (1) and the application of the adjustment factor under this subparagraph, the aggregate of the payments under this part shall not exceed the aggregate payments that would have been made under this part if subparagraphs (B) and (C) of paragraph (1) did not apply and if the floor-and-minimum-update payment adjustment factor under this subparagraph was 1.

“(6) NATIONAL PER CAPITA MEDICAREPLUS GROWTH PERCENTAGE DEFINED.—

“(A) IN GENERAL.—In this part, the ‘national per capita MedicarePlus growth percentage’ for a year is the percentage determined by the Secretary, by April 30th before the beginning of the year involved, to reflect the Secretary’s estimate of the projected per capita rate of growth in expenditures under this title for an individual entitled to benefits under part A and enrolled under part B, reduced by the number of percentage points specified in subparagraph (B) for the year. Separate determinations may be made for aged enrollees, disabled enrollees, and enrollees with end-stage renal disease. Such percentage shall include an adjustment for over or under projection in the growth percentage for previous years.

“(B) ADJUSTMENT.—The number of percentage points specified in this subparagraph is—

- “(i) for 1998, 0.5 percentage points,
- “(ii) for 1999, 0.5 percentage points,
- “(iii) for 2000, 0.5 percentage points,
- “(iv) for 2001, 0.5 percentage points,
- “(v) for 2002, 0.5 percentage points, and
- “(vi) for a year after 2002, 0 percentage points.

“(7) TREATMENT OF AREAS WITH HIGHLY VARIABLE PAYMENT RATES.—In the case of a MedicarePlus payment area for which the annual per capita rate of payment determined under section 1876(a)(1)(C) for 1997 varies by more than 20 percent from such rate for 1996, for purposes of this subsection the Secretary may substitute for such rate for 1997 a rate that is more representative of the costs of the enrollees in the area.

“(d) MEDICAREPLUS PAYMENT AREA DEFINED.—

“(1) IN GENERAL.—In this part, except as provided in paragraph (3), the term ‘MedicarePlus payment area’ means a county, or equivalent area specified by the Secretary.

“(2) RULE FOR ESRD BENEFICIARIES.—In the case of individuals who are determined to have end stage renal disease, the MedicarePlus payment area shall be a State or such other payment area as the Secretary specifies.

“(3) GEOGRAPHIC ADJUSTMENT.—

“(A) IN GENERAL.—Upon written request of the chief executive officer of a State for a contract year (beginning after 1998) made at least 7 months before the beginning of the year, the Secretary shall make a geographic adjustment to a MedicarePlus payment area in the State otherwise determined under paragraph (1)—

- “(i) to a single statewide MedicarePlus payment area,
- “(ii) to the metropolitan based system described in subparagraph (C), or
- “(iii) to consolidating into a single MedicarePlus payment area noncontiguous counties (or equivalent areas described in paragraph (1)) within a State.

Such adjustment shall be effective for payments for months beginning with January of the year following the year in which the request is received.

“(B) BUDGET NEUTRALITY ADJUSTMENT.—In the case of a State requesting an adjustment under this paragraph, the Secretary shall adjust the payment rates otherwise established under this section for MedicarePlus payment areas in the State in a manner so that the aggregate of the payments under this section in the State shall not exceed the aggregate payments that would have been made under this section for MedicarePlus payment areas in the State in the absence of the adjustment under this paragraph.

“(C) METROPOLITAN BASED SYSTEM.—The metropolitan based system described in this subparagraph is one in which—

“(i) all the portions of each metropolitan statistical area in the State or in the case of a consolidated metropolitan statistical area, all of the portions of each primary metropolitan statistical area within the consolidated area within the State, are treated as a single MedicarePlus payment area, and

“(ii) all areas in the State that do not fall within a metropolitan statistical area are treated as a single MedicarePlus payment area.

“(D) AREAS.—In subparagraph (C), the terms ‘metropolitan statistical area’, ‘consolidated metropolitan statistical area’, and ‘primary metropolitan statistical area’ mean any area designated as such by the Secretary of Commerce.

“(e) SPECIAL RULES FOR INDIVIDUALS ELECTING MSA PLANS.—

“(1) IN GENERAL.—If the amount of the monthly premium for an MSA plan for a MedicarePlus payment area for a year is less than $\frac{1}{12}$ of the annual MedicarePlus capitation rate applied under this section for the area and year involved, the Secretary shall deposit an amount equal to 100 percent of such difference in a MedicarePlus MSA established (and, if applicable, designated) by the individual under paragraph (2).

“(2) ESTABLISHMENT AND DESIGNATION OF MEDICAREPLUS MEDICAL SAVINGS ACCOUNT AS REQUIREMENT FOR PAYMENT OF CONTRIBUTION.—In the case of an individual who has elected coverage under an MSA plan, no payment shall be made under paragraph (1) 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 MedicarePlus MSA (as defined in section 138(b)(2) of the Internal Revenue Code of 1986), and

“(B) if the individual has established more than one such MedicarePlus MSA, has designated one of such accounts as the individual’s MedicarePlus 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 an MSA plan effective beginning with a month in a year, the amount of the contribution to the MedicarePlus 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.

“(f) PAYMENTS FROM TRUST FUND.—The payment to a MedicarePlus organization under this section for individuals enrolled under this part with the organization and payments to a MedicarePlus MSA under subsection (e)(1) 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. Monthly payments otherwise payable under this section for October 2001 shall be paid on the last business day of September 2001.

“(g) SPECIAL RULE FOR CERTAIN INPATIENT HOSPITAL STAYS.—In the case of an individual who is receiving inpatient hospital services from a subsection (d) hospital (as defined in section 1886(d)(1)(B)) as of the effective date of the individual’s—

“(1) election under this part of a MedicarePlus plan offered by a MedicarePlus organization—

“(A) payment for such services until the date of the individual’s discharge shall be made under this title through the MedicarePlus plan or the medicare fee-for-service program option described in section 1851(a)(1)(A) (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 MedicarePlus 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 MedicarePlus 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.

“PREMIUMS

“SEC. 1854. (a) SUBMISSION AND CHARGING OF PREMIUMS.—

“(1) IN GENERAL.—Subject to paragraph (3), each MedicarePlus 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 premium for coverage for services under section 1852(a) under each MedicarePlus plan it offers under this part in each MedicarePlus payment area (as defined in section 1853(d)) in which the plan is being offered; and

“(B) the enrollment capacity in relation to the plan in each such area.

“(2) TERMINOLOGY.—In this part—

“(A) the term ‘monthly premium’ means, with respect to a MedicarePlus plan offered by a MedicarePlus organization, the monthly premium filed under paragraph (1), not taking into account the amount of any payment made toward the premium under section 1853; and

“(B) the term ‘net monthly premium’ means, with respect to such a plan and an individual enrolled with the plan, the premium (as defined in subparagraph (A)) for the plan reduced by the amount of payment made toward such premium under section 1853.

“(b) MONTHLY PREMIUM CHARGED.—The monthly amount of the premium charged by a MedicarePlus organization for a MedicarePlus plan offered in a MedicarePlus payment area to an individual under this part shall be equal to the net monthly premium plus any monthly premium charged in accordance with subsection (e)(2) for supplemental benefits.

“(c) UNIFORM PREMIUM.—The monthly premium and monthly amount charged under subsection (b) of a MedicarePlus organization under this part may not vary among individuals who reside in the same MedicarePlus payment area.

“(d) TERMS AND CONDITIONS OF IMPOSING PREMIUMS.—Each MedicarePlus organization shall permit the payment of net monthly premiums on a monthly basis and may terminate election of individuals for a MedicarePlus plan for failure to make premium payments only in accordance with section 1851(g)(3)(B)(i). A MedicarePlus organization is not authorized to provide for cash or other monetary rebates as an inducement for enrollment or otherwise.

“(e) LIMITATION ON ENROLLEE COST-SHARING.—

“(1) FOR BASIC AND ADDITIONAL BENEFITS.—Except as provided in paragraph (2), in no event may—

“(A) the net monthly premium (multiplied by 12) and the actuarial value of the deductibles, coinsurance, and copayments applicable on average to individuals enrolled under this part with a MedicarePlus plan of an organization with respect to required benefits described in section 1852(a)(1) and additional benefits (if any) required under subsection (f)(1) for a year, exceed

“(B) the actuarial value of the deductibles, coinsurance, and copayments that would be applicable on average to individuals entitled to benefits under part A and enrolled under part B if they were not members of a MedicarePlus organization for the year.

“(2) FOR SUPPLEMENTAL BENEFITS.—If the MedicarePlus organization provides to its members enrolled under this part supplemental benefits described in section 1852(a)(3), the sum of the monthly premium rate (multiplied by 12) charged for such supplemental benefits and the actuarial value of its deductibles, coinsurance, and copayments charged with respect to such benefits may not exceed the adjusted community rate for such benefits (as defined in subsection (f)(4)).

“(3) EXCEPTION FOR MSA PLANS.—Paragraphs (1) and (2) do not apply to an MSA plan.

“(4) DETERMINATION ON OTHER BASIS.—If the Secretary determines that adequate data are not available to determine the actuarial value under paragraph (1)(A) or (2), the Secretary may determine such amount with respect to all individuals in the MedicarePlus payment area, the State, or in the United States, eligible to enroll in the MedicarePlus plan involved under this part or on the basis of other appropriate data.

“(f) REQUIREMENT FOR ADDITIONAL BENEFITS.—

“(1) REQUIREMENT.—

“(A) IN GENERAL.—Each MedicarePlus organization (in relation to a MedicarePlus plan it offers) shall provide that if there is an excess amount (as defined in subparagraph (B)) for the plan 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) in a 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 plan, is the amount (if any) by which—

“(i) the average of the capitation payments made to the organization under section 1853 for the plan at the beginning of contract year, exceeds

“(ii) the actuarial value of the required benefits described in section 1852(a)(1) under the plan for individuals under this part, as determined based upon an adjusted community rate described in paragraph (4) (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 plan, is the excess amount reduced to reflect any amount withheld and reserved for the organization for the year under paragraph (2).

“(D) NO APPLICATION TO MSA PLANS.—Subparagraph (A) shall not apply to an MSA plan.

“(E) UNIFORM APPLICATION.—This paragraph shall be applied uniformly for all enrollees for a plan in a MedicarePlus payment area.

“(F) CONSTRUCTION.—Nothing in this subsection shall be construed as preventing a MedicarePlus organization from providing health care benefits that are in addition to the benefits otherwise required to be provided under this para-

graph and from imposing a premium for such additional benefits.

“(2) STABILIZATION FUND.—A MedicarePlus organization may provide that a part of the value of an excess 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 offered in those subsequent periods by the organization in accordance with such paragraph. Any of such value of the amount reserved which is not provided as additional benefits described in paragraph (1)(A) to individuals electing the MedicarePlus plan of the organization in accordance with such paragraph prior to the end of such periods, shall revert for the use of such trust funds.

“(3) 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.

“(4) 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 MedicarePlus organization, either—

“(i) the rate of payment for that service or services which the Secretary annually determines would apply to an individual electing a MedicarePlus plan 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 plan (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 MedicarePlus coverage, or MedicarePlus eligible individuals in the area, in the State, or in the United States, eligible to elect MedicarePlus 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 MedicarePlus organization that is a provider-sponsored organization, the adjusted community rate under subparagraph (A) for a MedicarePlus plan of the organization 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 plan.

“(g) PERIODIC AUDITING.—The Secretary shall provide for the annual auditing of the financial records (including data relating to medicare utilization, costs, and computation of the adjusted community rate) of at least one-third of the MedicarePlus organizations offering MedicarePlus plans under this part. The Comptroller General shall monitor auditing activities conducted under this subsection.

“(h) PROHIBITION OF STATE IMPOSITION OF PREMIUM TAXES.—No State may impose a premium tax or similar tax with respect to premiums on MedicarePlus plans or the offering of such plans.

“ORGANIZATIONAL AND FINANCIAL REQUIREMENTS FOR MEDICAREPLUS ORGANIZATIONS; PROVIDER-SPONSORED ORGANIZATIONS

“SEC. 1855. (a) ORGANIZED AND LICENSED UNDER STATE LAW.—

“(1) IN GENERAL.—Subject to paragraphs (2) and (3), a MedicarePlus organization shall be organized and licensed under State law as a risk-bearing entity eligible to offer health insurance or health benefits coverage in each State in which it offers a MedicarePlus plan.

“(2) SPECIAL EXCEPTION FOR PROVIDER-SPONSORED ORGANIZATIONS.—

“(A) IN GENERAL.—In the case of a provider-sponsored organization that seeks to offer a MedicarePlus plan in a State, the Secretary shall waive the requirement of paragraph (1) that the organization be licensed in that State if—

“(i) the organization files an application for such waiver with the Secretary, and

“(ii) the Secretary determines, based on the application and other evidence presented to the Secretary, that any of the grounds for approval of the application described in subparagraph (B), (C), or (D) has been met.

“(B) FAILURE TO ACT ON LICENSURE APPLICATION ON A TIMELY BASIS.—A ground for approval of such a waiver application is that the State has failed to complete action on a licensing application of the organization within 90 days of the date of the State’s receipt of the application. No period before the date of the enactment of this section shall be included in determining such 90-day period.

“(C) DENIAL OF APPLICATION BASED ON DISCRIMINATORY TREATMENT.—A ground for approval of such a waiver application is that the State has denied such a licensing application and—

“(i) the State has imposed documentation or information requirements not related to solvency requirements that are not generally applicable to other entities engaged in substantially similar business, or

“(ii) the standards or review process imposed by the State as a condition of approval of the license imposes any material requirements, procedures, or standards (other than requirements and standards relating to solvency) to such organizations that are not generally applicable to other entities engaged in substantially similar business.

“(D) DENIAL OF APPLICATION BASED ON APPLICATION OF SOLVENCY REQUIREMENTS.—A ground for approval of such a waiver application is that the State has denied such a licensing application based (in whole or in part) on the organization’s failure to meet applicable solvency requirements and—

“(i) such requirements are not the same as the solvency standards established under section 1856(a); or

“(ii) the State has imposed as a condition of approval of the license any documentation or information requirements relating to solvency or other material requirements, procedures, or standards relating to solvency that are different from the requirements, procedures, and standards applied by the Secretary under subsection (d)(2).

For purposes of this subparagraph, the term ‘solvency requirements’ means requirements relating to solvency and other matters covered under the standards established under section 1856(a).

“(E) TREATMENT OF WAIVER.—Subject to section 1852(m), in the case of a waiver granted under this paragraph for a provider-sponsored organization—

“(i) the waiver shall be effective for a 36-month period, except it may be renewed based on a subsequent application filed during the last 6 months of such period,

“(ii) the waiver is conditioned upon the pendency of the licensure application during the period the waiver is in effect, and

“(iii) any provisions of State law which relate to the licensing of the organization and which prohibit the organization from providing coverage pursuant to a contract under this part shall be superseded.

Nothing in this subparagraph shall be construed as limiting the number of times such a waiver may be renewed. Nothing in clause (iii) shall be construed as waiving any provision of State law which relates to quality of care or consumer protection (and does not relate to solvency standards) and which is imposed on a uniform basis and is generally applicable to other entities engaged in substantially similar business.

“(F) PROMPT ACTION ON APPLICATION.—The Secretary shall grant or deny such a waiver application within 60

days after the date the Secretary determines that a substantially complete application has been filed. Nothing in this section shall be construed as preventing an organization which has had such a waiver application denied from submitting a subsequent waiver application.

“(3) EXCEPTION IF REQUIRED TO OFFER MORE THAN MEDICAREPLUS PLANS.—Paragraph (1) shall not apply to a MedicarePlus organization in a State if the State requires the organization, as a condition of licensure, to offer any product or plan other than a MedicarePlus plan.

“(4) LICENSURE DOES NOT SUBSTITUTE FOR OR CONSTITUTE CERTIFICATION.—The fact that an organization is licensed in accordance with paragraph (1) does not deem the organization to meet other requirements imposed under this part.

“(b) PREPAID PAYMENT.—A MedicarePlus organization shall be compensated (except for premiums, deductibles, coinsurance, and copayments) for the provision of health care services to enrolled members under the contract under this part 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.

“(c) ASSUMPTION OF FULL FINANCIAL RISK.—The MedicarePlus organization shall assume full financial risk on a prospective basis for the provision of the health care services (except, at the election of the organization, 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.

“(d) CERTIFICATION OF PROVISION AGAINST RISK OF INSOLVENCY FOR UNLICENSED PSOS.—

“(1) IN GENERAL.—Each MedicarePlus organization that is a provider-sponsored organization, that is not licensed by a State under subsection (a), and for which a waiver application has been approved under subsection (a)(2), shall meet standards established under section 1856(a) relating to the financial solvency and capital adequacy of the organization.

“(2) CERTIFICATION PROCESS FOR SOLVENCY STANDARDS FOR PSOS.—The Secretary shall establish a process for the receipt and approval of applications of a provider-sponsored organization described in paragraph (1) for certification (and periodic recertification) of the organization as meeting such solvency standards. Under such process, the Secretary shall act upon such an application not later than 60 days after the date the application has been received.

“(e) PROVIDER-SPONSORED ORGANIZATION DEFINED.—

“(1) IN GENERAL.—In this part, the term ‘provider-sponsored organization’ means a public or private entity—

“(A) that is established or organized by a health care provider, or group of affiliated health care providers,

“(B) that provides a substantial proportion (as defined by the Secretary in accordance with paragraph (2)) of the health care items and services under the contract under this part directly through the provider or affiliated group of providers, and

“(C) with respect to which those affiliated providers that share, directly or indirectly, substantial financial risk with respect to the provision of such items and services have at least a majority financial interest in the entity.

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

“(A) shall take into account (i) the need for such an organization to assume responsibility for a substantial proportion of services in order to assure financial stability and (ii) 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) both providers are part of a controlled group of corporations under section 1563 of the Internal Revenue Code of 1986, or

“(C) 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.

“(5) HEALTH CARE PROVIDER DEFINED.—In this subsection, the term ‘health care provider’ means—

“(A) any individual who is engaged in the delivery of health care services in a State and who 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, and

“(B) any entity that is engaged in the delivery of health care services in a State and that, if it 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, is so licensed.

“(6) REGULATIONS.—The Secretary shall issue regulations to carry out this subsection.

“ESTABLISHMENT OF STANDARDS

“SEC. 1856. (a) ESTABLISHMENT OF SOLVENCY STANDARDS FOR PROVIDER-SPONSORED ORGANIZATIONS.—

“(1) ESTABLISHMENT.—

“(A) IN GENERAL.—The Secretary shall establish, on an expedited basis and using a negotiated rulemaking process under subchapter III of chapter 5 of title 5, United States Code, standards described in section 1855(d)(1) (relating to the financial solvency and capital adequacy of the organization) that entities must meet to qualify as provider-sponsored organizations under this part.

“(B) FACTORS TO CONSIDER FOR SOLVENCY STANDARDS.—In establishing solvency standards under subparagraph (A) for provider-sponsored organizations, the Secretary shall consult with interested parties and shall take into account—

“(i) the delivery system assets of such an organization and ability of such an organization to provide services directly to enrollees through affiliated providers, and

“(ii) alternative means of protecting against insolvency, including reinsurance, unrestricted surplus, letters of credit, guarantees, organizational insurance coverage, partnerships with other licensed entities, and valuation attributable to the ability of such an organization to meet its service obligations through direct delivery of care.

“(C) ENROLLEE PROTECTION AGAINST INSOLVENCY.—Such standards shall include provisions to prevent enrollees from being held liable to any person or entity for the MedicarePlus organization’s debts in the event of the organization’s insolvency.

“(2) PUBLICATION OF NOTICE.—In carrying out the rulemaking process under this subsection, the Secretary, after consultation with the National Association of Insurance Commissioners, the American Academy of Actuaries, organizations representative of medicare beneficiaries, and other interested parties, shall publish the notice provided for under section 564(a) of title 5, United States Code, by not later than 45 days after the date of the enactment of this section.

“(3) TARGET DATE FOR PUBLICATION OF RULE.—As part of the notice under paragraph (2), and for purposes of this subsection, the ‘target date for publication’ (referred to in section 564(a)(5) of such title) shall be April 1, 1998.

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

“(5) APPOINTMENT OF NEGOTIATED RULEMAKING COMMITTEE AND FACILITATOR.—The Secretary shall provide for—

“(A) the appointment of a negotiated rulemaking committee under section 565(a) of such title by not later than 30 days after the end of the comment period provided for under section 564(c) of such title (as shortened under paragraph (4)), and

“(B) the nomination of a facilitator under section 566(c) of such title by not later than 10 days after the date of appointment of the committee.

“(6) PRELIMINARY COMMITTEE REPORT.—The negotiated rulemaking committee appointed under paragraph (5) shall report to the Secretary, by not later than January 1, 1998, regarding the committee’s progress on achieving a consensus with regard to the rulemaking proceeding and whether such consensus is likely to occur before one month before the target date for publication of the rule. If the committee reports that the committee has failed to make significant progress towards such consensus or is unlikely to reach such consensus by the target date, the Secretary may terminate such process and provide for the publication of a rule under this subsection through such other methods as the Secretary may provide.

“(7) FINAL COMMITTEE REPORT.—If the committee is not terminated under paragraph (6), the rulemaking committee shall submit a report containing a proposed rule by not later than one month before the target date of publication.

“(8) INTERIM, FINAL EFFECT.—The Secretary shall publish a rule under this subsection in the Federal Register by not later than the target date of publication. Such rule shall be effective and final immediately on an interim basis, but is subject to change and revision after public notice and opportunity for a period (of not less than 60 days) for public comment. In connection with such rule, the Secretary shall specify the process for the timely review and approval of applications of entities to be certified as provider-sponsored organizations pursuant to such rules and consistent with this subsection.

“(9) PUBLICATION OF RULE AFTER PUBLIC COMMENT.—The Secretary shall provide for consideration of such comments and republication of such rule by not later than 1 year after the target date of publication.

“(b) ESTABLISHMENT OF OTHER STANDARDS.—

“(1) IN GENERAL.—The Secretary shall establish by regulation other standards (not described in subsection (a)) for MedicarePlus organizations and plans consistent with, and to carry out, this part.

“(2) USE OF CURRENT STANDARDS.—Consistent with the requirements of this part, standards established under this subsection shall be based on standards established under section 1876 to carry out analogous provisions of such section. The Secretary shall also consider State model and other standards relating to consumer protection and assuring quality of care.

“(3) USE OF INTERIM STANDARDS.—For the period in which this part is in effect and standards are being developed and established under the preceding provisions of this subsection, the Secretary shall provide by not later than June 1, 1998, for the application of such interim standards (without regard to any requirements for notice and public comment) as may be appropriate to provide for the expedited implementation of this part. Such interim standards shall not apply after the date standards are established under the preceding provisions of this subsection.

“(4) APPLICATION OF NEW STANDARDS TO ENTITIES WITH A CONTRACT.—In the case of a MedicarePlus 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).

“(5) RELATION TO STATE LAWS.—Subject to section 1852(m), the standards established under this subsection shall supersede any State law or regulation with respect to MedicarePlus plans which are offered by MedicarePlus organizations under this part to the extent such law or regulation is inconsistent with such standards. The previous sentence shall not be construed as superseding a State law or regulation that is not related to solvency, that is applied on a uniform basis and is generally applicable to other entities engaged in substantially similar business, and that provides consumer protections in addition to, or more stringent than, those provided under the standards under this subsection.

“CONTRACTS WITH MEDICAREPLUS ORGANIZATIONS

“SEC. 1857. (a) IN GENERAL.—The Secretary shall not permit the election under section 1851 of a MedicarePlus plan offered by a MedicarePlus organization under this part, and no payment shall be made under section 1853 to an organization, unless the Secretary has entered into a contract under this section with the organization with respect to the offering of such plan. Such a contract with an organization may cover more than one MedicarePlus plan. 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) MINIMUM ENROLLMENT REQUIREMENTS.—

“(1) IN GENERAL.—Subject to paragraphs (2) and (3), the Secretary may not enter into a contract under this section with a MedicarePlus organization 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.

“(2) EXCEPTION FOR MSA PLAN.—Paragraph (1) shall not apply with respect to a contract that relates only to an MSA plan.

“(3) ALLOWING TRANSITION.—The Secretary may waive the requirement of paragraph (1) during the first 3 contract years with respect to an organization.

“(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 subsection (g)(3) on the MedicarePlus 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; or

“(C) 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, except that in no case shall a contract under this section which provides for coverage under an MSA plan be effective before January 1998 with respect to such coverage.

“(4) PREVIOUS TERMINATIONS.—The Secretary may not enter into a contract with a MedicarePlus 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) 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 MedicarePlus 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 MedicarePlus 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 MedicarePlus 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 MedicarePlus 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 MedicarePlus 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.

“(e) ADDITIONAL CONTRACT TERMS.—

“(1) IN GENERAL.—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.

“(2) COST-SHARING IN ENROLLMENT-RELATED COSTS.—The contract with a MedicarePlus organization shall require the payment to the Secretary for the organization’s pro rata share (as determined by the Secretary) of the estimated costs to be incurred by the Secretary in carrying out section 1851 (relating to enrollment and dissemination of information) and section 4360 of the Omnibus Budget Reconciliation Act of 1990 (relating to the health insurance counseling and assistance program). Such payments are appropriated to defray the costs described in the preceding sentence, to remain available until expended.

“(3) NOTICE TO ENROLLEES IN CASE OF DECERTIFICATION.—If a contract with a MedicarePlus organization is terminated under this section, the organization shall notify each enrollee with the organization under this part of such termination.

“(f) PROMPT PAYMENT BY MEDICAREPLUS ORGANIZATION.—

“(1) REQUIREMENT.—A contract under this part shall require a MedicarePlus organization to provide prompt payment (consistent with the provisions of sections 1816(c)(2) and 1842(c)(2)) of claims submitted for services and supplies furnished to individuals pursuant to the contract, if the services or supplies are

not furnished under a contract between the organization and the provider or supplier.

“(2) SECRETARY’S OPTION TO BYPASS NONCOMPLYING ORGANIZATION.—In the case of a MedicarePlus eligible organization which the Secretary determines, after notice and opportunity for a hearing, has failed to make payments of amounts in compliance with paragraph (1), the Secretary may provide for direct payment of the amounts owed to providers and suppliers for covered services and supplies furnished to individuals enrolled under this part under the contract. If the Secretary provides for the direct payments, the Secretary shall provide for an appropriate reduction in the amount of payments otherwise made to the organization under this part to reflect the amount of the Secretary’s payments (and the Secretary’s costs in making the payments).

“(g) INTERMEDIATE SANCTIONS.—

“(1) IN GENERAL.—If the Secretary determines that a MedicarePlus 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 net monthly premiums on individuals enrolled under this part in excess of the net monthly 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(j)(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 MedicarePlus 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 (g) during which the deficiency that is the basis of a determination under subsection (c)(2) exists.

“(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.

“(h) PROCEDURES FOR TERMINATION.—

“(1) IN GENERAL.—The Secretary may terminate a contract with a MedicarePlus organization under this section in accordance with formal investigation and compliance procedures established by the Secretary under which—

“(A) the Secretary provides the organization with the reasonable 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);

“(B) the Secretary shall impose more severe sanctions on an organization that has a history of deficiencies or that has not taken steps to correct deficiencies the Secretary has brought to the organization’s attention;

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

“(D) the Secretary provides the organization with reasonable notice and opportunity for hearing (including the right to appeal an initial decision) before terminating the contract.

“(2) CIVIL MONEY PENALTIES.—The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under subsection (f) or under paragraph (2) or (3) of subsection (g) in the same manner as they apply to a civil money penalty or proceeding under section 1128A(a).

“(3) EXCEPTION FOR IMMINENT AND SERIOUS RISK TO HEALTH.—Paragraph (1) shall not apply if the Secretary determines that a delay in termination, resulting from compliance with the procedures specified in such paragraph prior to termination, would pose an imminent and serious risk to the health of individuals enrolled under this part with the organization.

“DEFINITIONS; MISCELLANEOUS PROVISIONS

“SEC. 1859. (a) DEFINITIONS RELATING TO MEDICAREPLUS ORGANIZATIONS.—In this part—

“(1) MEDICAREPLUS ORGANIZATION.—The term ‘MedicarePlus organization’ means a public or private entity that is certified under section 1856 as meeting the requirements and standards of this part for such an organization.

“(2) PROVIDER-SPONSORED ORGANIZATION.—The term ‘provider-sponsored organization’ is defined in section 1855(e)(1).

“(b) DEFINITIONS RELATING TO MEDICAREPLUS PLANS.—

“(1) MEDICAREPLUS PLAN.—The term ‘MedicarePlus plan’ means health benefits coverage offered under a policy, contract, or plan by a MedicarePlus organization pursuant to and in accordance with a contract under section 1857.

“(2) MSA PLAN.—

“(A) IN GENERAL.—The term ‘MSA plan’ means a MedicarePlus plan that—

“(i) 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 plan) equal to the amount of an annual deductible (described in subparagraph (B));

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

“(iii) provides, after such deductible is met for a year and for all subsequent expenses for items and services

referred to in clause (i) 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.

“(B) DEDUCTIBLE.—The amount of annual deductible under an MSA plan—

“(i) for contract year 1999 shall be not more than \$6,000; and

“(ii) for a subsequent contract year shall be not more than the maximum amount of such deductible for the previous contract year under this subparagraph increased by the national per capita MedicarePlus growth percentage under section 1853(c)(6) for the year.

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

“(c) OTHER REFERENCES TO OTHER TERMS.—

“(1) MEDICAREPLUS ELIGIBLE INDIVIDUAL.—The term ‘MedicarePlus eligible individual’ is defined in section 1851(a)(3).

“(2) MEDICAREPLUS PAYMENT AREA.—The term ‘MedicarePlus payment area’ is defined in section 1853(d).

“(3) NATIONAL PER CAPITA MEDICAREPLUS GROWTH PERCENTAGE.—The ‘national per capita MedicarePlus growth percentage’ is defined in section 1853(c)(6).

“(4) MONTHLY PREMIUM; NET MONTHLY PREMIUM.—The terms ‘monthly premium’ and ‘net monthly premium’ are defined in section 1854(a)(2).

“(d) COORDINATED ACUTE AND LONG-TERM CARE BENEFITS UNDER A MEDICAREPLUS PLAN.—Nothing in this part shall be construed as preventing a State from coordinating benefits under a medicaid plan under title XIX with those provided under a MedicarePlus plan 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 plan.

“(e) RESTRICTION ON ENROLLMENT FOR CERTAIN MEDICAREPLUS PLANS.—

“(1) IN GENERAL.—In the case of a MedicarePlus religious fraternal benefit society plan described in paragraph (2), notwithstanding any other provision of this part to the contrary and in accordance with regulations of the Secretary, the society offering the plan may restrict the enrollment of individuals under this part to individuals who are members of the church, convention, or group described in paragraph (3)(B) with which the society is affiliated.

“(2) MEDICAREPLUS RELIGIOUS FRATERNAL BENEFIT SOCIETY PLAN DESCRIBED.—For purposes of this subsection, a MedicarePlus religious fraternal benefit society plan described

in this paragraph is a MedicarePlus plan described in section 1851(a)(2)(A) that—

“(A) is offered by a religious fraternal benefit society described in paragraph (3) only to members of the church, convention, or group described in paragraph (3)(B); and

“(B) permits all such members to enroll under the plan without regard to health status-related factors.

Nothing in this subsection shall be construed as waiving any plan requirements relating to financial solvency. In developing solvency standards under section 1856, the Secretary shall take into account open contract and assessment features characteristic of fraternal insurance certificates.

“(3) RELIGIOUS FRATERNAL BENEFIT SOCIETY DEFINED.—For purposes of paragraph (2)(A), a ‘religious fraternal benefit society’ described in this section is an organization that—

“(A) is exempt from Federal income taxation under section 501(c)(8) of the Internal Revenue Code of 1986;

“(B) is affiliated with, carries out the tenets of, and shares a religious bond with, a church or convention or association of churches or an affiliated group of churches;

“(C) offers, in addition to a MedicarePlus religious fraternal benefit society plan, health coverage to individuals not entitled to benefits under this title who are members of such church, convention, or group; and

“(D) does not impose any limitation on membership in the society based on any health status-related factor.

“(4) PAYMENT ADJUSTMENT.—Under regulations of the Secretary, in the case of individuals enrolled under this part under a MedicarePlus religious fraternal benefit society plan described in paragraph (2), the Secretary shall provide for such adjustment to the payment amounts otherwise established under section 1854 as may be appropriate to assure an appropriate payment level, taking into account the actuarial characteristics and experience of such individuals.”.

(b) REPORT ON COVERAGE OF BENEFICIARIES WITH END-STAGE RENAL DISEASE.—The Secretary of Health and Human Services shall provide for a study on the feasibility and impact of removing the limitation under section 1851(b)(3)(B) of the Social Security Act (as inserted by subsection (a)) on eligibility of most individuals medically determined to have end-stage renal disease to enroll in MedicarePlus plans. By not later than October 1, 1998, the Secretary shall submit to Congress a report on such study and shall include in the report such recommendations regarding removing or restricting the limitation as may be appropriate.

(c) REPORT ON MEDICAREPLUS TEACHING PROGRAMS AND USE OF DSH AND TEACHING HOSPITALS.—Based on the information provided to the Secretary of Health and Human Services under section 1852(k) of the Social Security Act and such information as the Secretary may obtain, by not later than October 1, 1999, the Secretary shall submit to Congress a report on graduate medical education programs operated by MedicarePlus organizations and the extent to which MedicarePlus organizations are providing for payments to hospitals described in such section.

SEC. 4002. TRANSITIONAL RULES FOR CURRENT MEDICARE HMO PROGRAM.

(a) **AUTHORIZING TRANSITIONAL WAIVER OF 50:50 RULE.**—Section 1876(f) (42 U.S.C. 1395mm(f)) is amended—

(1) in paragraph (2), by striking “The Secretary” and inserting “Subject to paragraph (4), the Secretary”, and

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

“(4) Effective for contract periods beginning after December 31, 1996, the Secretary may waive or modify the requirement imposed by paragraph (1) to the extent the Secretary finds that it is in the public interest.”.

(b) **TRANSITION.**—Section 1876 (42 U.S.C. 1395mm) is amended by adding at the end the following new subsection:

“(k)(1) Except as provided in paragraph (3), the Secretary shall not enter into, renew, or continue any risk-sharing contract under this section with an eligible organization for any contract year beginning on or after—

“(A) the date standards for MedicarePlus organizations and plans are first established under section 1856 with respect to MedicarePlus organizations that are insurers or health maintenance organizations, or

“(B) in the case of such an organization with such a contract in effect as of the date such standards were first established, 1 year after such date.

“(2) The Secretary shall not enter into, renew, or continue any risk-sharing contract under this section with an eligible organization for any contract year beginning on or after January 1, 2000.

“(3) An individual who is enrolled in part B only and is enrolled in an eligible organization with a risk-sharing contract under this section on December 31, 1998, may continue enrollment in such organization in accordance with regulations issued by not later than July 1, 1998.

“(4) Notwithstanding subsection (a), the Secretary shall provide that payment amounts under risk-sharing contracts under this section for months in a year (beginning with January 1998) shall be computed—

“(A) with respect to individuals entitled to benefits under both parts A and B, by substituting payment rates under section 1853(a) for the payment rates otherwise established under subsection 1876(a), and

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

For purposes of carrying out this paragraph for payments for months in 1998, the Secretary shall compute, announce, and apply the payment rates under section 1853(a) (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 under this section not in accordance with such rates.”.

(c) **ENROLLMENT TRANSITION RULE.**—An individual who is enrolled on December 31, 1998, with an eligible organization under

section 1876 of the Social Security Act (42 U.S.C. 1395mm) shall be considered to be enrolled with that organization on January 1, 1999, under part C of title XVIII of such Act if that organization has a contract under that part for providing services on January 1, 1999 (unless the individual has disenrolled effective on that date).

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

(1) in paragraph (1)—

(A) by inserting “1855(i),” after “1833(s),” and

(B) by inserting “, MedicarePlus organization,” after “provider of services”; and

(2) in paragraph (2)(E), by inserting “or a MedicarePlus organization” after “section 1833(a)(1)(A)”.

(e) EXTENSION OF PROVIDER REQUIREMENT.—Section 1866(a)(1)(O) (42 U.S.C. 1395cc(a)(1)(O)) is amended—

(1) by striking “in the case of hospitals and skilled nursing facilities,”;

(2) by striking “inpatient hospital and extended care”;

(3) by inserting “with a MedicarePlus organization under part C or” after “any individual enrolled”;

(4) by striking “(in the case of hospitals) or limits (in the case of skilled nursing facilities)”;

(5) by inserting “(less any payments under section 1858)” after “under this title”.

(f) ADDITIONAL CONFORMING CHANGES.—

(1) 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).

(2) SECRETARIAL SUBMISSION OF LEGISLATIVE PROPOSAL.—Not later than 90 days after the date of the enactment of this Act, the Secretary of Health and Human Services shall submit to the appropriate committees of Congress a legislative proposal providing for such technical and conforming amendments in the law as are required by the provisions of this chapter.

(g) IMMEDIATE EFFECTIVE DATE FOR CERTAIN REQUIREMENTS FOR DEMONSTRATIONS.—Section 1857(e)(2) of the Social Security Act (requiring contribution to certain costs related to the enrollment process comparative materials) applies to demonstrations with respect to which enrollment is effected or coordinated under section 1851 of such Act.

(h) USE OF INTERIM, FINAL REGULATIONS.—In order to carry out the amendments made by this chapter 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.

(i) TRANSITION RULE FOR PSO ENROLLMENT.—In applying subsection (g)(1) of section 1876 of the Social Security Act (42 U.S.C. 1395mm) to a risk-sharing contract entered into with an eligible organization that is a provider-sponsored organization (as defined in section 1855(e)(1) of such Act, as inserted by section 4001) for a contract year beginning on or after January 1, 1998, there shall be

substituted for the minimum number of enrollees provided under such section the minimum number of enrollees permitted under section 1857(b)(1) of such Act (as so inserted).

SEC. 4003. CONFORMING CHANGES IN MEDIGAP PROGRAM.

(a) CONFORMING AMENDMENTS TO MEDICAREPLUS CHANGES.—

(1) IN GENERAL.—Section 1882(d)(3)(A)(i) (42 U.S.C. 1395ss(d)(3)(A)(i)) is amended—

(A) in the matter before subclause (I), by inserting “including an individual electing a MedicarePlus plan under section 1851” after “of this title”; and

(B) in subclause (II)—

(i) by inserting “in the case of an individual not electing a MedicarePlus plan” after “(II)”, and

(ii) by inserting before the comma at the end the following: “or in the case of an individual electing a MedicarePlus plan, a medicare supplemental policy with knowledge that the policy duplicates health benefits to which the individual is otherwise entitled under the MedicarePlus plan or under another medicare supplemental policy”.

(2) CONFORMING AMENDMENTS.—Section 1882(d)(3)(B)(i)(I) (42 U.S.C. 1395ss(d)(3)(B)(i)(I)) is amended by inserting “including any MedicarePlus plan” after “health insurance policies”.

(3) MEDICAREPLUS PLANS NOT TREATED AS MEDICARE SUPPLEMENTARY POLICIES.—Section 1882(g)(1) (42 U.S.C. 1395ss(g)(1)) is amended by inserting “or a MedicarePlus plan or” after “does not include”

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

“(u)(1) It is unlawful for a person to sell or issue a policy described in paragraph (2) to an individual with knowledge that the individual has in effect under section 1851 an election of an MSA plan.

“(2) A policy described in this subparagraph is a health insurance policy that provides for coverage of expenses that are otherwise required to be counted toward meeting the annual deductible amount provided under the MSA plan.”.

Subchapter B—Special Rules for MedicarePlus Medical Savings Accounts

SEC. 4006. MEDICAREPLUS MSA.

(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 138 as section 139 and by inserting after section 137 the following new section:

“SEC. 138. MEDICAREPLUS MSA.

“(a) EXCLUSION.—Gross income shall not include any payment to the MedicarePlus MSA of an individual by the Secretary of Health and Human Services under part C of title XVIII of the Social Security Act.

“(b) **MEDICAREPLUS MSA.**—For purposes of this section, the term ‘MedicarePlus MSA’ means a medical savings account (as defined in section 220(d))—

“(1) which is designated as a MedicarePlus MSA,

“(2) with respect to which no contribution may be made other than—

“(A) a contribution made by the Secretary of Health and Human Services pursuant to part C of title XVIII of the Social Security Act, or

“(B) a trustee-to-trustee transfer described in subsection (c)(4),

“(3) the governing instrument of which provides that trustee-to-trustee transfers described in subsection (c)(4) may be made to and from such account, and

“(4) which is established in connection with an MSA plan described in section 1859(b)(2) of the Social Security Act.

“(c) **SPECIAL RULES FOR DISTRIBUTIONS.**—

“(1) **DISTRIBUTIONS FOR QUALIFIED MEDICAL EXPENSES.**—In applying section 220 to a MedicarePlus MSA—

“(A) qualified medical expenses shall not include amounts paid for medical care for any individual other than the account holder, and

“(B) section 220(d)(2)(C) shall not apply.

“(2) **PENALTY FOR DISTRIBUTIONS FROM MEDICAREPLUS MSA 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 MedicarePlus 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 such 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 MedicarePlus MSA plan covering the account holder as of January 1 of the calendar year in which the taxable year begins.

Section 220(f)(2) shall not apply to any payment or distribution from a MedicarePlus MSA.

“(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 MedicarePlus MSAs 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.—Section 220(f)(2) and paragraph (2) of this subsection shall not apply to any payment or distribution from a MedicarePlus MSA to the Secretary of Health and Human Services of an erroneous contribution to such MSA and of the net income attributable to such contribution.

“(4) TRUSTEE-TO-TRUSTEE TRANSFERS.—Section 220(f)(2) and paragraph (2) of this subsection shall not apply to any trustee-to-trustee transfer from a MedicarePlus MSA of an account holder to another MedicarePlus MSA of such account holder.

“(d) SPECIAL RULES FOR TREATMENT OF ACCOUNT AFTER DEATH OF ACCOUNT HOLDER.—In applying section 220(f)(8)(A) to an account which was a MedicarePlus MSA of a decedent, the rules of section 220(f) shall apply in lieu of the rules of subsection (c) of this section with respect to the spouse as the account holder of such MedicarePlus MSA.

“(e) REPORTS.—In the case of a MedicarePlus MSA, the report under section 220(h)—

“(1) shall include the fair market value of the assets in such MedicarePlus MSA as of the close of each calendar year, and

“(2) shall be furnished to the account holder—

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

“(B) in such manner as the Secretary prescribes in such regulations.

“(f) COORDINATION WITH LIMITATION ON NUMBER OF TAXPAYERS HAVING MEDICAL SAVINGS ACCOUNTS.—Subsection (i) of section 220 shall not apply to an individual with respect to a MedicarePlus MSA, and MedicarePlus MSA’s shall not be taken into account in determining whether the numerical limitations under section 220(j) are exceeded.”

(b) TECHNICAL AMENDMENTS.—

(1) The last sentence of section 4973(d) of such Code is amended by inserting “or section 138(c)(3)” after “section 220(f)(3)”.

(2) Subsection (b) of section 220 of such Code is amended by adding at the end the following new paragraph:

“(7) MEDICARE ELIGIBLE INDIVIDUALS.—The limitation under this subsection for any month with respect to an individual shall be zero for the first month such individual is entitled to benefits under title XVIII of the Social Security Act and for each month thereafter.”

(3) 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. 138. MedicarePlus MSA.

“Sec. 139. Cross references to other Acts.”

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

Subchapter C—GME, IME, and DSH Payments for Managed Care Enrollees

SEC. 4008. GRADUATE MEDICAL EDUCATION AND INDIRECT MEDICAL EDUCATION PAYMENTS FOR MANAGED CARE ENROLLEES.

(a) **PAYMENTS TO MANAGED CARE ORGANIZATIONS OPERATING GRADUATE MEDICAL EDUCATION PROGRAMS.**—Section 1853 (as inserted by section 4001) is amended by adding at the end the following:

“(h) **PAYMENTS FOR DIRECT COSTS OF GRADUATE MEDICAL EDUCATION PROGRAMS.**—

“(1) **ADDITIONAL PAYMENT TO BE MADE.**—Effective January 1, 1998, each contract with a MedicarePlus organization under this section (and each risk-sharing contract with an eligible organization under section 1876) shall provide for an additional payment for Medicare’s share of allowable direct graduate medical education costs incurred by such an organization for an approved medical residency program.

“(2) **ALLOWABLE COSTS.**—If the organization has an approved medical residency program that incurs all or substantially all of the costs of the program, subject to section 1858(a)(3), the allowable costs for such a program shall equal the national average per resident amount times the number of full-time-equivalent residents in the program in non-hospital settings.

“(3) **DEFINITIONS.**—As used in this subsection:

“(A) The terms ‘approved medical residency program’, ‘direct graduate medical education costs’, and ‘full-time-equivalent residents’ have the same meanings as under section 1886(h).

“(B) The term ‘Medicare’s share’ means, with respect to a MedicarePlus or eligible organization, the ratio of the number of individuals enrolled with the organization under this part (or enrolled under a risk-sharing contract under section 1876, respectively) to the total number of individuals enrolled with the organization.

“(C) The term ‘national average per resident amount’ means an amount estimated by the Secretary to equal the weighted average amount that would be paid per full-time-equivalent resident under section 1886(h) for the calendar year (determined separately for primary care residency programs as defined under section 1886(h) (including obstetrics and gynecology residency programs) and for other residency programs).”.

(b) **PAYMENTS TO HOSPITALS FOR DIRECT AND INDIRECT COSTS OF GRADUATE MEDICAL EDUCATION PROGRAMS ATTRIBUTABLE TO MANAGED CARE ENROLLEES.**—Part C of title XVIII, as amended by section 4001, is amended by inserting after section 1857 the following new section:

“PAYMENTS TO HOSPITALS FOR CERTAIN COSTS ATTRIBUTABLE TO
MANAGED CARE ENROLLEES

“SEC. 1858. (a) COSTS OF GRADUATE MEDICAL EDUCATION.—

“(1) IN GENERAL.—For portions of cost reporting periods occurring on or after January 1, 1998, the Secretary shall provide for an additional payment amount for each subsection (d) hospital (as defined in section 1886(d)(1)(B)), each PPS-exempt hospital described in clause (i) through (v) of such section, and for each hospital reimbursed under a reimbursement system authorized section 1814(b)(3) that—

“(A) furnishes services to individuals who are enrolled under a risk-sharing contract with an eligible organization under section 1876 and who are entitled to part A and to individuals who are enrolled with a MedicarePlus organization under part C, and

“(B) has an approved medical residency training program.

“(2) PAYMENT AMOUNT.—

“(A) IN GENERAL.—Subject to paragraph (3)(B), the amount of the payment under this subsection shall be the sum of—

“(i) the amount determined under subparagraph (B), and

“(ii) the amount determined under subparagraph (C).

Clause (ii) shall not apply in the case of a hospital that is not a PPS-exempt hospital described in clause (i) through (v) of section 1886(d)(1)(B),

“(B) DIRECT AMOUNT.—The amount determined under this subparagraph for a period is equal to the product of—

“(i) the aggregate approved amount (as defined in section 1886(h)(3)(B)) for that period; and

“(ii) the fraction of the total number of inpatient-bed-days (as established by the Secretary) during the period which are attributable to individuals described in paragraph (1).

“(C) INDIRECT AMOUNT.—The amount determined under this subparagraph is equal to the product of—

“(i) the amount of the indirect teaching adjustment factor applicable to the hospital under section 1886(d)(5)(B); and

“(ii) the product of—

“(I) the number of discharges attributable to individuals described in paragraph (1), and

“(II) the estimated average per discharge amount that would otherwise have been paid under section 1886(d)(1)(A) if the individuals had not been enrolled as described in such paragraph.

“(D) SPECIAL RULE.—The Secretary shall establish rules for the application of subparagraph (B) and for the computation of the amounts described in subparagraph (C)(i) and subparagraph (C)(ii)(I) to a hospital reimbursed under a reimbursement system authorized under section

1814(b)(3) in a manner similar to the manner of applying such subparagraph and computing such amounts as if the hospital were not reimbursed under such section.

“(3) LIMITATION.—

“(A) DETERMINATIONS.—At the beginning of each year, the Secretary shall—

“(i) estimate the sum of the amount of the payments under this subsection and the payments under section 1853(h), for services or discharges occurring in the year, and

“(ii) determine the amount of the annual payment limit under subparagraph (C) for such year.

“(B) IMPOSITION OF LIMIT.—If the amount estimated under subparagraph (A)(i) for a year exceeds the amount determined under subparagraph (A)(ii) for the year, then the Secretary shall adjust the amounts of the payments described in subparagraph (A)(i) for the year in a pro rata manner so that the total of such payments in the year do not exceed the annual payment limit determined under subparagraph (A)(ii) for that year.

“(C) ANNUAL PAYMENT LIMIT.—

“(i) IN GENERAL.—The annual payment limit under this subparagraph for a year is the sum, over all counties or MedicarePlus payment areas, of the product of—

“(I) the annual GME per capita payment rate (described in clause (ii)) for the county or area, and

“(II) the Secretary’s projection of average enrollment of individuals described in paragraph (1) who are residents of that county or area, adjusted to reflect the relative demographic or risk characteristics of such enrollees.

“(ii) GME PER CAPITA PAYMENT RATE.—The GME per capita payment rate described in this clause for a particular county or MedicarePlus payment area for a year is the GME proportion (as specified in clause (iii)) of the annual MedicarePlus capitation rate (as calculated under section 1853(c)) for the county or area and year involved.

“(iii) GME PROPORTION.—For purposes of clause (ii), the GME proportion for a county or area and a year is equal to the phase-in percentage (specified in clause (vi)) of the ratio of (I) the projected GME payment amount for the county or area (as determined under clause (v)), to (II) the average per capita cost for the county or area for the year (determined under clause (vi)).

“(iv) PHASE-IN PERCENTAGE.—The phase-in percentage specified in this clause for—

“(I) 1998 is 20 percent,

“(II) 1999 is 40 percent,

“(III) 2000 is 60 percent,

“(IV) 2001 is 80 percent, or

“(V) any subsequent year is 100 percent.

“(v) PROJECTED GME PAYMENT AMOUNT.—The projected GME payment amount for a county or area—

“(I) for 1998, is the amount included in the per capita rate of payment for 1997 determined under section 1876(a)(1)(C) for the payment adjustments described in section 1886(d)(5)(B) and section 1886(h) for that county or area, adjusted by the general GME update factor (as defined in clause (vii)) for 1998, or

“(II) for a subsequent year, is the projected GME payment amount for the county or area for the previous year, adjusted by the general GME update factor for such subsequent year.

The Secretary shall determine the amount described in subclause (I) for a county or other area that includes hospitals reimbursed under section 1814(b)(3) as though such hospitals had not been reimbursed under such section.

“(vi) AVERAGE PER CAPITA COST.—The average per capita cost for the county or area determined under this clause for—

“(I) 1998 is the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) for the county or area, increased by the national per capita MedicarePlus growth percentage for 1998 (as defined in section 1853(c)(6), but determined without regard to the adjustment described in subparagraph (B) of such section); or

“(II) a subsequent year is the average per capita cost determined under this clause for the previous year increased by the national per capita MedicarePlus growth percentage for the year involved (as defined in section 1853(c)(6), but determined without regard to the adjustment described in subparagraph (B) of such section).

“(vii) GENERAL GME UPDATE FACTOR.—For purposes of clause (v), the ‘general GME update factor’ for a year is equal to the Secretary’s estimate of the national average percentage change in average per capita payments under sections 1886(d)(5)(B) and 1886(h) from the previous year to the year involved. Such amount takes into account changes in law and regulation affecting payment amounts under such sections.”.

SEC. 4009. DISPROPORTIONATE SHARE HOSPITAL PAYMENTS FOR MANAGED CARE ENROLLEES.

Section 1858, as inserted by section 4008(b), is further amended by adding at the end the following new subsection:

“(b) DISPROPORTIONATE SHARE HOSPITAL PAYMENTS.—

“(1) IN GENERAL.—For portions of cost reporting periods occurring on or after January 1, 1998, the Secretary shall provide for an additional payment amount for each subsection (d) hospital (as defined in section 1886(d)(1)(B)) and for each hospital reimbursed a demonstration project reimbursement system under section 1814(b)(3) that—

“(A) furnishes services to individuals who are enrolled under a risk-sharing contract with an eligible organization under section 1876 and who are entitled to part A and to individuals who are enrolled with a MedicarePlus organization under this part, and

“(B) is (or, if it were not reimbursed under section 1814(b)(3), would qualify as) a disproportionate share hospital described in section 1886(d)(5)(F)(i).

“(2) AMOUNT OF PAYMENT.—Subject to paragraph (3)(B), the amount of the payment under this subsection shall be the product of—

“(A) the amount of the disproportionate share adjustment percentage applicable to the hospital under section 1886(d)(5)(F); and

“(B) the product described in subsection (a)(2)(C)(ii).

The Secretary shall establish rules for the computation of the amount described in subparagraph (A) for a hospital reimbursed under section 1814(b)(3).

“(3) LIMIT.—

“(A) DETERMINATION.—At the beginning of each year, the Secretary shall—

“(i) estimate the sum of the payments under this subsection for services or discharges occurring in the year, and

“(ii) determine the amount of the annual payment limit under subparagraph (C) for such year.

“(B) IMPOSITION OF LIMIT.—If the amount estimated under subparagraph (A)(i) for a year exceeds the amount determined under subparagraph (A)(ii) for the year, then the Secretary shall adjust the amounts of the payments under this subsection for the year in a pro rata manner so that the total of such payments in the year do not exceed the annual payment limit determined under subparagraph (A)(ii) for that year.

“(C) ANNUAL PAYMENT LIMIT.—The annual payment limit under this subparagraph for a year shall be determined in the same manner as the annual payment limit is determined under clause (i) of subsection (a)(3)(C), except that, for purposes of this clause, any reference in clauses (i) through (vii) of such subsection—

“(i) to a payment adjustment under subsection (a) is deemed a reference to a payment adjustment under this subsection, or

“(ii) to payments or payment adjustments under section 1886(d)(5)(B) and 1886(h) is deemed a reference to payments and payment adjustments under section 1886(d)(5)(F).”.

CHAPTER 2—INTEGRATED LONG-TERM CARE PROGRAMS

Subchapter A—Programs of All-inclusive Care for the Elderly (PACE)

SEC. 4011. REFERENCE TO COVERAGE OF PACE UNDER THE MEDICARE PROGRAM.

For provision amending title XVIII of the Social Security Act to provide for payments to, and coverage of benefits under, Programs of All-inclusive Care for the Elderly (PACE), see section 3431.

SEC. 4012. REFERENCE TO ESTABLISHMENT OF PACE PROGRAM AS MEDICAID STATE OPTION.

For provision amending title XIX of the Social Security Act to establish the PACE program as a medicaid State option, see section 3432.

Subchapter B—Social Health Maintenance Organizations

SEC. 4015. SOCIAL HEALTH MAINTENANCE ORGANIZATIONS (SHMOS).

(a) **EXTENSION OF DEMONSTRATION PROJECT AUTHORITIES.**—Section 4018(b) of the Omnibus Budget Reconciliation Act of 1987 is amended—

(1) in paragraph (1), by striking “1997” and inserting “2000”, and

(2) in paragraph (4), by striking “1998” and inserting “2001”.

(b) **EXPANSION OF CAP.**—Section 13567(c) of the Omnibus Budget Reconciliation Act of 1993 is amended by striking “12,000” and inserting “36,000”.

(b) **REPORT ON INTEGRATION AND TRANSITION.**—

(1) **IN GENERAL.**—The Secretary of Health and Human Services shall submit to Congress, by not later than January 1, 1999, a plan for the integration of health plans offered by social health maintenance organizations (including SHMO I and SHMO II sites developed under section 2355 of the Deficit Reduction Act of 1984 and under the amendment made by section 4207(b)(3)(B)(i) of OBRA–1990, respectively) and similar plans as an option under the MedicarePlus program under part C of title XVIII of the Social Security Act.

(2) **PROVISION FOR TRANSITION.**—Such plan shall include a transition for social health maintenance organizations operating under demonstration project authority under such section.

(3) **PAYMENT POLICY.**—The report shall also include recommendations on appropriate payment levels for plans offered by such organizations, including an analysis of the application of risk adjustment factors appropriate to the population served by such organizations.

Subchapter C—Other Programs

SEC. 4018. ORDERLY TRANSITION OF MUNICIPAL HEALTH SERVICE DEMONSTRATION PROJECTS.

Section 9215 of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended by section 6135 of OBRA–1989 and section 13557 of OBRA–1993, is further amended—

(1) by inserting “(a)” before “The Secretary”, and

(2) by adding at the end the following: “Subject to subsection (c), the Secretary may further extend such demonstration projects through December 31, 2000, but only with respect to individuals who are enrolled with such projects before January 1, 1998.

“(b) The Secretary shall work with each such demonstration project to develop a plan, to be submitted to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate by March 31, 1998, for the orderly transition of demonstration projects and the project enrollees to a non-demonstration project health care delivery system, such as through integration with a private or public health plan, including a medicaid managed care or MedicarePlus plan.

“(c) A demonstration project under subsection (a) which does not develop and submit a transition plan under subsection (b) by March 31, 1998, or, if later, 6 months after the date of the enactment of this Act, shall be discontinued as of December 31, 1998. The Secretary shall provide appropriate technical assistance to assist in the transition so that disruption of medical services to project enrollees may be minimized.”.

SEC. 4019. EXTENSION OF CERTAIN MEDICARE COMMUNITY NURSING ORGANIZATION DEMONSTRATION PROJECTS.

Notwithstanding any other provision of law, demonstration projects conducted under section 4079 of the Omnibus Budget Reconciliation Act of 1987 may be conducted for an additional period of 2 years, and the deadline for any report required relating to the results of such projects shall be not later than 6 months before the end of such additional period.

CHAPTER 3—MEDICARE PAYMENT ADVISORY COMMISSION

SEC. 4021. MEDICARE PAYMENT ADVISORY COMMISSION.

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

“MEDICARE PAYMENT ADVISORY COMMISSION

“SEC. 1805. (a) ESTABLISHMENT.—There is hereby established the Medicare Payment Advisory Commission (in this section referred to as the ‘Commission’).

“(b) DUTIES.—

“(1) REVIEW OF PAYMENT POLICIES AND ANNUAL REPORTS.—The Commission shall—

“(A) review payment policies under this title, including the topics described in paragraph (2);

“(B) make recommendations to Congress concerning such payment policies; and

“(C) by not later than March 1 of each year (beginning with 1998), submit a report to Congress containing the results of such reviews and its recommendations concerning such policies and an examination of issues affecting the medicare program.

“(2) SPECIFIC TOPICS TO BE REVIEWED.—

“(A) **MEDICAREPLUS PROGRAM.**—Specifically, the Commission shall review, with respect to the MedicarePlus program under part C, the following:

“(i) The methodology for making payment to plans under such program, including the making of differential payments and the distribution of differential updates among different payment areas.

“(ii) The mechanisms used to adjust payments for risk and the need to adjust such mechanisms to take into account health status of beneficiaries.

“(iii) The implications of risk selection both among MedicarePlus organizations and between the MedicarePlus option and the medicare fee-for-service option.

“(iv) The development and implementation of mechanisms to assure the quality of care for those enrolled with MedicarePlus organizations.

“(v) The impact of the MedicarePlus program on access to care for medicare beneficiaries.

“(vi) The appropriate role for the medicare program in addressing the needs of individuals with chronic illnesses.

“(vii) Other major issues in implementation and further development of the MedicarePlus program.

“(B) **FEE-FOR-SERVICE SYSTEM.**—Specifically, the Commission shall review payment policies under parts A and B, including—

“(i) the factors affecting expenditures for services in different sectors, including the process for updating hospital, skilled nursing facility, physician, and other fees,

“(ii) payment methodologies, and

“(iii) their relationship to access and quality of care for medicare beneficiaries.

“(C) **INTERACTION OF MEDICARE PAYMENT POLICIES WITH HEALTH CARE DELIVERY GENERALLY.**—Specifically, the Commission shall review the effect of payment policies under this title on the delivery of health care services other than under this title and assess the implications of changes in health care delivery in the United States and in the general market for health care services on the medicare program.

“(3) **COMMENTS ON CERTAIN SECRETARIAL REPORTS.**—If the Secretary submits to Congress (or a committee of Congress) a report that is required by law and that relates to payment policies under this title, the Secretary shall transmit a copy of the report to the Commission. The Commission shall review the report and, not later than 6 months after the date of submittal of the Secretary’s report to Congress, shall submit to the appropriate committees of Congress written comments on such report. Such comments may include such recommendations as the Commission deems appropriate.

“(4) **AGENDA AND ADDITIONAL REVIEWS.**—The Commission shall consult periodically with the chairmen and ranking mi-

nority members of the appropriate committees of Congress regarding the Commission's agenda and progress towards achieving the agenda. The Commission may conduct additional reviews, and submit additional reports to the appropriate committees of Congress, from time to time on such topics relating to the program under this title as may be requested by such chairmen and members and as the Commission deems appropriate.

“(5) AVAILABILITY OF REPORTS.—The Commission shall transmit to the Secretary a copy of each report submitted under this subsection and shall make such reports available to the public.

“(6) APPROPRIATE COMMITTEES.—For purposes of this section, the term ‘appropriate committees of Congress’ means the Committees on Ways and Means and Commerce of the House of Representatives and the Committee on Finance of the Senate.

“(c) MEMBERSHIP.—

“(1) NUMBER AND APPOINTMENT.—The Commission shall be composed of 11 members appointed by the Comptroller General.

“(2) QUALIFICATIONS.—

“(A) IN GENERAL.—The membership of the Commission shall include individuals with national recognition for their expertise in health finance and economics, actuarial science, health facility management, health plans and integrated delivery systems, reimbursement of health facilities, allopathic and osteopathic physicians, and other providers of health services, and other related fields, who provide a mix of different professionals, broad geographic representation, and a balance between urban and rural representatives.

“(B) INCLUSION.—The membership of the Commission shall include (but not be limited to) physicians and other health professionals, employers, third party payers, 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.

“(C) MAJORITY NONPROVIDERS.—Individuals who are directly involved in the provision, or management of the delivery, of items and services covered under this title shall not constitute a majority of the membership of the Commission.

“(D) ETHICAL DISCLOSURE.—The Comptroller General shall establish a system for public disclosure by members of the Commission of financial and other potential conflicts of interest relating to such members.

“(3) TERMS.—

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

"(4) 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.

"(5) 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.

"(6) 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—

“(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 nonproprietary data of the Commission, immediately upon request.

“(4) PERIODIC AUDIT.—The Commission shall be subject to periodic audit by the Comptroller General.

“(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 appropriated 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 Advisory Commission”.

(2) PPRC.—

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

(B) ELIMINATION OF CERTAIN REPORTS.—Section 1848 (42 U.S.C. 1395w–4) is amended by striking subparagraph (B) of subsection (f)(1).

(C) CONFORMING AMENDMENTS.—Section 1848 (42 U.S.C. 1395w-4) is amended by striking “Physician Payment Review Commission” and inserting “Medicare Payment Advisory Commission” each place it appears in subsections (c)(2)(B)(iii), (g)(6)(C), and (g)(7)(C).

(c) EFFECTIVE DATE; TRANSITION.—

(1) IN GENERAL.—The Comptroller General shall first provide for appointment of members to the Medicare Payment Advisory Commission (in this subsection referred to as “MedPAC”) by not later than September 30, 1997.

(2) TRANSITION.—As quickly as possible after the date a majority of members of MedPAC are first appointed, the Comptroller General, in consultation with 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”), shall provide for the termination of the ProPAC and the PPRC. As of the date of termination of the respective Commissions, the amendments made by paragraphs (1) and (2), respectively, of subsection (b) become effective. The Comptroller General, to the extent feasible, shall provide for the transfer to the MedPAC of assets and staff of the ProPAC and the PPRC, without any loss of benefits or seniority by virtue of such transfers. Fund balances available to the ProPAC or the PPRC for any period shall be available to the MedPAC for such period for like purposes.

(3) CONTINUING RESPONSIBILITY FOR REPORTS.—The MedPAC 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 MedPAC) by the ProPAC and the PPRC, and, for this purpose, any reference in law to either such Commission is deemed, after the appointment of the MedPAC, to refer to the MedPAC.

CHAPTER 4—MEDIGAP PROTECTIONS

SEC. 4031. MEDIGAP PROTECTIONS.

(a) GUARANTEEING ISSUE WITHOUT PREEXISTING CONDITIONS FOR CONTINUOUSLY COVERED INDIVIDUALS.—Section 1882(s) (42 U.S.C. 1395ss(s)) is amended—

(1) in paragraph (3), by striking “paragraphs (1) and (2)” and inserting “this subsection”,

(2) by redesignating paragraph (3) as paragraph (4), and

(3) by inserting after paragraph (2) the following new paragraph:

“(3)(A) The issuer of a medicare supplemental policy—

“(i) may not deny or condition the issuance or effectiveness of a medicare supplemental policy described in subparagraph (C) that is offered and is available for issuance to new enrollees by such issuer;

“(ii) may not discriminate in the pricing of such policy, because of health status, claims experience, receipt of health care, or medical condition; and

“(iii) may not impose an exclusion of benefits based on a pre-existing condition under such policy,

in the case of an individual described in subparagraph (B) who seeks to enroll under the policy not later than 63 days after the date of the termination of enrollment described in such subparagraph and who submits evidence of the date of termination or disenrollment along with the application for such medicare supplemental policy.

“(B) An individual described in this subparagraph is an individual described in any of the following clauses:

“(i) The individual is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under this title and the plan terminates or ceases to provide all such supplemental health benefits to the individual.

“(ii) The individual is enrolled with a MedicarePlus organization under a MedicarePlus plan under part C, and there are circumstances permitting discontinuance of the individual’s election of the plan under section 1851(e)(4).

“(iii) The individual is enrolled with an eligible organization under a contract under section 1876, a similar organization operating under demonstration project authority, with an organization under an agreement under section 1833(a)(1)(A), or with an organization under a policy described in subsection (t), and such enrollment ceases under the same circumstances that would permit discontinuance of an individual’s election of coverage under section 1851(e)(4) and, in the case of a policy described in subsection (t), there is no provision under applicable State law for the continuation of coverage under such policy.

“(iv) The individual is enrolled under a medicare supplemental policy under this section and such enrollment ceases because—

“(I) of the bankruptcy or insolvency of the issuer or because of other involuntary termination of coverage or enrollment under such policy and there is no provision under applicable State law for the continuation of such coverage;

“(II) the issuer of the policy substantially violated a material provision of the policy; or

“(III) the issuer (or an agent or other entity acting on the issuer’s behalf) materially misrepresented the policy’s provisions in marketing the policy to the individual.

“(v) The individual—

“(I) was enrolled under a medicare supplemental policy under this section,

“(II) subsequently terminates such enrollment and enrolls, for the first time, with any MedicarePlus organization under a MedicarePlus plan under part C, any eligible organization under a contract under section 1876, any similar organization operating under demonstration project authority, any organization under an agreement under section 1833(a)(1)(A), or any policy described in subsection (t), and

“(III) the subsequent enrollment under subclause (II) is terminated by the enrollee during the first 6 months (or 3 months for terminations occurring on or after January 1, 2003) of such enrollment.

“(vi) The individual—

“(I) was enrolled under a medicare supplemental policy under this section,

“(II) subsequently terminates such enrollment and enrolls, for the first time, during or after the annual, coordinated election period under section 1851(e)(3)(B) occurring during 2002, with an organization or policy described in clause (v)(II), and

“(III) the subsequent enrollment under subclause (II) is terminated by the enrollee during the next annual, coordinated election period under such section.

“(C)(i) Subject to clauses (ii) and (iii), a medicare supplemental policy described in this subparagraph has a benefit package classified as ‘A’, ‘B’, ‘C’, or ‘F’ under the standards established under subsection (p)(2).

“(ii) Only for purposes of an individual described in subparagraph (B)(v), a medicare supplemental policy described in this subparagraph also includes (if available from the same issuer) the same medicare supplemental policy referred to in such subparagraph in which the individual was most recently previously enrolled.

“(iii) For purposes of applying this paragraph in the case of a State that provides for offering of benefit packages other than under the classification referred to in clause (i), the references to benefit packages in such clause are deemed references to comparable benefit packages offered in such State.

“(D) At the time of an event described in subparagraph (B) because of which an individual ceases enrollment or loses coverage or benefits under a contract or agreement, policy, or plan, the organization that offers the contract or agreement, the insurer offering the policy, or the administrator of the plan, respectively, shall notify the individual of the rights of the individual, and obligations of issuers of medicare supplemental policies, under subparagraph (A).”.

(b) LIMITATION ON IMPOSITION OF PREEXISTING CONDITION EXCLUSION DURING INITIAL OPEN ENROLLMENT PERIOD.—Section 1882(s)(2) (42 U.S.C. 1395ss(s)(2)) is amended—

(1) in subparagraph (B), by striking “subparagraph (C)” and inserting “subparagraphs (C) and (D)”, and

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

“(D) In the case of a policy issued during the 6-month period described in subparagraph (A) to an individual who is 65 years of age or older as of the date of issuance and who as of the date of the application for enrollment has a continuous period of creditable coverage (as defined in 2701(c) of the Public Health Service Act) of—

“(i) at least 6 months, the policy may not exclude benefits based on a pre-existing condition; or

“(ii) of less than 6 months, if the policy excludes benefits based on a preexisting condition, the policy shall reduce the period of any preexisting condition exclusion by the aggregate of the periods of creditable coverage (if any, as so defined) applicable to the individual as of the enrollment date.

The Secretary shall specify the manner of the reduction under clause (ii), based upon the rules used by the Secretary in carrying out section 2701(a)(3) of such Act.”.

(c) EFFECTIVE DATES.—

(1) GUARANTEED ISSUE.—The amendment made by subsection (a) shall take effect on July 1, 1998.

(2) LIMIT ON PREEXISTING CONDITION EXCLUSIONS.—The amendment made by subsection (b) shall apply to policies issued on or after July 1, 1998.

(d) TRANSITION PROVISIONS.—

(1) IN GENERAL.—If the Secretary of Health and Human Services identifies a State as requiring a change to its statutes or regulations to conform its regulatory program to the changes made by this section, the State regulatory program shall not be considered to be out of compliance with the requirements of section 1882 of the Social Security Act due solely to failure to make such change until the date specified in paragraph (4).

(2) NAIC STANDARDS.—If, within 9 months after the date of the enactment of this Act, the National Association of Insurance Commissioners (in this subsection referred to as the “NAIC”) modifies its NAIC Model Regulation relating to section 1882 of the Social Security Act (referred to in such section as the 1991 NAIC Model Regulation, as modified pursuant to section 171(m)(2) of the Social Security Act Amendments of 1994 (Public Law 103–432) and as modified pursuant to section 1882(d)(3)(A)(vi)(IV) of the Social Security Act, as added by section 271(a) of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104–191) to conform to the amendments made by this section, such revised regulation incorporating the modifications shall be considered to be the applicable NAIC model regulation (including the revised NAIC model regulation and the 1991 NAIC Model Regulation) for the purposes of such section.

(3) SECRETARY STANDARDS.—If the NAIC does not make the modifications described in paragraph (2) within the period specified in such paragraph, the Secretary of Health and Human Services shall make the modifications described in such paragraph and such revised regulation incorporating the modifications shall be considered to be the appropriate Regulation for the purposes of such section.

(4) DATE SPECIFIED.—

(A) IN GENERAL.—Subject to subparagraph (B), the date specified in this paragraph for a State is the earlier of—

(i) the date the State changes its statutes or regulations to conform its regulatory program to the changes made by this section, or

(ii) 1 year after the date the NAIC or the Secretary first makes the modifications under paragraph (2) or (3), respectively.

(B) ADDITIONAL LEGISLATIVE ACTION REQUIRED.—In the case of a State which the Secretary identifies as—

(i) requiring State legislation (other than legislation appropriating funds) to conform its regulatory program to the changes made in this section, but

(ii) having a legislature which is not scheduled to meet in 1999 in a legislative session in which such legislation may be considered,

the date specified in this paragraph is the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after July 1, 1999. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

SEC. 4032. MEDICARE PREPAID COMPETITIVE PRICING DEMONSTRATION PROJECT.

(a) **ESTABLISHMENT OF PROJECT.**—The Secretary of Health and Human Services shall provide, beginning not later than 1 year after the date of the enactment of this Act, for implementation of a project (in this section referred to as the “project”) to demonstrate the application of, and the consequences of applying, a market-oriented pricing system for the provision of a full range of medicare benefits in a geographic area.

(b) **RESEARCH DESIGN ADVISORY COMMITTEE.**—

(1) **IN GENERAL.**—Before implementing the project under this section, the Secretary shall appoint a national advisory committee, including independent actuaries and individuals with expertise in competitive health plan pricing, to make recommendations to the Secretary concerning the appropriate research design for implementing the project.

(2) **INITIAL RECOMMENDATIONS.**—The committee initially shall submit recommendations respecting the method for area selection, benefit design among plans offered, structuring choice among health plans offered, methods for setting the price to be paid to plans, collection of plan information (including information concerning quality and access to care), information dissemination, and methods of evaluating the results of the project.

(3) **ADVICE DURING IMPLEMENTATION.**—Upon implementation of the project, the committee shall continue to advise the Secretary on the application of the design in different areas and changes in the project based on experience with its operations.

(c) **AREA SELECTION.**—

(1) **IN GENERAL.**—Taking into account the recommendations of the advisory committee submitted under subsection (b), the Secretary shall designate areas in which the project will operate.

(2) **APPOINTMENT OF AREA ADVISORY COMMITTEE.**—Upon the designation of an area for inclusion in the project, the Secretary shall appoint an area advisory committee, composed of representatives of health plans, providers, and medicare beneficiaries in the area, to advise the Secretary concerning how the project will actually be implemented in the area. Such advice may include advice concerning the marketing and pricing of plans in the area and other salient factors relating

(d) MONITORING AND REPORT.—

(1) **MONITORING IMPACT.**—Taking into consideration the recommendations of the general advisory committee (appointed under subsection (b)), the Secretary shall closely monitor the impact of projects in areas on the price and quality of, and access to, medicare covered services, choice of health plan, changes in enrollment, and other relevant factors.

(2) **REPORT.**—The Secretary shall periodically report to Congress on the progress under the project under this section.

(e) **WAIVER AUTHORITY.**—The Secretary of Health and Human Services may waive such requirements of section 1876 (and such requirements of part C of title XVIII, as amended by chapter 1), of the Social Security Act as may be necessary for the purposes of carrying out the project.

(f) **RELATIONSHIP TO OTHER AUTHORITY.**—Except pursuant to this section the Secretary of Health and Human Services may not conduct or continue any medicare demonstration project relating to payment of health maintenance organizations, MedicarePlus organizations, or similar prepaid managed care entities on the basis of a competitive bidding process or pricing system described in subsection (a) rather than on the bases described in section 1853 or 1876 of the Social Security Act.

Subtitle B—Prevention Initiatives

SEC. 4101. SCREENING MAMMOGRAPHY.

(a) **PROVIDING ANNUAL SCREENING MAMMOGRAPHY FOR WOMEN OVER AGE 39.**—Section 1834(c)(2)(A) (42 U.S.C. 1395m(c)(2)(A)) is amended—

(1) in clause (iii), to read as follows:

“(iii) In the case of a woman over 39 years of age, payment may not be made under this part for screening mammography performed within 11 months following the month in which a previous screening mammography was performed.”; and

(2) by striking clauses (iv) and (v).

(b) **WAIVER OF DEDUCTIBLE.**—The first sentence of section 1833(b) (42 U.S.C. 1395l(b)) is amended—

(1) by striking “and” before “(4)”, and

(2) by inserting before the period at the end the following: “, and (5) such deductible shall not apply with respect to screening mammography (as described in section 1861(jj))”.

(c) **CONFORMING AMENDMENT.**—Section 1834(c)(1)(C) of such Act (42 U.S.C. 1395m(c)(1)(C)) is amended by striking “, subject to the deductible established under section 1833(b),”.

(d) **EFFECTIVE DATE.**—The amendments made by this section shall apply to items and services furnished on or after January 1, 1998.

SEC. 4102. SCREENING PAP SMEAR AND PELVIC EXAMS.

(a) **COVERAGE OF PELVIC EXAM; INCREASING FREQUENCY OF COVERAGE OF PAP SMEAR.**—Section 1861(nn) (42 U.S.C. 1395x(nn)) is amended—

(1) in the heading, by striking “Smear” and inserting “Smear; Screening Pelvic Exam”;

(2) by inserting “or vaginal” after “cervical” each place it appears;

(3) by striking “(nn)” and inserting “(nn)(1)”;

(4) 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

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

“(2) The term ‘screening pelvic exam’ means a 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 or vaginal cancer; or

“(B) is at high risk of developing cervical or vaginal cancer (as determined pursuant to factors identified by the Secretary).”.

(b) **WAIVER OF DEDUCTIBLE.**—The first sentence of section 1833(b) (42 U.S.C. 1395l(b)), as amended by section 4101(b), is amended—

(1) by striking “and” before “(5)”, and

(2) by inserting before the period at the end 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))”.

(c) **CONFORMING AMENDMENTS.**—Sections 1861(s)(14) and 1862(a)(1)(F) (42 U.S.C. 1395x(s)(14), 1395y(a)(1)(F)) are each amended by inserting “and screening pelvic exam” after “screening pap smear”.

(d) **PAYMENT UNDER PHYSICIAN FEE SCHEDULE.**—Section 1848(j)(3)(42 U.S.C. 1395w-4(j)(3)) is amended by striking “and (4)” and inserting “, (4) and (14) (with respect to services described in section 1861(nn)(2))”.

(e) **EFFECTIVE DATE.**—The amendments made by this section shall apply to items and services furnished on or after January 1, 1998.

(f) **REPORT ON RESCREENING PAP SMEARS.**—Not later than 6 months after the date of the enactment of this Act, the Secretary of Health and Human Services shall submit to Congress a report on the extent to which the use of supplemental computer-assisted diagnostic tests consisting of interactive automated computer-imaging of an exfoliative cytology test, in conjunction with the pap smears, improves the early detection of cervical or vaginal cancer and the costs implications for coverage of such supplemental tests under the medicare program.

SEC. 4103. PROSTATE CANCER SCREENING TESTS.

(a) **COVERAGE.**—Section 1861 (42 U.S.C. 1395x) is amended—

(1) in subsection (s)(2)—

(A) by striking “and” at the end of subparagraphs (N) and (O), and

- (B) by inserting after subparagraph (O) the following new subparagraph:
 “(P) prostate cancer screening tests (as defined in subsection (oo)); and”; and
 (2) by adding at the end the following new subsection:

“Prostate Cancer Screening Tests

“(oo)(1) The term ‘prostate cancer screening test’ means a test that consists of any (or all) of the procedures described in paragraph (2) provided for the purpose of early detection of prostate cancer to a man over 50 years of age who has not had such a test during the preceding year.

“(2) The procedures described in this paragraph are as follows:

“(A) A digital rectal examination.

“(B) A prostate-specific antigen blood test.

“(C) For years beginning after 2001, such other procedures as the Secretary finds appropriate for the purpose of early detection of prostate cancer, taking into account changes in technology and standards of medical practice, availability, effectiveness, costs, and such other factors as the Secretary considers appropriate.”.

(b) 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)”.

(c) CONFORMING AMENDMENT.—Section 1862(a) (42 U.S.C. 1395y(a)) is amended—

(1) in paragraph (1)—

(A) in subparagraph (E), by striking “and” at the end,

(B) in subparagraph (F), by striking the semicolon at the end and inserting “, and”, and

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

“(G) in the case of prostate cancer screening tests (as defined in section 1861(oo)), which are performed more frequently than is covered under such section;”; and

(2) in paragraph (7), by striking “paragraph (1)(B) or under paragraph (1)(F)” and inserting “subparagraphs (B), (F), or (G) of paragraph (1)”.

(d) PAYMENT UNDER PHYSICIAN FEE SCHEDULE.—Section 1848(j)(3)(42 U.S.C. 1395w-4(j)(3)), as amended by section 4102, is amended by inserting “(2)(P) (with respect to services described in subparagraphs (A) and (C) of section 1861(oo),” after “(2)(G)”

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after January 1, 1998.

SEC. 4104. COVERAGE OF COLORECTAL SCREENING.

(a) COVERAGE.—

(1) IN GENERAL.—Section 1861 (42 U.S.C. 1395x), as amended by section 4103(a), is amended—

(A) in subsection (s)(2)—

- (i) by striking “and” at the end of subparagraph (P);
 - (ii) by adding “and” at the end of subparagraph (Q);
 - and
 - (iii) by adding at the end the following new subparagraph:
- “(R) colorectal cancer screening tests (as defined in subsection (pp)); and”;
- (B) by adding at the end the following new subsection:

“Colorectal Cancer Screening Tests

“(pp)(1) The term ‘colorectal cancer screening test’ means any of the following procedures furnished to an individual for the purpose of early detection of colorectal cancer:

“(A) Screening fecal-occult blood test.

“(B) Screening flexible sigmoidoscopy.

“(C) In the case of an individual at high risk for colorectal cancer, screening colonoscopy.

“(D) Screening barium enema, if found by the Secretary to be an appropriate alternative to screening flexible sigmoidoscopy under subparagraph (B) or screening colonoscopy under subparagraph (C).

“(E) For years beginning after 2002, such other procedures as the Secretary finds appropriate for the purpose of early detection of colorectal cancer, taking into account changes in technology and standards of medical practice, availability, effectiveness, costs, and such other factors as the Secretary considers appropriate.

“(2) In paragraph (1)(C), an ‘individual at high risk for colorectal cancer’ is an individual who, because of family history, prior experience of cancer or precursor neoplastic polyps, a history of chronic digestive disease condition (including inflammatory bowel disease, Crohn’s Disease, or ulcerative colitis), the presence of any appropriate recognized gene markers for colorectal cancer, or other predisposing factors, faces a high risk for colorectal cancer.”

(2) DEADLINE FOR DECISION ON COVERAGE OF SCREENING BARIUM ENEMA.—Not later than 2 years after the date of the enactment of this section, the Secretary of Health and Human Services shall issue and publish a determination on the treatment of screening barium enema as a colorectal cancer screening test under section 1861(pp) (as added by subparagraph (B)) as an alternative procedure to a screening flexible sigmoidoscopy or screening colonoscopy.

(b) FREQUENCY AND PAYMENT LIMITS.—

(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 COLORECTAL CANCER SCREENING TESTS.—

“(1) SCREENING FECAL-OCCULT BLOOD TESTS.—

“(A) PAYMENT LIMIT.—In establishing fee schedules under section 1833(h) with respect to colorectal cancer screening tests consisting of screening fecal-occult blood tests, except as provided by the Secretary under paragraph

(4)(A), the payment amount established for tests performed—

“(i) in 1998 shall not exceed \$5; and

“(ii) in a subsequent year, shall not exceed the limit on the payment amount established under this subsection for such tests for the preceding year, adjusted by the applicable adjustment under section 1833(h) for tests performed in such year.

“(B) FREQUENCY LIMIT.—Subject to revision by the Secretary under paragraph (4)(B), no payment may be made under this part for colorectal cancer screening test consisting of a screening fecal-occult blood test—

“(i) if the individual is under 50 years of age; or

“(ii) if the test is performed within the 11 months after a previous screening fecal-occult blood test.

“(2) SCREENING FLEXIBLE SIGMOIDOSCOPIES.—

“(A) FEE SCHEDULE.—The Secretary shall establish a payment amount under section 1848 with respect to colorectal cancer screening tests consisting of screening flexible sigmoidoscopies 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) PAYMENT LIMIT.—In the case of screening flexible sigmoidoscopy services—

“(i) the payment amount may not exceed such amount as the Secretary specifies, based upon the rates recognized under this part for diagnostic flexible sigmoidoscopy services; and

“(ii) that, in accordance with regulations, may be performed in an ambulatory surgical center and for which the Secretary permits ambulatory surgical center payments under this part and that are performed in an ambulatory surgical center or hospital outpatient department, the payment amount under this part may not exceed the lesser of (I) the payment rate that would apply to such services if they were performed in a hospital outpatient department, or (II) the payment rate that would apply to such services if they were performed in an ambulatory surgical center.

“(C) SPECIAL RULE FOR DETECTED LESIONS.—If during the course of such screening flexible sigmoidoscopy, a lesion or growth is detected which results in a biopsy or removal of the lesion or growth, payment under this part shall not be made for the screening flexible sigmoidoscopy but shall be made for the procedure classified as a flexible sigmoidoscopy with such biopsy or removal.

“(D) FREQUENCY LIMIT.—Subject to revision by the Secretary under paragraph (4)(B), no payment may be made under this part for a colorectal cancer screening test consisting of a screening flexible sigmoidoscopy—

“(i) if the individual is under 50 years of age; or

“(ii) if the procedure is performed within the 47 months after a previous screening flexible sigmoidoscopy.

“(3) SCREENING COLONOSCOPY FOR INDIVIDUALS AT HIGH RISK FOR COLORECTAL CANCER.—

“(A) FEE SCHEDULE.—The Secretary shall establish a payment amount under section 1848 with respect to colorectal cancer screening test consisting of a screening colonoscopy for individuals at high risk for colorectal cancer (as defined in section 1861(pp)(2)) 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) PAYMENT LIMIT.—In the case of screening colonoscopy services—

“(i) the payment amount may not exceed such amount as the Secretary specifies, based upon the rates recognized under this part for diagnostic colonoscopy services; and

“(ii) that are performed in an ambulatory surgical center or hospital outpatient department, the payment amount under this part may not exceed the lesser of (I) the payment rate that would apply to such services if they were performed in a hospital outpatient department, or (II) the payment rate that would apply to such services if they were performed in an ambulatory surgical center.

“(C) SPECIAL RULE FOR DETECTED LESIONS.—If during the course of such screening colonoscopy, a lesion or growth is detected which results in a biopsy or removal of the lesion or growth, payment under this part shall not be made for the screening colonoscopy but shall be made for the procedure classified as a colonoscopy with such biopsy or removal.

“(D) FREQUENCY LIMIT.—Subject to revision by the Secretary under paragraph (4)(B), no payment may be made under this part for a colorectal cancer screening test consisting of a screening colonoscopy for individuals at high risk for colorectal cancer if the procedure is performed within the 23 months after a previous screening colonoscopy.

“(4) REDUCTIONS IN PAYMENT LIMIT AND REVISION OF FREQUENCY.—

“(A) REDUCTIONS IN PAYMENT LIMIT FOR SCREENING FECAL-OCCULT BLOOD TESTS.—The Secretary shall review from time to time the appropriateness of the amount of the payment limit established for screening fecal-occult blood tests under paragraph (1)(A). The Secretary may, with respect to tests performed in a year after 2000, reduce the amount of such limit as it applies nationally or in any area to the amount that the Secretary estimates is required to assure that such tests of an appropriate quality are readily and conveniently available during the year.

“(B) REVISION OF FREQUENCY.—

“(i) REVIEW.—The Secretary shall review periodically the appropriate frequency for performing colorectal cancer screening tests based on age and such other factors as the Secretary believes to be pertinent.

“(ii) 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 may be paid for under this subsection, but no such revision shall apply to tests performed before January 1, 2001.

“(5) LIMITING CHARGES OF NONPARTICIPATING PHYSICIANS.—

“(A) IN GENERAL.—In the case of a colorectal cancer screening test consisting of a screening flexible sigmoidoscopy or a screening colonoscopy provided to an individual at high risk for colorectal cancer for which payment may be made under this part, if a nonparticipating physician provides the procedure to an individual enrolled under this part, the physician may not charge the individual more than the limiting charge (as defined in section 1848(g)(2)).

“(B) ENFORCEMENT.—If a physician or supplier knowing and willfully imposes a charge in violation of subparagraph (A), the Secretary may apply sanctions against such physician or supplier in accordance with section 1842(j)(2).”

(2) SPECIAL RULE FOR SCREENING BARIUM ENEMA.—If the Secretary of Health and Human Services issues a determination under subsection (a)(2) that screening barium enema should be covered as a colorectal cancer screening test under section 1861(pp) (as added by subsection (a)(1)(B)), the Secretary shall establish frequency limits (including revisions of frequency limits) for such procedure consistent with the frequency limits for other colorectal cancer screening tests under section 1834(d) (as added by subsection (b)(1)), and shall establish payment limits (including limits on charges of nonparticipating physicians) for such procedure consistent with the payment limits under part B of title XVIII for diagnostic barium enema procedures.

(c) CONFORMING AMENDMENTS.—(1) Paragraphs (1)(D) and (2)(D) of section 1833(a) (42 U.S.C. 1395l(a)) are each amended by inserting “or section 1834(d)(1)” after “subsection (h)(1)”.

(2) Section 1833(h)(1)(A) (42 U.S.C. 1395l(h)(1)(A)) is amended by striking “The Secretary” and inserting “Subject to paragraphs (1) and (4)(A) of section 1834(d), the Secretary”.

(3) Clauses (i) and (ii) of section 1848(a)(2)(A) (42 U.S.C. 1395w-4(a)(2)(A)) are each amended by inserting after “a service” the following: “(other than a colorectal cancer screening test consisting of a screening colonoscopy provided to an individual at high risk for colorectal cancer or a screening flexible sigmoidoscopy)”.

(4) Section 1862(a) (42 U.S.C. 1395y(a)), as amended by section 4103(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 colorectal cancer screening tests, which are performed more frequently than is covered under section 1834(d);” and
- (B) in paragraph (7), by striking “or (G)” and inserting “(G), or (H)”.
- (d) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after January 1, 1998.

SEC. 4105. DIABETES SCREENING TESTS.

(a) COVERAGE OF DIABETES OUTPATIENT SELF-MANAGEMENT TRAINING SERVICES.—

(1) IN GENERAL.—Section 1861 (42 U.S.C. 1395x), as amended by sections 4103(a) and 4104(a), is amended—

- (A) in subsection (s)(2)—
 - (i) by striking “and” at the end of subparagraph (Q);
 - (ii) by adding “and” at the end of subparagraph (R);
 - and
 - (iii) by adding at the end the following new subparagraph:
 - “(S) diabetes outpatient self-management training services (as defined in subsection (qq)); and”; and
- (B) by adding at the end the following new subsection:

“Diabetes Outpatient Self-Management Training Services

“(qq)(1) The term ‘diabetes outpatient self-management training services’ means educational and training services furnished to an individual with diabetes by 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 a physician, or other individual or entity designated by the Secretary, 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) a physician, or such other individual or entity, meets the quality standards described in this paragraph if the physician, or individual or entity, meets quality standards established by the Secretary, except that the physician or other individual or entity shall be deemed to have met such standards if the physician or other 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 an organization that represents individuals (including individuals under this title) with diabetes as meeting standards for furnishing the services.”.

(2) PAYMENT UNDER PHYSICIAN FEE SCHEDULE.—Section 1848(j)(3)(42 U.S.C. 1395w-4(j)(3)) as amended in sections 4102 and 4103, is amended by inserting “(2)(S),” before “(3),”.

(3) CONSULTATION WITH ORGANIZATIONS IN ESTABLISHING PAYMENT AMOUNTS FOR SERVICES PROVIDED BY PHYSICIANS.—In establishing payment amounts under section 1848 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 such organizations representing individuals or medicare beneficiaries with diabetes, in determining the relative value for such services under section 1848(c)(2) of such Act.

(b) BLOOD-TESTING STRIPS FOR INDIVIDUALS WITH DIABETES.—

(1) INCLUDING STRIPS AND MONITORS AS DURABLE MEDICAL EQUIPMENT.—The first sentence of section 1861(n) (42 U.S.C. 1395x(n)) is amended by inserting before the semicolon the following: “, and includes blood-testing strips and blood glucose monitors for individuals with diabetes without regard to whether the individual has Type I or Type II diabetes or to the individual’s use of insulin (as determined under standards established by the Secretary in consultation with the appropriate organizations)”.

(2) 10 PERCENT REDUCTION IN PAYMENTS FOR TESTING STRIPS.—Section 1834(a)(2)(B)(iv) (42 U.S.C. 1395m(a)(2)(B)(iv)) is amended by adding before the period the following: “(reduced by 10 percent, in the case of a blood glucose testing strip furnished after 1997 for an individual with diabetes)”.

(c) ESTABLISHMENT OF OUTCOME MEASURES FOR BENEFICIARIES WITH DIABETES.—

(1) IN GENERAL.—The Secretary of Health and Human Services, in consultation with appropriate organizations, shall establish outcome measures, including glycosylated hemoglobin (past 90-day average blood sugar levels), for purposes of evaluating the improvement of the health status of medicare beneficiaries with diabetes mellitus.

(2) RECOMMENDATIONS FOR MODIFICATIONS TO SCREENING BENEFITS.—Taking into account information on the health status of medicare beneficiaries with diabetes mellitus as measured under the outcome measures established under subparagraph (A), the Secretary shall from time to time submit recommendations to Congress regarding modifications to the coverage of services for such beneficiaries under the medicare program.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after January 1, 1998.

SEC. 4106. STANDARDIZATION OF MEDICARE COVERAGE OF BONE MASS MEASUREMENTS.

(a) IN GENERAL.—Section 1861 (42 U.S.C. 1395x), as amended by sections 4103(a), 4104(a), 4105(a), is amended—

(1) in subsection (s)—

(A) in paragraph (12)(C), by striking “and” at the end,

(B) by striking the period at the end of paragraph (14) and inserting “; and”,

(C) by redesignating paragraphs (15) and (16) as paragraphs (16) and (17), respectively, and

(D) by inserting after paragraph (14) the following new paragraph:

“(15) bone mass measurement (as defined in subsection (rr)).”; and

(2) by inserting after subsection (qq) the following new subsection:

“Bone Mass Measurement

“(rr)(1) The term ‘bone mass measurement’ means a radiologic or radioisotopic procedure or other procedure approved by the Food and Drug Administration performed on a qualified individual (as defined in paragraph (2)) for the purpose of identifying bone mass or detecting bone loss or determining bone quality, and includes a physician’s interpretation of the results of the procedure.

“(2) For purposes of this subsection, the term ‘qualified individual’ means an individual who is (in accordance with regulations prescribed by the Secretary)—

“(A) an estrogen-deficient woman at clinical risk for osteoporosis;

“(B) an individual with vertebral abnormalities;

“(C) an individual receiving long-term glucocorticoid steroid therapy;

“(D) an individual with primary hyperparathyroidism; or

“(E) an individual being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy.

“(3) The Secretary shall establish such standards regarding the frequency with which a qualified individual shall be eligible to be provided benefits for bone mass measurement under this title.”.

(b) PAYMENT UNDER PHYSICIAN FEE SCHEDULE.—Section 1848(j)(3) (42 U.S.C. 1395w-4(j)(3)), as amended by sections 4102, 4103, and 4105, is amended—

(1) by striking “(4) and (14)” and inserting “(4), (14)” and

(2) by inserting “and (15)” after “1861(nn)(2)”.

(c) CONFORMING AMENDMENTS.—Sections 1864(a), 1902(a)(9)(C), and 1915(a)(1)(B)(ii)(I) (42 U.S.C. 1395aa(a), 1396a(a)(9)(C), and 1396n(a)(1)(B)(ii)(I)) are amended by striking “paragraphs (15) and (16)” each place it appears and inserting “paragraphs (16) and (17)”.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to bone mass measurements performed on or after July 1, 1998.

SEC. 4107. VACCINES OUTREACH EXPANSION.

(a) EXTENSION OF INFLUENZA AND PNEUMOCOCCAL VACCINATION CAMPAIGN.—In order to increase utilization of pneumococcal and

influenza vaccines in medicare beneficiaries, the Influenza and Pneumococcal Vaccination Campaign carried out by the Health Care Financing Administration in conjunction with the Centers for Disease Control and Prevention and the National Coalition for Adult Immunization, is extended until the end of fiscal year 2002.

(b) APPROPRIATION.—There are hereby appropriated for each of fiscal years 1998 through 2002, \$8,000,000 to the Campaign described in subsection (a). Of the amount of such appropriation in each fiscal year, 60 percent of such appropriation shall be payable from the Federal Hospital Insurance Trust Fund, and 40 percent shall be payable from the Federal Supplementary Medical Insurance Trust Fund under title XVIII of the Social Security Act (42 U.S.C. 1395i, 1395t).

SEC. 4108. STUDY ON PREVENTIVE BENEFITS.

(a) STUDY.—The Secretary of Health and Human Services shall request the National Academy of Sciences, in conjunction with the United States Preventive Services Task Force, to analyze the expansion or modification of preventive benefits provided to medicare beneficiaries under title XVIII of the Social Security Act. The analysis shall consider both the short term and long term benefits, and costs to the medicare program, of such expansion or modification,

(b) REPORT.—

(1) INITIAL REPORT.—Not later than 2 years after the date of the enactment of this Act, the Secretary shall submit a report on the findings of the analysis conducted under subsection (a) to the Committee on Ways and Means and the Committee on Commerce of the House of Representatives and the Committee on Finance of the Senate.

(2) CONTENTS.—Such report shall include specific findings with respect to coverage of the following preventive benefits:

(A) Nutrition therapy, including parenteral and enteral nutrition.

(B) Skin cancer screening.

(C) Medically necessary dental care.

(D) Routine patient care costs for beneficiaries enrolled in approved clinical trial programs.

(E) Elimination of time limitation for coverage of immunosuppressive drugs for transplant patients.

(3) FUNDING.—From funds appropriated to the Department of Health and Human Services for fiscal years 1998 and 1999, the Secretary shall provide for such funding as may be necessary for the conduct of the analysis by the National Academy of Sciences under this section.

Subtitle C—Rural Initiatives

SEC. 4206. INFORMATICS, TELEMEDICINE, AND EDUCATION DEMONSTRATION PROJECT.

(a) PURPOSE AND AUTHORIZATION.—

(1) IN GENERAL.—Not later than 9 months after the date of enactment of this section, the Secretary of Health and Human Services shall provide for a demonstration project described in paragraph (2).

(2) DESCRIPTION OF PROJECT.—

(A) IN GENERAL.—The demonstration project described in this paragraph is a single demonstration project to use eligible health care provider telemedicine networks to apply high-capacity computing and advanced networks to improve primary care (and prevent health care complications) to medicare beneficiaries with diabetes mellitus who are residents of medically underserved rural areas or residents of medically underserved inner-city areas.

(B) MEDICALLY UNDERSERVED DEFINED.—As used in this paragraph, the term “medically underserved” has the meaning given such term in section 330(b)(3) of the Public Health Service Act (42 U.S.C. 254b(b)(3)).

(3) WAIVER.—The Secretary shall waive such provisions of title XVIII of the Social Security Act as may be necessary to provide for payment for services under the project in accordance with subsection (d).

(4) DURATION OF PROJECT.—The project shall be conducted over a 4-year period.

(b) OBJECTIVES OF PROJECT.—The objectives of the project include the following:

(1) Improving patient access to and compliance with appropriate care guidelines for individuals with diabetes mellitus through direct telecommunications link with information networks in order to improve patient quality-of-life and reduce overall health care costs.

(2) Developing a curriculum to train, and providing standards for credentialing and licensure of, health professionals (particularly primary care health professionals) in the use of medical informatics and telecommunications.

(3) Demonstrating the application of advanced technologies, such as video-conferencing from a patient’s home, remote monitoring of a patient’s medical condition, interventional informatics, and applying individualized, automated care guidelines, to assist primary care providers in assisting patients with diabetes in a home setting.

(4) Application of medical informatics to residents with limited English language skills.

(5) Developing standards in the application of telemedicine and medical informatics.

(6) Developing a model for the cost-effective delivery of primary and related care both in a managed care environment and in a fee-for-service environment.

(c) ELIGIBLE HEALTH CARE PROVIDER TELEMEDICINE NETWORK DEFINED.—For purposes of this section, the term “eligible health care provider telemedicine network” means a consortium that includes at least one tertiary care hospital (but no more than 2 such hospitals), at least one medical school, no more than 4 facilities in rural or urban areas, and at least one regional telecommunications provider and that meets the following requirements:

(1) The consortium is located in an area with one of the highest concentrations of medical schools and tertiary care facilities in the United States and has appropriate arrangements (within or outside the consortium) with such schools and facilities,

universities, and telecommunications providers, in order to conduct the project.

(2) The consortium submits to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require, including a description of the use to which the consortium would apply any amounts received under the project and the source and amount of non-Federal funds used in the project.

(3) The consortium guarantees that it will be responsible for payment for all costs of the project that are not paid under this section and that the maximum amount of payment that may be made to the consortium under this section shall not exceed the amount specified in subsection (d)(3).

(d) COVERAGE AS MEDICARE PART B SERVICES.—

(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, services related to the treatment or management of (including prevention of complications from) diabetes for medicare beneficiaries furnished under the project shall be considered to be services covered under part B of title XVIII of the Social Security Act.

(2) PAYMENTS.—

(A) IN GENERAL.—Subject to paragraph (3), payment for such services shall be made at a rate of 50 percent of the costs that are reasonable and related to the provision of such services. In computing such costs, the Secretary shall include costs described in subparagraph (B), but may not include costs described in subparagraph (C).

(B) COSTS THAT MAY BE INCLUDED.—The costs described in this subparagraph are the permissible costs (as recognized by the Secretary) for the following:

(i) The acquisition of telemedicine equipment for use in patients' homes (but only in the case of patients located in medically underserved areas).

(ii) Curriculum development and training of health professionals in medical informatics and telemedicine.

(iii) Payment of telecommunications costs (including salaries and maintenance of equipment), including costs of telecommunications between patients' homes and the eligible network and between the network and other entities under the arrangements described in subsection (c)(1).

(iv) Payments to practitioners and providers under the medicare programs.

(C) COSTS NOT INCLUDED.—The costs described in this subparagraph are costs for any of the following:

(i) The purchase or installation of transmission equipment (other than such equipment used by health professionals to deliver medical informatics services under the project).

(ii) The establishment or operation of a telecommunications common carrier network.

(iii) Construction (except for minor renovations related to the installation of reimbursable equipment) or the acquisition or building of real property.

(3) **LIMITATION.**—The total amount of the payments that may be made under this section shall not exceed \$30,000,000.

(4) **LIMITATION ON COST-SHARING.**—The project may not impose cost sharing on a medicare beneficiary for the receipt of services under the project in excess of 20 percent of the recognized costs of the project attributable to such services.

(e) **REPORTS.**—The Secretary shall submit to the Committees on Ways and Means and Commerce of the House of Representatives and the Committee on Finance of the Senate interim reports on the project and a final report on the project within 6 months after the conclusion of the project. The final report shall include an evaluation of the impact of the use of telemedicine and medical informatics on improving access of medicare beneficiaries to health care services, on reducing the costs of such services, and on improving the quality of life of such beneficiaries.

(f) **DEFINITIONS.**—For purposes of this section:

(1) **INTERVENTIONAL INFORMATICS.**—The term “interventional informatics” means using information technology and virtual reality technology to intervene in patient care.

(2) **MEDICAL INFORMATICS.**—The term “medical informatics” means the storage, retrieval, and use of biomedical and related information for problem solving and decision-making through computing and communications technologies.

(3) **PROJECT.**—The term “project” means the demonstration project under this section.

Subtitle D—Anti-Fraud and Abuse Provisions

SEC. 4301. PERMANENT EXCLUSION FOR THOSE CONVICTED OF 3 HEALTH CARE RELATED CRIMES.

Section 1128(c)(3) (42 U.S.C. 1320a–7(c)(3)) is amended—

(1) in subparagraph (A), by inserting “or in the case described in subparagraph (G)” after “subsection (b)(12)”;

(2) in subparagraphs (B) and (D), by striking “In the case” and inserting “Subject to subparagraph (G), in the case”; and

(3) by adding at the end the following new subparagraph:

“(G) In the case of an exclusion of an individual under subsection (a) based on a conviction occurring on or after the date of the enactment of this subparagraph, if the individual has (before, on, or after such date and before the date of the conviction for which the exclusion is imposed) been convicted—

“(i) on one previous occasion of one or more offenses for which an exclusion may be effected under such subsection, the period of the exclusion shall be not less than 10 years, or

“(ii) on 2 or more previous occasions of one or more offenses for which an exclusion may be effected under such subsection, the period of the exclusion shall be permanent.”.

SEC. 4302. AUTHORITY TO REFUSE TO ENTER INTO MEDICARE AGREEMENTS WITH INDIVIDUALS OR ENTITIES CONVICTED OF FELONIES.

(a) **MEDICARE PART A.**—Section 1866(b)(2) (42 U.S.C. 1395cc(b)(2)) is amended—

- (1) by striking “or” at the end of subparagraph (B);
- (2) by striking the period at the end of subparagraph (C) and inserting “, or”; and
- (3) by adding after subparagraph (C) the following new subparagraph:

“(D) has ascertained that the provider has been convicted of a felony under Federal or State law for an offense which the Secretary determines is inconsistent with the best interests of program beneficiaries.”

(b) **MEDICARE PART B.**—Section 1842 (42 U.S.C. 1395u) is amended by adding after subsection (r) the following new subsection:

“(s) The Secretary may refuse to enter into an agreement with a physician or supplier under subsection (h) or may terminate or refuse to renew such agreement, in the event that such physician or supplier has been convicted of a felony under Federal or State law for an offense which the Secretary determines is inconsistent with the best interests of program beneficiaries.”

(c) **MEDICAID.**—Section 1902(a)(23) (42 U.S.C. 1396(a)) is amended—

- (1) by relocating the matter that precedes “provide that, (A)” immediately before the semicolon;
- (2) by inserting a semicolon after “1915”;
- (3) by striking the comma after “Guam” and inserting a semicolon; and
- (4) by inserting before the semicolon at the end the following: “and except that this provision does not require a State to provide medical assistance for such services furnished by a person or entity convicted of a felony under Federal or State law for an offense which the State agency determines is inconsistent with the best interests of beneficiaries under the State plan”.

(d) **EFFECTIVE DATE.**—The amendments made by this section shall take effect on the date of the enactment of this Act and apply to the entry and renewal of contracts on or after such date.

SEC. 4303. INCLUSION OF TOLL-FREE NUMBER TO REPORT MEDICARE WASTE, FRAUD, AND ABUSE IN EXPLANATION OF BENEFITS FORMS.

(a) **IN GENERAL.**—Section 1842(h)(7) (42 U.S.C. 1395u(h)(7)) is amended—

- (1) by striking “and” at the end of subparagraph (D),
- (2) by striking the period at the end of subparagraph (E), and
- (3) by adding at the end the following new subparagraph: “(E) a toll-free telephone number maintained by the Inspector General in the Department of Health and Human Services for the receipt of complaints and information about waste, fraud, and abuse in the provision or billing of services under this title.”

(b) **EFFECTIVE DATE.**—The amendments made by subsection (a) shall apply to explanations of benefits provided on or after such date (not later than January 1, 1999) as the Secretary of Health and Human Services shall provide.

SEC. 4304. LIABILITY OF MEDICARE CARRIERS AND FISCAL INTERMEDIARIES FOR CLAIMS SUBMITTED BY EXCLUDED PROVIDERS.

(a) REIMBURSEMENT TO THE SECRETARY FOR AMOUNTS PAID TO EXCLUDED PROVIDERS.—

(1) REQUIREMENTS FOR FISCAL INTERMEDIARIES.—

(A) IN GENERAL.—Section 1816 (42 U.S.C. 1395h) is amended by adding at the end the following new subsection:

“(m) An agreement with an agency or organization under this section shall require that such agency or organization reimburse the Secretary for any amounts paid by the agency or organization for a service under this title which is furnished, directed, or prescribed by an individual or entity during any period for which the individual or entity is excluded pursuant to section 1128, 1128A, or 1156, from participation in the program under this title, if the amounts are paid after the Secretary notifies the agency or organization of the exclusion.”

(B) CONFORMING AMENDMENT.—Subsection (i) of such section is amended by adding at the end the following new paragraph:

“(4) Nothing in this subsection shall be construed to prohibit reimbursement by an agency or organization under subsection (m).”

(2) REQUIREMENTS FOR CARRIERS.—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 reimburse the Secretary for any amounts paid by the carrier for an item or service under this part which is furnished, directed, or prescribed by an individual or entity during any period for which the individual or entity is excluded pursuant to section 1128, 1128A, or 1156, from participation in the program under this title, if the amounts are paid after the Secretary notifies the carrier of the exclusion, and”.

(3) MEDICAID PROVISION.—Section 1902(a)(39) (42 U.S.C. 1396a(a)(39)) is amended by inserting before the semicolon at the end the following: “, and provide further for reimbursement to the Secretary of any payments made under the plan or any item or service furnished, directed, or prescribed by the excluded individual or entity during such period, after the Secretary notifies the State of such exclusion”.

(b) CONFORMING REPEAL OF MANDATORY PAYMENT RULE.—Paragraph (2) of section 1862(e) (42 U.S.C. 1395y(e)) is amended to read as follows:

“(2) No individual or entity may bill (or collect any amount from) any individual for any item or service for which payment is denied under paragraph (1). No person is liable for payment of any amounts billed for such an item or service in violation of the previous sentence.”

(c) EFFECTIVE DATES.—The amendments made by this section shall apply to contracts and agreements entered into, renewed, or extended after the date of the enactment of this Act, but only with respect to claims submitted on or after the later of January 1,

1998, or the date such entry, renewal, or extension becomes effective.

SEC. 4305. EXCLUSION OF ENTITY CONTROLLED BY FAMILY MEMBER OF A SANCTIONED INDIVIDUAL.

(a) IN GENERAL.—Section 1128 (42 U.S.C. 1320a–7) is amended—

(1) in subsection (b)(8)(A)—

(A) by striking “or” at the end of clause (i), and

(B) by striking the dash at the end of clause (ii) and inserting “; or”, and

(C) by inserting after clause (ii) the following:

“(iii) who was described in clause (i) but is no longer so described because of a transfer of ownership or control interest, in anticipation of (or following) a conviction, assessment, or exclusion described in subparagraph (B) against the person, to an immediate family member (as defined in subsection (j)(1)) or a member of the household of the person (as defined in subsection (j)(2)) who continues to maintain an interest described in such clause—”; and

(2) by adding after subsection (i) the following new subsection:

“(j) DEFINITION OF IMMEDIATE FAMILY MEMBER AND MEMBER OF HOUSEHOLD.—For purposes of subsection (b)(8)(A)(iii):

“(1) The term ‘immediate family member’ means, with respect to a person—

“(A) the husband or wife of the person;

“(B) the natural or adoptive parent, child, or sibling of the person;

“(C) the stepparent, stepchild, stepbrother, or stepsister of the person;

“(D) the father-, mother-, daughter-, son-, brother-, or sister-in-law of the person;

“(E) the grandparent or grandchild of the person; and

“(F) the spouse of a grandparent or grandchild of the person.

“(2) The term ‘member of the household’ means, with respect to a person, any individual sharing a common abode as part of a single family unit with the person, including domestic employees and others who live together as a family unit, but not including a roomer or boarder.”.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall take effect on the date that is 45 days after the date of the enactment of this Act.

SEC. 4306. IMPOSITION OF CIVIL MONEY PENALTIES.

(a) CIVIL MONEY PENALTIES FOR PERSONS THAT CONTRACT WITH EXCLUDED INDIVIDUALS.—Section 1128A(a) (42 U.S.C. 1320a–7a(a)) is amended—

(1) by striking “or” at the end of paragraph (4);

(2) by adding “or” at the end of paragraph (5); and

(3) by adding after paragraph (5) the following new paragraph:

“(6) arranges or contracts (by employment or otherwise) with an individual or entity that the person knows or should know is excluded from participation in a Federal health care pro-

gram (as defined in section 1128B(f), for the provision of items or services for which payment may be made under such a program;”.

(b) EFFECTIVE DATES.—The amendments made by subsection (a) shall apply to arrangements and contracts entered into after the date of the enactment of this Act.

SEC. 4307. DISCLOSURE OF INFORMATION AND SURETY BONDS.

(a) DISCLOSURE OF INFORMATION AND SURETY BOND REQUIREMENT FOR SUPPLIERS OF DURABLE MEDICAL EQUIPMENT.—Section 1834(a) (42 U.S.C. 1395m(a)) is amended by inserting after paragraph (15) the following new paragraph:

“(16) CONDITIONS FOR ISSUANCE OF PROVIDER NUMBER.—The Secretary shall not provide for the issuance (or renewal) of a provider number for a supplier of durable medical equipment, for purposes of payment under this part for durable medical equipment furnished by the supplier, unless the supplier provides the Secretary on a continuing basis with—

“(A)(i) full and complete information as to the identity of each person with an ownership or control interest (as defined in section 1124(a)(3)) in the supplier or in any subcontractor (as defined by the Secretary in regulations) in which the supplier directly or indirectly has a 5 percent or more ownership interest, and

“(ii) to the extent determined to be feasible under regulations of the Secretary, the name of any disclosing entity (as defined in section 1124(a)(2)) with respect to which a person with such an ownership or control interest in the supplier is a person with such an ownership or control interest in the disclosing entity; and

“(B) a surety bond in a form specified by the Secretary and in an amount that is not less than \$50,000.

The Secretary may waive the requirement of a bond under subparagraph (B) in the case of a supplier that provides a comparable surety bond under State law.”.

(b) SURETY BOND REQUIREMENT FOR HOME HEALTH AGENCIES.—

(1) IN GENERAL.—Section 1861(o) (42 U.S.C. 1395x(o)) is amended—

(A) in paragraph (7), by inserting “and including providing the Secretary on a continuing basis with a surety bond in a form specified by the Secretary and in an amount that is not less than \$50,000,” after “financial security of the program”, and

(B) by adding at the end the following: “The Secretary may waive the requirement of a bond under paragraph (7) in the case of an agency or organization that provides a comparable surety bond under State law.”.

(2) CONFORMING AMENDMENTS.—Section 1861(v)(1)(H) (42 U.S.C. 1395x(v)(1)(H)) is amended—

(A) in clause (i), by striking “the financial security requirement” and inserting “the financial security and surety bond requirements”; and

(B) in clause (ii), by striking “the financial security requirement described in subsection (o)(7) applies” and in-

serting “the financial security and surety bond requirements described in subsection (o)(7) apply”.

(3) REFERENCE TO CURRENT DISCLOSURE REQUIREMENT.—For provision of current law requiring home health agencies to disclose information on ownership and control interests, see section 1124 of the Social Security Act.

(c) AUTHORIZING APPLICATION OF DISCLOSURE AND SURETY BOND REQUIREMENTS TO AMBULANCE SERVICES AND CERTAIN CLINICS.—Section 1834(a)(16) (42 U.S.C. 1395m(a)(16)), as added by subsection (a), is amended by adding at the end the following: “The Secretary, in the Secretary’s discretion, may impose the requirements of the previous sentence with respect to some or all classes of suppliers of ambulance services described in section 1861(s)(7) and clinics that furnish medical and other health services (other than physicians’ services) under this part.”.

(d) APPLICATION TO COMPREHENSIVE OUTPATIENT REHABILITATION FACILITIES (CORFs).—Section 1861(cc)(2) (42 U.S.C. 1395x(cc)(2)) is amended—

(1) in subparagraph (I), by inserting before the period at the end the following: “and providing the Secretary on a continuing basis with a surety bond in a form specified by the Secretary and in an amount that is not less than \$50,000”, and

(2) by adding after and below subparagraph (I) the following: “The Secretary may waive the requirement of a bond under subparagraph (I) in the case of a facility that provides a comparable surety bond under State law.”.

(e) APPLICATION TO REHABILITATION AGENCIES.—Section 1861(p) (42 U.S.C. 1395x(p)) is amended—

(1) in paragraph (4)(A)(v), by inserting after “as the Secretary may find necessary,” the following: “and provides the Secretary, to the extent required by the Secretary, on a continuing basis with a surety bond in a form specified by the Secretary and in an amount that is not less than \$50,000”, and

(2) by adding at the end the following: “The Secretary may waive the requirement of a bond under paragraph (4)(A)(v) in the case of a clinic or agency that provides a comparable surety bond under State law.”.

(f) EFFECTIVE DATES.—(1) The amendment made by subsection (a) shall apply to suppliers of durable medical equipment with respect to such equipment furnished on or after January 1, 1998.

(2) The amendments made by subsection (b) shall apply to home health agencies with respect to services furnished on or after such date. The Secretary of Health and Human Services shall modify participation agreements under section 1866(a)(1) of the Social Security Act with respect to home health agencies to provide for implementation of such amendments on a timely basis.

(3) The amendments made by subsections (c) through (e) shall take effect on the date of the enactment of this Act and may be applied with respect to items and services furnished on or after the date specified in paragraph (1).

SEC. 4308. PROVISION OF CERTAIN IDENTIFICATION NUMBERS.

(a) REQUIREMENTS TO DISCLOSE EMPLOYER IDENTIFICATION NUMBERS (EINS) AND SOCIAL SECURITY ACCOUNT NUMBERS (SSNs).—Section 1124(a)(1) (42 U.S.C. 1320a–3(a)(1)) is amended by insert-

ing before the period at the end the following: “and supply the Secretary with both the employer identification number (assigned pursuant to section 6109 of the Internal Revenue Code of 1986) and social security account number (assigned under section 205(c)(2)(B)) of the disclosing entity, each person with an ownership or control interest (as defined in subsection (a)(3)), and any subcontractor in which the entity directly or indirectly has a 5 percent or more ownership interest. Use of the social security account number under this section shall be limited to identity verification and identity matching purposes only. The social security account number shall not be disclosed to any person or entity other than the Secretary, the Social Security Administration, or the Secretary of the Treasury, In obtaining the social security account numbers of the disclosing entity and other persons described in this section, the Secretary shall comply with section 7 of the Privacy Act of 1974 (5 U.S.C. 552a note)”.

(b) OTHER MEDICARE PROVIDERS.—Section 1124A (42 U.S.C. 1320a–3a) is amended—

(1) in subsection (a)—

(A) by striking “and” at the end of paragraph (1);

(B) by striking the period at the end of paragraph (2) and inserting “; and”; and

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

“(3) including the employer identification number (assigned pursuant to section 6109 of the Internal Revenue Code of 1986) and social security account number (assigned under section 205(c)(2)(B)) of the disclosing part B provider and any person, managing employee, or other entity identified or described under paragraph (1) or (2).”; and

(2) in subsection (c) by inserting “(or, for purposes of subsection (a)(3), any entity receiving payment)” after “on an assignment-related basis”.

(c) VERIFICATION BY SOCIAL SECURITY ADMINISTRATION (SSA).—Section 1124A (42 U.S.C. 1320a–3a) is amended—

(1) by redesignating subsection (c) as subsection (d); and

(2) by inserting after subsection (b) the following new subsection:

“(c) VERIFICATION.—

“(1) TRANSMITTAL BY HHS.—The Secretary shall transmit—

“(A) to the Commissioner of Social Security information concerning each social security account number (assigned under section 205(c)(2)(B)), and

“(B) to the Secretary of the Treasury information concerning each employer identification number (assigned pursuant to section 6109 of the Internal Revenue Code of 1986),

supplied to the Secretary pursuant to subsection (a)(3) or section 1124(c) to the extent necessary for verification of such information in accordance with paragraph (2).

“(2) VERIFICATION.—The Commissioner of Social Security and the Secretary of the Treasury shall verify the accuracy of, or correct, the information supplied by the Secretary to such official pursuant to paragraph (1), and shall report such verifications or corrections to the Secretary.

“(3) FEES FOR VERIFICATION.—The Secretary shall reimburse the Commissioner and Secretary of the Treasury, at a rate negotiated between the Secretary and such official, for the costs incurred by such official in performing the verification and correction services described in this subsection.”

(d) REPORT.—Before this subsection shall be effective, the Secretary of Health and Human Services shall submit to Congress a report on steps the Secretary has taken to assure the confidentiality of social security account numbers that will be provided to the Secretary under the amendments made by this section. If Congress determines that the Secretary has not taken adequate steps to assure the confidentiality of social security account numbers to be provided to the Secretary under the amendments made by this section, the amendments made by this section shall not take effect.

(e) EFFECTIVE DATES.—Subject to subsection (d)—

(1) the amendment made by subsection (a) shall apply to the application of conditions of participation, and entering into and renewal of contracts and agreements, occurring more than 90 days after the date of submission of the report under subsection (d); and

(2) the amendments made by subsection (b) shall apply to payment for items and services furnished more than 90 days after the date of submission of such report.

SEC. 4309. ADVISORY OPINIONS REGARDING CERTAIN PHYSICIAN SELF-REFERRAL PROVISIONS.

Section 1877(g) (42 U.S.C. 1395nn(g)) is amended by adding at the end the following new paragraph:

“(6) ADVISORY OPINIONS.—

“(A) IN GENERAL.—The Secretary shall issue written advisory opinions concerning whether a referral relating to designated health services (other than clinical laboratory services) is prohibited under this section.

“(B) BINDING AS TO SECRETARY AND PARTIES INVOLVED.—Each advisory opinion issued by the Secretary shall be binding as to the Secretary and the party or parties requesting the opinion.

“(C) APPLICATION OF CERTAIN PROCEDURES.—The Secretary shall, to the extent practicable, apply the regulations promulgated under section 1128D(b)(5) to the issuance of advisory opinions under this paragraph.

“(D) APPLICABILITY.—This paragraph shall apply to requests for advisory opinions made during the period described in section 1128D(b)(6).”

SEC. 4310. NONDISCRIMINATION IN POST-HOSPITAL REFERRAL TO HOME HEALTH AGENCIES.

(a) NOTIFICATION OF AVAILABILITY OF HOME HEALTH AGENCIES AS PART OF DISCHARGE PLANNING PROCESS.—Section 1861(ee)(2) (42 U.S.C. 1395x(ee)(2)) is amended—

(1) in subparagraph (D), by inserting before the period the following: “, including the availability of home health services through individuals and entities that participate in the program under this title and that serve the area in which the patient resides and that request to be listed by the hospital as available”; and

(2) by adding at the end the following:

“(H) Consistent with section 1802, the discharge plan shall—
 “(i) not specify or otherwise limit the qualified provider which may provide post-hospital home health services, and
 “(ii) identify (in a form and manner specified by the Secretary) any home health agency (to whom the individual is referred) in which the hospital has a disclosable financial interest (as specified by the Secretary consistent with section 1866(a)(1)(R)) or which has such an interest in the hospital.”

(b) MAINTENANCE AND DISCLOSURE OF INFORMATION ON POST-HOSPITAL HOME HEALTH AGENCIES.—Section 1866(a)(1) (42 U.S.C. 1395cc(a)(1)) is amended—

(1) by striking “and” at the end of subparagraph (Q),

(2) by striking the period at the end of subparagraph (R), and

(3) by adding at the end the following:

“(S) in the case of a hospital that has a financial interest (as specified by the Secretary in regulations) in a home health agency, or in which such an agency has such a financial interest, or in which another entity has such a financial interest (directly or indirectly) with such hospital and such an agency, to maintain and disclose to the Secretary (in a form and manner specified by the Secretary) information on—

“(i) the nature of such financial interest,

“(ii) the number of individuals who were discharged from the hospital and who were identified as requiring home health services, and

“(iii) the percentage of such individuals who received such services from such provider (or another such provider).”

(c) DISCLOSURE OF INFORMATION TO THE PUBLIC.—Title XI is amended by inserting after section 1145 the following new section:

“PUBLIC DISCLOSURE OF CERTAIN INFORMATION ON HOSPITAL FINANCIAL INTEREST AND REFERRAL PATTERNS

“SEC. 1146. The Secretary shall make available to the public, in a form and manner specified by the Secretary, information disclosed to the Secretary pursuant to section 1866(a)(1)(R).”

(d) EFFECTIVE DATES.—

(1) The amendments made by subsection (a) shall apply to discharges occurring on or after 90 days after the date of the enactment of this Act.

(2) The Secretary of Health and Human Services shall issue regulations by not later than 1 year after the date of the enactment of this Act to carry out the amendments made by subsections (b) and (c) and such amendments shall take effect as of such date (on or after the issuance of such regulations) as the Secretary specifies in such regulations.

SEC. 4311. OTHER FRAUD AND ABUSE RELATED PROVISIONS.

(a) REFERENCE CORRECTION.—(1) Section 1128D(b)(2)(D) (42 U.S.C. 1320a–7d(b)(2)(D)), as added by section 205 of the Health

Insurance Portability and Accountability Act of 1996, is amended by striking “1128B(b)” and inserting “1128A(b)”.

(2) Section 1128E(g)(3)(C) (42 U.S.C. 1320a-7e(g)(3)(C)) is amended by striking “Veterans’ Administration” and inserting “Department of Veterans Affairs”.

(b) LANGUAGE IN DEFINITION OF CONVICTION.—Section 1128E(g)(5) (42 U.S.C. 1320a-7e(g)(5)), as inserted by section 221(a) of the Health Insurance Portability and Accountability Act of 1996, is amended by striking “paragraph (4)” and inserting “paragraphs (1) through (4)”.

(c) IMPLEMENTATION OF EXCLUSIONS.—Section 1128 (42 U.S.C. 1320a-7) is amended—

(1) in subsection (a), by striking “any program under title XVIII and shall direct that the following individuals and entities be excluded from participation in any State health care program (as defined in subsection (h))” and inserting “any Federal health care program (as defined in section 1128B(f))”; and

(2) in subsection (b), by striking “any program under title XVIII and may direct that the following individuals and entities be excluded from participation in any State health care program” and inserting “any Federal health care program (as defined in section 1128B(f))”.

(d) SANCTIONS FOR FAILURE TO REPORT.—Section 1128E(b) (42 U.S.C. 1320a-7e(b)), as inserted by section 221(a) of the Health Insurance Portability and Accountability Act of 1996, is amended by adding at the end the following:

“(6) SANCTIONS FOR FAILURE TO REPORT.—

“(A) HEALTH PLANS.—Any health plan that fails to report information on an adverse action required to be reported under this subsection shall be subject to a civil money penalty of not more than \$25,000 for each such adverse action not reported. Such penalty shall be imposed and collected in the same manner as civil money penalties under subsection (a) of section 1128A are imposed and collected under that section.

“(B) GOVERNMENTAL AGENCIES.—The Secretary shall provide for a publication of a public report that identifies those Government agencies that have failed to report information on adverse actions as required to be reported under this subsection.”.

(e) EFFECTIVE DATES.—

(1) IN GENERAL.—Except as provided in this subsection, the amendments made by this section shall be effective as if included in the enactment of the Health Insurance Portability and Accountability Act of 1996.

(2) FEDERAL HEALTH PROGRAM.—The amendments made by subsection (c) shall take effect on the date of the enactment of this Act.

(3) SANCTION FOR FAILURE TO REPORT.—The amendment made by subsection (d) shall apply to failures occurring on or after the date of the enactment of this Act.

Subtitle E—Prospective Payment Systems

CHAPTER 2—PAYMENT UNDER PART B

Subchapter A—Payment for Hospital Outpatient Department Services

SEC. 4411. ELIMINATION OF FORMULA-DRIVEN OVERPAYMENTS (FDO) FOR CERTAIN OUTPATIENT HOSPITAL SERVICES.

(a) ELIMINATION OF FDO FOR 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) ELIMINATION OF FDO FOR RADIOLOGY SERVICES AND DIAGNOSTIC PROCEDURES.—Section 1833(n)(1)(B)(i) (42 U.S.C. 1395l(n)(1)(B)(i)) is amended—

(1) by striking “of 80 percent”, and

(2) by inserting before the period at the end 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 October 1, 1997.

SEC. 4412. EXTENSION OF REDUCTIONS IN PAYMENTS FOR COSTS OF HOSPITAL OUTPATIENT SERVICES.

(a) REDUCTION IN PAYMENTS FOR CAPITAL-RELATED COSTS.—Section 1861(v)(1)(S)(ii)(I) (42 U.S.C. 1395x(v)(1)(S)(ii)(I)) is amended by striking “through 1998” and inserting “through 1999 and during fiscal year 2000 before January 1, 2000”.

(b) REDUCTION IN PAYMENTS FOR OTHER COSTS.—Section 1861(v)(1)(S)(ii)(II) (42 U.S.C. 1395x(v)(1)(S)(ii)(II)) is amended by striking “through 1998” and inserting “through 1999 and during fiscal year 2000 before January 1, 2000”.

SEC. 4413. PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES.

(a) IN GENERAL.—Section 1833 (42 U.S.C. 1395l) is amended by adding at the end the following:

“(t) PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES.—

“(1) IN GENERAL.—With respect to hospital outpatient services designated by the Secretary (in this section referred to as ‘covered OPD services’) and furnished during a year beginning with 1999, the amount of payment under this part shall be determined under a prospective payment system established by the Secretary in accordance with this subsection.

“(2) SYSTEM REQUIREMENTS.—Under the payment system—

“(A) the Secretary shall develop a classification system for covered OPD services;

“(B) the Secretary may establish groups of covered OPD services, within the classification system described in subparagraph (A), so that services classified within each

group are comparable clinically and with respect to the use of resources;

“(C) the Secretary shall, using data on claims from 1996 and using data from the most recent available cost reports, establish relative payment weights for covered OPD services (and any groups of such services described in subparagraph (B)) based on median hospital costs and shall determine projections of the frequency of utilization of each such service (or group of services) in 1999;

“(D) the Secretary shall determine a wage adjustment factor to adjust the portion of payment and coinsurance attributable to labor-related costs for relative differences in labor and labor-related costs across geographic regions in a budget neutral manner;

“(E) the Secretary shall establish other adjustments, in a budget neutral manner, as determined to be necessary to ensure equitable payments, such as outlier adjustments, adjustments to account for variations in coinsurance payments for procedures with similar resource costs, or adjustments for certain classes of hospitals; and

“(F) the Secretary shall develop a method for controlling unnecessary increases in the volume of covered OPD services.

“(3) CALCULATION OF BASE AMOUNTS.—

“(A) AGGREGATE AMOUNTS THAT WOULD BE PAYABLE IF DEDUCTIBLES WERE DISREGARDED.—The Secretary shall estimate the total amounts that would be payable from the Trust Fund under this part for covered OPD services in 1999, determined without regard to this subsection, as though the deductible under section 1833(b) did not apply, and as though the coinsurance described in section 1866(a)(2)(A)(ii) (as in effect before the date of the enactment of this subsection) continued to apply.

“(B) UNADJUSTED COPAYMENT AMOUNT.—

“(i) IN GENERAL.—For purposes of this subsection, subject to clause (ii), the ‘unadjusted copayment amount’ applicable to a covered OPD service (or group of such services) is 20 percent of national median of the charges for the service (or services within the group) furnished during 1996, updated to 1999 using the Secretary’s estimate of charge growth during the period.

“(ii) ADJUSTED TO BE 20 PERCENT WHEN FULLY PHASED IN.—If the pre-deductible payment percentage for a covered OPD service (or group of such services) furnished in a year would be equal to or exceed 80 percent, then the unadjusted copayment amount shall be 25 percent of amount determined under subparagraph (D)(i).

“(iii) RULES FOR NEW SERVICES.—The Secretary shall establish rules for establishment of an unadjusted copayment amount for a covered OPD service not furnished during 1996, based upon its classification within a group of such services.

“(C) CALCULATION OF CONVERSION FACTORS.—

“(I) IN GENERAL.—The Secretary shall establish a 1999 conversion factor for determining the medicare pre-deductible OPD fee payment amounts for each covered OPD service (or group of such services) furnished in 1999. Such conversion factor shall be established on the basis of the weights and frequencies described in paragraph (2)(C) and in a manner such that the sum for all services and groups of the products (described in subclause (II) for each such service or group) equals the total projected amount described in subparagraph (A).

“(II) PRODUCT DESCRIBED.—The product described in this subclause, for a service or group, is the product of the medicare pre-deductible OPD fee payment amounts (taking into account appropriate adjustments described in paragraphs (2)(D) and (2)(E)) and the frequencies for such service or group.

“(ii) SUBSEQUENT YEARS.—Subject to paragraph (8)(B), the Secretary shall establish a conversion factor for covered OPD services furnished in subsequent years in an amount equal to the conversion factor established under this subparagraph and applicable to such services furnished in the previous year increased by the OPD payment increase factor specified under clause (iii) for the year involved.

“(iii) OPD PAYMENT INCREASE FACTOR.—For purposes of this subparagraph, the ‘OPD payment increase factor’ for services furnished in a year is equal to the sum of—

“(I) market basket percentage increase (applicable under section 1886(b)(3)(B)(iii)) to hospital discharges occurring during the fiscal year ending in such year, and

“(II) in the case of a covered OPD service (or group of such services) furnished in a year in which the pre-deductible payment percentage would not exceed 80 percent, 3.5 percentage points, but in no case greater than such number of percentage points as will result in the pre-deductible payment percentage exceeding 80 percent.

In applying the previous sentence for years beginning with 2000, the Secretary may substitute for the market basket percentage increase under subclause (I) an annual percentage increase that is computed and applied with respect to covered OPD services furnished in a year in the same manner as the market basket percentage increase is determined and applied to inpatient hospital services for discharges occurring in a fiscal year.

“(D) PRE-DEDUCTIBLE PAYMENT PERCENTAGE.—The pre-deductible payment percentage for a covered OPD service

(or group of such services) furnished in a year is equal to the ratio of—

“(i) the conversion factor established under subparagraph (C) for the year, multiplied by the weighting factor established under paragraph (2)(C) for the service (or group), to

“(ii) the sum of the amount determined under clause (i) and the unadjusted copayment amount determined under subparagraph (B) for such service or group.

“(E) CALCULATION OF MEDICARE OPD FEE SCHEDULE AMOUNTS.—The Secretary shall compute a medicare OPD fee schedule amount for each covered OPD service (or group of such services) furnished in a year, in an amount equal to the product of—

“(i) the conversion factor computed under subparagraph (C) for the year, and

“(ii) the relative payment weight (determined under paragraph (2)(C)) for the service or group.

“(4) MEDICARE PAYMENT AMOUNT.—The amount of payment made from the Trust Fund under this part for a covered OPD service (and such services classified within a group) furnished in a year is determined as follows:

“(A) FEE SCHEDULE AND COPAYMENT AMOUNT.—Add (i) the medicare OPD fee schedule amount (computed under paragraph (3)(E)) for the service or group and year, and (ii) the unadjusted copayment amount (determined under paragraph (3)(B)) for the service or group.

“(B) SUBTRACT APPLICABLE DEDUCTIBLE.—Reduce the adjusted sum by the amount of the deductible under section 1833(b), to the extent applicable.

“(C) APPLY PAYMENT PROPORTION TO REMAINDER.—Multiply the amount so determined under subparagraph (B) by the pre-deductible payment percentage (as determined under paragraph (3)(D)) for the service or group and year involved.

“(D) LABOR-RELATED ADJUSTMENT.—The amount of payment is the product determined under subparagraph (C) with the labor-related portion of such product adjusted for relative differences in the cost of labor and other factors determined by the Secretary, as computed under paragraph (2)(D).

“(5) COPAYMENT AMOUNT.—

“(A) IN GENERAL.—Except as provided in subparagraph (B), the copayment amount under this subsection is determined as follows:

“(i) UNADJUSTED COPAYMENT.—Compute the amount by which the amount described in paragraph (4)(B) exceeds the amount of payment determined under paragraph (4)(C).

“(ii) LABOR ADJUSTMENT.—The copayment amount is the difference determined under clause (i) with the labor-related portion of such difference adjusted for relative differences in the cost of labor and other factors determined by the Secretary, as computed under

paragraphs (2)(D). The adjustment under this clause shall be made in a manner that does not result in any change in the aggregate copayments made in any year if the adjustment had not been made.

“(B) ELECTION TO OFFER REDUCED COPAYMENT AMOUNT.—The Secretary shall establish a procedure under which a hospital, before the beginning of a year (beginning with 1999), may elect to reduce the copayment amount otherwise established under subparagraph (A) for some or all covered OPD services to an amount that is not less than 25 percent of the medicare OPD fee schedule amount (computed under paragraph (3)(E)) for the service involved, adjusted for relative differences in the cost of labor and other factors determined by the Secretary, as computed under subparagraphs (D) and (E) of paragraph (2). Under such procedures, such reduced copayment amount may not be further reduced or increased during the year involved and the hospital may disseminate information on the reduction of copayment amount effected under this subparagraph.

“(C) NO IMPACT ON DEDUCTIBLES.—Nothing in this paragraph shall be construed as affecting a hospital’s authority to waive the charging of a deductible under section 1833(b).

“(6) PERIODIC REVIEW AND ADJUSTMENTS COMPONENTS OF PROSPECTIVE PAYMENT SYSTEM.—

“(A) PERIODIC REVIEW.—The Secretary may periodically review and revise the groups, the relative payment weights, and the wage and other adjustments described in paragraph (2) to take into account changes in medical practice, changes in technology, the addition of new services, new cost data, and other relevant information and factors.

“(B) BUDGET NEUTRALITY ADJUSTMENT.—If the Secretary makes adjustments under subparagraph (A), then the adjustments for a year may not cause the estimated amount of expenditures under this part for the year to increase or decrease from the estimated amount of expenditures under this part that would have been made if the adjustments had not been made.

“(C) UPDATE FACTOR.—If the Secretary determines under methodologies described in subparagraph (2)(F) that the volume of services paid for under this subsection increased beyond amounts established through those methodologies, the Secretary may appropriately adjust the update to the conversion factor otherwise applicable in a subsequent year.

“(7) SPECIAL RULE FOR AMBULANCE SERVICES.—The Secretary shall pay for hospital outpatient services that are ambulance services on the basis described in the matter in subsection (a)(1) preceding subparagraph (A).

“(8) SPECIAL RULES FOR CERTAIN HOSPITALS.—In the case of hospitals described in section 1886(d)(1)(B)(v)—

“(A) the system under this subsection shall not apply to covered OPD services furnished before January 1, 2000; and

“(B) the Secretary may establish a separate conversion factor for such services in a manner that specifically takes into account the unique costs incurred by such hospitals by virtue of their patient population and service intensity.

“(9) LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1869, 1878, or otherwise of—

“(A) the development of the classification system under paragraph (2), including the establishment of groups and relative payment weights for covered OPD services, of wage adjustment factors, other adjustments, and methods described in paragraph (2)(F);

“(B) the calculation of base amounts under paragraph (3);

“(C) periodic adjustments made under paragraph (6); and

“(D) the establishment of a separate conversion factor under paragraph (8)(B).”.

(b) COINSURANCE.—Section 1866(a)(2)(A)(ii) (42 U.S.C. 1395cc(a)(2)(A)(ii)) is amended by adding at the end the following: “In the case of items and services for which payment is made under part B under the prospective payment system established under section 1833(t), clause (ii) of the first sentence shall be applied by substituting for 20 percent of the reasonable charge, the applicable copayment amount established under section 1833(t)(5).”.

(c) TREATMENT OF REDUCTION IN COPAYMENT AMOUNT.—Section 1128A(i)(6) (42 U.S.C. 1320a-7a(i)(6)) is amended—

(1) by striking “or” at the end of subparagraph (B),

(2) by striking the period at the end of subparagraph (C) and inserting “; or”, and

(3) by adding at the end the following new subparagraph:

“(D) a reduction in the copayment amount for covered OPD services under section 1833(t)(5)(B).”.

(d) CONFORMING AMENDMENTS.—

(1) APPROVED ASC PROCEDURES PERFORMED IN HOSPITAL OUTPATIENT DEPARTMENTS.—

(A)(i) Section 1833(i)(3)(A) (42 U.S.C. 13951(i)(3)(A)) is amended—

(I) by inserting “before January 1, 1999,” after “furnished”, and

(II) by striking “in a cost reporting period”.

(ii) The amendment made by clause (i) shall apply to services furnished on or after January 1, 1999.

(B) Section 1833(a)(4) (42 U.S.C. 13951(a)(4)) is amended by inserting “or subsection (t)” before the semicolon.

(2) RADIOLOGY AND OTHER DIAGNOSTIC PROCEDURES.—

(A) Section 1833(n)(1)(A) (42 U.S.C. 13951(n)(1)(A)) is amended by inserting “and before January 1, 1999,” after “October 1, 1988,” and after “October 1, 1989,”.

(B) Section 1833(a)(2)(E) (42 U.S.C. 13951(a)(2)(E)) is amended by inserting “or, for services or procedures per-

formed on or after January 1, 1999, (t)” before the semicolon.

(3) OTHER HOSPITAL OUTPATIENT SERVICES.—Section 1833(a)(2)(B) (42 U.S.C. 1395l(a)(2)(B)) is amended—

(A) in clause (i), by inserting “furnished before January 1, 1999,” after “(i),”

(B) in clause (ii), by inserting “before January 1, 1999,” after “furnished”,

(C) by redesignating clause (iii) as clause (iv), and

(D) by inserting after clause (ii), the following new clause:

“(iii) if such services are furnished on or after January 1, 1999, the amount determined under subsection (t), or”.

Subchapter B—Rehabilitation Services

SEC. 4421. REHABILITATION AGENCIES AND SERVICES.

(a) PAYMENT BASED ON FEE SCHEDULE.—

(1) SPECIAL PAYMENT RULES.—Section 1833(a) (42 U.S.C. 1395l(a)) is amended—

(A) in paragraph (2) in the matter before subparagraph (A), by inserting “(C),” before “(D)”;

(B) in paragraph (6), by striking “and” at the end;

(C) in paragraph (7), by striking the period at the end and inserting “; and”;

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

“(8) in the case of services described in section 1832(a)(2)(C) (that are not described in section 1832(a)(2)(B)), the amounts described in section 1834(k).”.

(2) PAYMENT RATES.—Section 1834 (42 U.S.C. 1395m) is amended by adding at the end the following new subsection:

“(k) PAYMENT FOR OUTPATIENT THERAPY SERVICES.—

“(1) IN GENERAL.—With respect to outpatient physical therapy services (which includes outpatient speech-language pathology services) and outpatient occupational therapy services for which payment is determined under this subsection, the payment basis shall be—

“(A) for services furnished during 1998, the amount determined under paragraph (2); or

“(B) for services furnished during a subsequent year, 80 percent of the lesser of—

“(i) the actual charge for the services, or

“(ii) the applicable fee schedule amount (as defined in paragraph (3)) for the services.

“(2) PAYMENT IN 1998 BASED UPON CHARGES OR ADJUSTED REASONABLE COSTS.—The amount under this paragraph for services is the lesser of—

“(A) the charges imposed for the services, or

“(B) the adjusted reasonable costs (as defined in paragraph (4)) for the services, less 20 percent of the amount of the charges imposed for such services.

“(3) APPLICABLE FEE SCHEDULE AMOUNT.—In this paragraph, the term ‘applicable fee schedule amount’ means, with respect

to services furnished in a year, the fee schedule amount established under section 1848 for such services furnished during the year or, if there is no such fee schedule amount established for such services, for such comparable services as the Secretary specifies.

“(4) ADJUSTED REASONABLE COSTS.—In paragraph (2), the term ‘adjusted reasonable costs’ means reasonable costs determined reduced by—

“(A) 5.8 percent of the reasonable costs for operating costs, and

“(B) 10 percent of the reasonable costs for capital costs.

“(5) UNIFORM CODING.—For claims for services submitted on or after April 1, 1998, for which the amount of payment is determined under this subsection, the claim shall include a code (or codes) under a uniform coding system specified by the Secretary that identifies the services furnished.

“(6) RESTRAINT ON BILLING.—The provisions of subparagraphs (A) and (B) of section 1842(b)(18) shall apply to therapy services for which payment is made under this subsection in the same manner as they apply to services provided by a practitioner described in section 1842(b)(18)(C).”.

(b) APPLICATION OF STANDARDS TO OUTPATIENT OCCUPATIONAL AND PHYSICAL THERAPY SERVICES PROVIDED AS AN INCIDENT TO A PHYSICIAN’S PROFESSIONAL SERVICES.—Section 1862(a), as amended by section 4401(b), (42 U.S.C. 1395y(a)) is amended—

(1) by striking “or” at the end of paragraph (16);

(2) by striking the period at the end of paragraph (17) and inserting “; or”; and

(3) by inserting after paragraph (17) the following:

“(18) in the case of outpatient occupational therapy services or outpatient physical therapy services furnished as an incident to a physician’s professional services (as described in section 1861(s)(2)(A)), that do not meet the standards and conditions under the second sentence of section 1861(g) or 1861(p) as such standards and conditions would apply to such therapy services if furnished by a therapist.”.

(c) APPLYING FINANCIAL LIMITATION TO ALL REHABILITATION SERVICES.—Section 1833(g) (42 U.S.C. 1395l(g)) is amended—

(1) in the first sentence, by striking “services described in the second sentence of section 1861(p)” and inserting “physical therapy services of the type described in section 1861(p) (regardless of who furnishes the services or whether the services may be covered as physicians’ services so long as the services are furnished other than in a hospital setting)”, and

(2) in the second sentence, by striking “outpatient occupational therapy services which are described in the second sentence of section 1861(p) through the operation of section 1861(g)” and inserting “occupational therapy services (of the type that are described in section 1861(p) through the operation of section 1861(g)), regardless of who furnishes the services or whether the services may be covered as physicians’ services so long as the services are furnished other than in a hospital setting”.

(d) **EFFECTIVE DATE.**—The amendments made by this section apply to services furnished on or after January 1, 1998; except that the amendments made by subsection (c) apply to services furnished on or after January 1, 1999.

SEC. 4422. COMPREHENSIVE OUTPATIENT REHABILITATION FACILITIES (CORF).

(a) **PAYMENT BASED ON FEE SCHEDULE.**—

(1) **SPECIAL PAYMENT RULES.**—Section 1833(a) (42 U.S.C. 1395l(a)), as amended by section 4421(a), is amended—

(A) in paragraph (3), by striking “subparagraphs (D) and (E) of section 1832(a)(2)” and inserting “section 1832(a)(2)(E)”;

(B) in paragraph (7), by striking “and” at the end;

(C) in paragraph (8), by striking the period at the end and inserting “; and”;

(D) by adding at the end the following new paragraph: “(9) in the case of services described in section 1832(a)(2)(E), the amounts described in section 1834(k).”.

(2) **PAYMENT RATES.**—Section 1834(k) (42 U.S.C. 1395m(k)), as added by section 4421(a), is amended—

(A) in the heading, by inserting “AND COMPREHENSIVE OUTPATIENT REHABILITATION FACILITY SERVICES” after “THERAPY SERVICES”; and

(B) in paragraph (1), by inserting “and with respect to comprehensive outpatient rehabilitation facility services” after “occupational therapy services”.

(b) **EFFECTIVE DATE.**—The amendments made by subsection (a) shall apply to services furnished on or after January 1, 1998, and to portions of cost reporting periods occurring on or after such date.

Subchapter C—Ambulance Services

SEC. 4431. PAYMENTS FOR AMBULANCE SERVICES.

(a) **INTERIM REDUCTIONS.**—

(1) **PAYMENTS DETERMINED ON REASONABLE COST BASIS.**—Section 1861(v)(1) (42 U.S.C. 1395x(v)(1)) is amended by adding at the end the following new subparagraph:

“(U) In determining the reasonable cost of ambulance services (as described in subsection (s)(7)) provided during a fiscal year (beginning with fiscal year 1998 and ending with fiscal year 2002), the Secretary shall not recognize the costs per trip in excess of costs recognized as reasonable for ambulance services provided on a per trip basis during the previous fiscal year after application of this subparagraph, increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) as estimated by the Secretary for the 12-month period ending with the midpoint of the fiscal year involved reduced (in the case of each of fiscal years 1998 and 1999) by 1 percentage point.”.

(2) **PAYMENTS DETERMINED ON REASONABLE CHARGE BASIS.**—Section 1842(b) (42 U.S.C. 1395u(b)) is amended by adding at the end the following new paragraph:

“(19) For purposes of section 1833(a)(1), the reasonable charge for ambulance services (as described in section 1861(s)(7)) provided

during a fiscal year (beginning with fiscal year 1998 and ending with fiscal year 2002) may not exceed the reasonable charge for such services provided during the previous fiscal year after the application of this subparagraph, increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) as estimated by the Secretary for the 12-month period ending with the midpoint of the year involved reduced (in the case of each of fiscal years 1998 and 1999) by 1 percentage point.”

(b) ESTABLISHMENT OF PROSPECTIVE FEE SCHEDULE.—

(1) PAYMENT IN ACCORDANCE WITH FEE SCHEDULE.—Section 1833(a)(1) (42 U.S.C. 1395l(a)(1)), as amended by section 4619(b)(1), is amended—

(A) by striking “and (P)” and inserting “(P)”; and

(B) by striking the semicolon at the end and inserting the following: “, and (Q) with respect to ambulance service, the amounts paid shall be 80 percent of the lesser of the actual charge for the services or the amount determined by a fee schedule established by the Secretary under section 1834(l);”.

(2) ESTABLISHMENT OF SCHEDULE.—Section 1834 (42 U.S.C. 1395m), as amended by section 4421(a)(2), is amended by adding at the end the following new subsection:

“(1) ESTABLISHMENT OF FEE SCHEDULE FOR AMBULANCE SERVICES.—

“(1) IN GENERAL.—The Secretary shall establish a fee schedule for payment for ambulance services under this part through a negotiated rulemaking process described in title 5, United States Code, and in accordance with the requirements of this subsection.

“(2) CONSIDERATIONS.—In establishing such fee schedule the Secretary shall—

“(A) establish mechanisms to control increases in expenditures for ambulance services under this part;

“(B) establish definitions for ambulance services which link payments to the type of services provided;

“(C) consider appropriate regional and operational differences;

“(D) consider adjustments to payment rates to account for inflation and other relevant factors; and

“(E) phase in the application of the payment rates under the fee schedule in an efficient and fair manner.

“(3) SAVINGS.—In establishing such fee schedule the Secretary shall—

“(A) ensure that the aggregate amount of payments made for ambulance services under this part during 2000 does not exceed the aggregate amount of payments which would have been made for such services under this part during such year if the amendments made by section 4431 of the Balanced Budget Act of 1997 had not been made; and

“(B) set the payment amounts provided under the fee schedule for services furnished in 2001 and each subsequent year at amounts equal to the payment amounts under the fee schedule for service furnished during the

previous year, increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 12-month period ending with June of the previous year.

“(4) CONSULTATION.—In establishing the fee schedule for ambulance services under this subsection, the Secretary shall consult with various national organizations representing individuals and entities who furnish and regulate ambulance services and share with such organizations relevant data in establishing such schedule.

“(5) LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1869 or otherwise of the amounts established under the fee schedule for ambulance services under this subsection, including matters described in paragraph (2).

“(6) RESTRAINT ON BILLING.—The provisions of subparagraphs (A) and (B) of section 1842(b)(18) shall apply to ambulance services for which payment is made under this subsection in the same manner as they apply to services provided by a practitioner described in section 1842(b)(18)(C).”

(3) EFFECTIVE DATE.—The amendments made by this section apply to ambulance services furnished on or after January 1, 2000.

(c) AUTHORIZING PAYMENT FOR PARAMEDIC INTERCEPT SERVICE PROVIDERS IN RURAL COMMUNITIES.—In promulgating regulations to carry out section 1861(s)(7) of the Social Security Act (42 U.S.C. 1395x(s)(7)) with respect to the coverage of ambulance service, the Secretary of Health and Human Services may include coverage of advanced life support services (in this subsection referred to as “ALS intercept services”) provided by a paramedic intercept service provider in a rural area if the following conditions are met:

(1) The ALS intercept services are provided under a contract with one or more volunteer ambulance services and are medically necessary based on the health condition of the individual being transported.

(2) The volunteer ambulance service involved—

(A) is certified as qualified to provide ambulance service for purposes of such section,

(B) provides only basic life support services at the time of the intercept, and

(C) is prohibited by State law from billing for any services.

(3) The entity supplying the ALS intercept services—

(A) is certified as qualified to provide such services under the medicare program under title XVIII of the Social Security Act, and

(B) bills all recipients who receive ALS intercept services from the entity, regardless of whether or not such recipients are medicare beneficiaries.

SEC. 4432. DEMONSTRATION OF COVERAGE OF AMBULANCE SERVICES UNDER MEDICARE THROUGH CONTRACTS WITH UNITS OF LOCAL GOVERNMENT.

(a) DEMONSTRATION PROJECT CONTRACTS WITH LOCAL GOVERNMENTS.—The Secretary of Health and Human Services shall estab-

lish up to 3 demonstration projects under which, at the request of a county or parish, the Secretary enters into a contract with the county or parish under which—

(1) the county or parish furnishes (or arranges for the furnishing) of ambulance services for which payment may be made under part B of title XVIII of the Social Security Act for individuals residing in the county or parish who are enrolled under such part, except that the county or parish may not enter into the contract unless the contract covers at least 80 percent of the individuals residing in the county or parish who are enrolled under such part;

(2) any individual or entity furnishing ambulance services under the contract meets the requirements otherwise applicable to individuals and entities furnishing such services under such part; and

(3) for each month during which the contract is in effect, the Secretary makes a capitated payment to the county or parish in accordance with subsection (b).

The projects may extend over a period of not to exceed 3 years each.

(b) AMOUNT OF PAYMENT.—

(1) IN GENERAL.—The amount of the monthly payment made for months occurring during a calendar year to a county or parish under a demonstration project contract under subsection (a) shall be equal to the product of—

(A) the Secretary's estimate of the number of individuals covered under the contract for the month; and

(B) $\frac{1}{12}$ of the capitated payment rate for the year established under paragraph (2).

(2) CAPITATED PAYMENT RATE DEFINED.—In this subsection, the "capitated payment rate" applicable to a contract under this subsection for a calendar year is equal to 95 percent of—

(A) for the first calendar year for which the contract is in effect, the average annual per capita payment made under part B of title XVIII of the Social Security Act with respect to ambulance services furnished to such individuals during the 3 most recent calendar years for which data on the amount of such payment is available; and

(B) for a subsequent year, the amount provided under this paragraph for the previous year increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 12-month period ending with June of the previous year.

(c) OTHER TERMS OF CONTRACT.—The Secretary and the county or parish may include in a contract under this section such other terms as the parties consider appropriate, including—

(1) covering individuals residing in additional counties or parishes (under arrangements entered into between such counties or parishes and the county or parish involved);

(2) permitting the county or parish to transport individuals to non-hospital providers if such providers are able to furnish quality services at a lower cost than hospital providers; or

(3) implementing such other innovations as the county or parish may propose to improve the quality of ambulance services and control the costs of such services.

(d) **CONTRACT PAYMENTS IN LIEU OF OTHER BENEFITS.**—Payments under a contract to a county or parish under this section shall be instead of the amounts which (in the absence of the contract) would otherwise be payable under part B of title XVIII of the Social Security Act for the services covered under the contract which are furnished to individuals who reside in the county or parish.

(e) **REPORT ON EFFECTS OF CAPITATED CONTRACTS.**—

(1) **STUDY.**—The Secretary shall evaluate the demonstration projects conducted under this section. Such evaluation shall include an analysis of the quality and cost-effectiveness of ambulance services furnished under the projects.

(2) **REPORT.**—Not later than January 1, 2000, the Secretary shall submit a report to Congress on the study conducted under paragraph (1), and shall include in the report such recommendations as the Secretary considers appropriate, including recommendations regarding modifications to the methodology used to determine the amount of payments made under such contracts and extending or expanding such projects.

CHAPTER 3—PAYMENT UNDER PARTS A AND B

SEC. 4441. PROSPECTIVE PAYMENT FOR HOME HEALTH SERVICES.

(a) **IN GENERAL.**—Title XVIII (42 U.S.C. 1395 et seq.), as amended by section 4011, is amended by adding at the end the following new section:

“PROSPECTIVE PAYMENT FOR HOME HEALTH SERVICES

“SEC. 1895. (a) IN GENERAL.—Notwithstanding section 1861(v), the Secretary shall provide, for cost reporting periods beginning on or after October 1, 1999, for payments for home health services in accordance with a prospective payment system established by the Secretary under this section.

“(b) SYSTEM OF PROSPECTIVE PAYMENT FOR HOME HEALTH SERVICES.—

“(1) IN GENERAL.—The Secretary shall establish under this subsection a prospective payment system for payment for all costs of home health services. Under the system under this subsection 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 this section, including medical supplies, shall be paid for on the basis of a prospective payment amount determined under this subsection and applicable to the services involved. In implementing the system, the Secretary may provide for a transition (of not longer than 4 years) during which a portion of such payment is based on agency-specific costs, but only if such transition does not result in aggregate payments under this title that exceed the aggregate payments that would be made if such a transition did not occur.

“(2) UNIT OF PAYMENT.—In defining a prospective payment amount under the system under this subsection, the Secretary

shall consider an appropriate unit of service and the number, type, and duration of visits provided within that unit, potential changes in the mix of services provided within that unit and their cost, and a general system design that provides for continued access to quality services.

“(3) PAYMENT BASIS.—

“(A) INITIAL BASIS.—

“(i) IN GENERAL.—Under such system the Secretary shall provide for computation of a standard prospective payment amount (or amounts). Such amount (or amounts) shall initially be based on the most current audited cost report data available to the Secretary and shall be computed in a manner so that the total amounts payable under the system for fiscal year 2000 shall be equal to the total amount that would have been made if the system had not been in effect but if the reduction in limits described in clause (ii) had been in effect. Such amount shall be standardized in a manner that eliminates the effect of variations in relative case mix and wage levels among different home health agencies in a budget neutral manner consistent with the case mix and wage level adjustments provided under paragraph (4)(A). Under the system, the Secretary may recognize regional differences or differences based upon whether or not the services or agency are in an urbanized area.

“(ii) REDUCTION.—The reduction described in this clause is a reduction by 15 percent in the cost limits and per beneficiary limits described in section 1861(v)(1)(L), as those limits are in effect on September 30, 1999.

“(B) ANNUAL UPDATE.—

“(i) IN GENERAL.—The standard prospective payment amount (or amounts) shall be adjusted for each fiscal year (beginning with fiscal year 2001) in a prospective manner specified by the Secretary by the home health market basket percentage increase applicable to the fiscal year involved.

“(ii) HOME HEALTH MARKET BASKET PERCENTAGE INCREASE.—For purposes of this subsection, the term ‘home health market basket percentage increase’ means, with respect to a fiscal year, a percentage (estimated by the Secretary before the beginning of the fiscal year) determined and applied with respect to the mix of goods and services included in home health services in the same manner as the market basket percentage increase under section 1886(b)(3)(B)(iii) is determined and applied to the mix of goods and services comprising inpatient hospital services for the fiscal year.

“(C) ADJUSTMENT FOR OUTLIERS.—The Secretary shall reduce the standard prospective payment amount (or amounts) under this paragraph applicable to home health services furnished during a period by such proportion as

will result in an aggregate reduction in payments for the period equal to the aggregate increase in payments resulting from the application of paragraph (5) (relating to outliers).

“(4) PAYMENT COMPUTATION.—

“(A) IN GENERAL.—The payment amount for a unit of home health services shall be the applicable standard prospective payment amount adjusted as follows:

“(i) CASE MIX ADJUSTMENT.—The amount shall be adjusted by an appropriate case mix adjustment factor (established under subparagraph (B)).

“(ii) AREA WAGE ADJUSTMENT.—The portion of such amount that the Secretary estimates to be attributable to wages and wage-related costs shall be adjusted for geographic differences in such costs by an area wage adjustment factor (established under subparagraph (C)) for the area in which the services are furnished or such other area as the Secretary may specify.

“(B) ESTABLISHMENT OF CASE MIX ADJUSTMENT FACTORS.—The Secretary shall establish appropriate case mix adjustment factors for home health services in a manner that explains a significant amount of the variation in cost among different units of services.

“(C) ESTABLISHMENT OF AREA WAGE ADJUSTMENT FACTORS.—The Secretary shall establish area wage adjustment factors that reflect the relative level of wages and wage-related costs applicable to the furnishing of home health services in a geographic area compared to the national average applicable level. Such factors may be the factors used by the Secretary for purposes of section 1886(d)(3)(E).

“(5) OUTLIERS.—The Secretary may provide for an addition or adjustment to the payment amount otherwise made in the case of outliers because of unusual variations in the type or amount of medically necessary care. The total amount of the additional payments or payment adjustments made under this paragraph with respect to a fiscal year may not exceed 5 percent of the total payments projected or estimated to be made based on the prospective payment system under this subsection in that year.

“(6) PRORATION OF PROSPECTIVE PAYMENT AMOUNTS.—If a beneficiary elects to transfer to, or receive services from, another home health agency within the period covered by the prospective payment amount, the payment shall be prorated between the home health agencies involved.

“(c) REQUIREMENTS FOR PAYMENT INFORMATION.—With respect to home health services furnished on or after October 1, 1998, no claim for such a service may be paid under this title unless—

“(1) the claim has the unique identifier (provided under section 1842(r)) for the physician who prescribed the services or made the certification described in section 1814(a)(2) or 1835(a)(2)(A); and

“(2) in the case of a service visit described in paragraph (1), (2), (3), or (4) of section 1861(m), the claim has information

(coded in an appropriate manner) on the length of time of the service visit, as measured in 15 minute increments.

“(d) LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1869, 1878, or otherwise of—

“(1) the establishment of a transition period under subsection (b)(1);

“(2) the definition and application of payment units under subsection (b)(2);

“(3) the computation of initial standard prospective payment amounts under subsection (b)(3)(A) (including the reduction described in clause (ii) of such subsection);

“(4) the adjustment for outliers under subsection (b)(3)(C);

“(5) case mix and area wage adjustments under subsection (b)(4);

“(6) any adjustments for outliers under subsection (b)(5); and

“(7) the amounts or types of exceptions or adjustments under subsection (b)(7).”.

(b) ELIMINATION OF PERIODIC INTERIM PAYMENTS FOR HOME HEALTH AGENCIES.—Section 1815(e)(2) (42 U.S.C. 1395g(e)(2)) is amended—

(1) by inserting “and” at the end of subparagraph (C),

(2) by striking subparagraph (D), and

(3) by redesignating subparagraph (E) as subparagraph (D).

(c) CONFORMING AMENDMENTS.—

(1) PAYMENTS UNDER PART A.—Section 1814(b) (42 U.S.C. 1395f(b)) is amended in the matter preceding paragraph (1) by striking “and 1886” and inserting “1886, and 1895”.

(2) TREATMENT OF ITEMS AND SERVICES PAID UNDER PART B.—

(A) PAYMENTS UNDER PART B.—Section 1833(a)(2) (42 U.S.C. 1395l(a)(2)) is amended—

(i) by amending subparagraph (A) to read as follows:

“(A) with respect to home health services (other than a covered osteoporosis drug) (as defined in section 1861(kk)), the amount determined under the prospective payment system under section 1895;”;

(ii) by striking “and” at the end of subparagraph (E);

(iii) by adding “and” at the end of subparagraph (F);

and

(iv) by adding at the end the following new subparagraph:

“(G) with respect to items and services described in section 1861(s)(10)(A), the lesser of—

“(i) the reasonable cost of such services, as determined under section 1861(v), or

“(ii) the customary charges with respect to such services,

or, if such services are furnished by a public provider of services, or by another provider which demonstrates to the satisfaction of the Secretary that a significant portion of its patients are low-income (and requests that payment be made under this provision), free of charge or at nominal charges to the public, the amount determined in accordance with section 1814(b)(2);”.

(B) REQUIRING PAYMENT FOR ALL ITEMS AND SERVICES TO BE MADE TO AGENCY.—

(i) **IN GENERAL.**—The first sentence of section 1842(b)(6) (42 U.S.C. 1395u(b)(6)), as amended by section 4401(b)(2), is amended—

(I) by striking “and (E)” and inserting “(E)”; and

(II) by striking the period at the end and inserting the following: “, and (F) in the case of home health services furnished to an individual who (at the time the item or service is furnished) is under a plan of care of a home health agency, payment shall be made to the agency (without regard to whether or not the item or service was furnished by the agency, by others under arrangement with them made by the agency, or when any other contracting or consulting arrangement, or otherwise).”.

(ii) **CONFORMING AMENDMENT.**—Section 1832(a)(1) (42 U.S.C. 1395k(a)(1)), as amended by section 4401(b), is amended by striking “and section 1842(b)(6)(E)” and inserting “, section 1842(b)(6)(E), and section 1842(b)(6)(F)”.

(C) EXCLUSIONS FROM COVERAGE.—Section 1862(a) (42 U.S.C. 1395y(a)), as amended by sections 4401(b) and 4421(b), is amended—

(i) by striking “or” at the end of paragraph (17);

(ii) by striking the period at the end of paragraph (18) and inserting “; or”; and

(iii) inserting after paragraph (18) the following new paragraph:

“(19) where such expenses are for home health services furnished to an individual who is under a plan of care of the home health agency if the claim for payment for such services is not submitted by the agency.”.

(d) **EFFECTIVE DATE.**—Except as otherwise provided, the amendments made by this section shall apply to cost reporting periods beginning on or after October 1, 1999.

Subtitle G—Provisions Relating to Part B Only

CHAPTER 1—PHYSICIANS’ SERVICES

SEC. 4601. ESTABLISHMENT OF SINGLE CONVERSION FACTOR FOR 1998.

(a) **IN GENERAL.**—Section 1848(d)(1) (42 U.S.C. 1395w-4(d)(1)) is amended—

(1) by redesignating subparagraph (C) as subparagraph (D), and

(2) by inserting after subparagraph (B) the following:

“(C) **SPECIAL RULES FOR 1998.**—The single conversion factor for 1998 under this subsection shall be the conversion factor for primary care services for 1997, increased by the Secretary’s estimate of the weighted average of the three

separate updates that would otherwise occur were it not for the enactment of chapter 1 of subtitle G of title X of the Balanced Budget Act of 1997.”

(b) CONFORMING AMENDMENTS.—Section 1848 (42 U.S.C. 1395w-4) is amended—

(1) by striking “(or factors)” each place it appears in subsection (d)(1)(A) and (d)(1)(D)(ii) (as redesignated by subsection (a)(1)),

(2) in subsection (d)(1)(A), by striking “or updates”,

(3) in subsection (d)(1)(D) (as redesignated by subsection (a)(1)), by striking “(or updates)” each place it appears, and

(4) in subsection (i)(1)(C), by striking “conversion factors” and inserting “the conversion factor”.

SEC. 4602. ESTABLISHING UPDATE TO CONVERSION FACTOR TO MATCH SPENDING UNDER SUSTAINABLE GROWTH RATE.

(a) UPDATE.—

(1) IN GENERAL.—Section 1848(d)(3) (42 U.S.C. 1395w-4(d)(3)) is amended to read as follows:

“(3) UPDATE.—

“(A) IN GENERAL.—Unless otherwise provided by law, subject to subparagraph (D) and the budget-neutrality factor determined by the Secretary under subsection (c)(2)(B)(ii), the update to the single conversion factor established in paragraph (1)(C) for a year beginning with 1999 is equal to the product of—

“(i) 1 plus the Secretary’s estimate of the percentage increase in the MEI (as defined in section 1842(i)(3)) for the year (divided by 100), and

“(ii) 1 plus the Secretary’s estimate of the update adjustment factor for the year (divided by 100),

minus 1 and multiplied by 100.

“(B) UPDATE ADJUSTMENT FACTOR.—For purposes of subparagraph (A)(ii), the ‘update adjustment factor’ for a year is equal to the quotient (as estimated by the Secretary) of—

“(i) the difference between (I) the sum of the allowed expenditures for physicians’ services (as determined under subparagraph (C)) during the period beginning July 1, 1997, and ending on June 30 of the year involved, and (II) the sum of the amount of actual expenditures for physicians’ services furnished during the period beginning July 1, 1997, and ending on June 30 of the preceding year; divided by

“(ii) the actual expenditures for physicians’ services for the 12-month period ending on June 30 of the preceding year, increased by the sustainable growth rate under subsection (f) for the fiscal year which begins during such 12-month period.

“(C) DETERMINATION OF ALLOWED EXPENDITURES.—For purposes of this paragraph, the allowed expenditures for physicians’ services for the 12-month period ending with June 30 of—

“(i) 1997 is equal to the actual expenditures for physicians’ services furnished during such 12-month period, as estimated by the Secretary; or

“(ii) a subsequent year is equal to the allowed expenditures for physicians’ services for the previous year, increased by the sustainable growth rate under subsection (f) for the fiscal year which begins during such 12-month period.

“(D) RESTRICTION ON VARIATION FROM MEDICARE ECONOMIC INDEX.—Notwithstanding the amount of the update adjustment factor determined under subparagraph (B) for a year, the update in the conversion factor under this paragraph for the year may not be—

“(i) greater than 100 times the following amount: $(1.03 + (\text{MEI percentage}/100)) - 1$; or

“(ii) less than 100 times the following amount: $(0.93 + (\text{MEI percentage}/100)) - 1$,

where ‘MEI percentage’ means the Secretary’s estimate of the percentage increase in the MEI (as defined in section 1842(i)(3)) for the year involved.”

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to the update for years beginning with 1999.

(b) ELIMINATION OF REPORT.—Section 1848(d) (42 U.S.C. 1395w-4(d)) is amended by striking paragraph (2).

SEC. 4603. REPLACEMENT OF VOLUME PERFORMANCE STANDARD WITH SUSTAINABLE GROWTH RATE.

(a) IN GENERAL.—Section 1848(f) (42 U.S.C. 1395w-4(f)) is amended by striking paragraphs (2) through (5) and inserting the following:

“(2) SPECIFICATION OF GROWTH RATE.—The sustainable growth rate for all physicians’ services for a fiscal year (beginning with fiscal year 1998) shall be equal to the product of—

“(A) 1 plus the Secretary’s estimate of the weighted average percentage increase (divided by 100) in the fees for all physicians’ services in the fiscal year involved,

“(B) 1 plus the Secretary’s estimate of the percentage change (divided by 100) in the average number of individuals enrolled under this part (other than MedicarePlus plan enrollees) from the previous fiscal year to the fiscal year involved,

“(C) 1 plus the Secretary’s estimate of the projected percentage growth in real gross domestic product per capita (divided by 100) from the previous fiscal year to the fiscal year involved, and

“(D) 1 plus the Secretary’s estimate of the percentage change (divided by 100) in expenditures for all physicians’ services in the fiscal year (compared with the previous fiscal year) which will result from changes in law and regulations, determined without taking into account estimated changes in expenditures due to changes in the volume and intensity of physicians’ services resulting from changes in the update to the conversion factor under subsection (d)(3), minus 1 and multiplied by 100.

“(3) DEFINITIONS.—In this subsection:

“(A) SERVICES INCLUDED IN PHYSICIANS’ SERVICES.—The term ‘physicians’ services’ includes other items and services (such as clinical diagnostic laboratory tests and radiology services), specified by the Secretary, that are commonly performed or furnished by a physician or in a physician’s office, but does not include services furnished to a MedicarePlus plan enrollee.

“(B) MEDICAREPLUS PLAN ENROLLEE.—The term ‘MedicarePlus plan enrollee’ means, with respect to a fiscal year, an individual enrolled under this part who has elected to receive benefits under this title for the fiscal year through a MedicarePlus plan offered under part C, and also includes an individual who is receiving benefits under this part through enrollment with an eligible organization with a risk-sharing contract under section 1876.”

(b) CONFORMING AMENDMENTS.—Section 1848(f) (42 U.S.C. 1395w-4(f)) is amended—

(1) in the heading, by striking “VOLUME PERFORMANCE STANDARD RATES OF INCREASE” and inserting “SUSTAINABLE GROWTH RATE”; and

(2) in paragraph (1)—

(A) in the heading, by striking “VOLUME PERFORMANCE STANDARD RATES OF INCREASE” and inserting “SUSTAINABLE GROWTH RATE”,

(B) by striking subparagraphs (A) and (B); and

(C) in paragraph (1)(C)—

(i) in the heading, by striking “PERFORMANCE STANDARD RATES OF INCREASE” and inserting “SUSTAINABLE GROWTH RATE”;

(ii) in the first sentence, by striking “with 1991), the performance standard rates of increase” and all that follows through the first period and inserting “with 1999), the sustainable growth rate for the fiscal year beginning in that year.”; and

(iii) in the second sentence, by striking “January 1, 1990, the performance standard rate of increase under subparagraph (D) for fiscal year 1990” and inserting “January 1, 1999, the sustainable growth rate for fiscal year 1999”.

SEC. 4604. PAYMENT RULES FOR ANESTHESIA SERVICES.

(a) IN GENERAL.—Section 1848(d)(1) (42 U.S.C. 1395w-4(d)(1)), as amended by section 4601, is amended—

(A) in subparagraph (C), striking “The single” and inserting “Except as provided in subparagraph (D), the single”;

(B) by redesignating subparagraph (D) as subparagraph (E); and

(C) by inserting after subparagraph (C) the following new subparagraph:

“(D) SPECIAL RULES FOR ANESTHESIA SERVICES.—The separate conversion factor for anesthesia services for a year shall be equal to 46 percent of the single conversion factor established for other physicians’ services, except as

adjusted for changes in work, practice expense, or malpractice relative value units. ”:

(b) **CLASSIFICATION OF ANESTHESIA SERVICES.**—The first sentence of section 1848(j)(1) (42 U.S.C. 1395w-4(j)(1)) is amended—

(1) by striking “and including anesthesia services”; and

(2) by inserting before the period the following: “(including anesthesia services)”.

(c) **EFFECTIVE DATE.**—The amendments made by this section shall apply to services furnished on or after January 1, 1998.

SEC. 4605. IMPLEMENTATION OF RESOURCE-BASED PHYSICIAN PRACTICE EXPENSE.

(a) **1-YEAR DELAY IN IMPLEMENTATION.**—Section 1848(c) (42 U.S.C. 1395w-4(c)) is amended—

(1) in paragraph (2)(C)(ii), in the matter before subclause (I) and after subclause (II), by striking “1998” and inserting “1999” each place it appears; and

(2) in paragraph (3)(C)(ii), by striking “1998” and inserting “1999”.

(b) **PHASED-IN IMPLEMENTATION.**—

(1) **IN GENERAL.**—Section 1848(c)(2)(C)(ii) (42 U.S.C. 1395w-4(c)(2)(C)(ii)) is further amended—

(A) by striking the comma at the end of clause (ii) and inserting a period and the following:

“For 1999, such number of units shall be determined based 75 percent on such product and based 25 percent on the relative practice expense resources involved in furnishing the service. For 2000, such number of units shall be determined based 50 percent on such product and based 50 percent on such relative practice expense resources. For 2001, such number of units shall be determined based 25 percent on such product and based 75 percent on such relative practice expense resources. For a subsequent year, such number of units shall be determined based entirely on such relative practice expense resources.”.

(2) **CONFORMING AMENDMENT.**—Section 1848(c)(3)(C)(ii) (42 U.S.C. 1395w-4(c)(3)(C)(ii)), as amended by subsection (a)(2), is amended by striking “1999” and inserting “2002”.

(c) **REQUIREMENTS FOR DEVELOPING NEW RESOURCE-BASED PRACTICE EXPENSE RELATIVE VALUE UNITS.**—

(1) **DEVELOPMENT.**—For purposes of section 1848(c)(2)(C) of the Social Security Act, the Secretary of Health and Human Services shall develop new resource-based relative value units. In developing such units the Secretary shall—

(A) utilize, to the maximum extent practicable, generally accepted accounting principles and standards which (i) recognize all staff, equipment, supplies, and expenses, not just those which can be tied to specific procedures, and (ii) use actual data on equipment utilization and other key assumptions, such as the proportion of costs which are direct versus indirect;

(B) study whether hospital cost reduction efforts and changing practice patterns may have increased physician practice costs under part B of the medicare program;

(C) consider potential adverse effects on patient access under the medicare program; and

(D) consult with organizations representing physicians regarding methodology and data to be used, including data for impact projections, in order to ensure that sufficient input has been received by the affected physician community.

(2) REPORT.—The Secretary shall transmit a report by March 1, 1998, on the development of resource-based relative value units under paragraph (1) to the Committee on Ways and Means and the Committee on Commerce of the House of Representatives and the Committee on Finance of the Senate. The report shall include a presentation of data to be used in developing the value units and an explanation of the methodology.

(3) NOTICE OF PROPOSED RULEMAKING.—The Secretary shall publish a notice of proposed rulemaking with the new resource-based relative value units on or before May 1, 1998, and shall allow for a 90-day public comment period.

(4) ITEMS INCLUDED.—The proposed new rule shall include the following:

(A) Detailed impact projections which compare new proposed payment amounts on data on actual physician practice expenses.

(B) Impact projections for specialties and subspecialties, geographic payment localities, urban versus rural localities, and academic versus nonacademic medical staffs.

(C) Impact projections on access to care for medicare patients and physician employment of clinical and administrative staff.

SEC. 4606. DISSEMINATION OF INFORMATION ON HIGH PER DISCHARGE RELATIVE VALUES FOR IN-HOSPITAL PHYSICIANS' SERVICES.

(a) DETERMINATION AND NOTICE CONCERNING HOSPITAL-SPECIFIC PER DISCHARGE RELATIVE VALUES.—

(1) IN GENERAL.—For 1999 and 2001 the Secretary of Health and Human Services shall determine for each hospital—

(A) the hospital-specific per discharge relative value under subsection (b); and

(B) whether the hospital-specific relative value is projected to be excessive (as determined based on such value represented as a percentage of the median of hospital-specific per discharge relative values determined under subsection (b)).

(2) NOTICE TO MEDICAL STAFFS AND CARRIERS.—The Secretary shall notify the medical executive committee of each hospital identifies under paragraph (1)(B) as having an excessive hospital-specific relative value, of the determinations made with respect to the medical staff under paragraph (1).

(b) DETERMINATION OF HOSPITAL-SPECIFIC PER DISCHARGE RELATIVE VALUES.—

(1) IN GENERAL.—For purposes of this section, the hospital-specific per discharge relative value for the medical staff of a hospital (other than a teaching hospital) for a year, shall be equal to the average per discharge relative value (as deter-

mined under section 1848(c)(2) of the Social Security Act) for physicians' services furnished to inpatients of the hospital by the hospital's medical staff (excluding interns and residents) during the second year preceding that calendar year, adjusted for variations in case-mix and disproportionate share status among hospitals (as determined by the Secretary under paragraph (3)).

(2) SPECIAL RULE FOR TEACHING HOSPITALS.—The hospital-specific relative value projected for a teaching hospital in a year shall be equal to the sum of—

(A) the average per discharge relative value (as determined under section 1848(c)(2) of such Act) for physicians' services furnished to inpatients of the hospital by the hospital's medical staff (excluding interns and residents) during the second year preceding that calendar year, and

(B) the equivalent per discharge relative value (as determined under such section) for physicians' services furnished to inpatients of the hospital by interns and residents of the hospital during the second year preceding that calendar year, adjusted for variations in case-mix, disproportionate share status, and teaching status among hospitals (as determined by the Secretary under paragraph (3)).

The Secretary shall determine the equivalent relative value unit per discharge for interns and residents based on the best available data and may make such adjustment in the aggregate.

(3) ADJUSTMENT FOR TEACHING AND DISPROPORTIONATE SHARE HOSPITALS.—The Secretary shall adjust the allowable per discharge relative values otherwise determined under this subsection to take into account the needs of teaching hospitals and hospitals receiving additional payments under subparagraphs (F) and (G) of section 1886(d)(5) of the Social Security Act. The adjustment for teaching status or disproportionate share shall not be less than zero.

(c) DEFINITIONS.—For purposes of this section:

(1) HOSPITAL.—The term "hospital" means a subsection (d) hospital as defined in section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)).

(2) MEDICAL STAFF.—An individual furnishing a physician's service is considered to be on the medical staff of a hospital—

(A) if (in accordance with requirements for hospitals established by the Joint Commission on Accreditation of Health Organizations)—

(i) the individual is subject to bylaws, rules, and regulations established by the hospital to provide a framework for the self-governance of medical staff activities,

(ii) subject to the bylaws, rules, and regulations, the individual has clinical privileges granted by the hospital's governing body, and

(iii) under the clinical privileges, the individual may provide physicians' services independently within the scope of the individual's clinical privileges, or

(B) if the physician provides at least one service to an individual entitled to benefits under this title in that hospital.

(3) PHYSICIANS' SERVICES.—The term “physicians” services” means the services described in section 1848(j)(3) of the Social Security Act (42 U.S.C. 1395w-4(j)(3)).

(4) RURAL AREA; URBAN AREA.—The terms “rural area” and “urban area” have the meaning given those terms under section 1886(d)(2)(D) of such Act (42 U.S.C. 1395ww(d)(2)(D)).

(5) SECRETARY.—The term “Secretary” means the Secretary of Health and Human Services .

(6) TEACHING HOSPITAL.—The term “teaching hospital” means a hospital which has a teaching program approved as specified in section 1861(b)(6) of the Social Security Act (42 U.S.C. 1395x(b)(6)).

SEC. 4607. NO X-RAY REQUIRED FOR CHIROPRACTIC SERVICES.

(a) IN GENERAL.—Section 1861(r)(5) (42 U.S.C. 1395x(r)(5)) is amended by striking “demonstrated by X-ray to exist”.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) applies to services furnished on or after January 1, 1998.

(c) UTILIZATION GUIDELINES.—The Secretary of Health and Human Services shall develop and implement utilization guidelines relating to the coverage of chiropractic services under part B of title XVIII of the Social Security Act in cases in which a subluxation has not been demonstrated by X-ray to exist.

SEC. 4608. TEMPORARY COVERAGE RESTORATION FOR PORTABLE ELECTROCARDIOGRAM TRANSPORTATION.

(a) IN GENERAL.—Effective for electrocardiogram tests performed during 1998, the Secretary of Health and Human Services shall restore separate payment, under part B of title XVIII of the Social Security Act, for the transportation of electrocardiogram equipment (HCPCS code R0076) based upon the status code and relative value units established for such service as of December 31, 1996.

(b) REPORT.—By not later than July 1, 1998, the Comptroller General shall submit to Congress a report on the appropriateness of continuing such payment.

CHAPTER 2—OTHER PAYMENT PROVISIONS

SEC. 4611. PAYMENTS FOR DURABLE MEDICAL EQUIPMENT.

(a) REDUCTION IN PAYMENT AMOUNTS FOR ITEMS OF DURABLE MEDICAL EQUIPMENT.—

(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, 1995, 1996, and 1997”, and

(ii) by striking the period at the end and inserting a semicolon; and

(C) by adding at the end the following:

“(C) for each of the years 1998 through 2002, 0 percentage points; 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) (42 U.S.C. 1395m(h)(4)(A)) is amended—

(A) by striking “, and” at the end of clause (iii) and inserting a semicolon;

(B) in clause (iv), by striking “a subsequent year” and inserting “1996 and 1997”, and

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

“(v) for each of the years 1998 through 2002, 1 percent, and

“(vi) for a subsequent year, the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period ending with June of the previous year;”.

(b) PAYMENT FREEZE FOR PARENTERAL AND ENTERAL NUTRIENTS, SUPPLIES, AND EQUIPMENT.—In determining the amount of payment under part B of title XVIII of the Social Security Act with respect to parenteral and enteral nutrients, supplies, and equipment during each of the years 1998 through 2002, the charges determined to be reasonable with respect to such nutrients, supplies, and equipment may not exceed the charges determined to be reasonable with respect to such nutrients, supplies, and equipment during 1995.

SEC. 4612. 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, 1995, 1996, and 1997”, and

(B) by striking the period at the end and inserting a semicolon; and

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

“(v) in each of the years 1998 through 2002, is 80 percent of the national limited monthly payment rate computed under subparagraph (B) for the item for the year; and

“(vi) in a subsequent year, is the national limited monthly payment rate computed under subparagraph (B) for the item for the year.”.

SEC. 4613. REDUCTION IN UPDATES TO PAYMENT AMOUNTS FOR CLINICAL DIAGNOSTIC LABORATORY TESTS.

(a) CHANGE IN UPDATE.—Section 1833(h)(2)(A)(ii)(IV) (42 U.S.C. 1395l(h)(2)(A)(ii)(IV)) is amended by inserting “and 1998 through 2002” after “1995”.

(b) LOWERING CAP ON PAYMENT AMOUNTS.—Section 1833(h)(4)(B) (42 U.S.C. 1395l(h)(4)(B)) is amended—

(1) in clause (vi), by striking “and” at the end;

(2) in clause (vii)—

(A) by inserting “and before January 1, 1998,” after “1995,” and

- (B) by striking the period at the end and inserting “, and”; and
- (3) by adding at the end the following new clause:
“(viii) after December 31, 1997, is equal to 72 percent of such median.”.

SEC. 4614. SIMPLIFICATION IN ADMINISTRATION OF LABORATORY TESTS.

(a) **SELECTION OF REGIONAL CARRIERS.—**

(1) **IN GENERAL.—**The Secretary of Health and Human Services (in this section referred to as the “Secretary”) shall—

(A) divide the United States into no more than 5 regions, and

(B) designate a single carrier for each such region, for the purpose of payment of claims under part B of title XVIII of the Social Security Act with respect to clinical diagnostic laboratory tests (other than for tests performed in physician offices) furnished on or after such date (not later than January 1, 1999) as the Secretary specifies.

(2) **DESIGNATION.—**In designating such carriers, the Secretary shall consider, among other criteria—

(A) a carrier’s timeliness, quality, and experience in claims processing, and

(B) a carrier’s capacity to conduct electronic data interchange with laboratories and data matches with other carriers.

(3) **SINGLE DATA RESOURCE.—**The Secretary may select one of the designated carriers to serve as a central statistical resource for all claims information relating to such clinical diagnostic laboratory tests handled by all the designated carriers under such part.

(4) **ALLOCATION OF CLAIMS.—**The allocation of claims for clinical diagnostic laboratory tests to particular designated carriers shall be based on whether a carrier serves the geographic area where the laboratory specimen was collected or other method specified by the Secretary.

(b) **ADOPTION OF UNIFORM POLICIES FOR CLINICAL LABORATORY TESTS.—**

(1) **IN GENERAL.—**Not later than July 1, 1998, the Secretary shall first adopt, consistent with paragraph (2), uniform coverage, administration, and payment policies for clinical diagnostic laboratory tests under part B of title XVIII of the Social Security Act, using a negotiated rulemaking process under subchapter III of chapter 5 of title 5, United States Code.

(2) **CONSIDERATIONS IN DESIGN OF UNIFORM POLICIES.—**The policies under paragraph (1) shall be designed to promote uniformity and program integrity and reduce administrative burdens with respect to clinical diagnostic laboratory tests payable under such part in connection with the following:

(A) Beneficiary information required to be submitted with each claim or order for laboratory tests.

(B) Physicians’ obligations regarding documentation requirements and recordkeeping.

(C) Procedures for filing claims and for providing remittances by electronic media.

(D) The documentation of medical necessity.

(E) Limitation on frequency of coverage for the same tests performed on the same individual.

(3) CHANGES IN CARRIER REQUIREMENTS PENDING ADOPTION OF UNIFORM POLICY.—During the period that begins on the date of the enactment of this Act and ends on the date the Secretary first implements uniform policies pursuant to regulations promulgated under this subsection, a carrier under such part may implement changes relating to requirements for the submission of a claim for clinical diagnostic laboratory tests.

(4) USE OF INTERIM REGIONAL POLICIES.—After the date the Secretary first implements such uniform policies, the Secretary shall permit any carrier to develop and implement interim policies of the type described in paragraph (1), in accordance with guidelines established by the Secretary, in cases in which a uniform national policy has not been established under this subsection and there is a demonstrated need for a policy to respond to aberrant utilization or provision of unnecessary services. Except as the Secretary specifically permits, no policy shall be implemented under this paragraph for a period of longer than 2 years.

(5) INTERIM NATIONAL POLICIES.—After the date the Secretary first designates regional carriers under subsection (a), the Secretary shall establish a process under which designated carriers can collectively develop and implement interim national standards of the type described in paragraph (1). No such policy shall be implemented under this paragraph for a period of longer than 2 years.

(6) BIENNIAL REVIEW PROCESS.—Not less often than once every 2 years, the Secretary shall solicit and review comments regarding changes in the uniform policies established under this subsection. As part of such biennial review process, the Secretary shall specifically review and consider whether to incorporate or supersede interim, regional, or national policies developed under paragraph (4) or (5). Based upon such review, the Secretary may provide for appropriate changes in the uniform policies previously adopted under this subsection.

(7) NOTICE.— Before a carrier implements a change or policy under paragraph (3), (4), or (5), the carrier shall provide for advance notice to interested parties and a 45-day period in which such parties may submit comments on the proposed change.

(c) INCLUSION OF LABORATORY REPRESENTATIVE ON CARRIER ADVISORY COMMITTEES.—The Secretary shall direct that any advisory committee established by such a carrier, to advise with respect to coverage, administration or payment policies under part B of title XVIII of the Social Security Act, shall include an individual to represent the interest and views of independent clinical laboratories and such other laboratories as the Secretary deems appropriate. Such individual shall be selected by such committee from among nominations submitted by national and local organizations that represent independent clinical laboratories.

SEC. 4615. UPDATES FOR AMBULATORY SURGICAL SERVICES.

Section 1833(i)(2)(C) (42 U.S.C. 1395l(i)(2)(C)) is amended by striking all that follows “shall be increased” and inserting the following: “as follows:

“(i) For fiscal years 1996 and 1997, by the percentage increase in the consumer price index for all urban consumers (U.S. city average) as estimated by the Secretary for the 12-month period ending with the midpoint of the year involved.

“(ii) For each of fiscal years 1998 through 2002 by such percentage increase minus 2.0 percentage points.

“(iii) For each succeeding fiscal year by such percentage increase.”.

SEC. 4616. REIMBURSEMENT FOR DRUGS AND BIOLOGICALS.

(a) **IN GENERAL.**—Section 1842 (42 U.S.C. 1395u) is amended by inserting after subsection (n) the following new subsection:

“(o) If a physician’s, supplier’s, or any other person’s bill or request for payment for services includes a charge for a drug or biological for which payment may be made under this part and the drug or biological is not paid on a cost or prospective payment basis as otherwise provided in this part, the amount payable for the drug or biological is equal to 95 percent of the average wholesale price.”.

(b) **EFFECTIVE DATE.**—The amendments made by subsection (a) apply to drugs and biologicals furnished on or after January 1, 1998.

SEC. 4617. COVERAGE OF ORAL ANTI-NAUSEA DRUGS UNDER CHEMOTHERAPEUTIC REGIMEN.

(a) **IN GENERAL.**—Section 1861(s)(2) (42 U.S.C. 1395x(s)(2)), as amended, is amended by inserting after subparagraph (S) the following new subparagraph:

“(T) an oral drug (which is approved by the Federal Food and Drug Administration) prescribed for use as an acute anti-emetic used as part of an anticancer chemotherapeutic regimen if the drug is administered by a physician (or as prescribed by a physician)—

“(i) for use immediately before, immediately after, or at the time of the administration of the anticancer chemotherapeutic agent; and

“(ii) as a full replacement for the anti-emetic therapy which would otherwise be administered intravenously.”.

(b) **PAYMENT LEVELS.**—Section 1834 (42 U.S.C. 1395m), as amended by sections 4421(a)(2) and 4431(b)(2), is amended by adding at the end the following new subsection:

“(m) **SPECIAL RULES FOR PAYMENT FOR ORAL ANTI-NAUSEA DRUGS.**—

“(1) **LIMITATION ON PER DOSE PAYMENT BASIS.**—Subject to paragraph (2), the per dose payment basis under this part for oral anti-nausea drugs (as defined in paragraph (3)) administered during a year shall not exceed 90 percent of the average per dose payment basis for the equivalent intravenous antiemetics administered during the year, as computed based on the payment basis applied during 1996.

“(2) **AGGREGATE LIMIT.**—The Secretary shall make such adjustment in the coverage of, or payment basis for, oral anti-nausea drugs so that coverage of such drugs under this part

does not result in any increase in aggregate payments per capita under this part above the levels of such payments per capita that would otherwise have been made if there were no coverage for such drugs under this part.

“(3) ORAL ANTI-NAUSEA DRUGS DEFINED.—For purposes of this subsection, the term ‘oral anti-nausea drugs’ means drugs for which coverage is provided under this part pursuant to section 1861(s)(2)(P).”

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after January 1, 1998.

SEC. 4618. RURAL HEALTH CLINIC SERVICES.

(a) PER-VISIT PAYMENT LIMITS FOR PROVIDER-BASED CLINICS.—

(1) EXTENSION OF LIMIT.—

(A) IN GENERAL.—The matter in section 1833(f) (42 U.S.C. 13951(f)) preceding paragraph (1) is amended by striking “independent rural health clinics” and inserting “rural health clinics (other than such clinics in rural hospitals with less than 50 beds)”.

(B) EFFECTIVE DATE.—The amendment made by subparagraph (A) applies to services furnished after 1997.

(2) TECHNICAL CLARIFICATION.—Section 1833(f)(1) (42 U.S.C. 13951(f)(1)) is amended by inserting “per visit” after “\$46”.

(b) ASSURANCE OF QUALITY SERVICES.—

(1) IN GENERAL.—Subparagraph (I) of the first sentence of section 1861(aa)(2) (42 U.S.C. 1395x(aa)(2)) is amended to read as follows:

“(I) has a quality assessment and performance improvement program, and appropriate procedures for review of utilization of clinic services, as the Secretary may specify,”.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on January 1, 1998.

(c) WAIVER OF CERTAIN STAFFING REQUIREMENTS LIMITED TO CLINICS IN PROGRAM.—

(1) IN GENERAL.—Section 1861(aa)(7)(B) (42 U.S.C. 1395x(aa)(7)(B)) is amended by inserting before the period at the end the following: “, or if the facility has not yet been determined to meet the requirements (including subparagraph (J) of the first sentence of paragraph (2)) of a rural health clinic”.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) applies to waiver requests made after 1997.

(d) REFINEMENT OF SHORTAGE AREA REQUIREMENTS.—

(1) DESIGNATION REVIEWED TRIENNIALY.—Section 1861(aa)(2) (42 U.S.C. 1395x(aa)(2)) is amended in the second sentence, in the matter in clause (i) preceding subclause (I)—

(A) by striking “and that is designated” and inserting “and that, within the previous three-year period, has been designated”; and

(B) by striking “or that is designated” and inserting “or designated”.

(2) AREA MUST HAVE SHORTAGE OF HEALTH CARE PRACTITIONERS.—Section 1861(aa)(2) (42 U.S.C. 1395x(aa)(2)), as amended by paragraph (1), is further amended in the second sentence, in the matter in clause (i) preceding subclause (I)—

(A) by striking the comma after “personal health services”; and

(B) by inserting “and in which there are insufficient numbers of needed health care practitioners (as determined by the Secretary),” after “Bureau of the Census”.

(3) PREVIOUSLY QUALIFYING CLINICS GRANDFATHERED ONLY TO PREVENT SHORTAGE.—Section 1861(aa)(2) (42 U.S.C. 1395x(aa)(2)) is amended in the third sentence by inserting before the period “if it is determined, in accordance with criteria established by the Secretary in regulations, to be essential to the delivery of primary care services that would otherwise be unavailable in the geographic area served by the clinic”.

(4) EFFECTIVE DATES; IMPLEMENTING REGULATIONS.—

(A) IN GENERAL.—Except as otherwise provided, the amendments made by the preceding paragraphs take effect on January 1 of the first calendar year beginning at least one month after enactment of this Act.

(B) CURRENT RURAL HEALTH CLINICS.—The amendments made by the preceding paragraphs take effect, with respect to entities that are rural health clinics under title XVIII of the Social Security Act on the date of enactment of this Act, on January 1 of the second calendar year following the calendar year specified in subparagraph (A).

(C) GRANDFATHERED CLINICS.—

(i) IN GENERAL.—The amendment made by paragraph (3) shall take effect on the effective date of regulations issued by the Secretary under clause (ii).

(ii) REGULATIONS.—The Secretary shall issue final regulations implementing paragraph (3) that shall take effect no later than January 1 of the third calendar year beginning at least one month after enactment of this Act.

SEC. 4619. INCREASED MEDICARE REIMBURSEMENT FOR NURSE PRACTITIONERS AND CLINICAL NURSE SPECIALISTS.

(a) REMOVAL OF RESTRICTIONS ON SETTINGS.—

(1) IN GENERAL.—Clause (ii) of section 1861(s)(2)(K) (42 U.S.C. 1395x(s)(2)(K)) is amended to read as follows:

“(ii) services which would be physicians’ services if furnished by a physician (as defined in subsection (r)(1)) and which are performed by a nurse practitioner or clinical nurse specialist (as defined in subsection (aa)(5)) working in collaboration (as defined in subsection (aa)(6)) with a physician (as defined in subsection (r)(1)) which the nurse practitioner or clinical nurse specialist is legally authorized to perform by the State in which the services are performed, and such services and supplies furnished as an incident to such services as would be covered under subparagraph (A) if furnished incident to a physician’s professional service, but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services;”.

(2) CONFORMING AMENDMENTS.—(A) Section 1861(s)(2)(K) of such Act (42 U.S.C. 1395x(s)(2)(K)) is further amended—

(i) in clause (i), by inserting “and such services and supplies furnished as incident to such services as would be

covered under subparagraph (A) if furnished incident to a physician's professional service; and" after "are performed,"; and

(ii) by striking clauses (iii) and (iv).

(B) Section 1861(b)(4) (42 U.S.C. 1395x(b)(4)) is amended by striking "clauses (i) or (iii) of subsection (s)(2)(K)" and inserting "subsection (s)(2)(K)".

(C) Section 1862(a)(14) (42 U.S.C. 1395y(a)(14)) is amended by striking "section 1861(s)(2)(K)(i) or 1861(s)(2)(K)(iii)" and inserting "section 1861(s)(2)(K)".

(D) Section 1866(a)(1)(H) (42 U.S.C. 1395cc(a)(1)(H)) is amended by striking "section 1861(s)(2)(K)(i) or 1861(s)(2)(K)(iii)" and inserting "section 1861(s)(2)(K)".

(E) Section 1888(e)(2)(A)(ii) (42 U.S.C. 1395yy(e)(2)(A)(ii)), as added by section 10401(a), is amended by striking "through (iii)" and inserting "and (ii)".

(b) INCREASED PAYMENT.—

(1) FEE SCHEDULE AMOUNT.—Clause (O) of section 1833(a)(1) (42 U.S.C. 1395l(a)(1)) is amended to read as follows: "(O) with respect to services described in section 1861(s)(2)(K)(ii) (relating to nurse practitioner or clinical nurse specialist services), the amounts paid shall be equal to 80 percent of (i) the lesser of the actual charge or 85 percent of the fee schedule amount provided under section 1848, or (ii) in the case of services as an assistant at surgery, the lesser of the actual charge or 85 percent of the amount that would otherwise be recognized if performed by a physician who is serving as an assistant at surgery; and".

(2) CONFORMING AMENDMENTS.—(A) Section 1833(r) (42 U.S.C. 1395l(r)) is amended—

(i) in paragraph (1), by striking "section 1861(s)(2)(K)(iii) (relating to nurse practitioner or clinical nurse specialist services provided in a rural area)" and inserting "section 1861(s)(2)(K)(ii) (relating to nurse practitioner or clinical nurse specialist services)";

(ii) by striking paragraph (2);

(iii) in paragraph (3), by striking "section 1861(s)(2)(K)(iii)" and inserting "section 1861(s)(2)(K)(ii)"; and

(iv) by redesignating paragraph (3) as paragraph (2).

(B) Section 1842(b)(12)(A) (42 U.S.C. 1395u(b)(12)(A)) is amended, in the matter preceding clause (i), by striking "clauses (i), (ii), or (iv) of section 1861(s)(2)(K) (relating to physician assistants and nurse practitioners)" and inserting "section 1861(s)(2)(K)(i) (relating to physician assistants)".

(c) DIRECT PAYMENT FOR NURSE PRACTITIONERS AND CLINICAL NURSE SPECIALISTS.—

(1) IN GENERAL.—Section 1832(a)(2)(B)(iv) (42 U.S.C. 1395k(a)(2)(B)(iv)) is amended by striking "provided in a rural area (as defined in section 1886(d)(2)(D))" and inserting "but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services".

(2) CONFORMING AMENDMENT.—Section 1842(b)(6)(C) (42 U.S.C. 1395u(b)(6)(C)) is amended—

(A) by striking “clauses (i), (ii), or (iv)” and inserting “clause (i)”; and

(B) by striking “or nurse practitioner”.

(d) DEFINITION OF CLINICAL NURSE SPECIALIST CLARIFIED.—Section 1861(aa)(5) (42 U.S.C. 1395x(aa)(5)) is amended—

(1) by inserting “(A)” after “(5)”;

(2) by striking “The term ‘physician assistant’ ” and all that follows through “who performs” and inserting “The term ‘physician assistant’ and the term ‘nurse practitioner’ mean, for purposes of this title, a physician assistant or nurse practitioner who performs”; and

(3) by adding at the end the following new subparagraph:

“(B) The term ‘clinical nurse specialist’ means, for purposes of this title, an individual who—

“(i) is a registered nurse and is licensed to practice nursing in the State in which the clinical nurse specialist services are performed; and

“(ii) holds a master’s degree in a defined clinical area of nursing from an accredited educational institution.”.

(e) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to services furnished and supplies provided on and after January 1, 1998.

SEC. 4620. INCREASED MEDICARE REIMBURSEMENT FOR PHYSICIAN ASSISTANTS.

(a) REMOVAL OF RESTRICTION ON SETTINGS.—Section 1861(s)(2)(K)(i) (42 U.S.C. 1395x(s)(2)(K)(i)) is amended—

(1) by striking “(I) in a hospital” and all that follows through “shortage area,”, and

(2) by adding at the end the following: “but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services.”.

(b) INCREASED PAYMENT.—Paragraph (12) of section 1842(b) (42 U.S.C. 1395u(b)), as amended by section 4619(b)(2)(B), is amended to read as follows:

“(12) With respect to services described in section 1861(s)(2)(K)(i)—

“(A) payment under this part may only be made on an assignment-related basis; and

“(B) the amounts paid under this part shall be equal to 80 percent of (i) the lesser of the actual charge or 85 percent of the fee schedule amount provided under section 1848 for the same service provided by a physician who is not a specialist; or (ii) in the case of services as an assistant at surgery, the lesser of the actual charge or 85 percent of the amount that would otherwise be recognized if performed by a physician who is serving as an assistant at surgery.”.

(c) REMOVAL OF RESTRICTION ON EMPLOYMENT RELATIONSHIP.—Section 1842(b)(6) (42 U.S.C. 1395u(b)(6)) is amended by adding at the end the following new sentence: “For purposes of clause (C) of the first sentence of this paragraph, an employment relationship may include any independent contractor arrangement, and employer status shall be determined in accordance with the law of the State in which the services described in such clause are performed.”.

(d) **EFFECTIVE DATE.**—The amendments made by this section shall apply with respect to services furnished and supplies provided on and after January 1, 1998.

SEC. 4621. RENAL DIALYSIS-RELATED SERVICES.

(a) **AUDITING OF COST REPORTS.**—The Secretary shall audit a sample of cost reports of renal dialysis providers for 1995 and for each third year thereafter.

(b) **IMPLEMENTATION OF QUALITY STANDARDS.**—The Secretary of Health and Human Services shall develop and implement, by not later than January 1, 1999, a method to measure and report quality of renal dialysis services provided under the medicare program under title XVIII of the Social Security Act in order to reduce payments for inappropriate or low quality care.

SEC. 4622. PAYMENT FOR COCHLEAR IMPLANTS AS CUSTOMIZED DURABLE MEDICAL EQUIPMENT.

(a) **IN GENERAL.**—Section 1834(h)(1)(E) (42 U.S.C. 1395m(h)(1)(E)) is amended by adding at the end the following: “Payment for cochlear implants shall be made in accordance with subsection (a)(4), and, in applying such subsection to cochlear implants, carriers shall take into consideration technological innovations and data on charges to the extent that such charges reflect such innovations.”

(b) **EFFECTIVE DATE.**—The amendment made by subsection (a) applies to implants implanted on or after January 1, 1998.

CHAPTER 3—PART B PREMIUM

SEC. 4631. PART B PREMIUM.

(a) **IN GENERAL.**—The first, second and third sentences of section 1839(a)(3) (42 U.S.C. 1395r(a)(3)) are amended to read as follows: “The Secretary, during September of each year, shall determine and promulgate a monthly premium rate for the succeeding calendar year. That monthly premium rate shall be equal to 50 percent of the monthly actuarial rate for enrollees age 65 and over, determined according to paragraph (1), for that succeeding calendar year.”

(b) **CONFORMING AND TECHNICAL AMENDMENTS.**—

(1) **SECTION 1839.**—Section 1839 (42 U.S.C. 1395r) is amended—

(A) in subsection (a)(2), by striking “(b) and (e)” and inserting “(b), (c), and (f)”,

(B) in the last sentence of subsection (a)(3)—

(i) by inserting “rate” after “premium”, and

(ii) by striking “and the derivation of the dollar amounts specified in this paragraph”,

(C) by striking subsection (e), and

(D) by redesignating subsection (g) as subsection (e) and inserting that subsection after subsection (d).

(2) **SECTION 1844.**—Subparagraphs (A)(i) and (B)(i) of section 1844(a)(1) (42 U.S.C. 1395w(a)(1)) are each amended by striking “or 1839(e), as the case may be”.

Subtitle H—Provisions Relating to Parts A and B

CHAPTER 1—PROVISIONS RELATING TO MEDICARE SECONDARY PAYER

SEC. 4701. PERMANENT EXTENSION AND REVISION OF CERTAIN SECONDARY PAYER PROVISIONS.

(a) 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)”.

(b) INDIVIDUALS WITH END STAGE RENAL DISEASE.—

(1) IN GENERAL.—Section 1862(b)(1)(C) (42 U.S.C. 1395y(b)(1)(C)) is amended—

(A) in the first sentence, by striking “12-month” each place it appears and inserting “30-month”, and

(B) by striking the second sentence.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to items and services furnished on or after the date of the enactment of this Act and with respect to periods beginning on or after the date that is 18 months prior to such date.

(c) IRS-SSA-HCFA DATA MATCH.—

(1) SOCIAL SECURITY ACT.—Section 1862(b)(5)(C) (42 U.S.C. 1395y(b)(5)(C)) is amended by striking clause (iii).

(2) INTERNAL REVENUE CODE.—Section 6103(l)(12) of the Internal Revenue Code of 1986 is amended by striking subparagraph (F).

SEC. 4702. CLARIFICATION OF TIME AND FILING LIMITATIONS.

(a) EXTENSION OF CLAIMS FILING PERIOD.—Section 1862(b)(2)(B) (42 U.S.C. 1395y(b)(2)(B)) is amended by adding at the end the following new clause:

“(v) CLAIMS-FILING PERIOD.—Notwithstanding any other time limits that may exist for filing a claim under an employer group health plan, the United States may seek to recover conditional payments in accordance with this subparagraph where the request for payment is submitted to the entity required or responsible under this subsection to pay with respect to the item or service (or any portion thereof) under a primary plan within the 3-year period beginning on the date on which the item or service was furnished.”.

(b) **EFFECTIVE DATE.**—The amendment made by subsection (a) applies to items and services furnished after 1990. The previous sentence shall not be construed as permitting any waiver of the 3-year-period requirement (imposed by such amendment) in the case of items and services furnished more than 3 years before the date of the enactment of this Act.

SEC. 4703. PERMITTING RECOVERY AGAINST THIRD PARTY ADMINISTRATORS.

(a) **PERMITTING RECOVERY AGAINST THIRD PARTY ADMINISTRATORS OF PRIMARY PLANS.**—Section 1862(b)(2)(B)(ii) (42 U.S.C. 1395y(b)(2)(B)(ii)) is amended—

(1) by striking “under this subsection to pay” and inserting “(directly, as a third-party administrator, or otherwise) to make payment”, and

(2) by adding at the end the following: “The United States may not recover from a third-party administrator under this clause in cases where the third-party administrator would not be able to recover the amount at issue from the employer or group health plan for whom it provides administrative services due to the insolvency or bankruptcy of the employer or plan.”.

(b) **CLARIFICATION OF BENEFICIARY LIABILITY.**—Section 1862(b)(1) (42 U.S.C. 1395y(b)(1)) is amended by adding at the end the following new subparagraph:

“(F) **LIMITATION ON BENEFICIARY LIABILITY.**—An individual who is entitled to benefits under this title and is furnished an item or service for which such benefits are incorrectly paid is not liable for repayment of such benefits under this paragraph unless payment of such benefits was made to the individual.”.

(c) **EFFECTIVE DATE.**—The amendments made by this section apply to items and services furnished on or after the date of the enactment of this Act.

CHAPTER 2—HOME HEALTH SERVICES

SEC. 4711. RECAPTURING SAVINGS RESULTING FROM TEMPORARY FREEZE ON PAYMENT INCREASES FOR HOME HEALTH SERVICES.

(a) **BASING UPDATES TO PER VISIT COST LIMITS ON LIMITS FOR FISCAL YEAR 1993.**—Section 1861(v)(1)(L) (42 U.S.C. 1395x(v)(1)(L)) is amended by adding at the end the following:

“(iv) In establishing limits under this subparagraph for cost reporting periods beginning after September 30, 1997, the Secretary shall not take into account any changes in the home health market basket, as determined by the Secretary, with respect to cost reporting periods which began on or after July 1, 1994, and before July 1, 1996.”.

(b) **NO EXCEPTIONS PERMITTED BASED ON AMENDMENT.**—The Secretary of Health and Human Services shall not consider the amendment made by subsection (a) in making any exemptions and exceptions pursuant to section 1861(v)(1)(L)(ii) of the Social Security Act (42 U.S.C. 1395x(v)(1)(L)(ii)).

SEC. 4712. INTERIM PAYMENTS FOR HOME HEALTH SERVICES.

(a) **REDUCTIONS IN COST LIMITS.**—Section 1861(v)(1)(L)(i) (42 U.S.C. 1395x(v)(1)(L)(i)) is amended—

(1) by moving the indentation of subclauses (I) through (III) 2-ems to the left;

(2) in subclause (I), by inserting “of the mean of the labor-related and nonlabor per visit costs for freestanding home health agencies” before the comma at the end;

(3) in subclause (II), by striking “, or” and inserting “of such mean,”;

(4) in subclause (III)—

(A) by inserting “and before October 1, 1997,” after “July 1, 1987,”, and

(B) by striking the comma at the end and inserting “of such mean, or”; and

(5) by striking the matter following subclause (III) and inserting the following:

“(IV) October 1, 1997, 105 percent of the median of the labor-related and nonlabor per visit costs for freestanding home health agencies.”.

(b) **DELAY IN UPDATES.**—Section 1861(v)(1)(L)(iii) (42 U.S.C. 1395x(v)(1)(L)(iii)) is amended by inserting “, or on or after July 1, 1997, and before October 1, 1997” after “July 1, 1996”.

(c) **ADDITIONS TO COST LIMITS.**—Section 1861(v)(1)(L) (42 U.S.C. 1395x(v)(1)(L)), as amended by section 4711(a), is amended by inserting adding at the end the following new clauses:

“(v) For services furnished by home health agencies for cost reporting periods beginning on or after October 1, 1997, the Secretary shall provide for an interim system of limits. Payment shall not exceed the costs determined under the preceding provisions of this subparagraph or, if lower, the product of—

“(I) an agency-specific per beneficiary annual limitation calculated based 75 percent on the reasonable costs (including nonroutine medical supplies) for the agency’s 12-month cost reporting period ending during 1994, and based 25 percent on the standardized regional average of such costs for the agency’s region for cost reporting periods ending during 1994, such costs updated by the home health market basket index; and

“(II) the agency’s unduplicated census count of patients (entitled to benefits under this title) for the cost reporting period subject to the limitation.

“(vi) For services furnished by home health agencies for cost reporting periods beginning on or after October 1, 1997, the following rules apply:

“(I) For new providers and those providers without a 12-month cost reporting period ending in calendar year 1994, the per beneficiary limitation shall be equal to the median of these limits (or the Secretary’s best estimates thereof) applied to other home health agencies as determined by the Secretary. A home health agency that has altered its corporate structure or name shall not be considered a new provider for this purpose.

“(II) For beneficiaries who use services furnished by more than one home health agency, the per beneficiary limitations shall be prorated among the agencies.”.

(d) **DEVELOPMENT OF CASE MIX SYSTEM.**—The Secretary of Health and Human Services shall expand research on a prospective payment system for home health agencies under the medicare program that ties prospective payments to a unit of service, including an intensive effort to develop a reliable case mix adjuster that explains a significant amount of the variances in costs.

(e) **SUBMISSION OF DATA FOR CASE MIX SYSTEM.**—Effective for cost reporting periods beginning on or after October 1, 1997, the Secretary of Health and Human Services may require all home health agencies to submit additional information that the Secretary considers necessary for the development of a reliable case mix system.

SEC. 4713. CLARIFICATION OF PART-TIME OR INTERMITTENT NURSING CARE.

(a) **IN GENERAL.**—Section 1861(m) (42 U.S.C. 1395x(m)) is amended by adding at the end the following: “For purposes of paragraphs (1) and (4), the term ‘part-time or intermittent services’ means skilled nursing and home health aide services furnished any number of days per week as long as they are furnished (combined) less than 8 hours each day and 28 or fewer hours each week (or, subject to review on a case-by-case basis as to the need for care, less than 8 hours each day and 35 or fewer hours per week). For purposes of sections 1814(a)(2)(C) and 1835(a)(2)(A), ‘intermittent’ means skilled nursing care that is either provided or needed on fewer than 7 days each week, or less than 8 hours of each day for periods of 21 days or less (with extensions in exceptional circumstances when the need for additional care is finite and predictable).”.

(b) **EFFECTIVE DATE.**—The amendment made by subsection (a) applies to services furnished on or after October 1, 1997.

SEC. 4714. STUDY ON DEFINITION OF HOMEBOUND.

(a) **STUDY.**—The Secretary of Health and Human Services shall conduct a study of the criteria that should be applied, and the method of applying such criteria, in the determination of whether an individual is homebound for purposes of qualifying for receipt of benefits for home health services under the medicare program. Such criteria shall include the extent and circumstances under which a person may be absent from the home but nonetheless qualify.

(b) **REPORT.**—Not later than October 1, 1998, the Secretary shall submit a report to the Congress on the study conducted under subsection (a). The report shall include specific recommendations on such criteria and methods.

SEC. 4715. PAYMENT BASED ON LOCATION WHERE HOME HEALTH SERVICE IS FURNISHED.

(a) **CONDITIONS OF PARTICIPATION.**—Section 1891 (42 U.S.C. 1395bbb) is amended by adding at the end the following:

“(g) **PAYMENT ON BASIS OF LOCATION OF SERVICE.**—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, as determined by the Secretary.”.

(b) **WAGE ADJUSTMENT.**—Section 1861(v)(1)(L)(iii) (42 U.S.C. 1395x(v)(1)(L)(iii)) is amended by striking “agency is located” and inserting “service is furnished”.

(c) **EFFECTIVE DATE.**—The amendments made by this section apply to cost reporting periods beginning on or after October 1, 1997.

SEC. 4716. NORMATIVE STANDARDS FOR HOME HEALTH CLAIMS DENIALS,

(a) **IN GENERAL.**—Section 1862(a)(1) (42 U.S.C. 1395y(a)(1)), as amended by section 4103(c), is amended—

(1) by striking “and” at the end of subparagraph (G),

(2) by striking the semicolon at the end of subparagraph (H) and inserting “, and”, and

(3) by inserting after subparagraph (H) the following new subparagraph:

“(I) the frequency and duration of home health services which are in excess of normative guidelines that the Secretary shall establish by regulation;”.

(b) **NOTIFICATION.**—The Secretary of Health and Human Services may establish a process for notifying a physician in cases in which the number of home health service visits furnished under the medicare program pursuant to a prescription or certification of the physician significantly exceeds such threshold (or thresholds) as the Secretary specifies. The Secretary may adjust such threshold to reflect demonstrated differences in the need for home health services among different beneficiaries.

(c) **EFFECTIVE DATE.**—The amendments made by this section apply to services furnished on or after October 1, 1997.

SEC. 4717. NO HOME HEALTH BENEFITS BASED SOLELY ON DRAWING BLOOD.

(a) **IN GENERAL.**—Sections 1814(a)(2)(C) and 1835(a)(2)(A) (42 U.S.C. 1395f(a)(2)(C), 1395n(a)(2)(A)) are each amended by inserting “(other than solely venipuncture for the purpose of obtaining a blood sample)” after “skilled nursing care”.

(b) **EFFECTIVE DATE.**—The amendments made by subsection (a) apply to home health services furnished after the 6-month period beginning after the date of enactment of this Act.

SEC. 4718. MAKING PART B PRIMARY PAYOR FOR CERTAIN HOME HEALTH SERVICES.

(a) **IN GENERAL.**—Section 1833(d) (42 U.S.C. 1395l(d)) is amended—

(1) by striking “(d) No” and inserting “(d)(1) Subject to paragraph (2), no”, and

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

“(2) Payment shall be made under this part (rather than under part A), for an individual entitled to benefits under part A, for home health services, other than the first 100 visits of post-hospital home health services furnished to an individual.”.

(b) **POST-HOSPITAL HOME HEALTH SERVICES.**—Section 1861 (42 U.S.C. 1395x) is amended by adding at the end the following:

“(ss) **POST-HOSPITAL HOME HEALTH SERVICES.**—The term ‘post-hospital home health services’ means home health services furnished to an individual under a plan of treatment established when

the individual was an inpatient of a hospital or rural primary care hospital for not less than 3 consecutive days before discharge, or during a covered post-hospital extended care stay, if home health services are initiated for the individual within 30 days after discharge from the hospital, rural primary care hospital or extended care facility.”

(c) PAYMENTS UNDER PART B.—Subparagraph (A) of section 1833(a)(2) (42 U.S.C. 1395l(a)(2)) is amended to read as follows:

“(A) with respect to home health services (other than a covered osteoporosis drug (as defined in section 1861(kk)), and to items and services described in section 1861(s)(10)(A), the amounts determined under section 1861(v)(1)(L) or section 1893, or, if the services are furnished by a public provider of services, or by another provider which demonstrates to the satisfaction of the Secretary that a significant portion of its patients are low-income (and requests that payment be made under this provision), free of charge, or at nominal charges to the public, the amount determined in accordance with section 1814(b)(2);”.

(d) PHASE-IN OF ADDITIONAL PART B COSTS IN DETERMINATION OF PART B MONTHLY PREMIUM.—Section 1839(a) (42 U.S.C. 1395r(a)) is amended—

(1) in paragraph (3) in last the sentence inserted by section 4631(a) of this title, by inserting “(except as provided in paragraph (5)(B))” before the period, and

(2) by adding after paragraph (4) the following:

“(5)(A) The Secretary shall, at the time of determining the monthly actuarial rate under paragraph (1) for 1998 through 2003, shall determine a transitional monthly actuarial rate for enrollees age 65 and over in the same manner as such rate is determined under paragraph (1), except that there shall be excluded from such determination an estimate of any benefits and administrative costs attributable to home health services for which payment would have been made under part A during the year but for paragraph (2) of section 1833(d).

“(B) The monthly premium for each individual enrolled under this part for each month for a year (beginning with 1998 and ending with 2003) shall be equal to 50 percent of the monthly actuarial rate determined under subparagraph (A) increased by the following proportion of the difference between such premium and the monthly premium otherwise determined under paragraph (3) (without regard to this paragraph):

“(i) For a month in 1998, $\frac{1}{7}$.

“(ii) For a month in 1999, $\frac{2}{7}$.

“(iii) For a month in 2000, $\frac{3}{7}$.

“(iv) For a month in 2001, $\frac{4}{7}$.

“(v) For a month in 2002, $\frac{5}{7}$.

“(vi) For a month in 2003, $\frac{6}{7}$.”.

(e) MAINTAINING APPEAL RIGHTS FOR HOME HEALTH SERVICES.—Section 1869(b)(2)(B) (42 U.S.C. 1395ff(b)(2)(B)) is amended by inserting “(or \$100 in the case of home health services)” after “\$500”.

(f) REPORT.—Not later than October 1, 1999, the Secretary of Health and Human Services shall submit a report to the Commit-

tees on Commerce and Ways and Means of the House of Representatives and the Committee on Finance of the Senate on the impact on home health utilization and admissions to hospitals and skilled nursing facilities of the amendment made by subsection (b). The Secretary shall further reexamine and submit a report to such Committees on this impact 1 year after the full implementation of the prospective payment system for home health services into the medicare program, effected under the amendments made by section 4441.

(g) **EFFECTIVE DATE.**—The amendments made by this section apply to services furnished on or after October 1, 1997.

CHAPTER 3—BABY BOOM GENERATION MEDICARE COMMISSION

SEC. 4721. BIPARTISAN 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 Bipartisan 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) Methods used by other nations to respond to comparable demographic patterns in eligibility for health care benefits for elderly and disabled individuals.

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

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

(E) The role medicare should play in addressing the needs of persons with chronic illness.

(c) **MEMBERSHIP.**—

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

(A) 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.

(B) 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.

(C) The 3 ex officio members of the Board of Trustees of the Federal Hospital Insurance Trust Fund and of the Federal Supplementary Medical Insurance Trust Fund who are Cabinet level officials.

(2) CHAIRMAN AND VICE CHAIRMAN.—As the first item of business at the Commission's first meeting (described in paragraph (5)(B)), the Commission shall elect a Chairman and Vice Chairman from among its members. The individuals elected as Chairman and Vice Chairman may not be of the same political party and may not have been appointed to the Commission by the same appointing authority.

(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 (f).

(5) MEETINGS.—

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

(B) The Commission shall hold its first meeting not later than February 1, 1998.

(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) ADVISORY PANEL.—

(1) IN GENERAL.—The Chairman, in consultation with the Vice Chairman, may establish a panel (in this section referred to as the "Advisory Panel") consisting of health care experts, consumers, providers, and others to advise and assist the members of the Commission in carrying out the duties described in subsection (b). The panel shall have only those powers that the Chairman, in consultation with the Vice Chairman, determines are necessary and appropriate to assist the Commission in carrying out such duties.

(2) COMPENSATION.—Members of the Advisory Panel are not entitled to receive compensation for service on the Advisory Panel. Subject to the approval of the chairman of the Commission, members may be reimbursed for travel, subsistence, and other necessary expenses incurred in carrying out the duties of the Advisory Panel.

(e) 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.

(f) 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.

(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) 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.

(g) REPORT.—Not later than May 1, 1999, 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.

(h) TERMINATION.—The Commission shall terminate 30 days after the date of submission of the report required in subsection (g).

(i) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated \$1,500,000 to carry out 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 under title XVIII of the Social Security Act (42 U.S.C. 1395i, 1395t).

CHAPTER 4—PROVISIONS RELATING TO DIRECT GRADUATE MEDICAL EDUCATION

SEC. 4731. LIMITATION ON PAYMENT BASED ON NUMBER OF RESIDENTS AND IMPLEMENTATION OF ROLLING AVERAGE FTE COUNT.

Section 1886(h)(4) (42 U.S.C. 1395ww(h)(4)) is amended by adding after subparagraph (E) the following:

“(F) LIMITATION ON NUMBER OF RESIDENTS FOR CERTAIN FISCAL YEARS.—Such rules shall provide that for purposes of a cost reporting period beginning on or after October 1, 1997, the total number of full-time equivalent residents before application of weighting factors (as determined under this paragraph) with respect to a hospital’s approved medical residency training program may not exceed the number of full-time equivalent residents with respect to the hospital’s most recent cost reporting period ending on or before December 31, 1996.

“(G) COUNTING INTERNS AND RESIDENTS FOR FY 1998 AND SUBSEQUENT YEARS.—

“(i) FY 1998.—For the hospital’s first cost reporting period beginning during fiscal year 1998, subject to the limit described in subparagraph (F), the total number of full-time equivalent residents, for determining the hospital’s graduate medical education payment, shall equal the average of the full-time equivalent resident counts for the cost reporting period and the preceding cost reporting period.

“(ii) SUBSEQUENT YEARS.—For each subsequent cost reporting period, subject to the limit described in subparagraph (F), the total number of full-time equivalent residents, for determining the hospital’s graduate medical education payment, shall equal the average of

the actual full-time equivalent resident counts for the cost reporting period and preceding two cost reporting periods.

“(iii) ADJUSTMENT FOR SHORT PERIODS.—If a hospital’s cost reporting period beginning on or after October 1, 1997, is not equal to twelve months, the Secretary shall make appropriate modifications to ensure that the average full-time equivalent resident counts pursuant to clause (ii) are based on the equivalent of full 12-month cost reporting periods.

“(iv) EXCLUSION OF RESIDENTS IN DENTISTRY.—Residents in an approved medical residency training program in dentistry shall not be counted for purposes of this subparagraph and subparagraph (F).”.

SEC. 4732. PHASED-IN LIMITATION ON HOSPITAL OVERHEAD AND SUPERVISORY PHYSICIAN COMPONENT OF DIRECT MEDICAL EDUCATION COSTS.

(a) IN GENERAL.—Section 1886(h)(3) (42 U.S.C. 1395ww(h)(3)) is amended—

(1) in subparagraph (B), by inserting “subject to subparagraph (D),” after “subparagraph (A)”, and

(2) by adding at the end the following:

“(D) PHASED-IN LIMITATION ON HOSPITAL OVERHEAD AND SUPERVISORY PHYSICIAN COMPONENT.—

“(i) IN GENERAL.—In the case of a hospital for which the overhead GME amount (as defined in clause (ii)) for the base period exceeds an amount equal to the 75th percentile of the overhead GME amounts in such period for all hospitals (weighted to reflect the full-time equivalent resident counts for all approved medical residency training programs), subject to clause (iv), the hospital’s approved FTE resident amount (for periods beginning on or after October 1, 1997) shall be reduced from the amount otherwise applicable (as previously reduced under this subparagraph) by an overhead reduction amount. The overhead reduction amount is equal to the lesser of—

“(I) 20 percent of the reference reduction amount (described in clause (iii)) for the period, or

“(II) 15 percent of the hospital’s overhead GME amount for the period (as otherwise determined before the reduction provided under this subparagraph for the period involved).

“(ii) OVERHEAD GME AMOUNT.—For purposes of this subparagraph, the term ‘overhead GME amount’ means, for a hospital for a period, the product of—

“(I) the percentage of the hospital’s approved FTE resident amount for the base period that is not attributable to resident salaries and fringe benefits, and

“(II) the hospital’s approved FTE resident amount for the period involved.

“(iii) REFERENCE REDUCTION AMOUNT.—

“(I) IN GENERAL.—The reference reduction amount described in this clause for a hospital for a cost reporting period is the base difference (described in subclause (II)) updated, in a compounded manner for each period from the base period to the period involved, by the update applied for such period to the hospital’s approved FTE resident amount.

“(II) BASE DIFFERENCE.—The base difference described in this subclause for a hospital is the amount by which the hospital’s overhead GME amount in the base period exceeded the 75th percentile of such amounts (as described in clause (i)).

“(iv) MAXIMUM REDUCTION TO 75TH PERCENTILE.—In no case shall the reduction under this subparagraph effected for a hospital for a period (below the amount that would otherwise apply for the period if this subparagraph did not apply for any period) exceed the reference reduction amount for the hospital for the period.

“(v) BASE PERIOD.—For purposes of this subparagraph, the term ‘base period’ means the cost reporting period beginning in fiscal year 1984 or the period used to establish the hospital’s approved FTE resident amount for hospitals that did not have approved residency training programs in fiscal year 1984.

“(vi) RULES FOR HOSPITALS INITIATING RESIDENCY TRAINING PROGRAMS.—The Secretary shall establish rules for the application of this subparagraph in the case of a hospital that initiates medical residency training programs during or after the base period.”

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to per resident payment amounts attributable to periods beginning on or after October 1, 1997.

SEC. 4733. PERMITTING PAYMENT TO NON-HOSPITAL PROVIDERS.

(a) IN GENERAL.—Section 1886 (42 U.S.C. 1395ww) is amended by adding at the end the following:

“(k) PAYMENT TO NON-HOSPITAL PROVIDERS.—

“(1) REPORT.—The Secretary shall submit to Congress, not later than 18 months after the date of the enactment of this subsection, a proposal for payment to qualified non-hospital providers for their direct costs of medical education, if those costs are incurred in the operation of an approved medical residency training program described in subsection (h). Such proposal shall specify the amounts, form, and manner in which such payments will be made and the portion of such payments that will be made from each of the trust funds under this title.

“(2) EFFECTIVENESS.—Except as otherwise provided in law, the Secretary may implement such proposal for residency years beginning not earlier than 6 months after the date of submittal of the report under paragraph (1).

“(3) QUALIFIED NON-HOSPITAL PROVIDERS.—For purposes of this subsection, the term ‘qualified non-hospital provider’ means—

“(A) a Federally qualified health center, as defined in section 1861(aa)(4);

“(B) a rural health clinic, as defined in section 1861(aa)(2); and

“(C) such other providers (other than hospitals) as the Secretary determines to be appropriate.”

(b) PROHIBITION ON DOUBLE PAYMENTS; BUDGET NEUTRALITY ADJUSTMENT.—Section 1886(h)(3)(B) (42 U.S.C. 1395ww(h)(3)(B)) is amended by adding at the end the following:

“The Secretary shall reduce the aggregate approved amount to the extent payment is made under subsection (k) for residents included in the hospital’s count of full-time equivalent residents and, in the case of residents not included in any such count, the Secretary shall provide for such a reduction in aggregate approved amounts under this subsection as will assure that the application of subsection (k) does not result in any increase in expenditures under this title in excess of those that would have occurred if subsection (k) were not applicable.”

SEC. 4734. INCENTIVE PAYMENTS UNDER PLANS FOR VOLUNTARY REDUCTION IN NUMBER OF RESIDENTS.

Section 1886(h) (42 U.S.C. 1395ww(h)) is further amended by adding at the end the following new paragraph:

“(6) INCENTIVE PAYMENT UNDER PLANS FOR VOLUNTARY REDUCTION IN NUMBER OF RESIDENTS.—

“(A) IN GENERAL.—In the case of a voluntary residency reduction plan for which an application is approved under subparagraph (B), the qualifying entity submitting the plan shall be paid an applicable hold harmless percentage (as specified in subparagraph (E)) of the sum of—

“(i) amount (if any) by which—

“(I) the amount of payment which would have been made under this subsection if there had been a 5 percent reduction in the number of full-time equivalent residents in the approved medical education training programs of the qualifying entity as of June 30, 1997, exceeds

“(II) the amount of payment which is made under this subsection, taking into account the reduction in such number effected under the reduction plan; and

“(ii) the amount of the reduction in payment under 1886(d)(5)(B) (for hospitals participating in the qualifying entity) that is attributable to the reduction in number of residents effected under the plan below 95 percent of the number of full-time equivalent residents in such programs of such entity as of June 30, 1997.

“(B) APPROVAL OF PLAN APPLICATIONS.—The Secretary may not approve the application of a qualifying entity unless—

“(i) the application is submitted in a form and manner specified by the Secretary and by not later than March 1, 2000,

“(ii) the application provides for the operation of a plan for the reduction in the number of full-time equivalent residents in the approved medical residency training programs of the entity consistent with the requirements of subparagraph (D);

“(iii) the entity elects in the application whether such reduction will occur over—

“(I) a period of not longer than 5 residency training years, or

“(II) a period of 6 residency training years, except that a qualifying entity described in subparagraph (C)(i)(III) may not make the election described in subclause (II); and

“(iv) the Secretary determines that the application and the entity and such plan meet such other requirements as the Secretary specifies in regulations.

“(C) QUALIFYING ENTITY.—

“(i) IN GENERAL.—For purposes of this paragraph, any of the following may be a qualifying entity:

“(I) Individual hospitals operating one or more approved medical residency training programs.

“(II) Subject to clause (ii), two or more hospitals that operate such programs and apply for treatment under this paragraph as a single qualifying entity.

“(III) Subject to clause (iii), a qualifying consortium (as described in section 4735 of the Balanced Budget Act of 1997).

“(ii) ADDITIONAL REQUIREMENT FOR JOINT PROGRAMS.—In the case of an application by a qualifying entity described in clause (i)(II), the Secretary may not approve the application unless the application represents that the qualifying entity either—

“(I) in the case of an entity that meets the requirements of clause (v) of subparagraph (D) will not reduce the number of full-time equivalent residents in primary care during the period of the plan, or

“(II) in the case of another entity will not reduce the proportion of its residents in primary care (to the total number of residents) below such proportion as in effect as of the applicable time described in subparagraph (D)(vi).

“(iii) ADDITIONAL REQUIREMENT FOR CONSORTIA.—In the case of an application by a qualifying entity described in clause (i)(III), the Secretary may not approve the application unless the application represents that the qualifying entity will not reduce the proportion of its residents in primary care (to the total number of residents) below such proportion as in effect as

of the applicable time described in subparagraph (D)(vi).

“(D) RESIDENCY REDUCTION REQUIREMENTS.—

“(i) INDIVIDUAL HOSPITAL APPLICANTS.—In the case of a qualifying entity described in subparagraph (C)(i)(I), the number of full-time equivalent residents in all the approved medical residency training programs operated by or through the entity shall be reduced as follows:

“(I) If base number of residents exceeds 750 residents, by a number equal to at least 20 percent of such base number.

“(II) Subject to subclause (IV), if base number of residents exceeds 500, but is less than 750 residents, by 150 residents.

“(III) Subject to subclause (IV), if base number of residents does not exceed 500 residents, by a number equal to at least 25 percent of such base number.

“(IV) In the case of a qualifying entity which is described in clause (v) and which elects treatment under this subclause, by a number equal to at least 20 percent of such base number.

“(ii) JOINT APPLICANTS.—In the case of a qualifying entity described in subparagraph (C)(i)(II), the number of full-time equivalent residents in all the approved medical residency training programs operated by or through the entity shall be reduced as follows:

“(I) Subject to subclause (II), by a number equal to at least 25 percent of such base number.

“(II) In the case of a qualifying entity which is described in clause (v) and which elects treatment under this subclause, by a number equal to at least 20 percent of such base number.

“(iii) CONSORTIA.—In the case of a qualifying entity described in subparagraph (C)(i)(III), the number of full-time equivalent residents in all the approved medical residency training programs operated by or through the entity shall be reduced by a number equal to at least 20 percent of such base number.

“(iv) MANNER OF REDUCTION.—The reductions specified under the preceding provisions of this subparagraph for a qualifying entity shall be below the base number of residents for that entity and shall be fully effective not later than—

“(I) the 5th residency training year in which the application under subparagraph (B) is effective, in the case of an entity making the election described in subparagraph (B)(iii)(I), or

“(II) the 6th such residency training year, in the case of an entity making the election described in subparagraph (B)(iii)(II).

“(v) ENTITIES PROVIDING ASSURANCE OF MAINTENANCE OF PRIMARY CARE RESIDENTS.—An entity is described in this clause if—

“(I) the base number of residents for the entity is less than 750;

“(II) the number of full-time equivalent residents in primary care included in the base number of residents for the entity is at least 10 percent of such base number; and

“(III) the entity represents in its application under subparagraph (B) that there will be no reduction under the plan in the number of full-time equivalent residents in primary care.

If a qualifying entity fails to comply with the representation described in subclause (III), the entity shall be subject to repayment of all amounts paid under this paragraph, in accordance with procedures established to carry out subparagraph (F).

“(vi) BASE NUMBER OF RESIDENTS DEFINED.—For purposes of this paragraph, the term ‘base number of residents’ means, with respect to a qualifying entity operating approved medical residency training programs, the number of full-time equivalent residents in such programs (before application of weighting factors) of the entity as of the most recent cost reporting period ending before June 30, 1997, or, if less, for any subsequent cost reporting period that ends before the date the entity makes application under this paragraph.

“(E) APPLICABLE HOLD HARMLESS PERCENTAGE.—

“(i) IN GENERAL.—For purposes of subparagraph (A), the ‘applicable hold harmless percentage’ is the percentages specified in clause (ii) or clause (iii), as elected by the qualifying entity in the application submitted under subparagraph (B).

“(ii) 5-YEAR REDUCTION PLAN.—In the case of an entity making the election described in subparagraph (B)(iii)(I), the percentages specified in this clause are, for the—

“(I) first and second residency training years in which the reduction plan is in effect, 100 percent,

“(II) third such year, 75 percent,

“(III) fourth such year, 50 percent, and

“(IV) fifth such year, 25 percent.

“(iii) 6-YEAR REDUCTION PLAN.—In the case of an entity making the election described in subparagraph (B)(iii)(II), the percentages specified in this clause are, for the—

“(I) first residency training year in which the reduction plan is in effect, 100 percent,

“(II) second such year, 95 percent,

“(III) third such year, 85 percent,

“(IV) fourth such year, 70 percent,

“(V) fifth such year, 50 percent, and

“(VI) sixth such year, 25 percent.

“(F) PENALTY FOR INCREASE IN NUMBER OF RESIDENTS IN SUBSEQUENT YEARS.—If payments are made under this paragraph to a qualifying entity, if the entity (or any hospital operating as part of the entity) increases the number of full-time equivalent residents above the number of such residents permitted under the reduction plan as of the completion of the plan, then, as specified by the Secretary, the entity is liable for repayment to the Secretary of the total amounts paid under this paragraph to the entity.

“(G) TREATMENT OF ROTATING RESIDENTS.—In applying this paragraph, the Secretary shall establish rules regarding the counting of residents who are assigned to institutions the medical residency training programs in which are not covered under approved applications under this paragraph.”

(b) RELATION TO DEMONSTRATION PROJECTS AND AUTHORITY.—

(1) Section 1886(h)(6) of the Social Security Act, added by subsection (a), shall not apply to any residency training program with respect to which a demonstration project described in paragraph (3) has been approved by the Health Care Financing Administration as of May 27, 1997. The Secretary of Health and Human Services shall take such actions as may be necessary to assure that (in the manner described in subparagraph (A) of such section) in no case shall payments be made under such a project with respect to the first 5 percent reduction in the base number of full-time equivalent residents otherwise used under the project.

(2) Effective May 27, 1997, the Secretary of Health and Human Services is not authorized to approve any demonstration project described in paragraph (3) for any residency training year beginning before July 1, 2006.

(3) A demonstration project described in this paragraph is a project that provides for additional payments under title XVIII of the Social Security Act in connection with reduction in the number of residents in a medical residency training program.

(c) 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 first promulgate regulations, that take effect on an interim basis, after notice and pending opportunity for public comment, by not later than 6 months after the date of the enactment of this Act.

SEC. 4735. DEMONSTRATION PROJECT ON USE OF CONSORTIA.

(a) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the Secretary) shall establish a demonstration project under which, instead of making payments to teaching hospitals pursuant to section 1886(h) of the Social Security Act, the Secretary shall make payments under this section to each consortium that meets the requirements of subsection (b).

(b) QUALIFYING CONSORTIA.—For purposes of subsection (a), a consortium meets the requirements of this subsection if the consortium is in compliance with the following:

(1) The consortium consists of an approved medical residency training program in a teaching hospital and one or more of the following entities:

(A) A school of allopathic medicine or osteopathic medicine.

(B) Another teaching hospital, which may be a children's hospital.

(C) Another approved medical residency training program.

(D) A Federally qualified health center.

(E) A medical group practice.

(F) A managed care entity.

(G) An entity furnishing outpatient services.

(I) Such other entity as the Secretary determines to be appropriate.

(2) The members of the consortium have agreed to participate in the programs of graduate medical education that are operated by the entities in the consortium.

(3) With respect to the receipt by the consortium of payments made pursuant to this section, the members of the consortium have agreed on a method for allocating the payments among the members.

(4) The consortium meets such additional requirements as the Secretary may establish.

(c) **AMOUNT AND SOURCE OF PAYMENT.**—The total of payments to a qualifying consortium for a fiscal year pursuant to subsection (a) shall not exceed the amount that would have been paid under section 1886(h) of the Social Security Act for the teaching hospital (or hospitals) in the consortium. Such payments shall be made in such proportion from each of the trust funds established under title XVIII of such Act as the Secretary specifies.

SEC. 4736. RECOMMENDATIONS ON LONG-TERM PAYMENT POLICIES REGARDING FINANCING TEACHING HOSPITALS AND GRADUATE MEDICAL EDUCATION.

(a) **IN GENERAL.**—The Medicare Payment Advisory Commission (established under section 1805 of the Social Security Act and in this section referred to as the “Commission”) shall examine and develop recommendations on whether and to what extent medicare payment policies and other Federal policies regarding teaching hospitals and graduate medical education should be reformed. Such recommendations shall include recommendations regarding each of the following:

(1) The financing of graduate medical education, including consideration of alternative broad-based sources of funding for such education and models for the distribution of payments under any all-payer financing mechanism.

(2) The financing of teaching hospitals, including consideration of the difficulties encountered by such hospitals as competition among health care entities increases. Matters considered under this paragraph shall include consideration of the effects on teaching hospitals of the method of financing used for the MedicarePlus program under part C of title XVIII of the Social Security Act.

(3) Possible methodologies for making payments for graduate medical education and the selection of entities to receive such payments. Matters considered under this paragraph shall include—

(A) issues regarding children's hospitals and approved medical residency training programs in pediatrics, and

(B) whether and to what extent payments are being made (or should be made) for training in the various non-physician health professions, including social workers and psychologists.

(4) Federal policies regarding international medical graduates.

(5) The dependence of schools of medicine on service-generated income.

(6) Whether and to what extent the needs of the United States regarding the supply of physicians, in the aggregate and in different specialties, will change during the 10-year period beginning on October 1, 1997, and whether and to what extent any such changes will have significant financial effects on teaching hospitals.

(7) Methods for promoting an appropriate number, mix, and geographical distribution of health professionals.

(c) CONSULTATION.—In conducting the study under subsection (a), the Commission shall consult with the Council on Graduate Medical Education and individuals with expertise in the area of graduate medical education, including—

(1) deans from allopathic and osteopathic schools of medicine;

(2) chief executive officers (or equivalent administrative heads) from academic health centers, integrated health care systems, approved medical residency training programs, and teaching hospitals that sponsor approved medical residency training programs;

(3) chairs of departments or divisions from allopathic and osteopathic schools of medicine, schools of dentistry, and approved medical residency training programs in oral surgery;

(4) individuals with leadership experience from representative fields of non-physician health professionals;

(5) individuals with substantial experience in the study of issues regarding the composition of the health care workforce of the United States; and

(6) individuals with expertise on the financing of health care.

(d) REPORT.—Not later than 2 years after the date of the enactment of this Act, the Commission shall submit to the Congress a report providing its recommendations under this section and the reasons and justifications for such recommendations.

SEC. 4737. MEDICARE SPECIAL REIMBURSEMENT RULE FOR CERTAIN COMBINED RESIDENCY PROGRAMS.

(a) IN GENERAL.—Section 1886(h)(5)(G) (42 U.S.C. 1395ww(h)(5)(G)) is amended—

(1) in clause (i), by striking “and (iii)” and inserting “, (iii), and (iv)”; and

(2) by adding at the end the following:

“(iv) SPECIAL RULE FOR CERTAIN COMBINED RESIDENCY PROGRAMS.—(I) In the case of a resident enrolled in a combined medical residency training program in which all of the individual programs (that are combined) are for training a primary care resident (as defined in subparagraph (H)), the period of board eligibility shall be the minimum number of years of formal training required to satisfy the requirements for initial board eligibility in the longest of the individual programs plus one additional year.

“(II) A resident enrolled in a combined medical residency training program that includes an obstetrics and gynecology program shall qualify for the period of board eligibility under subclause (I) if the other programs such resident combines with such obstetrics and gynecology program are for training a primary care resident.”.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) apply to combined medical residency programs for residency years beginning on or after July 1, 1998.

CHAPTER 5—OTHER PROVISIONS

SEC. 4741. CENTERS OF EXCELLENCE.

(a) IN GENERAL.—Title XVIII is amended by inserting after section 1888 the following:

“CENTERS OF EXCELLENCE

“SEC. 1889. (a) IN GENERAL.—The Secretary shall use a competitive process to contract with specific hospitals or other entities for furnishing services related to surgical procedures, and for furnishing services (unrelated to surgical procedures) to hospital inpatients that the Secretary determines to be appropriate. The services may include any services covered under this title that the Secretary determines to be appropriate, including post-hospital services.

“(b) QUALITY STANDARDS.—

“(1) IN GENERAL.—Only entities that meet quality standards established by the Secretary shall be eligible to contract under this section. Contracting entities shall implement a quality improvement plan approved by the Secretary.

“(2) PARTICIPATION DECISION BASED ON QUALITY.—Subject to subsection (c), the Secretary shall consider quality as the primary factor in selecting hospitals or other entities to enter into contracts under this section.

“(c) PAYMENT.—Payment under this section shall be made on the basis of negotiated all-inclusive rates. The amount of payment made by the Secretary to an entity under this title for services covered under a contract shall not exceed the aggregate amount of the payments that the Secretary would have otherwise made for the services.

“(d) CONTRACT PERIOD.—A contract period shall be 3 years (subject to renewal), so long as the entity continues to meet quality and other contractual standards.

“(e) INCENTIVES FOR USE OF CENTERS.—Entities under a contract under this section may furnish additional services (at no cost to an individual entitled to benefits under this title) or waive cost-sharing, subject to the approval of the Secretary.

“(f) LIMIT ON NUMBER OF CENTERS.—The Secretary shall limit the number of centers in a geographic area to the number needed to meet projected demand for contracted services.”.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) applies to services furnished on or after October 1, 1997.

SEC. 4742. MEDICARE PART B SPECIAL ENROLLMENT PERIOD AND WAIVER OF PART B LATE ENROLLMENT PENALTY AND MEDIGAP SPECIAL OPEN ENROLLMENT PERIOD FOR CERTAIN MILITARY RETIREES AND DEPENDENTS.

(a) MEDICARE PART B SPECIAL ENROLLMENT PERIOD; WAIVER OF PART B PENALTY FOR LATE ENROLLMENT.—

(1) IN GENERAL.—In the case of any eligible individual (as defined in subsection (c)), the Secretary of Health and Human Services shall provide for a special enrollment period during which the individual may enroll under part B of title XVIII of the Social Security Act. Such period shall be for a period of 6 months and shall begin with the first month that begins at least 45 days after the date of the enactment of this Act.

(2) COVERAGE PERIOD.—In the case of an eligible individual who enrolls during the special enrollment period provided under paragraph (1), the coverage period under part B of title XVIII of the Social Security Act shall begin on the first day of the month following the month in which the individual enrolls.

(3) WAIVER OF PART B LATE ENROLLMENT PENALTY.—In the case of an eligible individual who enrolls during the special enrollment period provided under paragraph (1), there shall be no increase pursuant to section 1839(b) of the Social Security Act in the monthly premium under part B of title XVIII of such Act.

(b) MEDIGAP SPECIAL OPEN ENROLLMENT PERIOD.—Notwithstanding any other provision of law, an issuer of a medicare supplemental policy (as defined in section 1882(g) of the Social Security Act)—

(1) may not deny or condition the issuance or effectiveness of a medicare supplemental policy that has a benefit package classified as “A”, “B”, “C”, or “F” under the standards established under section 1882(p)(2) of the Social Security Act (42 U.S.C. 1395rr(p)(2)); and

(2) may not discriminate in the pricing of the policy on the basis of the individual’s health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence), or disability;

in the case of an eligible individual who seeks to enroll (and is enrolled) during the 6-month period described in subsection (a)(1).

(c) ELIGIBLE INDIVIDUAL DEFINED.—In this section, the term “eligible individual” means an individual—

(1) who, as of the date of the enactment of this Act, has attained 65 years of age and was eligible to enroll under part B of title XVIII of the Social Security Act, and

(2) who at the time the individual first satisfied paragraph (1) or (2) of section 1836 of the Social Security Act—

(A) was a covered beneficiary (as defined in section 1072(5) of title 10, United States Code), and

(B) did not elect to enroll (or to be deemed enrolled) under section 1837 of the Social Security Act during the individual's initial enrollment period.

The Secretary of Health and Human Services shall consult with the Secretary of Defense in the identification of eligible individuals.

SEC. 4743. COMPETITIVE BIDDING FOR CERTAIN ITEMS AND SERVICES.

(a) **ESTABLISHMENT OF DEMONSTRATION.**—Not later than 1 year after the date of the enactment of this Act, the Secretary of Health and Human Services shall establish and operate over a 2-year period a demonstration project in 2 geographic regions selected by the Secretary under which (notwithstanding any provision of title XVIII of the Social Security Act to the contrary) the amount of payment made under the medicare program for a selected item or service furnished in the region shall be equal to the price determined pursuant to a competitive bidding process which meets the requirements of subsection (b).

(b) **REQUIREMENTS FOR COMPETITIVE BIDDING PROCESS.**—The competitive bidding process used under the demonstration project under this section shall meet such requirements as the Secretary may impose to ensure the cost-effective delivery to medicare beneficiaries in the project region of items and services of high quality.

(c) **DETERMINATION OF SELECTED ITEMS OR SERVICES.**—The Secretary shall select items and services to be subject to the demonstration project under this section if the Secretary determines that the use of competitive bidding with respect to the item or service under the project will be appropriate and cost-effective. In determining the items or services to be selected, the Secretary shall consult with an advisory taskforce which includes representatives of providers and suppliers of items and services (including small business providers and suppliers) in each geographic region in which the project will be effective.

Subtitle I—Medical Liability Reform

CHAPTER 1—GENERAL PROVISIONS

SEC. 4801. FEDERAL REFORM OF HEALTH CARE LIABILITY ACTIONS.

(a) **APPLICABILITY.**—This subtitle governs any health care liability action brought in any State or Federal court, except that this subtitle shall not apply to an action for damages arising from a vaccine-related injury or death to the extent that title XXI of the Public Health Service Act applies to the action.

(b) **PREEMPTION.**—This subtitle shall preempt any State or applicable Federal law to the extent such law is inconsistent with the limitations contained in this subtitle. This subtitle shall not preempt any State or applicable Federal law that provides for defenses

or places limitations on a person's liability in addition to those contained in this subtitle or otherwise imposes greater restrictions than those provided in this subtitle.

(c) EFFECT ON SOVEREIGN IMMUNITY AND CHOICE OF LAW OR VENUE.—Nothing in subsection (b) 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 chapter 97 of title 28, United States Code;

(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 of inconvenient forum.

(d) AMOUNT IN CONTROVERSY.—In an action to which this subtitle applies and which is brought under section 1332 of title 28, United States Code, the amount of noneconomic damages or punitive damages, and attorneys' fees or costs, shall not be included in determining whether the matter in controversy exceeds the sum or value of \$50,000.

(e) FEDERAL COURT JURISDICTION NOT ESTABLISHED ON FEDERAL QUESTION GROUNDS.—Nothing in this subtitle shall be construed to establish any jurisdiction in the district courts of the United States over health care liability actions on the basis of section 1331 or 1337 of title 28, United States Code.

SEC. 4802. DEFINITIONS.

As used in this subtitle:

(1) ACTUAL DAMAGES.—The term “actual damages” means damages awarded to pay for economic loss.

(2) ALTERNATIVE DISPUTE RESOLUTION SYSTEM; ADR.—The term “alternative dispute resolution system” or “ADR” means a system established under Federal or State law that provides for the resolution of health care liability claims in a manner other than through health care liability actions.

(3) CLAIMANT.—The term “claimant” means any person who brings a health care liability action and any person on whose behalf such an action is brought. If such action is brought through or on behalf of an estate, the term includes the claimant's decedent. If such action is brought through or on behalf of a minor or incompetent, the term includes the claimant's legal guardian.

(4) 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.

(5) COLLATERAL SOURCE PAYMENTS.—The term “collateral source payments” means any amount paid or reasonably likely to be paid in the future to or on behalf of a claimant, or any

service, product, or other benefit provided or reasonably likely to be provided in the future to or on behalf of a claimant, as a result of an injury or wrongful death, pursuant to—

(A) any State or Federal health, sickness, income-disability, accident or workers' compensation Act;

(B) any health, sickness, income-disability, or accident insurance that provides health benefits or income-disability coverage;

(C) any contract or agreement of any group, organization, partnership, or corporation to provide, pay for, or reimburse the cost of medical, hospital, dental, or income disability benefits; and

(D) any other publicly or privately funded program.

(6) **DEVICE.**—The term “device” has the same meaning given such term in section 201(h) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321(h)).

(7) **DRUG.**—The term “drug” has the same meaning given such term in section 201(g)(1) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321(g)(1)).

(8) **ECONOMIC LOSS.**—The term “economic loss” means any pecuniary loss resulting from harm (including the loss of earnings or other benefits related to employment, medical expense loss, replacement services loss, loss due to death, burial costs, and loss of business or employment opportunities), to the extent recovery for such loss is allowed under applicable State or Federal law.

(9) **HARM.**—The term “harm” means—

(A) any physical injury, illness, or death of the claimant, or

(B) any mental anguish or emotional injury to the claimant caused by or causing the claimant physical injury or illness.

(10) **HEALTH CARE LIABILITY ACTION.**—The term “health care liability action” means a civil action brought in a State or Federal court against a health care provider, an entity which is obligated to provide or pay for health benefits under any health plan (including any person or entity acting under a contract or arrangement to provide or administer any health benefit), or the manufacturer, distributor, supplier, marketer, promoter, or seller of a medical product, in which the claimant alleges a health care liability claim.

(11) **HEALTH CARE LIABILITY CLAIM.**—The term “health care liability claim” means a claim in which the claimant alleges that harm was caused by the provision of (or the failure to provide) health care services or the use of a medical product, regardless of the theory of liability on which the claim is based.

(12) **HEALTH CARE PROVIDER.**—The term “health care provider” means any individual, organization, or institution that is engaged in the delivery of health care services in a State and that is required by the laws or regulations of the State to be licensed or certified by the State to engage in the delivery of such services in the State.

(13) **MANUFACTURER.**—The term “manufacturer” means—

(A) any person who is engaged in a business to produce, create, make, or construct any product (or component part of a product) and who (i) designs or formulates the product (or component part of the product), or (ii) has engaged another person to design or formulate the product (or component part of the product);

(B) a product seller, but only with respect to those aspects of a product (or component part of a product) which are created or affected when, before placing the product in the stream of commerce, the product seller produces, creates, makes or constructs and designs, or formulates, or has engaged another person to design or formulate, an aspect of the product (or component part of the product) made by another person; or

(C) any product seller not described in subparagraph (B) which holds itself out as a manufacturer to the user of the product.

(14) NONECONOMIC DAMAGES.—The term “noneconomic damages” means damages paid to an individual for pain and suffering, inconvenience, emotional distress, mental anguish, loss of society and companionship, injury to reputation, humiliation, and other subjective, nonpecuniary losses.

(15) PERSON.—The term “person” means any individual, corporation, company, association, firm, partnership, society, joint stock company, or any other entity, including any governmental entity.

(16) PRODUCT SELLER.—

(A) IN GENERAL.—The term “product seller” means a person who in the course of a business conducted for that purpose—

(i) sells, distributes, rents, leases, prepares, blends, packages, labels, or otherwise is involved in placing a product in the stream of commerce; or

(ii) installs, repairs, refurbishes, reconditions, or maintains the harm-causing aspect of the product.

(B) EXCLUSION.—The term “product seller” does not include—

(i) a seller or lessor of real property;

(ii) a provider of professional services in any case in which the sale or use of a product is incidental to the transaction and the essence of the transaction is the furnishing of judgment, skill, or services; or

(iii) any person who—

(I) acts in only a financial capacity with respect to the sale of a product; or

(II) leases a product under a lease arrangement in which the lessor does not initially select the leased product and does not during the lease term ordinarily control the daily operations and maintenance of the product.

(17) PUNITIVE DAMAGES.—The term “punitive damages” means damages awarded against any person not to compensate for actual injury suffered, but to punish or deter such person or others from engaging in similar behavior in the future.

(18) STATE.—The term “State” means each of the several States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, the Northern Mariana Islands, the Trust Territories of the Pacific Islands, and any other territory or possession of the United States or any political subdivision of any of the foregoing.

SEC. 4803. EFFECTIVE DATE.

This subtitle will apply to any health care liability action brought in a Federal or State court and to any health care liability claim subject to an alternative dispute resolution system, that is initiated on or after the date of enactment of this subtitle.

CHAPTER 2—UNIFORM STANDARDS FOR HEALTH CARE LIABILITY ACTIONS

SEC. 4811. STATUTE OF LIMITATIONS.

(a) GENERAL RULE.—Except as provided in subsection (b), a health care liability action may be filed not later than 2 years after the date on which the claimant discovered or, in the exercise of reasonable care, should have discovered—

- (1) the harm that is the subject of the action; and
- (2) the cause of the harm.

(b) EXCEPTION.—A person with a legal disability (as determined under applicable law) may file a health care liability action not later than 2 years after the date on which the person ceases to have the legal disability.

(c) TRANSITIONAL PROVISION RELATING TO EXTENSION OF PERIOD FOR BRINGING CERTAIN ACTIONS.—If any provision of subsection (a) or (b) shortens the period during which a health care liability action could be otherwise brought pursuant to another provision of law, the claimant may, notwithstanding subsections (a) and (b), bring the health care liability action not later than 2 years after the date of enactment of this Act.

SEC. 4812. CALCULATION AND PAYMENT OF DAMAGES.

(a) TREATMENT OF NONECONOMIC DAMAGES.—

(1) LIMITATION ON NONECONOMIC DAMAGES.—The total amount of noneconomic damages that may be awarded to a claimant for harm which is the subject of a health care 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.

(2) FAIR SHARE RULE FOR NONECONOMIC DAMAGES.—

(A) GENERAL RULE.—In a health care liability action, the liability of each defendant for noneconomic damages shall be several only and shall not be joint.

(B) AMOUNT OF LIABILITY.—

(i) IN GENERAL.—Each defendant shall be liable only for the amount of noneconomic damages attributable to the defendant in direct proportion to the percentage of responsibility of the defendant (determined in accordance with paragraph (2)) for the harm to the claimant with respect to which the defendant is liable. The court shall render a separate judgment against

each defendant in an amount determined pursuant to the preceding sentence.

(ii) PERCENTAGE OF RESPONSIBILITY.—For purposes of determining the amount of noneconomic damages attributable to a defendant under this section, the trier of fact shall determine the percentage of responsibility of each person responsible for the claimant's harm, whether or not such person is a party to the action.

(b) TREATMENT OF PUNITIVE DAMAGES.—

(1) GENERAL RULE.—Punitive damages may, to the extent permitted by applicable law, be awarded in a health care liability action against a defendant if the claimant establishes by clear and convincing evidence that the harm suffered was result of conduct manifesting a conscious, flagrant indifference to the rights or safety of others.

(2) REQUIRED PROPORTIONALITY.—The amount of punitive damages that may be awarded in a health care liability action shall not exceed 3 times the amount of damages awarded to the claimant for economic loss, or \$250,000, whichever is greater. This subsection shall be applied by the court, and application of this subsection shall not be disclosed to the jury.

(c) BIFURCATION AT REQUEST OF ANY PARTY.—

(1) IN GENERAL.—At the request of any party the trier of fact in any action that is subject to this section shall consider in a separate proceeding, held subsequent to the determination of the amount of compensatory damages, whether punitive damages are to be awarded for the harm that is the subject of the action and the amount of the award.

(2) INADMISSIBILITY OF EVIDENCE RELATIVE ONLY TO A CLAIM OF PUNITIVE DAMAGES IN A PROCEEDING CONCERNING COMPENSATORY DAMAGES.—If any party requests a separate proceeding under paragraph (1), in a proceeding to determine whether the claimant may be awarded compensatory damages, any evidence, argument, or contention that is relevant only to the claim of punitive damages, as determined by applicable law, shall be inadmissible.

(d) DRUGS AND DEVICES.—

(1)(A) Punitive damages shall not be awarded against a manufacturer or product seller of a drug or device 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 or device was approved by the Food and Drug Administration; or

(ii) the drug or device 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 health care liability action 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.

(e) PERIODIC PAYMENTS FOR FUTURE LOSSES.—

(1) GENERAL RULE.—In any health care liability action in which the damages awarded for future economic and non-economic loss exceed \$50,000, a person shall not be required to pay such damages in a single, lump-sum payment, but shall be permitted to make such payments periodically based on when the damages are found likely to occur, with the amount and schedule of such payments determined by the court.

(2) FINALITY OF JUDGMENT.—The judgment of the court awarding periodic payments under this subsection may not, in the absence of fraud, be reopened at any time to contest, amend, or modify the schedule or amount of the payments.

(3) LUMP-SUM SETTLEMENTS.—This subsection shall not be construed to preclude a settlement providing for a single, lump-sum payment.

(f) TREATMENT OF COLLATERAL SOURCE PAYMENTS.—

(1) INTRODUCTION INTO EVIDENCE.—In any health care liability action, any defendant may introduce evidence of collateral source payments. If a defendant elects to introduce such evidence, the claimant may introduce evidence of any amount paid or contributed or reasonably likely to be paid or contributed in the future by or on behalf of the claimant to secure the right to such collateral source payments.

(2) NO SUBROGATION.—No provider of collateral source payments shall recover any amount against the claimant or receive any lien or credit against the claimant's recovery or be equitably or legally subrogated the right of the claimant in a health care liability action. This subsection shall apply to an action that is settled as well as an action that is resolved by a fact finder.

SEC. 4813. ALTERNATIVE DISPUTE RESOLUTION.

Any ADR used to resolve a health care liability action or claim shall contain provisions relating to statute of limitations, non-economic damages, joint and several liability, punitive damages, collateral source rule, and periodic payments which are identical to the provisions relating to such matters in this subtitle.

TITLE V—COMMITTEE ON EDUCATION AND THE WORKFORCE

Subtitle A—TANF Block Grant

SEC. 5001. WELFARE-TO-WORK GRANTS.

(a) GRANTS TO STATES.—Section 403(a) of the Social Security Act (42 U.S.C. 603(a)) is amended by adding at the end the following:

“(5) WELFARE-TO-WORK GRANTS.—

“(A) FORMULA GRANTS.—

“(i) ENTITLEMENT.—A State shall be entitled to receive from the Secretary a grant for each fiscal year specified in subparagraph (H) of this paragraph for which the State is a welfare-to-work State, in an amount that does not exceed the lesser of—

“(I) 2 times the total of the expenditures by the State (excluding qualified State expenditures (as defined in section 409(a)(7)(B)(i)) and expenditures described in section 409(a)(7)(B)(iv)) during the fiscal year for activities described in subparagraph (C)(i) of this paragraph; or

“(II) the allotment of the State under clause (iii) of this subparagraph for the fiscal year.

“(ii) WELFARE-TO-WORK STATE.—A State shall be considered a welfare-to-work State for a fiscal year for purposes of this subparagraph if the Secretary, after consultation (and the sharing of any plan or amendment thereto submitted under this clause) with the Secretary of Health and Human Services and the Secretary of Housing and Urban Development, determines that the State meets the following requirements:

“(I) The State has submitted to the Secretary (in the form of an addendum to the State plan submitted under section 402) a plan which—

“(aa) describes how, consistent with this subparagraph, the State will use any funds provided under this subparagraph during the fiscal year;

“(bb) specifies the formula to be used pursuant to clause (vi) to distribute funds in the State, and describes the process by which the formula was developed; and

“(cc) contains evidence that the plan was developed through a collaborative process that, at a minimum, included sub-State areas.

“(II) The State has provided the Secretary with an estimate of the amount that the State intends to expend during the fiscal year (excluding expenditures described in section 409(a)(7)(B)(iv)) for activities described in subparagraph (C)(i) of this paragraph.

“(III) The State has agreed to negotiate in good faith with the Secretary of Health and Human Services with respect to the substance of any evaluation under section 413(j), and to cooperate with the conduct of any such evaluation.

“(IV) The State is an eligible State for the fiscal year.

“(iii) ALLOTMENTS TO WELFARE-TO-WORK STATES.—The allotment of a welfare-to-work State for a fiscal year shall be the available amount for the fiscal year multiplied by the State percentage for the fiscal year.

“(iv) AVAILABLE AMOUNT.—As used in clause (iii), the term ‘available amount’ means, for a fiscal year, 95 percent of—

“(I) the amount specified in subparagraph (H) for the fiscal year; minus

“(II) the total of the amounts reserved pursuant to subparagraphs (F) and (G) for the fiscal year.

“(v) STATE PERCENTAGE.—As used in clause (iii), the term ‘State percentage’ means, with respect to a fiscal year, $\frac{1}{2}$ of the sum of—

“(I) the percentage represented by the number of individuals in the State whose income is less than the poverty line divided by the number of such individuals in the United States; and

“(II) the percentage represented by the number of individuals who are adult recipients of assistance under the State program funded under this part divided by the number of individuals in the United States who are adult recipients of assistance under any State program funded under this part.

“(vi) DISTRIBUTION OF FUNDS WITHIN STATES.—

“(I) IN GENERAL.—A State to which a grant is made under this subparagraph shall distribute not less than 85 percent of the grant funds among the service delivery areas in the State, in accordance with a formula which—

“(aa) determines the amount to be distributed for the benefit of a service delivery area in proportion to the number (if any) by which the number of individuals residing in the service delivery area with an income that is less than the poverty line exceeds 5 percent of the population of the service delivery area, relative to such number for the other service delivery areas in the State, and accords a

weight of not less than 50 percent to this factor;

“(bb) may determine the amount to be distributed for the benefit of a service delivery area in proportion to the number of adults residing in the service delivery area who are recipients of assistance under the State program funded under this part (whether in effect before or after the amendments made by section 103(a) of the Personal Responsibility and Work Opportunity Reconciliation Act first applied to the State) for at least 30 months (whether or not consecutive) relative to the number of such adults residing in the other service delivery areas in the State; and

“(cc) may determine the amount to be distributed for the benefit of a service delivery area in proportion to the number of unemployed individuals residing in the service delivery area relative to the number of such individuals residing in the other service delivery areas in the State.

“(II) SPECIAL RULE.—Notwithstanding subclause (I), if the formula used pursuant to subclause (I) would result in the distribution of less than \$100,000 during a fiscal year for the benefit of a service delivery area, then in lieu of distributing such sum in accordance with the formula, such sum shall be available for distribution under subclause (III) during the fiscal year.

“(III) PROJECTS TO HELP LONG-TERM RECIPIENTS OF ASSISTANCE INTO THE WORK FORCE.—The Governor of a State to which a grant is made under this subparagraph may distribute not more than 15 percent of the grant funds (plus any amount required to be distributed under this subclause by reason of subclause (II)) to projects that appear likely to help long-term recipients of assistance under the State program funded under this part (whether in effect before or after the amendments made by section 103(a) of the Personal Responsibility and Work Opportunity Reconciliation Act first applied to the State) enter the work force.

“(vii) ADMINISTRATION.—

“(I) IN GENERAL.—A grant made under this subparagraph to a State shall be administered by the State agency that is administering, or supervising the administration of, the State program funded under this part, or by another State agency designated by the Governor of the State.

“(II) SPENDING BY PRIVATE INDUSTRY COUNCILS.—The private industry council for a service delivery area shall have sole authority, in coordination with the chief elected official (as described

in section 103(c) of the Job Training Partnership Act) of the service delivery area, to expend the amounts provided for a service delivery area under subparagraph (vi)(I).

“(B) DEMONSTRATION PROJECTS.—

“(i) IN GENERAL.—The Secretary, in consultation with the Secretary of Health and Human Services and the Secretary of Housing and Urban Development, shall make grants in accordance with this subparagraph among eligible applicants based on the likelihood that the applicant can successfully make long-term placements of individuals into the work force.

“(ii) ELIGIBLE APPLICANTS.—As used in clause (i), the term ‘eligible applicant’ means a private industry council or a political subdivision of a State.

“(iii) DETERMINATION OF GRANT AMOUNT.—In determining the amount of a grant to be made under this subparagraph for a demonstration project proposed by an applicant, the Secretary shall provide the applicant with an amount sufficient to ensure that the project has a reasonable opportunity to be successful, taking into account the number of long-term recipients of assistance under a State program funded under this part, the level of unemployment, the job opportunities and job growth, the poverty rate, and such other factors as the Secretary deems appropriate, in the area to be served by the project.

“(iv) FUNDING.—For grants under this subparagraph for each fiscal year specified in subparagraph (H), there shall be available to the Secretary an amount equal to the sum of—

“(I) 5 percent of—

“(aa) the amount specified in subparagraph (H) for the fiscal year; minus

“(bb) the total of the amounts reserved pursuant to subparagraphs (F) and (G) for the fiscal year;

“(II) any amount available for grants under this paragraph for the immediately preceding fiscal year that has not been obligated;

“(III) any amount reserved pursuant to subparagraph (F) for the immediately preceding fiscal year that has not been obligated; and

“(IV) any available amount (as defined in subparagraph (A)(iv)) for the immediately preceding fiscal year that has not been obligated by a State or sub-State entity.

Amounts made available pursuant to this clause are authorized to remain available until the end of fiscal year 2001.

“(C) LIMITATIONS ON USE OF FUNDS.—

“(i) ALLOWABLE ACTIVITIES.—An entity to which funds are provided under this paragraph may use the funds to move into the work force recipients of assist-

ance under the program funded under this part of the State in which the entity is located, by means of any of the following:

“(I) Job creation through public or private sector employment wage subsidies.

“(II) On-the-job training.

“(III) Contracts with job placement companies or public job placement programs.

“(IV) Job vouchers.

“(V) Job retention or support services if such services are not otherwise available.

“(ii) REQUIRED BENEFICIARIES.—An entity that operates a project with funds provided under this paragraph shall expend at least 90 percent of all funds provided to the project for the benefit of recipients of assistance under the program funded under this part of the State in which the entity is located who meet the requirements of any of the following subclauses:

“(I) The individual has received assistance under the State program funded under this part (whether in effect before or after the amendments made by section 103 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 first apply to the State) for at least 30 months (whether or not consecutive).

“(II) At least 2 of the following apply to the recipient:

“(aa) The individual has not completed secondary school or obtained a certificate of general equivalency, and has low skills in reading and mathematics.

“(bb) The individual requires substance abuse treatment for employment.

“(cc) The individual has a poor work history.

The Secretary shall prescribe such regulations as may be necessary to interpret this subclause.

“(III) Within 12 months, the individual will become ineligible for assistance under the State program funded under this part by reason of a durational limit on such assistance, without regard to any exemption provided pursuant to section 408(a)(7)(C) that may apply to the individual.

“(iii) LIMITATION ON APPLICABILITY OF SECTION 404.—The rules of section 404, other than subsections (b), (f), and (h) of section 404, shall not apply to a grant made under this paragraph.

“(iv) PROHIBITION AGAINST PROVISION OF SERVICES BY PRIVATE INDUSTRY COUNCIL.—A private industry council may not directly provide services using funds provided under this paragraph.

“(v) PROHIBITION AGAINST USE OF GRANT FUNDS FOR ANY OTHER FUND MATCHING REQUIREMENT.—An entity to which funds are provided under this paragraph

shall not use any part of the funds to fulfill any obligation of any State, political subdivision, or private industry council to contribute funds under other Federal law.

“(vi) DEADLINE FOR EXPENDITURE.—An entity to which funds are provided under this paragraph shall remit to the Secretary any part of the funds that are not expended within 3 years after the date the funds are so provided.

“(D) INDIVIDUALS WITH INCOME LESS THAN THE POVERTY LINE.—For purposes of this paragraph, the number of individuals with an income that is less than the poverty line shall be determined based on the methodology used by the Bureau of the Census to produce and publish intercensal poverty data for 1993 for States and counties.

“(E) DEFINITIONS.—As used in this paragraph:

“(i) PRIVATE INDUSTRY COUNCIL.—The term ‘private industry council’ means, with respect to a service delivery area, the private industry council (or successor entity) established for the service delivery area pursuant to the Job Training Partnership Act.

“(ii) SECRETARY.—The term ‘Secretary’ means the Secretary of Labor, except as otherwise expressly provided.

“(iii) SERVICE DELIVERY AREA.—The term ‘service delivery area’ shall have the meaning given such term for purposes of the Job Training Partnership Act (or successor area).

“(F) FUNDING FOR INDIAN TRIBES.—1 percent of the amount specified in subparagraph (H) for each fiscal year shall be reserved for grants to Indian tribes under section 412(a)(3).

“(G) EVALUATIONS.—0.5 percent of the amount specified in subparagraph (H) for each fiscal year shall be reserved for use by the Secretary of Health and Human Services to carry out section 413(j).

“(H) FUNDING.—The amount specified in this subparagraph is—

“(i) \$750,000,000 for fiscal year 1998;

“(ii) \$1,250,000,000 for fiscal year 1999; and

“(iii) \$1,000,000,000 for fiscal year 2000.

“(I) BUDGET SCORING.—Notwithstanding section 457(b)(2) of the Balanced Budget and Emergency Deficit Control Act of 1985, the baseline shall assume that no grant shall be made under this paragraph or under section 412(a)(3) after fiscal year 2001.”.

(b) GRANTS TO TERRITORIES.—Section 1108(a) of such Act (42 U.S.C. 1308(a)) is amended by inserting “(except section 403(a)(5))” after “title IV”.

(c) GRANTS TO INDIAN TRIBES.—Section 412(a) of such Act (42 U.S.C. 612(a)) is amended by adding at the end the following:

“(3) WELFARE-TO-WORK GRANTS.—

“(A) IN GENERAL.—The Secretary shall make a grant in accordance with this paragraph to an Indian tribe for each

fiscal year specified in section 403(a)(5)(H) for which the Indian tribe is a welfare-to-work tribe, in such amount as the Secretary deems appropriate, subject to subparagraph (B) of this paragraph.

“(B) WELFARE-TO-WORK TRIBE.—An Indian tribe shall be considered a welfare-to-work tribe for a fiscal year for purposes of this paragraph if the Indian tribe meets the following requirements:

“(i) The Indian tribe has submitted to the Secretary (in the form of an addendum to the tribal family assistance plan, if any, of the Indian tribe) a plan which describes how, consistent with section 403(a)(5), the Indian tribe will use any funds provided under this paragraph during the fiscal year.

“(ii) The Indian tribe has provided the Secretary with an estimate of the amount that the Indian tribe intends to expend during the fiscal year (excluding tribal expenditures described in section 409(a)(7)(B)(iv)) for activities described in section 403(a)(5)(C)(i).

“(iii) The Indian tribe has agreed to negotiate in good faith with the Secretary of Health and Human Services with respect to the substance of any evaluation under section 413(j), and to cooperate with the conduct of any such evaluation.

“(C) LIMITATIONS ON USE OF FUNDS.—Section 403(a)(5)(C) shall apply to funds provided to Indian tribes under this paragraph in the same manner in which such section applies to funds provided under section 403(a)(5).”.

(d) FUNDS RECEIVED FROM GRANTS TO BE DISREGARDED IN APPLYING DURATIONAL LIMIT ON ASSISTANCE.—Section 408(a)(7) of such Act (42 U.S.C. 608(a)(7)) is amended by adding at the end the following:

“(G) INAPPLICABILITY TO WELFARE-TO-WORK GRANTS AND ASSISTANCE.—For purposes of subparagraph (A) of this paragraph, a grant made under section 403(a)(5) shall not be considered a grant made under section 403, and assistance from funds provided under section 403(a)(5) shall not be considered assistance.”.

(e) EVALUATIONS.—Section 413 of such Act (42 U.S.C. 613) is amended by adding at the end the following:

“(j) EVALUATION OF WELFARE-TO-WORK PROGRAMS.—The Secretary—

“(1) shall, in consultation with the Secretary of Labor, develop a plan to evaluate how grants made under sections 403(a)(5) and 412(a)(3) have been used; and

“(2) may evaluate the use of such grants by such grantees as the Secretary deems appropriate, in accordance with an agreement entered into with the grantees after good-faith negotiations.”.

SEC. 5002. NONDISPLACEMENT.

Section 407(f) of the Social Security Act (42 U.S.C. 607(f)) is amended to read as follows:

“(f) NONDISPLACEMENT IN WORK ACTIVITIES.—

“(1) PROHIBITIONS.—

“(A) GENERAL PROHIBITION.—A participant in a work activity pursuant to section 403(a)(5) or this section shall not displace (including a partial displacement, such as a reduction in the hours of nonovertime work, wages, or employment benefits) any individual who, as of the date of the participation, is an employee.

“(B) PROHIBITION ON IMPAIRMENT OF CONTRACTS.—A work activity shall not impair an existing contract for services or collective bargaining agreement, and a work activity that would be inconsistent with the terms of a collective bargaining agreement shall not be undertaken without the written concurrence of the labor organization and employer concerned.

“(C) OTHER PROHIBITIONS.—A participant in a work activity shall not be employed in a job—

“(i) when any other individual is on layoff from the same or any substantially equivalent job;

“(ii) when the employer has terminated the employment of any regular employee or otherwise reduced the workforce of the employer with the intention of filling the vacancy so created with the participant; or

“(iii) which is created in a promotional line that will infringe in any way upon the promotional opportunities of employed individuals.

“(2) HEALTH AND SAFETY.—Health and safety standards established under Federal and State law otherwise applicable to working conditions of employees shall be equally applicable to working conditions of participants engaged in a work activity. To the extent that a State workers’ compensation law applies, workers’ compensation shall be provided to participants on the same basis as the compensation is provided to other individuals in the State in similar employment.

“(3) NONDISCRIMINATION.—In addition to the protections provided under the provisions of law specified in section 408(c), an individual may not be discriminated against with respect to participation in work activities by reason of gender.

“(4) GRIEVANCE PROCEDURE.—

“(A) IN GENERAL.—Each State to which a grant is made under section 403 shall establish and maintain a procedure for grievances or complaints alleging violations of paragraph (1), (2), or (3) from participants and other interested or affected parties. The procedure shall include an opportunity for a hearing and be completed within 60 days after the grievance or complaint is filed.

“(B) INVESTIGATION.—

“(i) IN GENERAL.—The Secretary of Labor shall investigate an allegation of a violation of paragraph (1), (2), or (3) if—

“(I) a decision relating to the violation is not reached within 60 days after the date of the filing of the grievance or complaint, and either party appeals to the Secretary of Labor; or

“(II) a decision relating to the violation is reached within the 60-day period, and the party to which the decision is adverse appeals the decision to the Secretary of Labor.

“(ii) ADDITIONAL REQUIREMENT.—The Secretary of Labor shall make a final determination relating to an appeal made under clause (i) no later than 120 days after receiving the appeal.

“(C) REMEDIES.—Remedies for violation of paragraph (1), (2), or (3) shall be limited to—

“(i) suspension or termination of payments under section 403;

“(ii) prohibition of placement of a participant with an employer that has violated paragraph (1), (2), or (3);

“(iii) where applicable, reinstatement of an employee, payment of lost wages and benefits, and reestablishment of other relevant terms, conditions and privileges of employment; and

“(iv) where appropriate, other equitable relief.”

SEC. 5003. CLARIFICATION OF LIMITATION ON NUMBER OF PERSONS WHO MAY BE TREATED AS ENGAGED IN WORK BY REASON OF PARTICIPATION IN EDUCATIONAL ACTIVITIES.

(a) IN GENERAL.—Section 407(c)(2)(D) of the Social Security Act (42 U.S.C. 607(c)(2)(D)) is amended to read as follows:

“(D) LIMITATION ON NUMBER OF PERSONS WHO MAY BE TREATED AS ENGAGED IN WORK BY REASON OF PARTICIPATION IN EDUCATIONAL ACTIVITIES.—For purposes of determining monthly participation rates under paragraphs (1)(B)(i) and (2)(B) of subsection (b), not more than 20 percent of the number of individuals in all families and in 2-parent families, respectively, in a State who are treated as engaged in work for a month may consist of individuals who are determined to be engaged in work for the month by reason of participation in vocational educational training, or deemed to be engaged in work for the month by reason of subparagraph (C) of this paragraph.”

(b) RETROACTIVITY.—The amendment made by subsection (a) of this section shall take effect as if included in the enactment of section 103(a) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

SEC. 5004. COMPENSATION; MAXIMUM REQUIRED HOURS OF WORK ACTIVITIES.

(a) IN GENERAL.—Section 407 of the Social Security Act (42 U.S.C. 607) is amended by adding at the end the following:

“(j) COMPENSATION.—A State to which a grant is made under section 403 may not require a recipient of assistance under the State program funded under this part to participate in a work activity described in paragraph (1), (2), or (3) of subsection (d) unless the recipient is compensated at the same rates, including periodic increases, as trainees or employees who are similarly situated in similar occupations by the same employer and who have similar training, experience and skills, and such rates shall be in accordance with applicable law.

“(k) LIMITATION ON NUMBER OF HOURS PER MONTH THAT A RECIPIENT OF ASSISTANCE MAY BE REQUIRED TO PARTICIPATE IN ON-THE-JOB TRAINING, AND WITH A PUBLIC AGENCY OR NONPROFIT ORGANIZATION.—

“(1) IN GENERAL.—A State to which a grant is made under section 403 may not require a recipient of assistance under the State program funded under this part to be assigned to on-the-job training, and to a work experience or community service position with a public agency or nonprofit organization during a month for more than the allowable number of hours determined for the month under paragraph (2).

“(2) ALLOWABLE NUMBER OF HOURS.—

“(A) IN GENERAL.—Subject to subparagraph (B), the allowable number of hours determined for a month under this paragraph is—

“(i) the value of the includible benefits provided by the State to the recipient during the month; divided by

“(ii) the minimum wage rate in effect during the month under section 6 of the Fair Labor Standards Act of 1938.

“(B) STATE OPTION TO TAKE ACCOUNT OF CERTAIN WORK ACTIVITIES.—

“(i) IN GENERAL.—In determining the allowable number of hours for a month for a sufficiently employed recipient, the State may subtract from the allowable number of hours calculated under subparagraph (A) the number of hours during the month for which the recipient participates in a work activity described in paragraph (6), (8), (9), or (11) of subsection (d).

“(ii) SUFFICIENTLY EMPLOYED RECIPIENT.—As used in clause (i), the term ‘sufficiently employed recipient’ means, with respect to a month, a recipient who is employed during the month for a number of hours that is not less than—

“(I) the sum of the dollar value of any assistance provided to the recipient during the month under the State program funded under this part, and the dollar value equivalent of any benefits provided to the recipient during the month under the food stamp program under the Food Stamp Act of 1977; divided by

“(II) the minimum wage rate in effect during the month under section 6 of the Fair Labor Standards Act of 1938.

“(3) DEFINITION OF VALUE OF THE INCLUDIBLE BENEFITS.—As used in paragraph (2)(A), the term ‘value of the includible benefits’ means, with respect to a recipient—

“(A) the dollar value of any assistance under the State program funded under this part;

“(B) the dollar value equivalent of any benefits under the food stamp program under the Food Stamp Act of 1977;

“(C) at the option of the State, the dollar value of benefits under the State plan approved under title XIX, as determined in accordance with paragraph (4);

“(D) at the option of the State, the dollar value of child care assistance; and

“(E) at the option of the State, the dollar value of housing benefits.

“(4) VALUATION OF MEDICAID BENEFITS.—Annually, the Secretary shall publish a table that specifies the dollar value of the insurance coverage provided under title XIX to a family of each size, which may take account of geographical variations or other factors identified by the Secretary.

“(5) TREATMENT OF RECIPIENTS ASSIGNED TO CERTAIN POSITIONS WITH A PUBLIC AGENCY OR NONPROFIT ORGANIZATION.—A recipient of assistance under a State program funded under this part who is engaged in work experience or community service with a public agency or nonprofit organization shall not be considered an employee of the public agency or the nonprofit organization.”

(b) RETROACTIVITY.—The amendment made by subsection (a) of this section shall take effect as if included in the enactment of section 103(a) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

SEC. 5005. PENALTY FOR FAILURE OF STATE TO REDUCE ASSISTANCE FOR RECIPIENTS REFUSING WITHOUT GOOD CAUSE TO WORK.

(a) IN GENERAL.—Section 409(a) of the Social Security Act (42 U.S.C. 609(a)) is amended by adding at the end the following:

“(13) PENALTY FOR FAILURE TO REDUCE ASSISTANCE FOR RECIPIENTS REFUSING WITHOUT GOOD CAUSE TO WORK.—

“(A) IN GENERAL.—If the Secretary determines that a State to which a grant is made under section 403 in a fiscal year has violated section 407(e) during the fiscal year, the Secretary shall reduce the grant payable to the State under section 403(a)(1) for the immediately succeeding fiscal year by an amount equal to not less than 1 percent and not more than 5 percent of the State family assistance grant.

“(B) PENALTY BASED ON SEVERITY OF FAILURE.—The Secretary shall impose reductions under subparagraph (A) with respect to a fiscal year based on the degree of non-compliance.”

(b) RETROACTIVITY.—The amendment made by subsection (a) of this section shall take effect as if included in the enactment of section 103(a) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

Subtitle B—Higher Education Programs

SEC. 5101. MANAGEMENT AND RECOVERY OF RESERVES.

(a) AMENDMENT.—Section 422 of the Higher Education Act of 1965 (20 U.S.C. 1072) is amended by adding after subsection (g) the following new subsection:

“(h) RECALL OF RESERVES; LIMITATIONS ON USE OF RESERVE FUNDS AND ASSETS.—(1) Notwithstanding any other provision of law, the Secretary shall, except as otherwise provided in this subsection, recall \$1,000,000,000 from the reserve funds held by guaranty agencies on September 1, 2002.

“(2) Funds recalled by the Secretary under this subsection shall be deposited in the Treasury.

“(3) The Secretary shall require each guaranty agency to return reserve funds under paragraph (1) based on such agency’s required share of recalled reserve funds held by guaranty agencies as of September 30, 1996. For purposes of this paragraph, a guaranty agency’s required share of recalled reserve funds shall be determined as follows:

“(A) The Secretary shall compute each agency’s reserve ratio by dividing (i) the amount held in such agency’s reserve funds as of September 30, 1996 (but reflecting later accounting or auditing adjustments approved by the Secretary), by (ii) the original principal amount of all loans for which such agency has an outstanding insurance obligation as of such date.

“(B) If the reserve ratio of any agency as computed under subparagraph (A) exceeds 2.0 percent, the agency’s required share shall include so much of the amounts held in such agency’s reserve fund as exceed a reserve ratio of 2.0 percent.

“(C) If any additional amount is required to be recalled under paragraph (1) (after deducting the total of the required shares calculated under subparagraph (B)), the agencies’ required shares shall include additional amounts—

“(i) determined by imposing on each such agency an equal percentage reduction in the amount of each agency’s reserve fund remaining after deduction of the amount recalled under subparagraph (B); and

“(ii) the total of which equals the additional amount that is required to be recalled under paragraph (1) (after deducting the total of the required shares calculated under subparagraph (B)).

“(4) Within 90 days after the beginning of each of fiscal years 1998 through 2002, each guaranty agency shall transfer a portion of each agency’s required share determined under paragraph (3) to a restricted account established by the guaranty agency that is of a type selected by the guaranty agency with the approval of the Secretary. Funds transferred to such restricted accounts shall be invested in obligations issued or guaranteed by the United States or in other similarly low-risk securities. A guaranty agency shall not use the funds in such a restricted account for any purpose without the express written permission of the Secretary, except that a guaranty agency may use the earnings from such restricted account to assist in meeting the agency’s operational expenses under this part. In each of fiscal years 1998 through 2002, each agency shall transfer its required share to such restricted account in 5 equal annual installments, except that—

“(A) a guarantee agency that has a reserve ratio (as computed under subparagraph (3)(A)) equal to or less than 1.10 percent may transfer its required share to such account in 4 equal installments beginning in fiscal year 1999; and

“(B) a guarantee agency may transfer such required share to such account in accordance with such other payment schedules as are approved by the Secretary.

“(5) If, on September 1, 2002, the total amount in the restricted accounts described in paragraph (4) is less than the amount the Secretary is required to recall under paragraph (1), the Secretary may require the return of the amount of the shortage from other reserve funds held by guaranty agencies under procedures established by the Secretary.

“(6) The Secretary may take such reasonable measures, and require such information, as may be necessary to ensure that guaranty agencies comply with the requirements of this subsection. Notwithstanding any other provision of this part, if the Secretary determines that a guaranty agency is not in compliance with the requirements of this subsection, such agency may not receive any other funds under this part until the Secretary determines that such agency is in compliance.

“(7) The Secretary shall not have any authority to direct a guaranty agency to return reserve funds under subsection (g)(1)(A) during the period from the date of enactment of this subsection through September 30, 2002, and any reserve funds otherwise returned under subsection (g)(1) during such period shall be treated as amounts recalled under this subsection and shall not be available under subsection (g)(4).

“(8) For purposes of this subsection, the term ‘reserve funds’ when used with respect to a guaranty agency—

“(A) includes any cash reserve funds held by the guaranty agency, or held by, or under the control of, any other entity; and

“(B) does not include buildings, equipment, or other nonliquid assets.”

(b) CONFORMING AMENDMENT.—Section 428(c)(9)(A) of the Higher Education Act of 1965 (20 U.S.C. 1078(c)(9)(A)) is amended—

(1) in the first sentence, by striking “for the fiscal year of the agency that begins in 1993”; and

(2) by striking the third sentence.

SEC. 5102. REPEAL OF DIRECT LOAN ORIGINATION FEES TO INSTITUTIONS OF HIGHER EDUCATION.

Section 452 of the Higher Education Act of 1965 (20 U.S.C. 1087b) is amended—

(1) by striking subsection (b); and

(2) by redesignating subsections (c) and (d) as subsections (b) and (c), respectively.

SEC. 5103. FUNDS FOR ADMINISTRATIVE EXPENSES.

Subsection (a) of section 458 of the Higher Education Act of 1965 (20 U.S.C. 1087h(a)) is amended to read as follows:

“(a) IN GENERAL.—(1) Each fiscal year, there shall be available to the Secretary from funds not otherwise appropriated, funds to be obligated for—

“(A) administrative costs under this part and part B, including the costs of the direct student loan programs under this part, and

“(B) administrative cost allowances payable to guaranty agencies under part B and calculated in accordance with paragraph (2), not to exceed (from such funds not otherwise appropriated) \$532,000,000 in fiscal year 1998, \$610,000,000 in fiscal year 1999, \$705,000,000 in fiscal year 2000, \$750,000,000 in fiscal year 2001, and \$750,000,000 in fiscal year 2002. Administrative cost allowances under subparagraph (B) of this paragraph shall be paid quarterly and used in accordance with section 428(f). The Secretary may carry over funds available under this section to a subsequent fiscal year.

“(2) Administrative cost allowances payable to guaranty agencies under paragraph (1)(B) shall be calculated on the basis of 0.85 percent of the total principal amount of loans upon which insurance is issued on or after the date of enactment of the Balanced Budget Act of 1997, except that such allowances shall not exceed—

“(A) \$170,000,000 for each of the fiscal years 1998 and 1999;

or

“(B) \$150,000,000 for each of the fiscal years 2000, 2001, and 2002.”.

SEC. 5104. SECRETARY'S EQUITABLE SHARE OF COLLECTIONS ON CONSOLIDATED DEFAULTED LOANS.

Section 428(c)(6)(A) of the Higher Education Act of 1965 (20 U.S.C. 1078(c)(6)(A)) is amended—

(1) in the matter preceding clause (i), by striking “made by the borrower” and inserting “made by or on behalf of the borrower, including payments made to discharge loans made under this title to obtain a consolidation loan pursuant to this part or part D,”; and

(2) in clause (ii), by striking “(ii) an amount equal to 27 percent of such payments (subject to subparagraph (D) of this paragraph) for costs related” and inserting the following:

“(ii) an amount equal to 27 percent of such payments for covered costs, except that the amount determined under this clause for such covered costs shall be (I) 18.5 percent of such payments for defaulted loans consolidated pursuant to this part or part D on or after July 1, 1997; and (II) 18.5 percent of such payments for defaulted loans consolidated pursuant to this part or part D on or after the date of enactment of the Higher Education Amendments of 1992 with respect to any guaranty agency that has, after such date, made deductions from such payments under this clause (ii) in an amount equal to 18.5 percent of such payments.

For purposes of clause (ii) of this subparagraph, the term ‘covered costs’ means costs related”.

SEC. 5105. EXTENSION OF STUDENT AID PROGRAMS.

Title IV of the Higher Education Act of 1965 (20 U.S.C. 1070 et seq.) is amended—

(1) in section 424(a), by striking “1998.” and “2002.” and inserting “2002.” and “2006.”, respectively;

(2) in section 428(a)(5), by striking “1998,” and “2002.” and inserting “2002,” and “2006.”, respectively; and

(3) in section 428C(e), by striking “1998.” and inserting “2002.”.

Subtitle C—Repeal of Smith-Hughes Vocational Education Act

SEC. 5201. REPEAL OF SMITH-HUGHES VOCATIONAL EDUCATION ACT.

The Act of February 23, 1917 (39 Stat. 929; 20 U.S.C. 11) (commonly known as the “Smith-Hughes Vocational Education Act”) is repealed.

Subtitle D—Expansion of Portability and Health Insurance Coverage

SEC. 5301. SHORT TITLE OF SUBTITLE.

This subtitle may be cited as the “Expansion of Portability and Health Insurance Coverage Act of 1997”.

SEC. 5302. RULES GOVERNING ASSOCIATION HEALTH PLANS.

(a) **IN GENERAL.**—Subtitle B of title I of the Employee Retirement Income Security Act of 1974 is amended by adding after part 7 the following new part:

“PART 8—RULES GOVERNING ASSOCIATION HEALTH PLANS

“SEC. 801. ASSOCIATION HEALTH PLANS.

“(a) **IN GENERAL.**—For purposes of this part, the term ‘association health plan’ means a group health plan—

“(1) whose sponsor is (or is deemed under this part to be) described in subsection (b), and

“(2) under which at least one option of health insurance coverage offered by a health insurance issuer (which may include, among other options, managed care options, point of service options, and preferred provider options) is provided to participants and beneficiaries.

“(b) **SPONSORSHIP.**—The sponsor of a group health plan is described in this subsection if such sponsor—

“(1) is organized and maintained in good faith, with a constitution and bylaws specifically stating its purpose and providing for periodic meetings on at least an annual basis, as a trade association, an industry association (including a rural electric cooperative association or a rural telephone cooperative association), a professional association, or a chamber of commerce (or similar business group, including a corporation or similar organization that operates on a cooperative basis (within the meaning of section 1381 of the Internal Revenue Code of 1986)), for substantial purposes other than that of obtaining or providing medical care,

“(2) is established as a permanent entity which receives the active support of its members and collects from its members on a periodic basis dues or payments necessary to maintain eligibility for membership in the sponsor, and

“(3) does not condition such dues or payments or coverage under the plan on the basis of health status-related factors with respect to the employees of its members (or affiliated members), or the dependents of such employees, and does not condition such dues or payments on the basis of group health plan participation.

Any sponsor consisting of an association of entities which meet the requirements of paragraphs (1) and (2) shall be deemed to be a sponsor described in this subsection.

“SEC. 802. CERTIFICATION OF ASSOCIATION HEALTH PLANS.

“(a) IN GENERAL.—The Secretary shall prescribe by regulation a procedure under which, subject to subsection (b), the Secretary shall certify association health plans which apply for certification as meeting the requirements of this part.

“(b) STANDARDS.—Under the procedure prescribed pursuant to subsection (a), the Secretary shall certify an association health plan as meeting the requirements of this part only if the Secretary is satisfied that—

“(1) such certification—

“(A) is administratively feasible,

“(B) is not adverse to the interests of the individuals covered under the plan, and

“(C) is protective of the rights and benefits of the individuals covered under the plan, and

“(2) the applicable requirements of this part are met (or, upon the date on which the plan is to commence operations, will be met) with respect to the plan.

“(c) REQUIREMENTS APPLICABLE TO CERTIFIED PLANS.—An association health plan with respect to which certification under this part is in effect shall meet the applicable requirements of this part, effective on the date of certification (or, if later, on the date on which the plan is to commence operations).

“(d) REQUIREMENTS FOR CONTINUED CERTIFICATION.—The Secretary may provide by regulation for continued certification under this part, including requirements relating to any commencement, by an association health plan which has been certified under this part, of a benefit option which does not consist of health insurance coverage.

“(e) CLASS CERTIFICATION FOR FULLY-INSURED PLANS.—The Secretary shall establish a class certification procedure for association health plans under which all benefits consist of health insurance coverage. Under such procedure, the Secretary shall provide for the granting of certification under this part to the plans in each class of such association health plans upon appropriate filing under such procedure in connection with plans in such class and payment of the prescribed fee under section 807(a).

“SEC. 803. REQUIREMENTS RELATING TO SPONSORS AND BOARDS OF TRUSTEES.

“(a) SPONSOR.—The requirements of this subsection are met with respect to an association health plan if—

“(1) the sponsor (together with its immediate predecessor, if any) has met (or is deemed under this part to have met) for a continuous period of not less than 3 years ending with the

date of the application for certification under this part, the requirements of paragraphs (1) and (2) of section 801(b), and

“(2) the sponsor meets (or is deemed under this part to meet) the requirements of section 801(b)(3).

“(b) BOARD OF TRUSTEES.—The requirements of this subsection are met with respect to an association health plan if the following requirements are met:

“(1) FISCAL CONTROL.—The plan is operated, pursuant to a trust agreement, by a board of trustees which has complete fiscal control over the plan and which is responsible for all operations of the plan.

“(2) RULES OF OPERATION AND FINANCIAL CONTROLS.—The board of trustees has in effect rules of operation and financial controls, based on a 3-year plan of operation, adequate to carry out the terms of the plan and to meet all requirements of this title applicable to the plan.

“(3) RULES GOVERNING RELATIONSHIP TO PARTICIPATING EMPLOYERS AND TO CONTRACTORS.—

“(A) IN GENERAL.—Except as provided in subparagraph (B), the members of the board of trustees are individuals selected from individuals who are the owners, officers, directors, or employees of the participating employers or who are partners in the participating employers and actively participate in the business.

“(B) LIMITATION.—

“(i) GENERAL RULE.—Except as provided in clauses (ii) and (iii), no such member is an owner, officer, director, or employee of, or partner in, a contract administrator or other service provider to the plan.

“(ii) LIMITED EXCEPTION FOR PROVIDERS OF SERVICES SOLELY ON BEHALF OF THE SPONSOR.—Officers or employees of a sponsor which is a service provider (other than a contract administrator) to the plan may be members of the board if they constitute not more than 25 percent of the membership of the board and they do not provide services to the plan other than on behalf of the sponsor.

“(iii) TREATMENT OF PROVIDERS OF MEDICAL CARE.—In the case of a sponsor which is an association whose membership consists primarily of providers of medical care, clause (i) shall not apply in the case of any service provider described in subparagraph (A) who is a provider of medical care under the plan.

“(C) SOLE AUTHORITY.—The board has sole authority to approve applications for participation in the plan and to contract with a service provider to administer the day-to-day affairs of the plan.

“(c) TREATMENT OF FRANCHISE NETWORKS.—In the case of a group health plan which is established and maintained by a franchiser for a franchise network consisting of its franchisees—

“(1) the requirements of subsection (a) and section 801(a)(1) shall be deemed met if such requirements would otherwise be met if the franchiser were deemed to be the sponsor referred to in section 801(b), such network were deemed to be an asso-

ciation described in section 801(b), and each franchisee were deemed to be a member (of the association and the sponsor) referred to in section 801(b), and

“(2) the requirements of section 804(a)(1) shall be deemed met.

“(d) CERTAIN COLLECTIVELY BARGAINED PLANS.—

“(1) IN GENERAL.—In the case of a group health plan described in paragraph (2)—

“(A) the requirements of subsection (a) and section 801(a)(1) shall be deemed met,

“(B) the joint board of trustees shall be deemed a board of trustees with respect to which the requirements of subsection (b) are met, and

“(C) the requirements of section 804 shall be deemed met.

“(2) REQUIREMENTS.—A group health plan is described in this paragraph if—

“(A) the plan is a multiemployer plan,

“(B) the plan is in existence on April 1, 1997, and would be described in section 3(40)(A)(i) but solely for the failure to meet the requirements of section 3(40)(C)(ii) or (to the extent provided in regulations of the Secretary) solely for the failure to meet the requirements of subparagraph (D) of section 3(40), or

“(C)(i) the plan is in existence on April 1, 1997, has been in existence as of such date for at least 3 years, meets the requirements of paragraphs (2) and (3) of section 801(b), and would be described in section 3(40)(A)(i) but solely for the failure to meet the requirements of subparagraph (C)(i) or (C)(ii), and

“(ii) individuals who are members of the plan sponsor—

“(I) participate by elections in the organizational governance of the plan sponsor,

“(II) are eligible for appointment as trustee of the plan or for participation in the appointment of trustees of the plan, and

“(III) if covered under the plan, have full rights under the plan of a participant in an employee welfare benefit plan.

“(e) CERTAIN PLANS NOT MEETING SINGLE EMPLOYER REQUIREMENT.—

“(1) IN GENERAL.—In any case in which the majority of the employees covered under a group health plan are employees of a single employer (within the meaning of clauses (i) and (ii) of section 3(40)(B)), if all other employees covered under the plan are employed by employers who are related to such single employer—

“(A) the requirements of subsection (a) and section 801(a)(1) shall not apply if such single employer is the sponsor of the plan, and

“(B) the requirements of subsection (b) shall be deemed met if the board of trustees is the named fiduciary in connection with the plan.

“(2) RELATED EMPLOYERS.—For purposes of paragraph (1), employers are ‘related’ if there is among all such employers a common ownership interest or a substantial commonality of business operations based on common suppliers or customers.

“SEC. 804. PARTICIPATION AND COVERAGE REQUIREMENTS.

“(a) COVERED EMPLOYERS AND INDIVIDUALS.—The requirements of this subsection are met with respect to an association health plan if, under the terms of the plan—

“(1) all participating employers must be members or affiliated members of the sponsor, except that, in the case of a sponsor which is a professional association or other individual-based association, if at least one of the officers, directors, or employees of an employer, or at least one of the individuals who are partners in an employer and who actively participates in the business, is a member or affiliated member of the sponsor, participating employers may also include such employer, and

“(2) all individuals commencing coverage under the plan after certification under this part must be—

“(A) active or retired owners (including self-employed individuals), officers, directors, or employees of, or partners in, participating employers, or

“(B) the beneficiaries of individuals described in subparagraph (A).

“(b) COVERAGE OF PREVIOUSLY UNINSURED EMPLOYEES.—The requirements of this subsection are met with respect to an association health plan if, under the terms of the plan, no affiliated member of the sponsor may be offered coverage under the plan as a participating employer unless—

“(1) the affiliated member was an affiliated member on the date of certification under this part, or

“(2) during the 12-month period preceding the date of the offering of such coverage, the affiliated member has not maintained or contributed to a group health plan with respect to any of its employees who would otherwise be eligible to participate in such association health plan.

“(c) INDIVIDUAL MARKET UNAFFECTED.—The requirements of this subsection are met with respect to an association health plan if, under the terms of the plan, no participating employer may provide health insurance coverage in the individual market for any employee not covered under the plan which is similar to the coverage contemporaneously provided to employees of the employer under the plan, if such exclusion of the employee from coverage under the plan is based on a health status-related factor with respect to the employee and such employee would, but for such exclusion on such basis, be eligible for coverage under the plan.

“(d) PROHIBITION OF DISCRIMINATION AGAINST EMPLOYERS AND EMPLOYEES ELIGIBLE TO PARTICIPATE.—The requirements of this subsection are met with respect to an association health plan if—

“(1) under the terms of the plan, no employer meeting the preceding requirements of this section is excluded as a participating employer, unless—

“(A) participation or contribution requirements of the type referred to in section 2711 of the Public Health Serv-

ice Act are not met with respect to the excluded employer, or

“(B) the excluded employer does not satisfy a required minimum level of employment uniformly applicable to participating employers,

“(2) the applicable requirements of sections 701, 702, and 703 are met with respect to the plan, and

“(3) applicable benefit options under the plan are actively marketed to all eligible participating employers.

“SEC. 805. OTHER REQUIREMENTS RELATING TO PLAN DOCUMENTS, CONTRIBUTION RATES, AND BENEFIT OPTIONS.

“(a) IN GENERAL.—The requirements of this section are met with respect to an association health plan if the following requirements are met:

“(1) CONTENTS OF GOVERNING INSTRUMENTS.—The instruments governing the plan include a written instrument, meeting the requirements of an instrument required under section 402(a)(1), which—

“(A) provides that the board of trustees serves as the named fiduciary required for plans under section 402(a)(1) and serves in the capacity of a plan administrator (referred to in section 3(16)(A)),

“(B) provides that the sponsor of the plan is to serve as plan sponsor (referred to in section 3(16)(B)), and

“(C) incorporates the requirements of section 806.

“(2) CONTRIBUTION RATES MUST BE NONDISCRIMINATORY.—

“(A) The contribution rates for any participating employer do not vary significantly on the basis of the claims experience of such employer and do not vary on the basis of the type of business or industry in which such employer is engaged.

“(B) Nothing in this title or any other provision of law shall be construed to preclude an association health plan, or a health insurance issuer offering health insurance coverage in connection with an association health plan, from setting contribution rates based on the claims experience of the plan, to the extent contribution rates under the plan meet the requirements of section 702(b).

“(3) FLOOR FOR NUMBER OF COVERED INDIVIDUALS WITH RESPECT TO CERTAIN PLANS.—If any benefit option under the plan does not consist of health insurance coverage, the plan has as of the beginning of the plan year not fewer than 1,000 participants and beneficiaries.

“(4) REGULATORY REQUIREMENTS.—Such other requirements as the Secretary may prescribe by regulation as necessary to carry out the purposes of this part.

“(b) ABILITY OF ASSOCIATION HEALTH PLANS TO DESIGN BENEFIT OPTIONS.—Nothing in this part or any provision of State law (as defined in section 514(c)(1)) shall be construed to preclude an association health plan, or a health insurance issuer offering health insurance coverage in connection with an association health plan, from exercising its sole discretion in selecting the specific items and services consisting of medical care to be included as benefits under such plan or coverage, except in the case of any law to the

extent that it (1) prohibits an exclusion of a specific disease from such coverage, or (2) is not preempted under section 731(a)(1) with respect to matters governed by section 711 or 712.

“SEC. 806. MAINTENANCE OF RESERVES AND PROVISIONS FOR SOLVENCY FOR PLANS PROVIDING HEALTH BENEFITS IN ADDITION TO HEALTH INSURANCE COVERAGE.

“(a) IN GENERAL.—The requirements of this section are met with respect to an association health plan if—

“(1) the benefits under the plan consist solely of health insurance coverage, or

“(2) if the plan provides any additional benefit options which do not consist of health insurance coverage, the plan—

“(A) establishes and maintains reserves with respect to such additional benefit options, in amounts recommended by the qualified actuary, consisting of—

“(i) a reserve sufficient for unearned contributions,

“(ii) a reserve sufficient for benefit liabilities which have been incurred, which have not been satisfied, and for which risk of loss has not yet been transferred, and for expected administrative costs with respect to such benefit liabilities,

“(iii) a reserve sufficient for any other obligations of the plan, and

“(iv) a reserve sufficient for a margin of error and other fluctuations, taking into account the specific circumstances of the plan,

and

“(B) establishes and maintains aggregate excess/stop loss insurance and solvency indemnification, with respect to such additional benefit options for which risk of loss has not yet been transferred, as follows:

“(i) The plan shall secure aggregate excess/stop loss insurance for the plan with an attachment point which is not greater than 125 percent of expected gross annual claims. The Secretary may by regulation provide for upward adjustments in the amount of such percentage in specified circumstances in which the plan specifically provides for and maintains reserves in excess of the amounts required under subparagraph (A).

“(ii) The plan shall secure a means of indemnification for any claims which the plan is unable to satisfy by reason of a termination pursuant to section 809(b) (relating to mandatory termination).

Any regulations prescribed by the Secretary pursuant to paragraph (2)(B)(i) may allow for such adjustments in the required levels of excess/stop loss insurance as the qualified actuary may recommend, taking into account the specific circumstances of the plan.

“(b) MINIMUM SURPLUS IN ADDITION TO CLAIMS RESERVES.—The requirements of this subsection are met if the plan establishes and maintains surplus in an amount at least equal to the excess of—

“(1) the greater of—

“(A) 25 percent of expected incurred claims and expenses for the plan year, or

“(B) \$400,000,

over

“(2) the amount required under subsection (a)(2)(A)(ii).

“(c) **ADDITIONAL REQUIREMENTS.**—In the case of any association health plan described in subsection (a)(2), the Secretary may provide such additional requirements relating to reserves and excess/stop loss insurance as the Secretary considers appropriate. Such requirements may be provided, by regulation or otherwise, with respect to any such plan or any class of such plans.

“(d) **ADJUSTMENTS FOR EXCESS/STOP LOSS INSURANCE.**—The Secretary may provide for adjustments to the levels of reserves otherwise required under subsections (a) and (b) with respect to any plan or class of plans to take into account excess/stop loss insurance provided with respect to such plan or plans.

“(e) **ALTERNATIVE MEANS OF COMPLIANCE.**—The Secretary may permit an association health plan described in subsection (a)(2) to substitute, for all or part of the requirements of this section, such security, guarantee, hold-harmless arrangement, or other financial arrangement as the Secretary determines to be adequate to enable the plan to fully meet all its financial obligations on a timely basis and is otherwise no less protective of the interests of participants and beneficiaries than the requirements for which it is substituted. The Secretary may take into account, for purposes of this subsection, evidence provided by the plan or sponsor which demonstrates an assumption of liability with respect to the plan. Such evidence may be in the form of a contract of indemnification, lien, bonding, insurance, letter of credit, recourse under applicable terms of the plan in the form of assessments of participating employers, security, or other financial arrangement.

“(f) **EXCESS/STOP LOSS INSURANCE.**—For purposes of this section, the term ‘excess/stop loss insurance’ means, in connection with an association health plan, a contract under which an insurer (meeting such minimum standards as may be prescribed in regulations of the Secretary) provides for payment to the plan with respect to claims under the plan in excess of an amount or amounts specified in such contract.

“SEC. 807. REQUIREMENTS FOR APPLICATION AND RELATED REQUIREMENTS.

“(a) **FILING FEE.**—Under the procedure prescribed pursuant to section 802(a), an association health plan shall pay to the Secretary at the time of filing an application for certification under this part a filing fee in the amount of \$5,000, which shall be available, to the extent provided in appropriation Acts, to the Secretary for the sole purpose of administering the certification procedures applicable with respect to association health plans.

“(b) **INFORMATION TO BE INCLUDED IN APPLICATION FOR CERTIFICATION.**—An application for certification under this part meets the requirements of this section only if it includes, in a manner and form prescribed in regulations of the Secretary, at least the following information:

“(1) **IDENTIFYING INFORMATION.**—The names and addresses of—

“(A) the sponsor, and

“(B) the members of the board of trustees of the plan.

“(2) STATES IN WHICH PLAN INTENDS TO DO BUSINESS.—The States in which participants and beneficiaries under the plan are to be located and the number of them expected to be located in each such State.

“(3) BONDING REQUIREMENTS.—Evidence provided by the board of trustees that the bonding requirements of section 412 will be met as of the date of the application or (if later) commencement of operations.

“(4) PLAN DOCUMENTS.—A copy of the documents governing the plan (including any bylaws and trust agreements), the summary plan description, and other material describing the benefits that will be provided to participants and beneficiaries under the plan.

“(5) AGREEMENTS WITH SERVICE PROVIDERS.—A copy of any agreements between the plan and contract administrators and other service providers.

“(6) FUNDING REPORT.—In the case of association health plans providing benefits options in addition to health insurance coverage, a report setting forth information with respect to such additional benefit options determined as of a date within the 120-day period ending with the date of the application, including the following:

“(A) RESERVES.—A statement, certified by the board of trustees of the plan, and a statement of actuarial opinion, signed by a qualified actuary, that all applicable requirements of section 806 are or will be met in accordance with regulations which the Secretary shall prescribe.

“(B) ADEQUACY OF CONTRIBUTION RATES.—A statement of actuarial opinion, signed by a qualified actuary, which sets forth a description of the extent to which contribution rates are adequate to provide for the payment of all obligations and the maintenance of required reserves under the plan for the 12-month period beginning with such date within such 120-day period, taking into account the expected coverage and experience of the plan. If the contribution rates are not fully adequate, the statement of actuarial opinion shall indicate the extent to which the rates are inadequate and the changes needed to ensure adequacy.

“(C) CURRENT AND PROJECTED VALUE OF ASSETS AND LIABILITIES.—A statement of actuarial opinion signed by a qualified actuary, which sets forth the current value of the assets and liabilities accumulated under the plan and a projection of the assets, liabilities, income, and expenses of the plan for the 12-month period referred to in subparagraph (B). The income statement shall identify separately the plan’s administrative expenses and claims.

“(D) COSTS OF COVERAGE TO BE CHARGED AND OTHER EXPENSES.—A statement of the costs of coverage to be charged, including an itemization of amounts for administration, reserves, and other expenses associated with the operation of the plan.

“(E) OTHER INFORMATION.—Any other information which may be prescribed in regulations of the Secretary as necessary to carry out the purposes of this part.

“(c) FILING NOTICE OF CERTIFICATION WITH STATES.—A certification granted under this part to an association health plan shall not be effective unless written notice of such certification is filed with the applicable State authority of each State in which at least 25 percent of the participants and beneficiaries under the plan are located. For purposes of this subsection, an individual shall be considered to be located in the State in which a known address of such individual is located or in which such individual is employed.

“(d) NOTICE OF MATERIAL CHANGES.—In the case of any association health plan certified under this part, descriptions of material changes in any information which was required to be submitted with the application for the certification under this part shall be filed in such form and manner as shall be prescribed in regulations of the Secretary. The Secretary may require by regulation prior notice of material changes with respect to specified matters which might serve as the basis for suspension or revocation of the certification.

“(e) REPORTING REQUIREMENTS FOR CERTAIN ASSOCIATION HEALTH PLANS.—An association health plan certified under this part which provides benefit options in addition to health insurance coverage for such plan year shall meet the requirements of section 103 by filing an annual report under such section which shall include information described in subsection (b)(6) with respect to the plan year and, notwithstanding section 104(a)(1)(A), shall be filed not later than 90 days after the close of the plan year (or on such later date as may be prescribed by the Secretary).

“(f) ENGAGEMENT OF QUALIFIED ACTUARY.—The board of trustees of each association health plan which provides benefits options in addition to health insurance coverage and which is applying for certification under this part or is certified under this part shall engage, on behalf of all participants and beneficiaries, a qualified actuary who shall be responsible for the preparation of the materials comprising information necessary to be submitted by a qualified actuary under this part. The qualified actuary shall utilize such assumptions and techniques as are necessary to enable such actuary to form an opinion as to whether the contents of the matters reported under this part—

“(1) are in the aggregate reasonably related to the experience of the plan and to reasonable expectations, and

“(2) represent such actuary’s best estimate of anticipated experience under the plan.

The opinion by the qualified actuary shall be made with respect to, and shall be made a part of, the annual report.

“SEC. 808. NOTICE REQUIREMENTS FOR VOLUNTARY TERMINATION.

“Except as provided in section 809(b), an association health plan which is or has been certified under this part may terminate (upon or at any time after cessation of accruals in benefit liabilities) only if the board of trustees—

“(1) not less than 60 days before the proposed termination date, provides to the participants and beneficiaries a written notice of intent to terminate stating that such termination is intended and the proposed termination date,

“(2) develops a plan for winding up the affairs of the plan in connection with such termination in a manner which will re-

sult in timely payment of all benefits for which the plan is obligated, and

“(3) submits such plan in writing to the Secretary.

Actions required under this section shall be taken in such form and manner as may be prescribed in regulations of the Secretary.

“SEC. 809. CORRECTIVE ACTIONS AND MANDATORY TERMINATION.

“(a) ACTIONS TO AVOID DEPLETION OF RESERVES.—An association health plan which is certified under this part and which provides benefits other than health insurance coverage shall continue to meet the requirements of section 806, irrespective of whether such certification continues in effect. The board of trustees of such plan shall determine quarterly whether the requirements of section 806 are met. In any case in which the board determines that there is reason to believe that there is or will be a failure to meet such requirements, or the Secretary makes such a determination and so notifies the board, the board shall immediately notify the qualified actuary engaged by the plan, and such actuary shall, not later than the end of the next following month, make such recommendations to the board for corrective action as the actuary determines necessary to ensure compliance with section 806. Not later than 30 days after receiving from the actuary recommendations for corrective actions, the board shall notify the Secretary (in such form and manner as the Secretary may prescribe by regulation) of such recommendations of the actuary for corrective action, together with a description of the actions (if any) that the board has taken or plans to take in response to such recommendations. The board shall thereafter report to the Secretary, in such form and frequency as the Secretary may specify to the board, regarding corrective action taken by the board until the requirements of section 806 are met.

“(b) MANDATORY TERMINATION.—In any case in which—

“(1) the Secretary has been notified under subsection (a) of a failure of an association health plan which is or has been certified under this part and is described in section 806(a)(2) to meet the requirements of section 806 and has not been notified by the board of trustees of the plan that corrective action has restored compliance with such requirements, and

“(2) the Secretary determines that there is a reasonable expectation that the plan will continue to fail to meet the requirements of section 806,

the board of trustees of the plan shall, at the direction of the Secretary, terminate the plan and, in the course of the termination, take such actions as the Secretary may require, including satisfying any claims referred to in section 806(a)(2)(B)(ii) and recovering for the plan any liability under subsection (a)(2)(B)(ii) or (e) of section 806, as necessary to ensure that the affairs of the plan will be, to the maximum extent possible, wound up in a manner which will result in timely provision of all benefits for which the plan is obligated.

“(c) GUARANTEE FUND.—In any case in which claims against an association health plan terminated under subsection (b) remain outstanding after all actions required under subsection (b) have been undertaken in connection with the termination, the Secretary shall assess all ongoing association health plans which are or have

been certified under this part and are described in section 806(a)(2) in an amount—

“(1) expressed as a uniform percentage of claims paid by such plans per year for coverage, other than health insurance coverage, commencing with the last plan year ending before the date of the termination, and

“(2) equal, in the aggregate, to the total amount of such outstanding claims,

except that any such assessment shall not exceed 2 percent per year. The Secretary shall promptly pay such outstanding claims with the amounts assessed pursuant to this subsection. The Secretary shall deposit and hold such assessments in a guarantee fund which shall be established by the Secretary for payment of such claims until such payment of such claims has been completed. The Secretary may invest amounts of the fund in such obligations as the Secretary considers appropriate.

“SEC. 810. SPECIAL RULES FOR CHURCH PLANS.

“(a) ELECTION FOR CHURCH PLANS.—Notwithstanding section 4(b)(2), if a church, a convention or association of churches, or an organization described in section 3(33)(C)(i) maintains a church plan which is a group health plan (as defined in section 733(a)(1)), and such church, convention, association, or organization makes an election with respect to such plan under this subsection (in such form and manner as the Secretary may by regulation prescribe), then the provisions of this section shall apply to such plan, with respect to benefits provided under such plan consisting of medical care, as if section 4(b)(2) did not contain an exclusion for church plans. Nothing in this paragraph shall be construed to render any other section of this title applicable to church plans, except to the extent that such other section is incorporated by reference in this section.

“(b) EFFECT OF ELECTION.—

“(1) PREEMPTION OF STATE INSURANCE LAWS REGULATING COVERED CHURCH PLANS.—Subject to paragraphs (2) and (3), this section shall supersede any and all State laws which regulate insurance insofar as they may now or hereafter regulate church plans to which this section applies or trusts established under such church plans.

“(2) GENERAL STATE INSURANCE REGULATION UNAFFECTED.—

“(A) IN GENERAL.—Except as provided in subparagraph (B) and paragraph (3), nothing in this section shall be construed to exempt or relieve any person from any provision of State law which regulates insurance.

“(B) CHURCH PLANS NOT TO BE DEEMED INSURANCE COMPANIES OR INSURERS.—Neither a church plan to which this section applies, nor any trust established under such a church plan, shall be deemed to be an insurance company or other insurer or to be engaged in the business of insurance for purposes of any State law purporting to regulate insurance companies or insurance contracts.

“(3) PREEMPTION OF CERTAIN STATE LAWS RELATING TO PREMIUM RATE REGULATION AND BENEFIT MANDATES.—The provisions of subsections (a)(2)(B) and (b) of section 805 shall apply with respect to a church plan to which this section applies in

the same manner and to the same extent as such provisions apply with respect to association health plans.

“(4) DEFINITIONS.—For purposes of this subsection—

“(A) STATE LAW.—The term ‘State law’ includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State. A law of the United States applicable only to the District of Columbia shall be treated as a State law rather than a law of the United States.

“(B) STATE.—The term ‘State’ includes a State, any political subdivision thereof, or any agency or instrumentality of either, which purports to regulate, directly or indirectly, the terms and conditions of church plans covered by this section.

“(c) REQUIREMENTS FOR COVERED CHURCH PLANS.—

“(1) FIDUCIARY RULES AND EXCLUSIVE PURPOSE.—A fiduciary shall discharge his duties with respect to a church plan to which this section applies—

“(A) for the exclusive purpose of:

“(i) providing benefits to participants and their beneficiaries; and

“(ii) defraying reasonable expenses of administering the plan;

“(B) with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims; and

“(C) in accordance with the documents and instruments governing the plan.

The requirements of this paragraph shall not be treated as not satisfied solely because the plan assets are commingled with other church assets, to the extent that such plan assets are separately accounted for.

“(2) CLAIMS PROCEDURE.—In accordance with regulations of the Secretary, every church plan to which this section applies shall—

“(A) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant;

“(B) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate fiduciary of the decision denying the claim; and

“(C) provide a written statement to each participant describing the procedures established pursuant to this paragraph.

“(3) ANNUAL STATEMENTS.—In accordance with regulations of the Secretary, every church plan to which this section applies shall file with the Secretary an annual statement—

“(A) stating the names and addresses of the plan and of the church, convention, or association maintaining the plan (and its principal place of business);

“(B) certifying that it is a church plan to which this section applies and that it complies with the requirements of paragraphs (1) and (2);

“(C) identifying the States in which participants and beneficiaries under the plan are or likely will be located during the 1-year period covered by the statement; and

“(D) containing a copy of a statement of actuarial opinion signed by a qualified actuary that the plan maintains capital, reserves, insurance, other financial arrangements, or any combination thereof adequate to enable the plan to fully meet all of its financial obligations on a timely basis.

“(4) DISCLOSURE.—At the time that the annual statement is filed by a church plan with the Secretary pursuant to paragraph (3), a copy of such statement shall be made available by the Secretary to the State insurance commissioner (or similar official) of any State. The name of each church plan and sponsoring organization filing an annual statement in compliance with paragraph (3) shall be published annually in the Federal Register.

“(c) ENFORCEMENT.—The Secretary may enforce the provisions of this section in a manner consistent with section 502, to the extent applicable with respect to actions under section 502(a)(5), and with section 3(33)(D), except that, other than for the purpose of seeking a temporary restraining order, a civil action may be brought with respect to the plan’s failure to meet any requirement of this section only if the plan fails to correct its failure within the correction period described in section 3(33)(D). The other provisions of part 5 (except sections 501(a), 503, 512, 514, and 515) shall apply with respect to the enforcement and administration of this section.

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

“(1) IN GENERAL.—Except as otherwise provided in this section, any term used in this section which is defined in any provision of this title shall have the definition provided such term by such provision.

“(2) SEMINARY STUDENTS.—Seminary students who are enrolled in an institution of higher learning described in section 3(33)(C)(iv) and who are treated as participants under the terms of a church plan to which this section applies shall be deemed to be employees as defined in section 3(6) if the number of such students constitutes an insignificant portion of the total number of individuals who are treated as participants under the terms of the plan.

“SEC. 811. DEFINITIONS AND RULES OF CONSTRUCTION.

“(a) DEFINITIONS.—For purposes of this part—

“(1) GROUP HEALTH PLAN.—The term ‘group health plan’ has the meaning provided in section 733(a)(1).

“(2) MEDICAL CARE.—The term ‘medical care’ has the meaning provided in section 733(a)(2).

“(3) HEALTH INSURANCE COVERAGE.—The term ‘health insurance coverage’ has the meaning provided in section 733(b)(1).

“(4) HEALTH INSURANCE ISSUER.—The term ‘health insurance issuer’ has the meaning provided in section 733(b)(2).

“(5) HEALTH STATUS-RELATED FACTOR.—The term ‘health status-related factor’ has the meaning provided in section 733(d)(2).

“(6) INDIVIDUAL MARKET.—

“(A) IN GENERAL.—The term ‘individual market’ means the market for health insurance coverage offered to individuals other than in connection with a group health plan.

“(B) TREATMENT OF VERY SMALL GROUPS.—

“(i) IN GENERAL.—Subject to clause (ii), such term includes coverage offered in connection with a group health plan that has fewer than 2 participants as current employees or participants described in section 732(d)(3) on the first day of the plan year.

“(ii) STATE EXCEPTION.—Clause (i) shall not apply in the case of health insurance coverage offered in a State if such State regulates the coverage described in such clause in the same manner and to the same extent as coverage in the small group market (as defined in section 2791(e)(5) of the Public Health Service Act) is regulated by such State.

“(7) PARTICIPATING EMPLOYER.—The term ‘participating employer’ means, in connection with an association health plan, any employer, if any individual who is an employee of such employer, a partner in such employer, or a self-employed individual who is such employer (or any dependent, as defined under the terms of the plan, of such individual) is or was covered under such plan in connection with the status of such individual as such an employee, partner, or self-employed individual in relation to the plan.

“(8) APPLICABLE STATE AUTHORITY.—The term ‘applicable State authority’ means, with respect to a health insurance issuer in a State, the State insurance commissioner or official or officials designated by the State to enforce the requirements of title XXVII of the Public Health Service Act for the State involved with respect to such issuer.

“(9) QUALIFIED ACTUARY.—The term ‘qualified actuary’ means an individual who is a member of the American Academy of Actuaries or meets such reasonable standards and qualifications as the Secretary may provide by regulation.

“(10) AFFILIATED MEMBER.—The term ‘affiliated member’ means, in connection with a sponsor, a person eligible to be a member of the sponsor or, in the case of a sponsor with member associations, a person who is a member, or is eligible to be a member, of a member association.

“(b) RULES OF CONSTRUCTION.—

“(1) EMPLOYERS AND EMPLOYEES.—For purposes of determining whether a plan, fund, or program is an employee welfare benefit plan which is an association health plan, and for purposes of applying this title in connection with such plan, fund, or program so determined to be such an employee welfare benefit plan—

“(A) in the case of a partnership, the term ‘employer’ (as defined in section (3)(5)) includes the partnership in relation to the partners, and the term ‘employee’ (as defined

in section 3(6)) includes any partner in relation to the partnership, and

“(B) in the case of a self-employed individual, the term ‘employer’ (as defined in section 3(5)) and the term ‘employee’ (as defined in section 3(6)) shall include such individual.”

“(2) PLANS, FUNDS, AND PROGRAMS TREATED AS EMPLOYEE WELFARE BENEFIT PLANS.—In the case of any plan, fund, or program which was established or is maintained for the purpose of providing medical care (through the purchase of insurance or otherwise) for employees (or their dependents) covered thereunder and which demonstrates to the Secretary that all requirements for certification under this part would be met with respect to such plan, fund, or program if such plan, fund, or program were a group health plan, such plan, fund, or program shall be treated for purposes of this title as an employee welfare benefit plan on and after the date of such demonstration.”

(b) CONFORMING AMENDMENTS TO PREEMPTION RULES.—

(1) Section 514(b)(6) of such Act (29 U.S.C. 1144(b)(6)) is amended by adding at the end the following new subparagraph:

“(E) The preceding subparagraphs of this paragraph do not apply with respect to any State law in the case of an association health plan which is certified under part 8.”

(2) Section 514 of such Act (29 U.S.C. 1144) is amended—

(A) in subsection (b)(4), by striking “Subsection (a)” and inserting “Subsections (a) and (d)”;

(B) in subsection (b)(5), by striking “subsection (a)” in subparagraph (A) and inserting “subsection (a) of this section and subsections (a)(2)(B) and (b) of section 805”, and by striking “subsection (a)” in subparagraph (B) and inserting “subsection (a) of this section or subsection (a)(2)(B) or (b) of section 805”;

(C) by redesignating subsection (d) as subsection (e); and

(D) by inserting after subsection (c) the following new subsection:

“(d)(1) Except as provided in subsection (b)(4), the provisions of this title shall supersede any and all State laws insofar as they may now or hereafter preclude a health insurance issuer from offering health insurance coverage in connection with an association health plan which is certified under part 8.

“(2) Except as provided in paragraphs (4) and (5) of subsection (b) of this section—

“(A) In any case in which health insurance coverage of any policy type is offered under an association health plan certified under part 8 to a participating employer operating in such State, the provisions of this title shall supersede any and all laws of such State insofar as they may preclude a health insurance issuer from offering health insurance coverage of the same policy type to other employers operating in the State which are eligible for coverage under such association health plan, whether or not such other employers are participating employers in such plan.

“(B) In any case in which health insurance coverage of any policy type is offered under an association health plan in a State and the filing, with the applicable State authority, of the policy form in connection with such policy type is approved by such State authority, the provisions of this title shall supersede any and all laws of any other State in which health insurance coverage of such type is offered, insofar as they may preclude, upon the filing in the same form and manner of such policy form with the applicable State authority in such other State, the approval of the filing in such other State.

“(3) For additional provisions relating to association health plans, see subsections (a)(2)(B) and (b) of section 805.

“(4) For purposes of this subsection, the term ‘association health plan’ has the meaning provided in section 801(a), and the terms ‘health insurance coverage’, ‘participating employer’, and ‘health insurance issuer’ have the meanings provided such terms in section 811, respectively.”

(3) Section 514(b)(6)(A) of such Act (29 U.S.C. 1144(b)(6)(A)) is amended—

(A) in clause (i)(II), by striking “and” at the end;

(B) in clause (ii), by inserting “and which does not provide medical care (within the meaning of section 733(a)(2)),” after “arrangement,” and by striking “title.” and inserting “title, and”; and

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

“(iii) subject to subparagraph (E), in the case of any other employee welfare benefit plan which is a multiple employer welfare arrangement and which provides medical care (within the meaning of section 733(a)(2)), any law of any State which regulates insurance may apply.”

(c) PLAN SPONSOR.—Section 3(16)(B) of such Act (29 U.S.C. 102(16)(B)) is amended by adding at the end the following new sentence: “Such term also includes a person serving as the sponsor of an association health plan under part 8.”

(d) SAVINGS CLAUSE.—Section 731(c) of such Act is amended by inserting “or part 8” after “this part”.

(e) CLERICAL AMENDMENT.—The table of contents in section 1 of the Employee Retirement Income Security Act of 1974 is amended by inserting after the item relating to section 734 the following new items:

“PART 8—RULES GOVERNING ASSOCIATION HEALTH PLANS

“Sec. 801. Association health plans.

“Sec. 802. Certification of association health plans.

“Sec. 803. Requirements relating to sponsors and boards of trustees.

“Sec. 804. Participation and coverage requirements.

“Sec. 805. Other requirements relating to plan documents, contribution rates, and benefit options.

“Sec. 806. Maintenance of reserves and provisions for solvency for plans providing health benefits in addition to health insurance coverage.

“Sec. 807. Requirements for application and related requirements.

“Sec. 808. Notice requirements for voluntary termination.

“Sec. 809. Corrective actions and mandatory termination.

“Sec. 810. Special rules for church plans.

“Sec. 811. Definitions and rules of construction.”

SEC. 5303. CLARIFICATION OF TREATMENT OF SINGLE EMPLOYER ARRANGEMENTS.

Section 3(40)(B) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(40)(B)) is amended—

(1) in clause (i), by inserting “for any plan year of any such plan, or any fiscal year of any such other arrangement;” after “single employer”, and by inserting “during such year or at any time during the preceding 1-year period” after “control group”;

(2) in clause (iii)—

(A) by striking “common control shall not be based on an interest of less than 25 percent” and inserting “an interest of greater than 25 percent may not be required as the minimum interest necessary for common control”; and

(B) by striking “similar to” and inserting “consistent and coextensive with”;

(3) by redesignating clauses (iv) and (v) as clauses (v) and (vi), respectively; and

(4) by inserting after clause (iii) the following new clause:

“(iv) in determining, after the application of clause (i), whether benefits are provided to employees of two or more employers, the arrangement shall be treated as having only 1 participating employer if, after the application of clause (i), the number of individuals who are employees and former employees of any one participating employer and who are covered under the arrangement is greater than 75 percent of the aggregate number of all individuals who are employees or former employees of participating employers and who are covered under the arrangement.”

SEC. 5304. CLARIFICATION OF TREATMENT OF CERTAIN COLLECTIVELY BARGAINED ARRANGEMENTS.

(a) **IN GENERAL.**—Section 3(40)(A)(i) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(40)(A)(i)) is amended to read as follows:

“(i)(I) under or pursuant to one or more collective bargaining agreements which are reached pursuant to collective bargaining described in section 8(d) of the National Labor Relations Act (29 U.S.C. 158(d)) or paragraph Fourth of section 2 of the Railway Labor Act (45 U.S.C. 152, paragraph Fourth) or which are reached pursuant to labor-management negotiations under similar provisions of State public employee relations laws, and (II) in accordance with subparagraphs (C), (D), and (E).”

(b) **LIMITATIONS.**—Section 3(40) of such Act (29 U.S.C. 1002(40)) is amended by adding at the end the following new subparagraphs:

“(C) For purposes of subparagraph (A)(i)(II), a plan or other arrangement shall be treated as established or maintained in accordance with this subparagraph only if the following requirements are met:

“(i) The plan or other arrangement, and the employee organization or any other entity sponsoring the plan or other arrangement, do not—

“(I) utilize the services of any licensed insurance agent or broker for soliciting or enrolling employers or individuals as participating employers or covered individuals under the plan or other arrangement; or

“(II) pay a commission or any other type of compensation to a person, other than a full time employee of the employee organization (or a member of the organization to the extent provided in regulations of the Secretary), that is related either to the volume or number of employers or individuals solicited or enrolled as participating employers or covered individuals under the plan or other arrangement, or to the dollar amount or size of the contributions made by participating employers or covered individuals to the plan or other arrangement;

except to the extent that the services used by the plan, arrangement, organization, or other entity consist solely of preparation of documents necessary for compliance with the reporting and disclosure requirements of part 1 or administrative, investment, or consulting services unrelated to solicitation or enrollment of covered individuals.

“(ii) As of the end of the preceding plan year, the number of covered individuals under the plan or other arrangement who are identified to the plan or arrangement and who are neither—

“(I) employed within a bargaining unit covered by any of the collective bargaining agreements with a participating employer (nor covered on the basis of an individual’s employment in such a bargaining unit); nor

“(II) present employees (or former employees who were covered while employed) of the sponsoring employee organization, of an employer who is or was a party to any of the collective bargaining agreements, or of the plan or other arrangement or a related plan or arrangement (nor covered on the basis of such present or former employment);

does not exceed 15 percent of the total number of individuals who are covered under the plan or arrangement and who are present or former employees who are or were covered under the plan or arrangement pursuant to a collective bargaining agreement with a participating employer. The requirements of the preceding provisions of this clause shall be treated as satisfied if, as of the end of the preceding plan year, such covered individuals are comprised solely of individuals who were covered individuals under the plan or other arrangement as of the date of the enactment of the Expansion of Portability and Health Insurance Coverage Act of 1997 and, as of the end of the preceding plan year, the number of such covered individuals does not exceed 25 percent of the total number of present and former employees enrolled under the plan or other arrangement.

“(iii) The employee organization or other entity sponsoring the plan or other arrangement certifies to the Secretary each year, in a form and manner which shall be prescribed in regulations of the Secretary that the plan or other arrangement meets the requirements of clauses (i) and (ii).

“(D) For purposes of subparagraph (A)(i)(II), a plan or arrangement shall be treated as established or maintained in accordance with this subparagraph only if—

“(i) all of the benefits provided under the plan or arrangement consist of health insurance coverage; or

“(ii)(I) the plan or arrangement is a multiemployer plan; and

“(II) the requirements of clause (B) of the proviso to clause (5) of section 302(c) of the Labor Management Relations Act, 1947 (29 U.S.C. 186(c)) are met with respect to such plan or other arrangement.

“(E) For purposes of subparagraph (A)(i)(II), a plan or arrangement shall be treated as established or maintained in accordance with this subparagraph only if—

“(i) the plan or arrangement is in effect as of the date of the enactment of the Expansion of Portability and Health Insurance Coverage Act of 1997, or

“(ii) the employee organization or other entity sponsoring the plan or arrangement—

“(I) has been in existence for at least 3 years or is affiliated with another employee organization which has been in existence for at least 3 years, or

“(II) demonstrates to the satisfaction of the Secretary that the requirements of subparagraphs (C) and (D) are met with respect to the plan or other arrangement.”.

(c) CONFORMING AMENDMENTS TO DEFINITIONS OF PARTICIPANT AND BENEFICIARY.—Section 3(7) of such Act (29 U.S.C. 1002(7)) is amended by adding at the end the following new sentence: “Such term includes an individual who is a covered individual described in paragraph (40)(C)(ii).”.

SEC. 5305. ENFORCEMENT PROVISIONS RELATING TO ASSOCIATION HEALTH PLANS.

(a) CRIMINAL PENALTIES FOR CERTAIN WILLFUL MISREPRESENTATIONS.—Section 501 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1131) is amended—

(1) by inserting “(a)” after “SEC. 501.”; and

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

“(b) Any person who, either willfully or with willful blindness, falsely represents, to any employee, any employee’s beneficiary, any employer, the Secretary, or any State, a plan or other arrangement established or maintained for the purpose of offering or providing any benefit described in section 3(1) to employees or their beneficiaries as—

“(1) being an association health plan which has been certified under part 8;

“(2) having been established or maintained under or pursuant to one or more collective bargaining agreements which are reached pursuant to collective bargaining described in section 8(d) of the National Labor Relations Act (29 U.S.C. 158(d)) or paragraph Fourth of section 2 of the Railway Labor Act (45 U.S.C. 152, paragraph Fourth) or which are reached pursuant to labor-management negotiations under similar provisions of State public employee relations laws; or

“(3) being a plan or arrangement with respect to which the requirements of subparagraph (C), (D), or (E) of section 3(40) are met;

shall, upon conviction, be imprisoned not more than five years, be fined under title 18, United States Code, or both.”.

(b) CEASE ACTIVITIES ORDERS.—Section 502 of such Act (29 U.S.C. 1132) is amended by adding at the end the following new subsection:

“(n)(1) Subject to paragraph (2), upon application by the Secretary showing the operation, promotion, or marketing of an association health plan (or similar arrangement providing benefits consisting of medical care (as defined in section 733(a)(2))) that—

“(A) is not certified under part 8, is subject under section 514(b)(6) to the insurance laws of any State in which the plan or arrangement offers or provides benefits, and is not licensed, registered, or otherwise approved under the insurance laws of such State; or

“(B) is an association health plan certified under part 8 and is not operating in accordance with the requirements under part 8 for such certification,

a district court of the United States shall enter an order requiring that the plan or arrangement cease activities.

“(2) Paragraph (1) shall not apply in the case of an association health plan or other arrangement if the plan or arrangement shows that—

“(A) all benefits under it referred to in paragraph (1) consist of health insurance coverage; and

“(B) with respect to each State in which the plan or arrangement offers or provides benefits, the plan or arrangement is operating in accordance with applicable State laws that are not superseded under section 514.

“(3) The court may grant such additional equitable relief, including any relief available under this title, as it deems necessary to protect the interests of the public and of persons having claims for benefits against the plan.”.

(c) RESPONSIBILITY FOR CLAIMS PROCEDURE.—Section 503 of such Act (29 U.S.C. 1133) is amended by adding at the end (after and below paragraph (2)) the following new sentence:

“The terms of each association health plan which is or has been certified under part 8 shall require the board of trustees or the named fiduciary (as applicable) to ensure that the requirements of this section are met in connection with claims filed under the plan.”.

SEC. 5306. COOPERATION BETWEEN FEDERAL AND STATE AUTHORITIES.

Section 506 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1136) is amended by adding at the end the following new subsection:

“(c) RESPONSIBILITY OF STATES WITH RESPECT TO ASSOCIATION HEALTH PLANS.—

“(1) AGREEMENTS WITH STATES.—A State may enter into an agreement with the Secretary for delegation to the State of some or all of the Secretary’s authority under sections 502 and 504 to enforce the requirements for certification under part 8. The Secretary shall enter into the agreement if the Secretary determines that the delegation provided for therein would not result in a lower level or quality of enforcement of the provisions of this title.

“(2) DELEGATIONS.—Any department, agency, or instrumentality of a State to which authority is delegated pursuant to an agreement entered into under this paragraph may, if authorized under State law and to the extent consistent with such agreement, exercise the powers of the Secretary under this title which relate to such authority.

“(3) RECOGNITION OF PRIMARY DOMICILE STATE.—In entering into any agreement with a State under subparagraph (A), the Secretary shall ensure that, as a result of such agreement and all other agreements entered into under subparagraph (A), only one State will be recognized, with respect to any particular association health plan, as the primary domicile State to which authority has been delegated pursuant to such agreements.”.

SEC. 5307. EFFECTIVE DATE AND TRANSITIONAL RULES.

(a) EFFECTIVE DATE.—The amendments made by sections 5302, 5305, and 5306 shall take effect on January 1, 1999. The amendments made by sections 5303 and 5304 shall take effect on the date of the enactment of this Act. The Secretary of Labor shall issue all regulations necessary to carry out the amendments made by this Act before January 1, 1999.

(b) EXCEPTION.—Section 801(a)(2) of the Employee Retirement Income Security Act of 1974 (added by section 5302) does not apply with respect to group health plans (as defined in section 733(a)(1) of such Act) existing on April 1, 1997, which do not provide health insurance coverage (as defined in section 733(b)(1) of such Act) on such date.

TITLE VI—COMMITTEE ON GOVERNMENT REFORM AND OVERSIGHT

Subtitle A—Postal Service

SEC. 6001. REPEAL OF AUTHORIZATION OF TRANSITIONAL APPROPRIATIONS FOR THE UNITED STATES POSTAL SERVICE.

(a) REPEAL.—

(1) IN GENERAL.—Section 2004 of title 39, United States Code, is repealed.

(2) TECHNICAL AND CONFORMING AMENDMENTS.—

(A) The table of sections for chapter 20 of such title is amended by repealing the item relating to section 2004.

(B) Section 2003(e)(2) of such title is amended by striking “sections 2401 and 2004” each place it appears and inserting “section 2401”.

(b) CLARIFICATION THAT LIABILITIES FORMERLY PAID PURSUANT TO SECTION 2004 REMAIN LIABILITIES PAYABLE BY THE POSTAL SERVICE.—Section 2003 of title 39, United States Code, is amended by adding at the end the following:

“(h) Liabilities of the former Post Office Department to the Employees’ Compensation Fund (appropriations for which were authorized by former section 2004, as in effect before the effective

date of this subsection) shall be liabilities of the Postal Service payable out of the Fund.”

(c) EFFECTIVE DATE.—

(1) IN GENERAL.—This section and the amendments made by this section shall take effect on the date of the enactment of this Act or October 1, 1997, whichever is later.

(2) PROVISIONS RELATING TO PAYMENTS FOR FISCAL YEAR 1998.—

(A) AMOUNTS NOT YET PAID.—No payment may be made to the Postal Service Fund, on or after the date of the enactment of this Act, pursuant to any appropriation for fiscal year 1998 authorized by section 2004 of title 39, United States Code (as in effect before the effective date of this section).

(B) AMOUNTS PAID.—If any payment to the Postal Service Fund is or has been made pursuant to an appropriation for fiscal year 1998 authorized by such section 2004, then, an amount equal to the amount of such payment shall be paid from such Fund into the Treasury as miscellaneous receipts before October 1, 1998.

Subtitle B—Civil Service

SEC. 6101. CONTRIBUTIONS UNDER THE CIVIL SERVICE RETIREMENT SYSTEM.

(a) INDIVIDUAL CONTRIBUTIONS.—

(1) IN GENERAL.—Subsection (c) of section 8334 of title 5, United States Code, is amended to read as follows:

“(c) Each employee or Member credited with civilian service after July 31, 1920, for which retirement deductions or deposits have not been made, may deposit with interest an amount equal to the following percentages of his basic pay received for that service:

	“Percentage of basic pay	Service period
Employee	2.50	August 1, 1920, to June 30, 1926.
	3.50	July 1, 1926, to June 30, 1942.
	5	July 1, 1942, to June 30, 1948.
	6	July 1, 1948, to October 31, 1956.
	6.50	November 1, 1956, to December 31, 1969.
	7	January 1, 1970, to December 31, 1998.
	7.25	January 1, 1999, to December 31, 1999.
	7.40	January 1, 2000, to December 31, 2000.
	7.50	January 1, 2001, to December 31, 2002.
	7	After December 31, 2002.
Member or employee for Congressional employee service	2.50	August 1, 1920, to June 30, 1926.
	3.50	July 1, 1926, to June 30, 1942.
	5	July 1, 1942, to June 30, 1948.
	6	July 1, 1948, to October 31, 1956.
	6.50	November 1, 1956, to December 31, 1969.
	7.50	January 1, 1970, to December 31, 1998.

	"Percentage of basic pay	Service period
	7.75	January 1, 1999, to December 31, 1999.
	7.90	January 1, 2000, to December 31, 2000.
	8	January 1, 2001, to December 31, 2002.
	7.50	After December 31, 2002.
Member for Member service	2.50	August 1, 1920, to June 30, 1926.
	3.50	July 1, 1926, to June 30, 1942.
	5	July 1, 1942, to August 1, 1946.
	6	August 2, 1946, to October 31, 1956.
	7.50	November 1, 1956, to December 31, 1969.
	8	January 1, 1970, to December 31, 1998.
	8.25	January 1, 1999, to December 31, 1999.
	8.40	January 1, 2000, to December 31, 2000.
	8.50	January 1, 2001, to December 31, 2002.
	8	After December 31, 2002.
Law enforcement officer for law enforcement service and fire- fighter for firefighter service	2.50	August 1, 1920, to June 30, 1926.
	3.50	July 1, 1926, to June 30, 1942.
	5	July 1, 1942, to June 30, 1948.
	6	July 1, 1948, to October 31, 1956.
	6.50	November 1, 1956, to December 31, 1969.
	7	January 1, 1970, to December 31, 1974.
	7.50	January 1, 1975, to December 31, 1998.
	7.75	January 1, 1999, to December 31, 1999.
	7.90	January 1, 2000, to December 31, 2000.
	8	January 1, 2001, to December 31, 2002.
	7.50	After December 31, 2002.
Bankruptcy judge	2.50	August 1, 1920, to June 30, 1926.
	3.50	July 3, 1926, to June 30, 1942.
	5	July 1, 1942, to June 30, 1948.
	6	July 1, 1948, to October 31, 1956.
	6.50	November 1, 1956, to December 31, 1969.
	7	January 1, 1970, to December 31, 1983.
	8	January 1, 1984, to December 31, 1998.
	8.25	January 1, 1999, to December 31, 1999.
	8.40	January 1, 2000, to December 31, 2000.
	8.50	January 1, 2001, to December 31, 2002.
	8	After December 31, 2002.
Judge of the United States Court of Appeals for the Armed Forces for service as a judge of that court	6	May 5, 1950, to October 31, 1956.
	6.50	November 1, 1956, to December 31, 1969.
	7	January 1, 1970, to (but not including) the date of the enactment of the Department of Defense Authorization Act, 1984.

	"Percentage of basic pay	Service period
	8	The date of the enactment of the Department of Defense Authorization Act, 1984, to December 31, 1998.
	8.25	January 1, 1999, to December 31, 1999.
	8.40	January 1, 2000, to December 31, 2000.
	8.50	January 1, 2001, to December 31, 2002.
	8	After December 31, 2002.
United States magistrate	2.50	August 1, 1920, to June 30, 1926.
	3.50	July 1, 1926, to June 30, 1942.
	5	July 1, 1942, to June 30, 1948.
	6	July 1, 1948, to October 31, 1956.
	6.50	November 1, 1956, to December 31, 1969.
	7	January 1, 1970, to September 30, 1987.
	8	October 1, 1987, to December 31, 1998.
	8.25	January 1, 1999, to December 31, 1999.
	8.40	January 1, 2000, to December 31, 2000.
	8.50	January 1, 2001, to December 31, 2002.
	8	After December 31, 2002.
Claims Court Judge	2.50	August 1, 1920, to June 30, 1926.
	3.50	July 1, 1926, to June 30, 1942.
	5	July 1, 1942, to June 30, 1948.
	6	July 1, 1948, to October 31, 1956.
	6.50	November 1, 1956, to December 31, 1969.
	7	January 1, 1970, to September 30, 1988.
	8	October 1, 1988, to December 31, 1998.
	8.25	January 1, 1999, to December 31, 1999.
	8.40	January 1, 2000, to December 31, 2000.
	8.50	January 1, 2001, to December 31, 2002.
	8	After December 31, 2002.

Notwithstanding the preceding provisions of this subsection and any provision of section 206(b)(3) of the Federal Employees' Retirement Contribution Temporary Adjustment Act of 1983, the percentage of basic pay required under this subsection in the case of an individual described in section 8402(b)(2) shall, with respect to any covered service (as defined by section 203(a)(3) of such Act) performed by such individual after December 31, 1983, and before January 1, 1987, be equal to 1.3 percent, and, with respect to any such service performed after December 31, 1986, be equal to the amount that would have been deducted from the employee's basic pay under subsection (k) of this section if the employee's pay had been subject to that subsection during such period."

(2) DEDUCTIONS.—The first sentence of section 8334(a)(1) of title 5, United States Code, is amended to read as follows: "The employing agency shall deduct and withhold from the basic pay of an employee, Member, Congressional employee, law enforcement officer, firefighter, bankruptcy judge, judge of the United

States Court of Appeals for the Armed Forces, United States magistrate, or Claims Court judge, as the case may be, the percentage of basic pay applicable under subsection (c).”.

(3) OTHER SERVICE.—

(A) MILITARY SERVICE.—Section 8334(j) of title 5, United States Code, is amended—

(i) in paragraph (1)(A) by inserting “and subject to paragraph (5),” after “Except as provided in subparagraph (B),”; and

(ii) by adding at the end the following:

“(5) Effective with respect to any period of military service performed after December 31, 1998, and before January 1, 2003, the percentage of basic pay under section 204 of title 37 payable under paragraph (1) shall be equal to the same percentage as would be applicable under section 8334(c) for that same period for service as an ‘employee’, subject to paragraph (1)(B).”.

(B) VOLUNTEER SERVICE.—Section 8334(l) of title 5, United States Code, is amended—

(i) in paragraph (1) by striking the period at the end and inserting “, subject to paragraph (4).”; and

(ii) by adding at the end the following:

“(4) Effective with respect to any period of service as a volunteer or volunteer leader performed after December 31, 1998, and before January 1, 2003, the percentage of the readjustment allowance or stipend (as the case may be) payable under paragraph (1) shall be equal to the same percentage as would be applicable under section 8334(c) for that same period for service as an ‘employee’.”.

(b) GOVERNMENT CONTRIBUTIONS.—

(1) IN GENERAL.—Section 8334 of title 5, United States Code, is amended by adding at the end the following:

“(m)(1) This subsection shall govern for purposes of determining the amount to be contributed under the second sentence of subsection (a)(1) with respect to any service—

“(A) which is performed after September 30, 1997, and before January 1, 2003; and

“(B) as to which a contribution under such sentence would otherwise be payable.

“(2) The amount of the contribution required under the second sentence of subsection (a)(1) with respect to any service described in paragraph (1) shall (instead of the amount which would otherwise apply under such sentence) be equal to the amount of basic pay received for such service by the employee or Member involved, multiplied by the percentage under paragraph (3).

“(3)(A) The percentage under this paragraph is, with respect to any service, equal to the sum of—

“(i) the percentage which would have been applicable under subsection (c), with respect to such service, if it had been performed in fiscal year 1997, plus

“(ii) the applicable percentage under subparagraph (B).

“(B) The applicable percentage under this subparagraph is, with respect to service performed—

“(i) after September 30, 1997, and before October 1, 2002, 1.51 percent; or

“(ii) after September 30, 2002, and before January 1, 2003, 0 percent.

“(4) An amount determined under this subsection with respect to any period of service shall, for purposes of subsection (k)(1)(B) (and any other provision of law which similarly refers to contributions under the second sentence of subsection (a)(1)), be treated as the amount required under such sentence with respect to such service.

“(5)(A) Notwithstanding paragraphs (1) through (4), the amount to be contributed by the Postal Service by reason of the second sentence of subsection (a)(1) with respect to any service performed by an officer or employee of the Postal Service during the period described in subparagraph (A) of paragraph (1) shall be determined as if section 6101 of the Balanced Budget Act of 1997 had never been enacted.

“(B) For purposes of this paragraph, the term ‘Postal Service’ means the United States Postal Service and the Postal Rate Commission.”.

(2) CONFORMING AMENDMENT.—The second sentence of section 8334(a)(1) of title 5, United States Code, is amended by striking the period and inserting “, subject to subsection (m).”.

SEC. 6102. CONTRIBUTIONS UNDER THE FEDERAL EMPLOYEES’ RETIREMENT SYSTEM.

(a) INDIVIDUAL CONTRIBUTIONS.—

(1) IN GENERAL.—Subsection (a) of section 8422 of title 5, United States Code, is amended—

(A) in paragraph (1) by striking “paragraph (2).” and inserting “paragraph (2) or (3), as applicable.”;

(B) in paragraph (2) by striking “The applicable” and inserting “Subject to paragraph (3), the applicable”; and

(C) by adding at the end the following:

“(3)(A) The applicable percentage under this subsection shall, for purposes of service performed after December 31, 1998, and before January 1, 2003, be equal to—

- “(i) the applicable percentage under subparagraph (B), minus
- “(ii) the percentage then in effect under section 3101(a) of the Internal Revenue Code of 1986 (relating to rate of tax for old-age, survivors, and disability insurance).

“(B) The applicable percentage under this subparagraph shall be as follows:

	“Percentage of basic pay	Service period
Employee	7.25	January 1, 1999, to December 31, 1999.
	7.40	January 1, 2000, to December 31, 2000.
	7.50	January 1, 2001, to December 31, 2002.
Congressional employee	7.75	January 1, 1999, to December 31, 1999.
	7.90	January 1, 2000, to December 31, 2000.
	8	January 1, 2001, to December 31, 2002.
Member	7.75	January 1, 1999, to December 31, 1999.

	"Percentage of basic pay	Service period
	7.90	January 1, 2000, to December 31, 2000.
	8	January 1, 2001, to December 31, 2002.
Law enforcement officer	7.75	January 1, 1999, to December 31, 1999.
	7.90	January 1, 2000, to December 31, 2000.
	8	January 1, 2001, to December 31, 2002.
Firefighter	7.75	January 1, 1999, to December 31, 1999.
	7.90	January 1, 2000, to December 31, 2000.
	8	January 1, 2001, to December 31, 2002.
Air traffic controller	7.75	January 1, 1999, to December 31, 1999.
	7.90	January 1, 2000, to December 31, 2000.
	8	January 1, 2001, to December 31, 2002."

(2) OTHER SERVICE.—

(A) MILITARY SERVICE.—Section 8422(e) of title 5, United States Code, is amended—

(i) in paragraph (1)(A) by inserting “and subject to paragraph (5),” after “Except as provided in subparagraph (B),”; and

(ii) by adding at the end the following:

“(5) Effective with respect to any period of military service performed after December 31, 1998, and before January 1, 2003, the percentage of basic pay under section 204 of title 37 payable under paragraph (1) shall be equal to the sum of the percentage specified in paragraph (1), plus—

“(A) .25 percent, if performed after December 31, 1998, and before January 1, 2000;

“(B) .40 percent, if performed after December 31, 1999, and before January 1, 2001;

“(C) .50 percent, if performed after December 31, 2000, and before January 1, 2003.”.

(B) VOLUNTEER SERVICE.—Section 8422(f) of title 5, United States Code, is amended—

(i) in paragraph (1) by striking the period at the end and inserting “, subject to paragraph (4).”; and

(ii) by adding at the end the following:

“(4) Effective with respect to any period of service as a volunteer or volunteer leader performed after December 31, 1998, and before January 1, 2003, the percentage of the readjustment allowance or stipend (as the case may be) payable under paragraph (1) shall be equal to the sum of the percentage specified in paragraph (1), plus—

“(A) .25 percent, if performed after December 31, 1998, and before January 1, 2000;

“(B) .40 percent, if performed after December 31, 1999, and before January 1, 2001;

“(C) .50 percent, if performed after December 31, 2000, and before January 1, 2003.”

(b) GOVERNMENT CONTRIBUTIONS.—

(1) IN GENERAL.—Section 8423 of title 5, United States Code, is amended by adding at the end the following:

“(d)(1) This subsection shall govern for purposes of determining the amount to be contributed by an employing agency for any period (or portion thereof)—

“(A) which is occurs after September 30, 1997, and before January 1, 2003; and

“(B) as to which a contribution under subsection (a) would otherwise be payable by such agency.

“(2) The amount of the contribution required under subsection (a) with respect to any period (or portion thereof) described in paragraph (1) shall (instead of the amount which would otherwise apply) be equal to the amount which would be required under subsection (a) if section 6102(a) of the Balanced Budget Act of 1997 had never been enacted.”.

(2) CONFORMING AMENDMENT.—Section 8423(a)(1) of title 5, United States Code, is amended by striking “Each” and inserting “Subject to subsection (d), each”.

SEC. 6103. GOVERNMENT CONTRIBUTION FOR HEALTH BENEFITS.

(a) IN GENERAL.—Section 8906 of title 5, United States Code, is amended by striking subsection (a) and all that follows through the end of paragraph (1) of subsection (b) and inserting the following:

“(a)(1) The Office of Personnel Management shall, not later than October 1 of each year, determine the weighted average of the subscription charges that will be in effect during the following contract year with respect to—

“(A) enrollments under this chapter for self alone; and

“(B) enrollments under this chapter for self and family.

“(2) In determining each weighted average under paragraph (1), the weight to be given to a particular subscription charge shall, with respect to each plan (and option) to which it is to apply, be commensurate with the number of enrollees enrolled in such plan (and option) as of March 31 of the year in which the determination is being made.

“(3) For purposes of paragraph (2), the term ‘enrollee’ means any individual who, during the contract year for which the weighted average is to be used under this section, will be eligible for a Government contribution for health benefits.

“(b)(1) Except as provided in paragraphs (2) and (3), the biweekly Government contribution for health benefits for an employee or annuitant enrolled in a health benefits plan under this chapter is adjusted to an amount equal to 72 percent of the weighted average under subsection (a)(1)(A) or (B), as applicable. For an employee, the adjustment begins on the first day of the employee’s first pay period of each year. For an annuitant, the adjustment begins on the first day of the first period of each year for which an annuity payment is made.”.

(b) EFFECTIVE DATE.—This section and the amendment made by this section shall take effect on the first day of the contract year that begins in 1999, except that nothing in this subsection shall prevent the Office of Personnel Management from taking any ac-

tion, before such first day, which it considers necessary in order to ensure the timely implementation of such amendment.

SEC. 6104. EFFECTIVE DATE.

(a) **IN GENERAL.**—Except as provided in section 6103, this subtitle shall take effect on—

(1) October 1, 1997; or

(2) if later, the date of the enactment of this Act.

(b) **SPECIAL RULE.**—If the date of the enactment of this Act is later than October 1, 1997, then, for purposes of applying the amendments made by sections 6101 and 6102—

(1) any reference in any such amendment to “September 30, 1997” shall be treated as referring to the day before the date of the enactment of this Act; and

(2) any reference in any such amendment to “October 1, 1997” shall be treated as referring to the date of the enactment of this Act.

TITLE VII—COMMITTEE ON TRANSPORTATION AND INFRASTRUCTURE

SEC. 7001. EXTENSION OF HIGHER VESSEL TONNAGE DUTIES.

(a) **EXTENSION OF DUTIES.**—Section 36 of the Act of August 5, 1909 (36 Stat. 111; 46 U.S.C. App. 121), is amended by striking “for fiscal years 1991, 1992, 1993, 1994, 1995, 1996, 1997, 1998,” each place it appears and inserting “for fiscal years through fiscal year 2002.”

(b) **CONFORMING AMENDMENT.**—The Act entitled “An Act concerning tonnage duties on vessels entering otherwise than by sea”, approved March 8, 1910 (36 Stat. 234; 46 U.S.C. App. 132), is amended by striking “for fiscal years 1991, 1992, 1993, 1994, 1995, 1996, 1997, and 1998,” and inserting “for fiscal years through fiscal year 2002.”

SEC. 7002. SALE OF GOVERNORS ISLAND, NEW YORK.

(a) **IN GENERAL.**—Notwithstanding any other provision of law, no earlier than fiscal year 2002, the Administrator of General Services shall dispose of by sale at fair market value all rights, title, and interests of the United States in and to the land of, and improvements to, Governors Island, New York.

(b) **RIGHT OF FIRST REFUSAL.**—Before a sale is made under subsection (a) to any other parties, the State of New York and the city of New York shall be given the right of first refusal to purchase all or part of Governors Island. Such right may be exercised by either the State of New York or the city of New York or by both parties acting jointly.

(c) **PROCEEDS.**—Proceeds from the disposal of Governors Island under subsection (a) shall be deposited in the general fund of the Treasury and credited as miscellaneous receipts.

SEC. 7003. SALE OF AIR RIGHTS.

(a) **IN GENERAL.**—Notwithstanding any other provision of law, the Administrator of General Services shall sell, at fair market value and in a manner to be determined by the Administrator, the air rights adjacent to Washington Union Station described in sub-

section (b), including air rights conveyed to the Administrator under subsection (d). The Administrator shall complete the sale by such date as is necessary to ensure that the proceeds from the sale will be deposited in accordance with subsection (c).

(b) DESCRIPTION.—The air rights referred to in subsection (a) total approximately 16.5 acres and are depicted on the plat map of the District of Columbia as follows:

- (1) Part of lot 172, square 720.
- (2) Part of lots 172 and 823, square 720.
- (3) Part of lot 811, square 717.

(c) PROCEEDS.—Before September 30, 2002, proceeds from the sale of air rights under subsection (a) shall be deposited in the general fund of the Treasury and credited as miscellaneous receipts.

(d) CONVEYANCE OF AMTRAK AIR RIGHTS.—

(1) GENERAL RULE.—As a condition of future Federal financial assistance, Amtrak shall convey to the Administrator of General Services on or before December 31, 1997, at no charge, all of the air rights of Amtrak described in subsection (b).

(2) FAILURE TO COMPLY.—If Amtrak does not meet the condition established by paragraph (1), Amtrak shall be prohibited from obligating Federal funds after March 1, 1998.

TITLE VIII—COMMITTEE ON VETERANS' AFFAIRS

SEC. 8001. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This title may be cited as the “Veterans Reconciliation Act of 1997”.

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

Sec. 8001. Short title; table of contents.

Subtitle A—Extension of Temporary Authorities

- Sec. 8011. Authority to require that certain veterans make copayments in exchange for receiving health-care benefits.
- Sec. 8012. Medical care cost recovery for non-service-connected disabilities of service-connected veterans.
- Sec. 8013. Department of Veterans Affairs medical-care receipts.
- Sec. 8014. Income verification authority.
- Sec. 8015. Limitation on pension for certain recipients of medicaid-covered nursing home care.
- Sec. 8016. Home loan fees.
- Sec. 8017. Procedures applicable to liquidation sales on defaulted home loans guaranteed by the Secretary of Veterans Affairs.
- Sec. 8018. Enhanced loan asset sale authority.

Subtitle B—Other Matters

- Sec. 8021. Rounding down of cost-of-living adjustments in compensation and DIC rates.
- Sec. 8022. Withholding of payments and benefits.

Subtitle A—Extension of Temporary Authorities

SEC. 8011. AUTHORITY TO REQUIRE THAT CERTAIN VETERANS MAKE COPAYMENTS IN EXCHANGE FOR RECEIVING HEALTH-CARE BENEFITS.

(a) HOSPITAL AND MEDICAL CARE.—

(1) EXTENSION.—Section 1710(f)(2)(B) of title 38, United States Code, is amended by inserting “before September 30, 2002,” after “(B)”.

(2) REPEAL OF SUPERSEDED PROVISION.—Section 8013(e) of the Omnibus Budget Reconciliation Act of 1990 (38 U.S.C. 1710 note) is repealed.

(b) OUTPATIENT MEDICATIONS.—Section 1722A(c) of title 38, United States Code, is amended by striking out “September 30, 1998” and inserting in lieu thereof “September 30, 2002”.

SEC. 8012. MEDICAL CARE COST RECOVERY FOR NON-SERVICE-CONNECTED DISABILITIES OF SERVICE-CONNECTED VETERANS.

Section 1729(a)(2)(E) of title 38, United States Code, is amended by striking out “before October 1, 1998,” and inserting “before October 1, 2002,”.

SEC. 8013. DEPARTMENT OF VETERANS AFFAIRS MEDICAL-CARE RECEIPTS.

(a) ALLOCATION OF RECEIPTS.—(1) Chapter 17 of title 38, United States Code, is amended by inserting after section 1729 the following new section:

“§ 1729A. Department of Veterans Affairs Medical Care Collections Fund

“(a) There is in the Treasury a fund to be known as the Department of Veterans Affairs Medical Care Collections Fund.

“(b) Amounts recovered or collected after September 30, 1997, under any of the following provisions of law shall be deposited in the fund:

“(1) Section 1710(f) of this title.

“(2) Section 1710(g) of this title.

“(3) Section 1711 of this title.

“(4) Section 1722A of this title.

“(5) Section 1729 of this title.

“(6) Public Law 87–693, popularly known as the ‘Federal Medical Care Recovery Act’ (42 U.S.C. 2651 et seq.), to the extent that a recovery or collection under that law is based on medical care or services furnished under this chapter.

“(c)(1) Amounts in the fund are available to the Secretary for the following purposes:

“(A) Furnishing medical care and services under this chapter, to be available during any fiscal year for the same purposes and subject to the same limitations as apply to amounts appropriated for that fiscal year for medical care.

“(B) Expenses of the Department for the identification, billing, auditing, and collection of amounts owed the United States

by reason of medical care and services furnished under this chapter.

“(2)(A) If for fiscal year 1998, 1999, or 2000 the Secretary determines that the total amount to be recovered for that fiscal year under the provisions of law specified in subsection (b) will be less than the amount contained in the latest Congressional Budget Office baseline estimate (computed under section 257 of the Balanced Budget and Emergency Deficit Control Act of 1985) for the amount of such recoveries for that fiscal year by at least \$25,000,000, the Secretary shall promptly certify to the Secretary of the Treasury the amount of the shortfall (as estimated by the Secretary) that is in excess of \$25,000,000. Upon receipt of such a certification, the Secretary of the Treasury shall, not later than 30 days after receiving the certification, deposit in the fund, from any unobligated amounts in the Treasury, an amount equal to the amount certified by the Secretary.

“(B) For a fiscal year for which a deposit is made under subparagraph (A), if the Secretary subsequently determines that the actual amount recovered for that fiscal year under the provisions of law specified in subsection (b) is greater than the amount estimated by the Secretary that was used for purposes of the certification by the Secretary under subparagraph (A), the Secretary shall pay into the general fund of the Treasury, from amounts available for medical care, an amount equal to the difference between the amount actually recovered and the amount so estimated (but not in excess of the amount of the deposit under subparagraph (A) pursuant to such certification).

“(C) For a fiscal year for which a deposit is made under subparagraph (A), if the Secretary subsequently determines that the actual amount recovered for that fiscal year under the provisions of law specified in subsection (b) is less than the amount estimated by the Secretary that was used for purposes of the certification by the Secretary under subparagraph (A), the Secretary shall promptly certify to the Secretary of the Treasury the amount of the shortfall. Upon receipt of such a certification, the Secretary of the Treasury shall, not later than 30 days after receiving the certification, deposit in the fund, from any unobligated amounts in the Treasury, an amount equal to the amount certified by the Secretary.

“(d)(1) The Secretary may allocate amounts available to the Secretary under subsection (c) among components of the Department in such manner as the Secretary considers appropriate.

“(2) The Secretary shall establish a policy for the allocation under paragraph (1) of amounts in the fund. Such policy shall be designed so as to facilitate the realization of the maximum feasible collections under the provisions of law specified in subsection (b). In developing the policy, the Secretary shall take into account any factors beyond the control of the Secretary that the Secretary considers may impede such collections.

“(e)(1) The Secretary shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives quarterly reports on the operation of this section for fiscal years 1998, 1999, and 2000 and for the first quarter of fiscal year 2001. Each such report shall specify the amount collected under each of the provisions specified in subsection (b) during the preceding quarter and

the amount originally estimated to be collected under each such provision during such quarter.

“(2) A report under paragraph (1) for a quarter shall be submitted not later than 45 days after the end of that quarter.”.

(2) The table of sections at the beginning of such chapter is amended by inserting after the item relating to section 1729 the following new item:

“1729A. Department of Veterans Affairs Medical Care Collections Fund.”.

(b) CONFORMING AMENDMENTS.—Chapter 17 of such title is amended as follows:

(1) Section 1710(f) is amended by striking out paragraph (4) and redesignating paragraph (5) as paragraph (4).

(2) Section 1710(g) is amended by striking out paragraph (4).

(3) Section 1722A(b) is amended by striking out “Department of Veterans Affairs Medical-Care Cost Recovery Fund” and inserting in lieu thereof “Department of Veterans Affairs Medical Care Collections Fund”.

(4) Section 1729 is amended by striking out subsection (g).

(c) TERMINATION OF MEDICAL-CARE COST RECOVERY FUND.—The amount of the unobligated balance remaining in the Department of Veterans Affairs Medical-Care Cost Recovery Fund (established pursuant to section 1729(g)(1) of title 38, United States Code), at the close of September 30, 1997, shall be deposited, not later than December 31, 1997, in the Treasury as miscellaneous receipts, and that fund shall be terminated when the deposit occurs.

(d) DETERMINATION OF AMOUNTS SUBJECT TO RECOVERY.—Section 1729 of title 38, United States Code, is amended—

(1) in subsection (a)(1), by striking out “the reasonable cost of” and inserting in lieu thereof “reasonable charges for”;

(2) in subsection (c)(2)—

(A) by striking out “the reasonable cost of” in the first sentence of subparagraph (A) and in subparagraph (B) and inserting in lieu thereof “reasonable charges for”; and

(B) by striking out “cost” in the second sentence of subparagraph (A) and inserting in lieu thereof “charges”.

(e) TECHNICAL AMENDMENT.—Paragraph (2) of section 712(b) of title 38, United States Code, is amended—

(1) by striking out subparagraph (B); and

(2) by redesignating subparagraph (C) as subparagraph (B).

(f) IMPLEMENTATION.—(1) Not later than January 1, 1999, the Secretary of Veterans Affairs shall submit to the Committees on Veterans’ Affairs of the Senate and House of Representatives a report on the implementation of this section. The report shall describe the collections under each of the provisions specified in section 1729A(b) of title 38, United States Code, as added by subsection (a). Information on such collections shall be shown for each of the health service networks (known as Veterans Integrated Service Networks) and, to the extent practicable for each facility within each such network. The Secretary shall include in the report an analysis of differences among the networks with respect to (A) the market in which the networks operates, (B) the effort expended to achieve collections, (C) the efficiency of such effort, and (D) any other relevant information.

(2) The Secretary shall adjust the allocation policy established under section 1729A(d)(2) of title 38, United States Code, as added by subsection (a), to take account of differences in collections that the Secretary determines are attributable to the different markets in which networks operate and shall include in the report under paragraph (1) a description of such adjustments.

(g) EFFECTIVE DATE.—(1) Except as provided in paragraph (2), this section and the amendments made by this section shall take effect on October 1, 1997.

(2) The amendments made by subsection (d) shall take effect on the date of the enactment of this Act.

SEC. 8014. INCOME VERIFICATION AUTHORITY.

(a) EXTENSION.—Section 5317(g) of title 38, United States Code, is amended by striking out “September 30, 1998” and inserting in lieu thereof “September 30, 2002”.

(b) SOCIAL SECURITY AND TAX RETURN INFORMATION.—Section 6103(l)(7) of the Internal Revenue Code of 1986 is amended by striking out “Clause (viii) shall not apply after September 30, 1998” and inserting in lieu thereof “Clause (viii) shall not apply after September 30, 2002”.

SEC. 8015. LIMITATION ON PENSION FOR CERTAIN RECIPIENTS OF MEDICAID-COVERED NURSING HOME CARE.

Section 5503(f)(7) of title 38, United States Code, is amended by striking out “September 30, 1998” and inserting in lieu thereof “September 30, 2002”.

SEC. 8016. HOME LOAN FEES.

(a) INCREASE IN LOAN FEE UNDER PROPERTY MANAGEMENT PROGRAM.—Paragraph (2) of section 3729(a) of title 38, United States Code, is amended—

- (1) in subparagraph (A), by striking out “or 3733(a)”;
- (2) by striking out “and” at the end of subparagraph (D);
- (3) by striking out the period at the end of subparagraph (E) and inserting in lieu thereof “; and”; and
- (4) by adding at the end the following new subparagraph:
“(F) in the case of a loan made under section 3733(a) of this title, the amount of such fee shall be 2.25 percent of the total loan amount.”

(b) EXTENSIONS.—Such section is further amended—

- (1) in paragraph (4)—
 - (A) by striking out “October 1, 1998” and inserting in lieu thereof “October 1, 2002”; and
 - (B) by striking out “or (E)” and inserting in lieu thereof “(E), or (F)”;
- (2) in paragraph (5)(C), by striking out “October 1, 1998” and inserting in lieu thereof “October 1, 2002”.

SEC. 8017. PROCEDURES APPLICABLE TO LIQUIDATION SALES ON DEFAULTED HOME LOANS GUARANTEED BY THE SECRETARY OF VETERANS AFFAIRS.

Section 3732(c)(11) of title 38, United States Code, is amended by striking out “October 1, 1998” and inserting “October 1, 2002”.

SEC. 8018. ENHANCED LOAN ASSET SALE AUTHORITY.

Section 3720(h)(2) of title 38, United States Code, is amended by striking out “December 31, 1997” and inserting in lieu thereof “September 30, 2002”.

Subtitle B—Other Matters

SEC. 8021. ROUNDING DOWN OF COST-OF-LIVING ADJUSTMENTS IN COMPENSATION AND DIC RATES.

(a) COMPENSATION COLAS.—(1) Chapter 11 of title 38, United States Code, is amended by inserting after section 1102 the following new section:

“§ 1103. Cost-of-living adjustments

“(a) In the computation of cost-of-living adjustments for fiscal years 1998 through 2002 in the rates of, and dollar limitations applicable to, compensation payable under this chapter, such adjustments shall be made by a uniform percentage that is no more than the percentage equal to the social security increase for that fiscal year, with all increased monthly rates and limitations (other than increased rates or limitations equal to a whole dollar amount) rounded down to the next lower whole dollar amount.

“(b) For purposes of this section, the term ‘social security increase’ means the percentage by which benefit amounts payable under title II of the Social Security Act (42 U.S.C. 401 et seq.) are increased for any fiscal year as a result of a determination under section 215(i) of such Act (42 U.S.C. 415(i)).”.

(2) The table of sections at the beginning of such chapter is amended by inserting after the item relating to section 1102 the following new item:

“1103. Cost-of-living adjustments.”.

(b) OUT-YEAR DIC COLAS.—(1) Chapter 13 of title 38, United States Code, is amended by inserting after section 1302 the following new section:

“§ 1303. Cost-of-living adjustments

“(a) In the computation of cost-of-living adjustments for fiscal years 1998 through 2002 in the rates of dependency and indemnity compensation payable under this chapter, such adjustments shall be made by a uniform percentage that is no more than the percentage equal to the social security increase for that fiscal year, with all increased monthly rates (other than increased rates equal to a whole dollar amount) rounded down to the next lower whole dollar amount.

“(b) For purposes of this section, the term ‘social security increase’ means the percentage by which benefit amounts payable under title II of the Social Security Act (42 U.S.C. 401 et seq.) are increased for any fiscal year as a result of a determination under section 215(i) of such Act (42 U.S.C. 415(i)).”.

(2) The table of sections at the beginning of such chapter is amended by inserting after the item relating to section 1302 the following new item:

“1303. Cost-of-living adjustments.”.

SEC. 8022. WITHHOLDING OF PAYMENTS AND BENEFITS.

(a) NOTICE REQUIRED IN LIEU OF CONSENT OR COURT ORDER.—Section 3726 of title 38, United States Code, is amended by striking out “unless” and all that follows and inserting in lieu thereof the following: “unless the Secretary provides such veteran or surviving spouse with notice by certified mail with return receipt requested of the authority of the Secretary to waive the payment of indebtedness under section 5302(b) of this title. If the Secretary does not waive the entire amount of the liability, the Secretary shall then determine whether the veteran or surviving spouse should be released from liability under section 3713(b) of this title. If the Secretary determines that the veteran or surviving spouse should not be released from liability, the Secretary shall notify the veteran or surviving spouse of that determination and provide a notice of the procedure for appealing that determination, unless the Secretary has previously made such determination and notified the veteran or surviving spouse of the procedure for appealing the determination.”

(b) CONFORMING AMENDMENT.—Section 5302(b) of such title is amended by inserting “with return receipt requested” after “certified mail”.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to any indebtedness to the United States arising pursuant to chapter 37 of title 38, United States Code, before, on, or after the date of the enactment of this Act.

TITLE IX—COMMITTEE ON WAYS AND MEANS—NONMEDICARE

SEC. 9000. TABLE OF CONTENTS.

The table of contents of this title is as follows:

Sec. 9000. Table of contents.

Subtitle A—TANF Block Grant

Sec. 9001. Welfare-to-work grants.

Sec. 9002. Limitation on amount of Federal funds transferable to title XX programs.

Sec. 9003. Clarification of limitation on number of persons who may be treated as engaged in work by reason of participation in vocational educational training.

Sec. 9004. Required hours of work; health and safety.

Sec. 9005. Penalty for failure of State to reduce assistance for recipients refusing without good cause to work.

Subtitle B—Supplemental Security Income

Sec. 9101. Requirement to perform childhood disability redeterminations in missed cases.

Sec. 9102. Repeal of maintenance of effort requirements applicable to optional State programs for supplementation of SSI benefits.

Sec. 9103. Fees for Federal administration of State supplementary payments.

Subtitle C—Child Support Enforcement

Sec. 9201. Clarification of authority to permit certain redisclosures of wage and claim information.

Subtitle D—Restricting Welfare and Public Benefits for Aliens

- Sec. 9301. Extension of eligibility period for refugees and certain other qualified aliens from 5 to 7 years for SSI and medicaid.
- Sec. 9302. SSI eligibility for aliens receiving SSI on August 22, 1996.
- Sec. 9303. SSI eligibility for permanent resident aliens who are members of an Indian tribe.
- Sec. 9304. Verification of eligibility for State and local public benefits.
- Sec. 9305. Derivative eligibility for benefits.
- Sec. 9306. Effective date.

Subtitle E—Unemployment Compensation

- Sec. 9401. Clarifying provision relating to base periods.
- Sec. 9402. Increase in Federal unemployment account ceiling.
- Sec. 9403. Special distribution to States from Unemployment Trust Fund.
- Sec. 9404. Interest-free advances to State accounts in Unemployment Trust Fund restricted to States which meet funding goals.
- Sec. 9405. Exemption of service performed by election workers from the Federal unemployment tax.
- Sec. 9406. Treatment of certain services performed by inmates.
- Sec. 9407. Exemption of service performed for an elementary or secondary school operated primarily for religious purposes from the Federal unemployment tax.
- Sec. 9408. State program integrity activities for unemployment compensation.

Subtitle F—Increase in Public Debt Limit

- Sec. 9501. Increase in public debt limit.

Subtitle A—TANF Block Grant

SEC. 9001. WELFARE-TO-WORK GRANTS.

(a) GRANTS TO STATES.—

(1) IN GENERAL.—Section 403(a) of the Social Security Act (42 U.S.C. 603(a)) is amended by adding at the end the following:

“(5) WELFARE-TO-WORK GRANTS.—

“(A) NONCOMPETITIVE GRANTS.—

“(i) ENTITLEMENT.—A State shall be entitled to receive from the Secretary a grant for each fiscal year specified in subparagraph (H) of this paragraph for which the State is a welfare-to-work State, in an amount that does not exceed the lesser of—

“(I) 2 times the total of the expenditures by the State (excluding qualified State expenditures (as defined in section 409(a)(7)(B)(i)) and any expenditure described in subclause (I), (II), or (IV) of section 409(a)(7)(B)(iv)) during the fiscal year for activities described in subparagraph (C)(i) of this paragraph; or

“(II) the allotment of the State under clause (iii) of this subparagraph for the fiscal year.

“(ii) WELFARE-TO-WORK STATE.—A State shall be considered a welfare-to-work State for a fiscal year for purposes of this subparagraph if the Secretary, after consultation (and the sharing of any plan or amendment thereto submitted under this clause) with the Secretary of Health and Human Services and the Secretary of Housing and Urban Development, deter-

mines that the State meets the following requirements:

“(I) The State has submitted to the Secretary (in the form of an addendum to the State plan submitted under section 402) a plan which—

“(aa) describes how, consistent with this subparagraph, the State will use any funds provided under this subparagraph during the fiscal year;

“(bb) specifies the formula to be used pursuant to clause (vi) to distribute funds in the State, and describes the process by which the formula was developed;

“(cc) contains evidence that the plan was developed in consultation and coordination with sub-State areas; and

“(dd) is approved by the agency administering the State program funded under this part.

“(II) The State has provided the Secretary with an estimate of the amount that the State intends to expend during the fiscal year (excluding expenditures described in section 409(a)(7)(B)(iv)) for activities described in subparagraph (C)(i) of this paragraph.

“(III) The State has agreed to negotiate in good faith with the Secretary of Health and Human Services with respect to the substance of any evaluation under section 413(j), and to cooperate with the conduct of any such evaluation.

“(IV) The State is an eligible State for the fiscal year.

“(V) Qualified State expenditures (within the meaning of section 409(a)(7)) are at least 80 percent of historic State expenditures (within the meaning of such section), with respect to the fiscal year or the immediately preceding fiscal year.

“(iii) ALLOTMENTS TO WELFARE-TO-WORK STATES.—The allotment of a welfare-to-work State for a fiscal year shall be the available amount for the fiscal year multiplied by the State percentage for the fiscal year.

“(iv) AVAILABLE AMOUNT.—As used in this subparagraph, the term ‘available amount’ means, for a fiscal year, the sum of—

“(I) 50 percent of the sum of—

“(aa) the amount specified in subparagraph (H) for the fiscal year, minus the total of the amounts reserved pursuant to subparagraphs (F) and (G) for the fiscal year; and

“(bb) any amount reserved pursuant to subparagraph (F) for the immediately preceding fiscal year that has not been obligated; and

“(II) any available amount for the immediately preceding fiscal year that has not been obligated by a State or sub-State entity.

“(v) STATE PERCENTAGE.—As used in clause (iii), the term ‘State percentage’ means, with respect to a fiscal year, $\frac{1}{3}$ of the sum of—

“(aa) the percentage represented by the number of individuals in the State whose income is less than the poverty line divided by the number of such individuals in the United States;

“(bb) the percentage represented by the number of unemployed individuals in the State divided by the number of such individuals in the United States; and

“(cc) the percentage represented by the number of individuals who are adult recipients of assistance under the State program funded under this part divided by the number of individuals in the United States who are adult recipients of assistance under any State program funded under this part.

“(vi) DISTRIBUTION OF FUNDS WITHIN STATES.—

“(I) IN GENERAL.—A State to which a grant is made under this subparagraph shall distribute not less than 85 percent of the grant funds among the service delivery areas in the State, in accordance with a formula which—

“(aa) determines the amount to be distributed for the benefit of a service delivery area in proportion to the number (if any) by which the number of individuals residing in the service delivery area with an income that is less than the poverty line exceeds 5 percent of the population of the service delivery area, relative to such number for the other service delivery areas in the State, and accords a weight of not less than 50 percent to this factor;

“(bb) may determine the amount to be distributed for the benefit of a service delivery area in proportion to the number of adults residing in the service delivery area who are recipients of assistance under the State program funded under this part (whether in effect before or after the amendments made by section 103(a) of the Personal Responsibility and Work Opportunity Reconciliation Act first applied to the State) for at least 30 months (whether or not consecutive) relative to the number of such adults residing in the other service delivery areas in the State; and

“(cc) may determine the amount to be distributed for the benefit of a service delivery area in proportion to the number of unemployed individuals residing in the service delivery area relative to the number of such in-

dividuals residing in the other service delivery areas in the State.

“(II) SPECIAL RULE.—Notwithstanding subclause (I), if the formula used pursuant to subclause (I) would result in the distribution of less than \$100,000 during a fiscal year for the benefit of a service delivery area, then in lieu of distributing such sum in accordance with the formula, such sum shall be available for distribution under subclause (III) during the fiscal year.

“(III) PROJECTS TO HELP LONG-TERM RECIPIENTS OF ASSISTANCE INTO THE WORK FORCE.—The Governor of a State to which a grant is made under this subparagraph may distribute not more than 15 percent of the grant funds (plus any amount required to be distributed under this subclause by reason of subclause (II)) to projects that appear likely to help long-term recipients of assistance under the State program funded under this part (whether in effect before or after the amendments made by section 103(a) of the Personal Responsibility and Work Opportunity Reconciliation Act first applied to the State) enter the work force.

“(vii) ADMINISTRATION.—

“(I) IN GENERAL.—A grant made under this subparagraph to a State shall be administered by the State agency that is administering, or supervising the administration of, the State program funded under this part, or by another State agency designated by the Governor of the State.

“(II) SPENDING BY PRIVATE INDUSTRY COUNCILS.—The private industry council for a service delivery area shall have sole authority to expend the amounts provided for the benefit of a service delivery area under subparagraph (vi)(I), pursuant to an agreement with the agency that is administering the State program funded under this part in the service delivery area.

“(B) COMPETITIVE GRANTS.—

“(i) IN GENERAL.—The Secretary, in consultation with the Secretary of Health and Human Services and the Secretary of Housing and Urban Development, shall award grants in accordance with this subparagraph, in fiscal years 1998 and 2000, for projects proposed by eligible applicants, based on the following:

“(I) The effectiveness of the proposal in—

“(aa) expanding the base of knowledge about programs aimed at moving recipients of assistance under State programs funded under this part who are least job ready into the work force.

“(bb) moving recipients of assistance under State programs funded under this part who are least job ready into the work force; and

“(cc) moving recipients of assistance under State programs funded under this part who are least job ready into the work force, even in labor markets that have a shortage of low-skill jobs.

“(II) At the discretion of the Secretary, any of the following:

“(aa) The history of success of the applicant in moving individuals with multiple barriers into work.

“(bb) Evidence of the applicant’s ability to leverage private, State, and local resources.

“(cc) Use by the applicant of State and local resources beyond those required by subparagraph (A).

“(dd) Plans of the applicant to coordinate with other organizations at the local and State level.

“(ee) Use by the applicant of current or former recipients of assistance under a State program funded under this part as mentors, case managers, or service providers.

“(ii) ELIGIBLE APPLICANTS.—As used in clause (i), the term ‘eligible applicant’ means a private industry council or a political subdivision of a State that submits a proposal that is approved by the agency administering the State program funded under this part.

“(iii) DETERMINATION OF GRANT AMOUNT.—In determining the amount of a grant to be made under this subparagraph for a project proposed by an applicant, the Secretary shall provide the applicant with an amount sufficient to ensure that the project has a reasonable opportunity to be successful, taking into account the number of long-term recipients of assistance under a State program funded under this part, the level of unemployment, the job opportunities and job growth, the poverty rate, and such other factors as the Secretary deems appropriate, in the area to be served by the project.

“(iv) TARGETING OF FUNDS TO CERTAIN AREAS.—

“(I) CITIES WITH GREATEST NUMBER OF PERSONS WITH INCOME LESS THAN THE POVERTY LINE.—The Secretary shall use not less than 65 percent of the funds available for grants under this subparagraph for a fiscal year to award grants for expenditures in cities that are among the 100 cities in the United States with the highest number of residents with an income that is less than the poverty line.

“(II) RURAL AREAS.—

“(aa) IN GENERAL.—The Secretary shall use not less than 25 percent of the funds available for grants under this subparagraph for a fis-

cal year to award grants for expenditures in rural areas.

“(bb) RURAL AREA DEFINED.—As used in item (aa), the term ‘rural area’ means a city, town, or unincorporated area that has a population of 50,000 or fewer inhabitants and that is not an urbanized area immediately adjacent to a city, town, or unincorporated area that has a population of more than 50,000 inhabitants.

“(v) FUNDING.—For grants under this subparagraph for each fiscal year specified in subparagraph (H), there shall be available to the Secretary an amount equal to the sum of—

“(I) 50 percent of the sum of—

“(aa) the amount specified in subparagraph (H) for the fiscal year, minus the total of the amounts reserved pursuant to subparagraphs (F) and (G) for the fiscal year; and

“(bb) any amount reserved pursuant to subparagraph (F) for the immediately preceding fiscal year that has not been obligated; and

“(II) any amount available for grants under this subparagraph for the immediately preceding fiscal year that has not been obligated.

“(C) LIMITATIONS ON USE OF FUNDS.—

“(i) ALLOWABLE ACTIVITIES.—An entity to which funds are provided under this paragraph may use the funds to move into the work force recipients of assistance under the program funded under this part of the State in which the entity is located and the noncustodial parent of any minor who is such a recipient, by means of any of the following:

“(I) Job creation through public or private sector employment wage subsidies.

“(II) On-the-job training.

“(III) Contracts with public or private providers of readiness, placement, and post-employment services.

“(IV) Job vouchers for placement, readiness, and postemployment services.

“(V) Job support services (excluding child care services) if such services are not otherwise available.

“(ii) REQUIRED BENEFICIARIES.—An entity that operates a project with funds provided under this paragraph shall expend at least 90 percent of all funds provided to the project for the benefit of recipients of assistance under the program funded under this part of the State in which the entity is located who meet the requirements of each of the following subclauses:

“(I) At least 2 of the following apply to the recipient:

“(aa) The individual has not completed secondary school or obtained a certificate of general equivalency, and has low skills in reading and mathematics.

“(bb) The individual requires substance abuse treatment for employment.

“(cc) The individual has a poor work history.

The Secretary shall prescribe such regulations as may be necessary to interpret this subclause.

“(II) The individual—

“(aa) has received assistance under the State program funded under this part (whether in effect before or after the amendments made by section 103 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 first apply to the State) for at least 30 months (whether or not consecutive); or

“(bb) within 12 months, will become ineligible for assistance under the State program funded under this part by reason of a durational limit on such assistance, without regard to any exemption provided pursuant to section 408(a)(7)(C) that may apply to the individual.

“(iii) LIMITATION ON APPLICABILITY OF SECTION 404.—The rules of section 404, other than subsections (b), (f), and (h) of section 404, shall not apply to a grant made under this paragraph.

“(iv) LIMITATIONS RELATING TO PRIVATE INDUSTRY COUNCILS.—

“(I) NO DIRECT PROVISION OF SERVICES.—A private industry council may not directly provide services using funds provided under this paragraph.

“(II) COOPERATION WITH TANF AGENCY.—On a determination by the Secretary, in consultation with the Secretary of Health and Human Services and the Secretary of Housing and Urban Development, that the private industry council for a service delivery area in a State for which funds are provided under this paragraph and the agency administering the State program funded under this part are not adhering to the agreement referred to in subparagraph (A)(vii)(II) to implement any plan or project for which the funds are provided, the recipient of the funds shall remit the funds to the Secretary.

“(v) PROHIBITION AGAINST USE OF GRANT FUNDS FOR ANY OTHER FUND MATCHING REQUIREMENT.—An entity to which funds are provided under this paragraph shall not use any part of the funds to fulfill any obligation of any State, political subdivision, or private in-

dustry council to contribute funds under other Federal law.

“(vi) DEADLINE FOR EXPENDITURE.—An entity to which funds are provided under this paragraph shall remit to the Secretary any part of the funds that are not expended within 3 years after the date the funds are so provided.

“(D) INDIVIDUALS WITH INCOME LESS THAN THE POVERTY LINE.—For purposes of this paragraph, the number of individuals with an income that is less than the poverty line shall be determined based on the methodology used by the Bureau of the Census to produce and publish intercensal poverty data for 1993 for States and counties.

“(E) DEFINITIONS.—As used in this paragraph:

“(i) PRIVATE INDUSTRY COUNCIL.—The term ‘private industry council’ means, with respect to a service delivery area, the private industry council (or successor entity) established for the service delivery area pursuant to the Job Training Partnership Act.

“(ii) SECRETARY.—The term ‘Secretary’ means the Secretary of Labor, except as otherwise expressly provided.

“(iii) SERVICE DELIVERY AREA.—The term ‘service delivery area’ shall have the meaning given such term for purposes of the Job Training Partnership Act.

“(F) SET-ASIDE FOR INDIAN TRIBES.—1 percent of the amount specified in subparagraph (H) for each fiscal year shall be reserved for grants to Indian tribes under section 412(a)(3).

“(G) SET-ASIDE FOR EVALUATIONS.—0.5 percent of the amount specified in subparagraph (H) for each fiscal year shall be reserved for use by the Secretary of Health and Human Services to carry out section 413(j).

“(H) FUNDING.—The amount specified in this subparagraph is—

“(i) \$750,000,000 for fiscal year 1998;

“(ii) \$1,250,000,000 for fiscal year 1999; and

“(iii) \$1,000,000,000 for fiscal year 2000.

“(I) AVAILABILITY OF FUNDS.—Amounts appropriated pursuant to this paragraph shall remain available through fiscal year 2002.

“(J) BUDGET SCORING.—Notwithstanding section 457(b)(2) of the Balanced Budget and Emergency Deficit Control Act of 1985, the baseline shall assume that no grant shall be awarded under this paragraph or under section 412(a)(3) after fiscal year 2000.

“(K) WORKER PROTECTIONS.—

“(i) LABOR STANDARDS.—

“(I) DISPLACEMENT.—

“(aa) PROHIBITION.—A participant in an activity under this paragraph shall not displace (including a partial displacement, such as a reduction in the hours of nonovertime work, wages, or employment benefits) any currently

employed employee (as of the date of the participation).

“(bb) PROHIBITION ON IMPAIRMENT OF CONTRACTS.—An activity under this paragraph shall not impair an existing contract for services or collective bargaining agreement, and no such activity that would be inconsistent with the terms of a collective bargaining agreement shall be undertaken without the written concurrence of the labor organization and employer concerned.

“(II) OTHER PROHIBITIONS.—A participant in an activity under this paragraph shall not be employed in a job—

“(aa) when any other individual is on layoff from the same or any substantially equivalent job;

“(bb) when the employer has terminated the employment of any regular employee or otherwise reduced the workforce of the employer with the intention of filling the vacancy so created with the participant; or

“(cc) which is created in a promotional line that will infringe in any way upon the promotional opportunities of currently employed individuals.

“(III) HEALTH AND SAFETY.—Health and safety standards established under Federal and State law otherwise applicable to working conditions of employees shall be equally applicable to working conditions of participants engaged in activities under this paragraph. To the extent that a State workers’ compensation law applies, workers’ compensation shall be provided to participants on the same basis as the compensation is provided to other individuals in the State in similar employment.

“(IV) EMPLOYMENT CONDITIONS.—Individuals in on-the-job training or individuals employed in activities under this paragraph shall be provided benefits and working conditions at the same level and to the same extent as other trainees or employees working a similar length of time and doing the same type of work.

“(V) OPPORTUNITY TO SUBMIT COMMENTS.—Interested parties shall be provided an opportunity to submit comments with respect to training programs proposed to be funded under this paragraph.

“(ii) GRIEVANCE PROCEDURE.—

“(I) IN GENERAL.—A State to which funds are provided under this paragraph shall establish and maintain a procedure for addressing grievances or complaints alleging violations of this paragraph

from participants and other interested or affected parties. The procedure shall include an opportunity for a hearing and be completed within 60 days of filing the grievance or complaint.

“(II) INVESTIGATION.—

“(aa) IN GENERAL.—The Secretary shall investigate an allegation of a violation of this paragraph if a decision relating to the allegation is made within 60 days after the date of the filing of the grievance or complaint and either party appeals to the Secretary, or if a decision relating to the allegation is made within the 60-day period and the party to which the decision is adverse appeals the decision to the Secretary.

“(bb) ADDITIONAL REQUIREMENT.—The Secretary shall make a final determination relating to an appeal made under item (aa) no later than 120 days after receiving the appeal.

“(III) REMEDIES.—Remedies shall be limited to—

“(aa) suspension or termination of payments under this paragraph;

“(bb) prohibition of placement of a participant with an employer who has violated this subparagraph;

“(cc) where applicable, reinstatement of an employee, payment of lost wages and benefits, and reestablishment of other relevant terms, conditions and privileges of employment; and

“(dd) where appropriate, other equitable relief.”

(2) CONFORMING AMENDMENT.—Section 409(a)(7)(B)(iv) of such Act (42 U.S.C. 609(a)(7)(B)(iv)) is amended to read as follows:

“(iv) EXPENDITURES BY THE STATE.—The term ‘expenditures by the State’ does not include—

“(I) any expenditure from amounts made available by the Federal Government;

“(II) any State funds expended for the medicaid program under title XIX;

“(III) any State funds which are used to match Federal funds provided under section 403(a)(5); or

“(IV) any State funds which are expended as a condition of receiving Federal funds other than under this part.

Notwithstanding subclause (IV) of the preceding sentence, such term includes expenditures by a State for child care in a fiscal year to the extent that the total amount of the expenditures does not exceed the amount of State expenditures in fiscal year 1994 or 1995 (whichever is the greater) that equal the non-Federal share for the programs described in section 418(a)(1)(A).”

(b) GRANTS TO OUTLYING AREAS.—Section 1108(a) of such Act (42 U.S.C. 1308(a)) is amended by inserting “(except section 403(a)(5))” after “title IV”.

(c) GRANTS TO INDIAN TRIBES.—Section 412(a) of such Act (42 U.S.C. 612(a)) is amended by adding at the end the following:

“(3) WELFARE-TO-WORK GRANTS.—

“(A) IN GENERAL.—The Secretary shall award a grant in accordance with this paragraph to an Indian tribe for each fiscal year specified in section 403(a)(5)(H) for which the Indian tribe is a welfare-to-work tribe, in such amount as the Secretary deems appropriate, subject to subparagraph (B) of this paragraph.

“(B) WELFARE-TO-WORK TRIBE.—An Indian tribe shall be considered a welfare-to-work tribe for a fiscal year for purposes of this paragraph if the Indian tribe meets the following requirements:

“(i) The Indian tribe has submitted to the Secretary (in the form of an addendum to the tribal family assistance plan, if any, of the Indian tribe) a plan which describes how, consistent with section 403(a)(5), the Indian tribe will use any funds provided under this paragraph during the fiscal year.

“(ii) The Indian tribe has provided the Secretary with an estimate of the amount that the Indian tribe intends to expend during the fiscal year (excluding tribal expenditures described in section 409(a)(7)(B)(iv)) for activities described in section 403(a)(5)(C)(i).

“(iii) The Indian tribe has agreed to negotiate in good faith with the Secretary of Health and Human Services with respect to the substance of any evaluation under section 413(j), and to cooperate with the conduct of any such evaluation.

“(C) LIMITATIONS ON USE OF FUNDS.—Section 403(a)(5)(C) shall apply to funds provided to Indian tribes under this paragraph in the same manner in which such section applies to funds provided under section 403(a)(5).”.

(d) FUNDS RECEIVED FROM GRANTS TO BE DISREGARDED IN APPLYING DURATIONAL LIMIT ON ASSISTANCE.—Section 408(a)(7) of such Act (42 U.S.C. 608(a)(7)) is amended by adding at the end the following:

“(G) INAPPLICABILITY TO WELFARE-TO-WORK GRANTS AND ASSISTANCE.—For purposes of subparagraph (A) of this paragraph, a grant made under section 403(a)(5) shall not be considered a grant made under section 403, and assistance from funds provided under section 403(a)(5) shall not be considered assistance.”.

(e) EVALUATIONS.—Section 413 of such Act (42 U.S.C. 613) is amended by adding at the end the following:

“(j) EVALUATION OF WELFARE-TO-WORK PROGRAMS.—

“(1) EVALUATION.—The Secretary—

“(A) shall, in consultation with the Secretary of Labor, develop a plan to evaluate how grants made under sections 403(a)(5) and 412(a)(3) have been used;

“(B) may evaluate the use of such grants by such grantees as the Secretary deems appropriate, in accordance with an agreement entered into with the grantees after good-faith negotiations; and

“(C) is urged to include the following outcome measures in the plan developed under subparagraph (A):

“(i) Placements in the labor force and placements in the labor force that last for at least 6 months.

“(ii) Placements in the private and public sectors.

“(iii) Earnings of individuals who obtain employment.

“(iv) Average expenditures per placement.

“(2) REPORTS TO THE CONGRESS.—

“(A) IN GENERAL.—Subject to subparagraphs (B) and (C), the Secretary, in consultation with the Secretary of Labor and the Secretary of Housing and Urban Development, shall submit to the Congress reports on the projects funded under sections 403(a)(5) and 412(a)(3) and on the evaluations of the projects.

“(B) INTERIM REPORT.—Not later than January 1, 1999, the Secretary shall submit an interim report on the matter described in subparagraph (A).

“(C) FINAL REPORT.—Not later than January 1, 2001, (or at a later date, if the Secretary informs the Committees of the Congress with jurisdiction over the subject matter of the report) the Secretary shall submit a final report on the matter described in subparagraph (A).”

SEC. 9002. LIMITATION ON AMOUNT OF FEDERAL FUNDS TRANSFERABLE TO TITLE XX PROGRAMS.

(a) IN GENERAL.—Section 404(d) of the Social Security Act (42 U.S.C. 604(d)) is amended—

(1) in paragraph (1), by striking “A State may” and inserting “Subject to paragraph (2), a State may”; and

(2) by amending paragraph (2) to read as follows:

“(2) LIMITATION ON AMOUNT TRANSFERABLE TO TITLE XX PROGRAMS.—A State may use not more than 10 percent of the amount of any grant made to the State under section 403(a) for a fiscal year to carry out State programs pursuant to title XX.”

(b) RETROACTIVITY.—The amendments made by subsection (a) of this section shall take effect as if included in the enactment of section 103(a) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

SEC. 9003. CLARIFICATION OF LIMITATION ON NUMBER OF PERSONS WHO MAY BE TREATED AS ENGAGED IN WORK BY REASON OF PARTICIPATION IN VOCATIONAL EDUCATIONAL TRAINING.

(a) IN GENERAL.—Section 407(c)(2)(D) of the Social Security Act (42 U.S.C. 607(c)(2)(D)) is amended to read as follows:

“(D) LIMITATION ON NUMBER OF PERSONS WHO MAY BE TREATED AS ENGAGED IN WORK BY REASON OF PARTICIPATION IN VOCATIONAL EDUCATIONAL TRAINING.—For purposes of determining monthly participation rates under paragraphs (1)(B)(i) and (2)(B) of subsection (b), not more than 30 percent of the number of individuals in all families

and in 2-parent families, respectively, in a State who are treated as engaged in work for a month may consist of individuals who are determined to be engaged in work for the month by reason of participation in vocational educational training.”.

(b) **RETROACTIVITY.**—The amendment made by subsection (a) of this section shall take effect as if included in the enactment of section 103(a) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

SEC. 9004. REQUIRED HOURS OF WORK; HEALTH AND SAFETY.

(a) **IN GENERAL.**—Section 407 of the Social Security Act (42 U.S.C. 607) is amended by adding at the end the following:

“(j) **LIMITATION ON NUMBER OF HOURS PER MONTH THAT A RECIPIENT OF ASSISTANCE MAY BE REQUIRED TO WORK FOR A PUBLIC AGENCY OR NONPROFIT ORGANIZATION.**—

“(1) **IN GENERAL.**—A State to which a grant is made under section 403 may not require a recipient of assistance under the State program funded under this part to be assigned to a work experience, on-the-job training, or community service position with a public agency or nonprofit organization during a month for more than the allowable number of hours determined for the month under paragraph (2).

“(2) **ALLOWABLE NUMBER OF HOURS.**—

“(A) **GENERAL METHOD.**—Subject to this paragraph, the allowable number of hours determined for a month under this paragraph—

“(i) for a recipient to whom the benefit described in paragraph (3)(A) is provided during the month is—

“(I) the average value of the benefit provided by the State during the month to families that the State determines are similarly situated to the family of the recipient, or (at the option of the State) the value of the benefit provided by the State to the recipient during the month; divided by

“(II) the minimum wage rate in effect during the month under section 6 of the Fair Labor Standards Act of 1938;

“(ii) for a recipient to whom the benefits described in subparagraphs (A) and (B) of paragraph (3) are provided during the month is—

“(I) the average value of such benefits provided by the State during the month to families that the State determines are similarly situated to the family of the recipient, or (at the option of the State) the value of such benefits provided by the State to the recipient during the month; divided by

“(II) the minimum wage rate in effect during the month under section 6 of the Fair Labor Standards Act of 1938;

“(iii) for a recipient to whom the benefits described in subparagraphs (A), (B), and (C) of paragraph (3) are provided during the month is—

“(I) the average value of such benefits provided by the State during the month to families that the State determines are similarly situated to the family of the recipient, or (at the option of the State) the value of such benefits provided by the State to the recipient during the month; divided by

“(II) the minimum wage rate in effect during the month under section 6 of the Fair Labor Standards Act of 1938;

“(iv) for a recipient to whom the benefits described in subparagraphs (A), (B), (C), and (D) of paragraph (3) are provided during the month is—

“(I) the average value of such benefits provided by the State during the month to families that the State determines are similarly situated to the family of the recipient, or (at the option of the State) the value of such benefits provided by the State to the recipient during the month; divided by

“(II) the minimum wage rate in effect during the month under section 6 of the Fair Labor Standards Act of 1938; and

“(v) for a recipient to whom the benefits described in subparagraphs (A), (B), (C), (D), and (E) of paragraph (3) are provided during the month is—

“(I) the average value of such benefits provided by the State during the month to families that the State determines are similarly situated to the family of the recipient, or (at the option of the State) the value of such benefits provided by the State to the recipient during the month; divided by

“(II) the minimum wage rate in effect during the month under section 6 of the Fair Labor Standards Act of 1938.

“(B) STATE OPTION TO TAKE ACCOUNT OF CERTAIN WORK ACTIVITIES.—

“(i) IN GENERAL.—In determining the number of hours for a month for which a sufficiently employed recipient may be determined to be engaged in work under subsection (c)(1), the State may, notwithstanding subsection (c)(2), count the number of hours during the month for which the recipient participates in a work activity described in paragraph (6), (8), (9), (10), or (11) of subsection (d).

“(ii) SUFFICIENTLY EMPLOYED RECIPIENT.—As used in clause (i), the term ‘sufficiently employed recipient’ means, with respect to a month, a recipient who is in a position described in paragraph (1) during the month for a number of hours that is not less than—

“(I) the sum of the dollar value of any assistance provided to the recipient during the month under the State program funded under this part, and the

dollar value equivalent of any benefits provided to the recipient during the month under the food stamp program under the Food Stamp Act of 1977; divided by

“(II) the minimum wage rate in effect during the month under section 6 of the Fair Labor Standards Act of 1938.

“(3) BENEFITS.—As used in paragraph (2)(A), the term ‘value of the benefits’ means—

“(A) in the case of assistance under the State program funded under this part, the dollar value of such assistance;

“(B) in the case of food stamp benefits under the food stamp program under the Food Stamp Act of 1977, the dollar value equivalent of such benefits;

“(C) at the option of the State, in the case of medical assistance benefits provided under the State plan approved under title XIX, the dollar value of such benefits, as determined in accordance with paragraph (4);

“(D) at the option of the State, in the case of child care assistance, the dollar value of such assistance; and

“(E) at the option of the State, in the case of housing benefits, the dollar value of such benefits.

“(4) VALUATION OF MEDICAID BENEFITS.—Annually, the Secretary shall publish a table that specifies the dollar value of the insurance coverage provided under title XIX to a family of each size, which may take account of geographical variations or other factors identified by the Secretary.

“(5) TREATMENT OF RECIPIENTS ASSIGNED TO CERTAIN POSITIONS WITH A PUBLIC AGENCY OR NONPROFIT ORGANIZATION.—A recipient of assistance under a State program funded under this part who is engaged in work experience or community service with a public agency or nonprofit organization shall not be considered an employee of the public agency or the nonprofit organization.

“(k) HEALTH AND SAFETY.—Health and safety standards established under Federal and State law otherwise applicable to working conditions of employees shall be equally applicable to working conditions of participants engaged in a work activity. To the extent that a State workers’ compensation law applies, workers’ compensation shall be provided to participants on the same basis as the compensation is provided to other individuals in the State in similar employment.”.

(b) RETROACTIVITY.—The amendment made by subsection (a) of this section shall take effect as if included in the enactment of section 103(a) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

SEC. 9005. PENALTY FOR FAILURE OF STATE TO REDUCE ASSISTANCE FOR RECIPIENTS REFUSING WITHOUT GOOD CAUSE TO WORK.

(a) IN GENERAL.—Section 409(a) of the Social Security Act (42 U.S.C. 609(a)) is amended by adding at the end the following:

“(13) PENALTY FOR FAILURE TO REDUCE ASSISTANCE FOR RECIPIENTS REFUSING WITHOUT GOOD CAUSE TO WORK.—

“(A) IN GENERAL.—If the Secretary determines that a State to which a grant is made under section 403 in a fiscal year has violated section 407(e) during the fiscal year, the Secretary shall reduce the grant payable to the State under section 403(a)(1) for the immediately succeeding fiscal year by an amount equal to not less than 1 percent and not more than 5 percent of the State family assistance grant.

“(B) PENALTY BASED ON SEVERITY OF FAILURE.—The Secretary shall impose reductions under subparagraph (A) with respect to a fiscal year based on the degree of non-compliance.”.

(b) RETROACTIVITY.—The amendment made by subsection (a) of this section shall take effect as if included in the enactment of section 103(a) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

Subtitle B—Supplemental Security Income

SEC. 9101. REQUIREMENT TO PERFORM CHILDHOOD DISABILITY REDETERMINATIONS IN MISSED CASES.

Section 211(d)(2) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (110 Stat. 2190) is amended—

(1) in subparagraph (A)—

(A) in the 1st sentence, by striking “1 year” and inserting “18 months”; and

(B) by inserting after the 1st sentence the following: “Any redetermination required by the preceding sentence that is not performed before the end of the period described in the preceding sentence shall be performed as soon as is practicable thereafter.”; and

(2) in subparagraph (C), by adding at the end the following: “Before commencing a redetermination under the 2nd sentence of subparagraph (A), in any case in which the individual involved has not already been notified of the provisions of this paragraph, the Commissioner of Social Security shall notify the individual involved of the provisions of this paragraph.”.

SEC. 9102. REPEAL OF MAINTENANCE OF EFFORT REQUIREMENTS APPLICABLE TO OPTIONAL STATE PROGRAMS FOR SUPPLEMENTATION OF SSI BENEFITS.

Section 1618 of the Social Security Act (42 U.S.C. 1382g) is repealed.

SEC. 9103. FEES FOR FEDERAL ADMINISTRATION OF STATE SUPPLEMENTARY PAYMENTS.

(a) FEE SCHEDULE.—

(1) OPTIONAL STATE SUPPLEMENTARY PAYMENTS.—

(A) IN GENERAL.—Section 1616(d)(2)(B) of the Social Security Act (42 U.S.C. 1382e(d)(2)(B)) is amended—

(i) by striking “and” at the end of clause (iii); and

(ii) by striking clause (iv) and inserting the following:

“(iv) for fiscal year 1997, \$5.00;

“(v) for fiscal year 1998, \$6.20;

- “(vi) for fiscal year 1999, \$7.60;
- “(vii) for fiscal year 2000, \$7.80;
- “(viii) for fiscal year 2001, \$8.10;
- “(ix) for fiscal year 2002, \$8.50; and
- “(x) for fiscal year 2003 and each succeeding fiscal year—

“(I) the applicable rate in the preceding fiscal year, increased by the percentage, if any, by which the Consumer Price Index for the month of June of the calendar year of the increase exceeds the Consumer Price Index for the month of June of the calendar year preceding the calendar year of the increase, and rounded to the nearest whole cent; or

“(II) such different rate as the Commissioner determines is appropriate for the State.”.

(B) CONFORMING AMENDMENT.—Section 1616(d)(2)(C) of such Act (42 U.S.C. 1382e(d)(2)(C)) is amended by striking “(B)(iv)” and inserting “(B)(x)(II)”.

(2) MANDATORY STATE SUPPLEMENTARY PAYMENTS.—

(A) IN GENERAL.—Section 212(b)(3)(B)(ii) of Public Law 93–66 (42 U.S.C. 1382 note) is amended—

(i) by striking “and” at the end of subclause (III); and

(ii) by striking subclause (IV) and inserting the following:

- “(IV) for fiscal year 1997, \$5.00;
- “(V) for fiscal year 1998, \$6.20;
- “(VI) for fiscal year 1999, \$7.60;
- “(VII) for fiscal year 2000, \$7.80;
- “(VIII) for fiscal year 2001, \$8.10;
- “(IX) for fiscal year 2002, \$8.50; and
- “(X) for fiscal year 2003 and each succeeding fiscal year—

“(aa) the applicable rate in the preceding fiscal year, increased by the percentage, if any, by which the Consumer Price Index for the month of June of the calendar year of the increase exceeds the Consumer Price Index for the month of June of the calendar year preceding the calendar year of the increase, and rounded to the nearest whole cent; or

“(bb) such different rate as the Commissioner determines is appropriate for the State.”.

(B) CONFORMING AMENDMENT.—Section 212(b)(3)(B)(iii) of such Act (42 U.S.C. 1382 note) is amended by striking “(ii)(IV)” and inserting “(ii)(X)(bb)”.

(b) USE OF NEW FEES TO DEFRAY THE SOCIAL SECURITY ADMINISTRATION’S ADMINISTRATIVE EXPENSES.—

(1) CREDIT TO SPECIAL FUND FOR FISCAL YEAR 1998 AND SUBSEQUENT YEARS.—

(A) OPTIONAL STATE SUPPLEMENTARY PAYMENT FEES.—Section 1616(d)(4) of the Social Security Act (42 U.S.C. 1382e(d)(4)) is amended to read as follows:

“(4)(A) The first \$5 of each administration fee assessed pursuant to paragraph (2), upon collection, shall be deposited in the general fund of the Treasury of the United States as miscellaneous receipts.

“(B) That portion of each administration fee in excess of \$5, and 100 percent of each additional services fee charged pursuant to paragraph (3), upon collection for fiscal year 1998 and each subsequent fiscal year, shall be credited to a special fund established in the Treasury of the United States for State supplementary payment fees. The amounts so credited, to the extent and in the amounts provided in advance in appropriations Acts, shall be available to defray expenses incurred in carrying out this title and related laws.”.

(B) MANDATORY STATE SUPPLEMENTARY PAYMENT FEES.—
Section 212(b)(3)(D) of Public Law 93–66 (42 U.S.C. 1382 note) is amended to read as follows:

“(D)(i) The first \$5 of each administration fee assessed pursuant to subparagraph (B), upon collection, shall be deposited in the general fund of the Treasury of the United States as miscellaneous receipts.

“(ii) The portion of each administration fee in excess of \$5, and 100 percent of each additional services fee charged pursuant to subparagraph (C), upon collection for fiscal year 1998 and each subsequent fiscal year, shall be credited to a special fund established in the Treasury of the United States for State supplementary payment fees. The amounts so credited, to the extent and in the amounts provided in advance in appropriations Acts, shall be available to defray expenses incurred in carrying out this section and title XVI of the Social Security Act and related laws.”.

(2) LIMITATIONS ON AUTHORIZATION OF APPROPRIATIONS.—

From amounts credited pursuant to section 1616(d)(4)(B) of the Social Security Act and section 212(b)(3)(D)(ii) of Public Law 93–66 to the special fund established in the Treasury of the United States for State supplementary payment fees, there is authorized to be appropriated an amount not to exceed \$35,000,000 for fiscal year 1998, and such sums as may be necessary for each fiscal year thereafter.

Subtitle C—Child Support Enforcement

SEC. 9201. CLARIFICATION OF AUTHORITY TO PERMIT CERTAIN RE- DISCLOSURES OF WAGE AND CLAIM INFORMATION.

Section 303(h)(1)(C) of the Social Security Act (42 U.S.C. 503(h)(1)(C)) is amended by striking “section 453(i)(1) in carrying out the child support enforcement program under title IV” and inserting “subsections (i)(1), (i)(3), and (j) of section 453”.

Subtitle D—Restricting Welfare and Public Benefits for Aliens

SEC. 9301. EXTENSION OF ELIGIBILITY PERIOD FOR REFUGEES AND CERTAIN OTHER QUALIFIED ALIENS FROM 5 TO 7 YEARS FOR SSI AND MEDICAID.

(a) SSI.—Section 402(a)(2)(A) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1612(a)(2)(A)) is amended to read as follows:

“(A) TIME-LIMITED EXCEPTION FOR REFUGEES AND ASYLEES.—

“(i) SSI.—With respect to the specified Federal program described in paragraph (3)(A) paragraph 1 shall not apply to an alien until 7 years after the date—

“(I) an alien is admitted to the United States as a refugee under section 207 of the Immigration and Nationality Act;

“(II) an alien is granted asylum under section 208 of such Act; or

“(III) an alien’s deportation is withheld under section 243(h) of such Act.

“(ii) FOOD STAMPS.—With respect to the specified Federal program described in paragraph (3)(B), paragraph 1 shall not apply to an alien until 5 years after the date—

“(I) an alien is admitted to the United States as a refugee under section 207 of the Immigration and Nationality Act;

“(II) an alien is granted asylum under section 208 of such Act; or

“(III) an alien’s deportation is withheld under section 243(h) of such Act.”.

(b) MEDICAID.—Section 402(b)(2)(A) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1612(b)(2)(A)) is amended to read as follows:

“(A) TIME-LIMITED EXCEPTION FOR REFUGEES AND ASYLEES.—

“(i) MEDICAID.—With respect to the designated Federal program described in paragraph (3)(C), paragraph 1 shall not apply to an alien until 7 years after the date—

“(I) an alien is admitted to the United States as a refugee under section 207 of the Immigration and Nationality Act;

“(II) an alien is granted asylum under section 208 of such Act; or

“(III) an alien’s deportation is withheld under section 243(h) of such Act.

“(ii) OTHER DESIGNATED FEDERAL PROGRAMS.—With respect to the designated Federal programs under paragraph (3) (other than subparagraph (C)), paragraph 1 shall not apply to an alien until 5 years after the date—

“(I) an alien is admitted to the United States as a refugee under section 207 of the Immigration and Nationality Act;

“(II) an alien is granted asylum under section 208 of such Act; or

“(III) an alien’s deportation is withheld under section 243(h) of such Act.”.

SEC. 9302. SSI ELIGIBILITY FOR ALIENS RECEIVING SSI ON AUGUST 22, 1996.

(a) **IN GENERAL.**—Section 402(a)(2) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1612(a)(2)) is amended by adding after subparagraph (D) the following new subparagraph:

“(E) **ALIENS RECEIVING SSI ON AUGUST 22, 1996.**—With respect to eligibility for benefits for the program defined in paragraph (3)(A) (relating to the supplemental security income program), paragraph (1) shall not apply to an alien who was receiving such benefits on August 22, 1996.”

(b) **STATUS OF CUBAN AND HAITIAN ENTRANTS AND AMERASIAN PERMANENT RESIDENT ALIENS.**—For purposes of section 402(a)(2)(E) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, the following aliens shall be considered qualified aliens:

(1) An alien who is a Cuban and Haitian entrant as defined in section 501(e) of the Refugee Education Assistance Act of 1980.

(2) An alien admitted to the United States as an Amerasian immigrant pursuant to section 584 of the Foreign Operations, Export Financing, and Related Programs Appropriations Act, 1988, as contained in section 101(e) of Public Law 100–202, (other than an alien admitted pursuant to section 584(b)(1)(C)).

(c) **CONFORMING AMENDMENTS.**—Section 402(a)(2)(D) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1612(a)(D)) is amended—

(1) by striking clause (i);

(2) in the subparagraph heading by striking “BENEFITS” and inserting “FOOD STAMPS”;

(3) by striking “(ii) FOOD STAMPS’.—”;

(4) by redesignating subclauses (I), (II), and (III) as clauses (i), (ii), and (iii).

SEC. 9303. SSI ELIGIBILITY FOR PERMANENT RESIDENT ALIENS WHO ARE MEMBERS OF AN INDIAN TRIBE.

Section 402(a)(2) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1612(a)(2)) (as amended by section 9302) is amended by adding after subparagraph (E) the following new subparagraph:

“(F) **PERMANENT RESIDENT ALIENS WHO ARE MEMBERS OF AN INDIAN TRIBE.**—With respect to eligibility for benefits for the program defined in paragraph (3)(A) (relating to the supplemental security income program), paragraph (1) shall not apply to an alien who—

“(i) is lawfully admitted for permanent residence under the Immigration and Nationality Act; and

“(ii) is a member of an Indian tribe (as defined in section 4(e) of the Indian Self-Determination and Education Assistance Act).”

SEC. 9304. VERIFICATION OF ELIGIBILITY FOR STATE AND LOCAL PUBLIC BENEFITS.

(a) **IN GENERAL.**—The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 is amended by adding after section 412 the following new section:

“SEC. 413. AUTHORIZATION FOR VERIFICATION OF ELIGIBILITY FOR STATE AND LOCAL PUBLIC BENEFITS.

“A State or political subdivision of a State is authorized to require an applicant for State and local public benefits (as defined in section 411(c)) to provide proof of eligibility.”.

(b) CLERICAL AMENDMENT.—Section 2 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 is amended by adding after the item related to section 412 the following:

“Sec. 413. Authorization for verification of eligibility for state and local public benefits.”.

SEC. 9305. DERIVATIVE ELIGIBILITY FOR BENEFITS.

(a) IN GENERAL.—The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 is amended by adding after section 435 the following new section:

“SEC. 436. DERIVATIVE ELIGIBILITY FOR BENEFITS.

“(a) FOOD STAMPS.—Notwithstanding any other provision of law, an alien who under the provisions of this title is ineligible for benefits under the food stamp program (as defined in section 402(a)(3)(A)) shall not be eligible for such benefits because the alien receives benefits under the supplemental security income program (as defined in section 402(a)(3)(B)).

“(b) MEDICAID.—Notwithstanding any other provision of this title, an alien who under the provisions of this title is ineligible for benefits under the medicaid program (as defined in section 402(b)(3)(C)) shall be eligible for such benefits if the alien is receiving benefits under the supplemental security income program and title XIX of the Social Security Act provides for such derivative eligibility.”.

(b) CLERICAL AMENDMENT.—Section 2 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 is amended by adding after the item related to section 435 the following:

“Sec. 436. Derivative eligibility for benefits.”.

SEC. 9306. EFFECTIVE DATE.

Except as otherwise provided, the amendments made by this subtitle shall be effective as if included in the enactment of title IV of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

Subtitle E—Unemployment Compensation

SEC. 9401. CLARIFYING PROVISION RELATING TO BASE PERIODS.

(a) IN GENERAL.—No provision of a State law under which the base period for such State is defined or otherwise determined shall, for purposes of section 303(a)(1) of the Social Security Act (42 U.S.C. 503(a)(1)), be considered a provision for a method of administration.

(b) DEFINITIONS.—For purposes of this section, the terms “State law”, “base period”, and “State” shall have the meanings given them under section 205 of the Federal-State Extended Unemployment Compensation Act of 1970 (26 U.S.C. 3304 note).

(c) **EFFECTIVE DATE.**—This section shall apply for purposes of any period beginning before, on, or after the date of the enactment of this Act.

SEC. 9402. INCREASE IN FEDERAL UNEMPLOYMENT ACCOUNT CEILING.

(a) **IN GENERAL.**—Section 902(a)(2) of the Social Security Act (42 U.S.C. 1102(a)(2)) is amended by striking “0.25 percent” and inserting “0.5 percent”.

(b) **EFFECTIVE DATE.**—This section and the amendment made by this section—

- (1) shall take effect on October 1, 2001, and
- (2) shall apply to fiscal years beginning on or after that date.

SEC. 9403. SPECIAL DISTRIBUTION TO STATES FROM UNEMPLOYMENT TRUST FUND.

(a) **IN GENERAL.**—Subsection (a) of section 903 of the Social Security Act (42 U.S.C. 1103(a)) is amended by adding at the end the following new paragraph:

“(3)(A) Notwithstanding any other provision of this section, for purposes of carrying out this subsection with respect to any excess amount (referred to in paragraph (1)) remaining in the employment security administration account as of the close of fiscal year 1999, 2000, or 2001, such amount shall—

“(i) to the extent of any amounts not in excess of \$100,000,000, be subject to subparagraph (B), and

“(ii) to the extent of any amounts in excess of \$100,000,000, be subject to subparagraph (C).

“(B) Paragraphs (1) and (2) shall apply with respect to any amounts described in subparagraph (A)(i), except that—

“(i) in carrying out the provisions of paragraph (2)(B) with respect to such amounts (to determine the portion of such amounts which is to be allocated to a State for a succeeding fiscal year), the ratio to be applied under such provisions shall be the same as the ratio that—

“(I) the amount of funds to be allocated to such State for such fiscal year pursuant to title III, bears to

“(II) the total amount of funds to be allocated to all States for such fiscal year pursuant to title III, as determined by the Secretary of Labor, and

“(ii) the amounts allocated to a State pursuant to this subparagraph shall be available to such State, subject to the last sentence of subsection (c)(2).

Nothing in this paragraph shall preclude the application of subsection (b) with respect to any allocation determined under this subparagraph.

“(C) Any amounts described in clause (ii) of subparagraph (A) (remaining in the employment security administration account as of the close of any fiscal year specified in such subparagraph) shall, as of the beginning of the succeeding fiscal year, accrue to the Federal unemployment account, without regard to the limit provided in section 902(a).”

(b) **CONFORMING AMENDMENT.**—Paragraph (2) of section 903(c) of the Social Security Act is amended by adding at the end, as a flush left sentence, the following:

“Any amount allocated to a State under this section for fiscal year 2000, 2001, or 2002 may be used by such State only to pay expenses incurred by it for the administration of its unemployment compensation law, and may be so used by it without regard to any of the conditions prescribed in any of the preceding provisions of this paragraph.”

SEC. 9404. INTEREST-FREE ADVANCES TO STATE ACCOUNTS IN UNEMPLOYMENT TRUST FUND RESTRICTED TO STATES WHICH MEET FUNDING GOALS.

(a) **IN GENERAL.**—Paragraph (2) of section 1202(b) of the Social Security Act (42 U.S.C. 1322(b)) is amended—

- (1) by striking “and” at the end of subparagraph (A),
- (2) by striking the period at the end of subparagraph (B) and inserting “, and”, and
- (3) by adding at the end the following new subparagraph:

“(C) the average daily balance in the account of such State in the Unemployment Trust Fund for each of 4 of the 5 calendar quarters preceding the calendar quarter in which such advances were made exceeds the funding goal of such State (as defined in subsection (d)).”

(b) **FUNDING GOAL DEFINED.**—Section 1202 of the Social Security Act is amended by adding at the end the following new subsection:

“(d) For purposes of subsection (b)(2)(C), the term ‘funding goal’ means, for any State for any calendar quarter, the average of the unemployment insurance benefits paid by such State during each of the 3 years, in the 20-year period ending with the calendar year containing such calendar quarter, during which the State paid the greatest amount of unemployment benefits.”

(c) **EFFECTIVE DATE.**—The amendments made by this section shall apply to calendar years beginning after the date of the enactment of this Act.

SEC. 9405. EXEMPTION OF SERVICE PERFORMED BY ELECTION WORKERS FROM THE FEDERAL UNEMPLOYMENT TAX.

(a) **IN GENERAL.**—Paragraph (3) of section 3309(b) of the Internal Revenue Code of 1986 (relating to exemption for certain services) is amended—

- (1) by striking “or” at the end of subparagraph (D),
- (2) by adding “or” at the end of subparagraph (E), and
- (3) by inserting after subparagraph (E) the following new subparagraph:

“(F) as an election official or election worker if the amount of remuneration received by the individual during the calendar year for services as an election official or election worker is less than \$1,000;”.

(b) **EFFECTIVE DATE.**—The amendments made by this section shall apply with respect to service performed after the date of the enactment of this Act.

SEC. 9406. TREATMENT OF CERTAIN SERVICES PERFORMED BY INMATES.

(a) **IN GENERAL.**—Subsection (c) of section 3306 of the Internal Revenue Code of 1986 (defining employment) is amended—

- (1) by striking “or” at the end of paragraph (19),
- (2) by striking the period at the end of paragraph (20) and inserting “; or”, and

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

“(21) service performed by a person committed to a penal institution.”

(b) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to service performed after March 26, 1996.

SEC. 9407. EXEMPTION OF SERVICE PERFORMED FOR AN ELEMENTARY OR SECONDARY SCHOOL OPERATED PRIMARILY FOR RELIGIOUS PURPOSES FROM THE FEDERAL UNEMPLOYMENT TAX.

(a) IN GENERAL.—Paragraph (1) of section 3309(b) of the Internal Revenue Code of 1986 (relating to exemption for certain services) is amended—

(1) by striking “or” at the end of subparagraph (A), and

(2) by inserting before the semicolon at the end the following: “, or (C) an elementary or secondary school which is operated primarily for religious purposes, which is described in section 501(c)(3), and which is exempt from tax under section 501(a)”.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to service performed after the date of the enactment of this Act.

SEC. 9408. STATE PROGRAM INTEGRITY ACTIVITIES FOR UNEMPLOYMENT COMPENSATION.

Section 901(c) of the Social Security Act (42 U.S.C. 1101(c)) is amended by adding at the end the following new paragraph:

“(5)(A) There are authorized to be appropriated out of the employment security administration account to carry out program integrity activities, in addition to any amounts available under paragraph (1)(A)(i)—

“(i) \$89,000,000 for fiscal year 1998;

“(ii) \$91,000,000 for fiscal year 1999;

“(iii) \$93,000,000 fiscal year 2000;

“(iv) \$96,000,000 for fiscal year 2001; and

“(v) \$98,000,000 for fiscal year 2002.

“(B) In any fiscal year in which a State receives funds appropriated pursuant to this paragraph, the State shall expend a proportion of the funds appropriated pursuant to paragraph (1)(A)(i) to carry out program integrity activities that is not less than the proportion of the funds appropriated under such paragraph that was expended by the State to carry out program integrity activities in fiscal year 1997.

“(C) For purposes of this paragraph, the term ‘program integrity activities’ means initial claims review activities, eligibility review activities, benefit payments control activities, and employer liability auditing activities.”.

Subtitle F—Increase in Public Debt Limit

SEC. 9501. INCREASE IN PUBLIC DEBT LIMIT.

Subsection (b) of section 3101 of title 31, United States Code, is amended by striking the dollar amount contained therein and inserting “\$5,950,000,000,000”.

TITLE X—COMMITTEE ON WAYS AND MEANS—MEDICARE

SEC. 10000. AMENDMENTS TO SOCIAL SECURITY ACT AND REFERENCES TO OBRA; TABLE OF CONTENTS OF TITLE.

(a) 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.

(b) 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 OF TITLE.—The table of contents of this title is as follows:

Sec. 10000. Amendments to Social Security Act and references to OBRA; table of contents of title.

Subtitle A—MedicarePlus Program

CHAPTER 1—MEDICAREPLUS PROGRAM

SUBCHAPTER A—MEDICAREPLUS PROGRAM

Sec. 10001. Establishment of MedicarePlus program.

“PART C—MEDICAREPLUS PROGRAM

“Sec. 1851. Eligibility, election, and enrollment.

“Sec. 1852. Benefits and beneficiary protections.

“Sec. 1853. Payments to MedicarePlus organizations.

“Sec. 1854. Premiums.

“Sec. 1855. Organizational and financial requirements for MedicarePlus organizations; provider-sponsored organizations.

“Sec. 1856. Establishment of standards.

“Sec. 1857. Contracts with MedicarePlus organizations.

“Sec. 1859. Definitions; miscellaneous provisions.

Sec. 10002. Transitional rules for current medicare HMO program.

Sec. 10003. Conforming changes in medigap program.

SUBCHAPTER B—SPECIAL RULES FOR MEDICAREPLUS MEDICAL SAVINGS ACCOUNTS

Sec. 10006. MedicarePlus MSA.

CHAPTER 2—INTEGRATED LONG-TERM CARE PROGRAMS

SUBCHAPTER A—PROGRAMS OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)

Sec. 10011. Coverage of PACE under the medicare program.

Sec. 10012. Establishment of PACE program as medicaid State option.

Sec. 10013. Effective date; transition.

Sec. 10014. Study and reports.

SUBCHAPTER B—SOCIAL HEALTH MAINTENANCE ORGANIZATIONS

Sec. 10015. Social health maintenance organizations (SHMOs).

SUBCHAPTER C—OTHER PROGRAMS

Sec. 10018. Orderly transition of municipal health service demonstration projects.

Sec. 10019. Extension of certain medicare community nursing organization demonstration projects.

CHAPTER 3—MEDICARE PAYMENT ADVISORY COMMISSION

Sec. 10021. Medicare Payment Advisory Commission.

CHAPTER 4—MEDIGAP PROTECTIONS

Sec. 10031. Medigap protections.

Sec. 10032. Medicare prepaid competitive pricing demonstration project.

CHAPTER 5—TAX TREATMENT OF HOSPITALS PARTICIPATING IN PROVIDER-SPONSORED ORGANIZATIONS

Sec. 10041. Tax treatment of hospitals which participate in provider-sponsored organizations.

Subtitle B—Prevention Initiatives

Sec. 10101. Screening mammography.

Sec. 10102. Screening pap smear and pelvic exams.

Sec. 10103. Prostate cancer screening tests.

Sec. 10104. Coverage of colorectal screening.

Sec. 10105. Diabetes screening tests.

Sec. 10106. Standardization of medicare coverage of bone mass measurements.

Sec. 10107. Vaccines outreach expansion.

Sec. 10108. Study on preventive benefits.

Subtitle C—Rural Initiatives

Sec. 10201. Rural primary care hospital program.

Sec. 10202. Prohibiting denial of request by rural referral centers for reclassification on basis of comparability of wages.

Sec. 10203. Hospital geographic reclassification permitted for purposes of disproportionate share payment adjustments.

Sec. 10204. Medicare-dependent, small rural hospital payment extension.

Sec. 10205. Geographic reclassification for certain disproportionately large hospitals.

Sec. 10206. Floor on area wage index.

Sec. 10207. Informatics, telemedicine, and education demonstration project.

Subtitle D—Anti-Fraud and Abuse Provisions

Sec. 10301. Permanent exclusion for those convicted of 3 health care related crimes.

Sec. 10302. Authority to refuse to enter into medicare agreements with individuals or entities convicted of felonies.

Sec. 10303. Inclusion of toll-free number to report medicare waste, fraud, and abuse in explanation of benefits forms.

Sec. 10304. Liability of medicare carriers and fiscal intermediaries for claims submitted by excluded providers.

Sec. 10305. Exclusion of entity controlled by family member of a sanctioned individual.

Sec. 10306. Imposition of civil money penalties.

Sec. 10307. Disclosure of information and surety bonds.

Sec. 10308. Provision of certain identification numbers.

Sec. 10309. Advisory opinions regarding certain physician self-referral provisions.

Sec. 10310. Other fraud and abuse related provisions.

Subtitle E—Prospective Payment Systems

CHAPTER 1—PAYMENT UNDER PART A

Sec. 10401. Prospective payment for skilled nursing facility services.

Sec. 10402. Prospective payment for inpatient rehabilitation hospital services.

CHAPTER 2—PAYMENT UNDER PART B

SUBCHAPTER A—PAYMENT FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES

Sec. 10411. Elimination of formula-driven overpayments (FDO) for certain outpatient hospital services.

Sec. 10412. Extension of reductions in payments for costs of hospital outpatient services.

Sec. 10413. Prospective payment system for hospital outpatient department services.

SUBCHAPTER B—REHABILITATION SERVICES

- Sec. 10421. Rehabilitation agencies and services.
- Sec. 10422. Comprehensive outpatient rehabilitation facilities (CORF).

SUBCHAPTER C—AMBULANCE SERVICES

- Sec. 10431. Payments for ambulance services.
- Sec. 10432. Demonstration of coverage of ambulance services under medicare through contracts with units of local government.

CHAPTER 3—PAYMENT UNDER PARTS A AND B

- Sec. 10441. Prospective payment for home health services.

Subtitle F—Provisions Relating to Part A

CHAPTER 1—PAYMENT OF PPS HOSPITALS

- Sec. 10501. PPS hospital payment update.
- Sec. 10502. Capital payments for PPS hospitals.
- Sec. 10503. Freeze in disproportionate share.
- Sec. 10504. Medicare capital asset sales price equal to book value.
- Sec. 10505. Elimination of IME and DSH payments attributable to outlier payments.
- Sec. 10506. Reduction in adjustment for indirect medical education.
- Sec. 10507. Treatment of transfer cases.
- Sec. 10508. Increase base payment rate to Puerto Rico hospitals.

CHAPTER 2—PAYMENT OF PPS EXEMPT HOSPITALS

- Sec. 10511. Payment update.
- Sec. 10512. Reductions to capital payments for certain PPS-exempt hospitals and units.
- Sec. 10513. Cap on TEFRA limits.
- Sec. 10514. Change in bonus and relief payments.
- Sec. 10515. Change in payment and target amount for new providers.
- Sec. 10516. Rebasing.
- Sec. 10517. Treatment of certain long-term care hospitals.
- Sec. 10518. Elimination of exemptions; report on exceptions and adjustments.

CHAPTER 3—PROVISIONS RELATED TO HOSPICE SERVICES

- Sec. 10521. Payments for hospice services.
- Sec. 10522. Payment for home hospice care based on location where care is furnished.
- Sec. 10523. Hospice care benefits periods.
- Sec. 10524. Other items and services included in hospice care.
- Sec. 10525. Contracting with independent physicians or physician groups for hospice care services permitted.
- Sec. 10526. Waiver of certain staffing requirements for hospice care programs in non-urbanized areas.
- Sec. 10527. Limitation on liability of beneficiaries for certain hospice coverage denials.
- Sec. 10528. Extending the period for physician certification of an individual's terminal illness.
- Sec. 10529. Effective date.

CHAPTER 4—MODIFICATION OF PART A HOME HEALTH BENEFIT

- Sec. 10531. Modification of part A home health benefit for individuals enrolled under part B.

CHAPTER 5—OTHER PAYMENT PROVISIONS

- Sec. 10541. Reductions in payments for enrollee bad debt.
- Sec. 10542. Permanent extension of hemophilia pass-through.
- Sec. 10543. Reduction in part A medicare premium for certain public retirees.

Subtitle G—Provisions Relating to Part B Only

CHAPTER 1—PHYSICIANS' SERVICES

- Sec. 10601. Establishment of single conversion factor for 1998.

- Sec. 10602. Establishing update to conversion factor to match spending under sustainable growth rate.
- Sec. 10603. Replacement of volume performance standard with sustainable growth rate.
- Sec. 10604. Payment rules for anesthesia services.
- Sec. 10605. Implementation of resource-based physician practice expense.
- Sec. 10606. Dissemination of information on high per discharge relative values for in-hospital physicians' services.
- Sec. 10607. No X-ray required for chiropractic services.
- Sec. 10608. Temporary coverage restoration for portable electrocardiogram transportation.

CHAPTER 2—OTHER PAYMENT PROVISIONS

- Sec. 10611. Payments for durable medical equipment.
- Sec. 10612. Oxygen and oxygen equipment.
- Sec. 10613. Reduction in updates to payment amounts for clinical diagnostic laboratory tests.
- Sec. 10614. Simplification in administration of laboratory tests.
- Sec. 10615. Updates for ambulatory surgical services.
- Sec. 10616. Reimbursement for drugs and biologicals.
- Sec. 10617. Coverage of oral anti-nausea drugs under chemotherapeutic regimen.
- Sec. 10618. Rural health clinic services.
- Sec. 10619. Increased medicare reimbursement for nurse practitioners and clinical nurse specialists.
- Sec. 10620. Increased medicare reimbursement for physician assistants.
- Sec. 10621. Renal dialysis-related services.

CHAPTER 3—PART B PREMIUM

- Sec. 10631. Part B premium.

Subtitle H—Provisions Relating to Parts A and B

CHAPTER 1—PROVISIONS RELATING TO MEDICARE SECONDARY PAYER

- Sec. 10701. Permanent extension and revision of certain secondary payer provisions.
- Sec. 10702. Clarification of time and filing limitations.
- Sec. 10703. Permitting recovery against third party administrators.

CHAPTER 2—HOME HEALTH SERVICES

- Sec. 10711. Recapturing savings resulting from temporary freeze on payment increases for home health services.
- Sec. 10712. Interim payments for home health services.
- Sec. 10713. Clarification of part-time or intermittent nursing care.
- Sec. 10714. Study of definition of homebound.
- Sec. 10715. Payment based on location where home health service is furnished.
- Sec. 10716. Normative standards for home health claims denials.
- Sec. 10717. No home health benefits based solely on drawing blood.

CHAPTER 3—BABY BOOM GENERATION MEDICARE COMMISSION

- Sec. 10721. Bipartisan Commission on the Effect of the Baby Boom Generation on the Medicare Program.

CHAPTER 4—PROVISIONS RELATING TO DIRECT GRADUATE MEDICAL EDUCATION

- Sec. 10731. Limitation on payment based on number of residents and implementation of rolling average FTE count.
- Sec. 10732. Phased-in limitation on hospital overhead and supervisory physician component of direct medical education costs.
- Sec. 10733. Permitting payment to non-hospital providers.
- Sec. 10734. Incentive payments under plans for voluntary reduction in number of residents.
- Sec. 10735. Demonstration project on use of consortia.
- Sec. 10736. Recommendations on long-term payment policies regarding financing teaching hospitals and graduate medical education.
- Sec. 10737. Medicare special reimbursement rule for certain combined residency programs.

CHAPTER 5—OTHER PROVISIONS

- Sec. 10741. Centers of excellence.
 Sec. 10742. Medicare part B special enrollment period and waiver of part B late enrollment penalty and medigap special open enrollment period for certain military retirees and dependents.
 Sec. 10743. Protections under the medicare program for disabled workers who lose benefits under a group health plan.
 Sec. 10744. Placement of advance directive in medical record.

Subtitle I—Medical Liability Reform

CHAPTER 1—GENERAL PROVISIONS

- Sec. 10801. Federal reform of health care liability actions.
 Sec. 10802. Definitions.
 Sec. 10803. Effective date.

CHAPTER 2—UNIFORM STANDARDS FOR HEALTH CARE LIABILITY ACTIONS

- Sec. 10811. Statute of limitations.
 Sec. 10812. Calculation and payment of damages.
 Sec. 10813. Alternative dispute resolution.

Subtitle A—MedicarePlus Program**CHAPTER 1—MEDICAREPLUS PROGRAM****Subchapter A—MedicarePlus Program****SEC. 10001. ESTABLISHMENT OF MEDICAREPLUS 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—MEDICAREPLUS PROGRAM

“ELIGIBILITY, ELECTION, AND ENROLLMENT

“SEC. 1851. (a) CHOICE OF MEDICARE BENEFITS THROUGH MEDICAREPLUS PLANS.—

“(1) IN GENERAL.—Subject to the provisions of this section, each MedicarePlus eligible individual (as defined in paragraph (3)) is entitled to elect to receive benefits under this title—

“(A) through the medicare fee-for-service program under parts A and B, or

“(B) through enrollment in a MedicarePlus plan under this part.

“(2) TYPES OF MEDICAREPLUS PLANS THAT MAY BE AVAILABLE.—A MedicarePlus plan may be any of the following types of plans of health insurance:

“(A) COORDINATED CARE PLANS.—Coordinated care plans which provide health care services, including health maintenance organization plans and preferred provider organization plans.

“(B) PLANS OFFERED BY PROVIDER-SPONSORED ORGANIZATION.—A MedicarePlus plan offered by a provider-sponsored organization, as defined in section 1855(e).

“(C) COMBINATION OF MSA PLAN AND CONTRIBUTIONS TO MEDICAREPLUS MSA.—An MSA plan, as defined in section 1859(b)(2), and a contribution into a MedicarePlus medical savings account (MSA).

“(3) MEDICAREPLUS ELIGIBLE INDIVIDUAL.—

“(A) IN GENERAL.—In this title, subject to subparagraph (B), the term ‘MedicarePlus eligible individual’ means an individual who is entitled to benefits under part A and enrolled under part B.

“(B) SPECIAL RULE FOR END-STAGE RENAL DISEASE.—Such term shall not include an individual medically determined to have end-stage renal disease, except that an individual who develops end-stage renal disease while enrolled in a MedicarePlus plan may continue to be enrolled in that plan.

“(b) SPECIAL RULES.—

“(1) RESIDENCE REQUIREMENT.—

“(A) IN GENERAL.—Except as the Secretary may otherwise provide, an individual is eligible to elect a MedicarePlus plan offered by a MedicarePlus organization only if the organization serves the geographic area in which the individual resides.

“(B) CONTINUATION OF ENROLLMENT PERMITTED.—Pursuant to rules specified by the Secretary, the Secretary shall provide that an individual may continue enrollment in a plan, notwithstanding that the individual no longer resides in the service area of the plan, so long as the plan provides benefits for enrollees located in the area in which the individual resides.

“(2) SPECIAL RULE FOR CERTAIN INDIVIDUALS COVERED UNDER FEHBP OR ELIGIBLE FOR VETERANS OR MILITARY HEALTH BENEFITS, VETERANS.—

“(A) FEHBP.—An individual who is enrolled in a health benefit plan under chapter 89 of title 5, United States Code, is not eligible to enroll in an MSA plan until such time as the Director of the Office of Management and Budget certifies to the Secretary that the Office of Personnel Management has adopted policies which will ensure that the enrollment of such individuals in such plans will not result in increased expenditures for the Federal Government for health benefit plans under such chapter.

“(B) VA AND DOD.—The Secretary may apply rules similar to the rules described in subparagraph (A) in the case of individuals who are eligible for health care benefits under chapter 55 of title 10, United States Code, or under chapter 17 of title 38 of such Code.

“(3) LIMITATION ON ELIGIBILITY OF QUALIFIED MEDICARE BENEFICIARIES AND OTHER MEDICAID BENEFICIARIES TO ENROLL IN AN MSA PLAN.—An individual who is a qualified medicare beneficiary (as defined in section 1905(p)(1)), a qualified disabled and working individual (described in section 1905(s)), an individual described in section 1902(a)(10)(E)(iii), or otherwise entitled to medicare cost-sharing under a State plan under title XIX is not eligible to enroll in an MSA plan.

“(4) COVERAGE UNDER MSA PLANS ON A DEMONSTRATION BASIS.—

“(A) IN GENERAL.—An individual is not eligible to enroll in an MSA plan under this part—

“(i) on or after January 1, 2003, unless the enrollment is the continuation of such an enrollment in effect as of such date; or

“(ii) as of any date if the number of such individuals so enrolled as of such date has reached 500,000.

Under rules established by the Secretary, an individual is not eligible to enroll (or continue enrollment) in an MSA plan for a year unless the individual provides assurances satisfactory to the Secretary that the individual will reside in the United States for at least 183 days during the year.

“(B) EVALUATION.—The Secretary shall regularly evaluate the impact of permitting enrollment in MSA plans under this part on selection (including adverse selection), use of preventive care, access to care, and the financial status of the Trust Funds under this title.

“(C) REPORTS.—The Secretary shall submit to Congress periodic reports on the numbers of individuals enrolled in such plans and on the evaluation being conducted under subparagraph (B). The Secretary shall submit such a report, by not later than March 1, 2002, on whether the time limitation under subparagraph (A)(i) should be extended or removed and whether to change the numerical limitation under subparagraph (A)(ii).

“(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) COORDINATION THROUGH MEDICAREPLUS ORGANIZATIONS.—

“(A) ENROLLMENT.—Such process shall permit an individual who wishes to elect a MedicarePlus plan offered by a MedicarePlus 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 MedicarePlus plan offered by a MedicarePlus organization and who wishes to terminate such election, to terminate such election through the filing of an appropriate election form with the organization.

“(3) 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 medicare fee-for-service program option.

“(ii) SEAMLESS CONTINUATION OF COVERAGE.—The Secretary may establish procedures under which an individual who is enrolled in a health plan (other than MedicarePlus plan) offered by a MedicarePlus organi-

zation at the time of the initial election period and who fails to elect to receive coverage other than through the organization is deemed to have elected the MedicarePlus plan offered by the organization (or, if the organization offers more than one such plan, such plan or plans as the Secretary identifies under such procedures).

“(B) CONTINUING PERIODS.—An individual who has made (or is 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 MedicarePlus plan is discontinued, if the individual had elected such plan at the time of the discontinuation.

“(d) PROVIDING INFORMATION TO PROMOTE INFORMED CHOICE.—

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

“(2) PROVISION OF NOTICE.—

“(A) OPEN SEASON NOTIFICATION.—At least 30 days before the beginning of each annual, coordinated election period (as defined in subsection (e)(3)(B)), the Secretary shall mail to each MedicarePlus eligible individual residing in an area the following:

“(i) GENERAL INFORMATION.—The general information described in paragraph (3).

“(ii) LIST OF PLANS AND COMPARISON OF PLAN OPTIONS.—A list identifying the MedicarePlus plans that are (or will be) available to residents of the area and information described in paragraph (4) concerning such plans. Such information shall be presented in a comparative form.

“(iii) MEDICAREPLUS MONTHLY CAPITATION RATE.—The amount of the monthly MedicarePlus capitation rate for the area.

“(iv) ADDITIONAL INFORMATION.—Any other information that the Secretary determines will assist the individual in making the election under this section.

The mailing of such information shall be coordinated with the mailing of any annual notice under section 1804.

“(B) NOTIFICATION TO NEWLY MEDICAREPLUS ELIGIBLE INDIVIDUALS.—To the extent practicable, the Secretary shall, not later than 2 months before the beginning of the initial MedicarePlus enrollment period for an individual described in subsection (e)(1), mail to the individual the information described in subparagraph (A).

“(C) FORM.—The information disseminated under this paragraph shall be written and formatted using language that is easily understandable by medicare beneficiaries.

“(D) PERIODIC UPDATING.—The information described in subparagraph (A) shall be updated on at least an annual basis to reflect changes in the availability of MedicarePlus plans and the benefits and monthly premiums (and net monthly premiums) for such plans.

“(3) GENERAL INFORMATION.—General information under this paragraph, with respect to coverage under this part during a year, shall include the following:

“(A) BENEFITS UNDER FEE-FOR-SERVICE PROGRAM OPTION.—A general description of the benefits covered (and not covered) under the medicare fee-for-service program under parts A and B, including—

“(i) covered items and services,

“(ii) beneficiary cost sharing, such as deductibles, co-insurance, and copayment amounts, and

“(iii) any beneficiary liability for balance billing.

“(B) PART B PREMIUM.—The part B premium rates that will be charged for part B coverage.

“(C) ELECTION PROCEDURES.—Information and instructions on how to exercise election options under this section.

“(D) RIGHTS.—The general description of procedural rights (including grievance and appeals procedures) of beneficiaries under the medicare fee-for-service program and the MedicarePlus program and right to be protected against discrimination based on health status-related factors under section 1852(b).

“(E) INFORMATION ON MEDIGAP AND MEDICARE SELECT.—A general description of the benefits, enrollment rights, and other requirements applicable to medicare supplemental policies under section 1882 and provisions relating to medicare select policies described in section 1882(t).

“(F) POTENTIAL FOR CONTRACT TERMINATION.—The fact that a MedicarePlus organization may terminate or refuse to renew its contract under this part and the effect the termination or nonrenewal of its contract may have on individuals enrolled with the MedicarePlus plan under this part.

“(4) INFORMATION COMPARING PLAN OPTIONS.—Information under this paragraph, with respect to a MedicarePlus plan for a year, shall include the following:

“(A) BENEFITS.—The benefits covered (and not covered) under the plan, including—

“(i) covered items and services beyond those provided under the medicare fee-for-service program,

“(ii) any beneficiary cost sharing,

“(iii) any maximum limitations on out-of-pocket expenses, and

“(iv) in the case of an MSA plan, differences in cost sharing and balance billing under such a plan compared to under other MedicarePlus plans.

“(B) PREMIUMS.—The monthly premium (and net monthly premium), if any, for the plan.

“(C) SERVICE AREA.—The service area of the plan.

“(D) QUALITY AND PERFORMANCE.—To the extent available, plan quality and performance indicators for the benefits under the plan (and how they compare to such indicators under the medicare fee-for-service program under parts A and B in the area involved), including—

“(i) disenrollment rates for medicare enrollees electing to receive benefits through the plan for the previous 2 years (excluding disenrollment due to death or moving outside the plan’s service area),

“(ii) information on medicare enrollee satisfaction,

“(iii) information on health outcomes, and

“(iv) the recent record regarding compliance of the plan with requirements of this part (as determined by the Secretary).

“(E) SUPPLEMENTAL BENEFITS OPTIONS.—Whether the organization offering the plan offers optional supplemental benefits and the terms and conditions (including premiums) for such coverage.

“(5) MAINTAINING A TOLL-FREE NUMBER AND INTERNET SITE.—The Secretary shall maintain a toll-free number for inquiries regarding MedicarePlus options and the operation of this part in all areas in which MedicarePlus plans are offered and an Internet site through which individuals may electronically obtain information on such options and MedicarePlus plans.

“(6) USE OF NONFEDERAL ENTITIES.—The Secretary may enter into contracts with non-Federal entities to carry out activities under this subsection.

“(7) PROVISION OF INFORMATION.—A MedicarePlus organization shall provide the Secretary with such information on the organization and each MedicarePlus plan it offers as may be required for the preparation of the information referred to in paragraph (2)(A).

“(e) COVERAGE ELECTION PERIODS.—

“(1) INITIAL CHOICE UPON ELIGIBILITY TO MAKE ELECTION IF MEDICAREPLUS PLANS AVAILABLE TO INDIVIDUAL.—If, at the time an individual first becomes entitled to benefits under part A and enrolled under part B, there is one or more MedicarePlus plans offered in the area in which the individual resides, 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 such time. Such period shall be specified in a manner so that, in the case of an individual who elects a MedicarePlus plan during the period, coverage under the plan becomes effective as of the first date on which the individual may receive such coverage.

“(2) OPEN ENROLLMENT AND DISENROLLMENT OPPORTUNITIES.—Subject to paragraph (5)—

“(A) CONTINUOUS OPEN ENROLLMENT AND DISENROLLMENT THROUGH 2000.—At any time during 1998, 1999, and 2000, a MedicarePlus eligible individual may change the election under subsection (a)(1).

“(B) CONTINUOUS OPEN ENROLLMENT AND DISENROLLMENT FOR FIRST 6 MONTHS DURING 2001.—

“(i) IN GENERAL.—Subject to clause (ii), at any time during the first 6 months of 2001, or, if the individual first becomes a MedicarePlus eligible individual during 2001, during the first 6 months during 2001 in which the individual is a MedicarePlus eligible individual, a MedicarePlus eligible individual may change the election under subsection (a)(1).

“(ii) LIMITATION OF ONE CHANGE PER YEAR.—An individual may exercise the right under clause (i) only once during 2001. The limitation under this clause shall not apply to changes in elections effected during an annual, coordinated election period under paragraph (3) or during a special enrollment period under paragraph (4).

“(C) CONTINUOUS OPEN ENROLLMENT AND DISENROLLMENT FOR FIRST 3 MONTHS IN SUBSEQUENT YEARS.—

“(i) IN GENERAL.—Subject to clause (ii), at any time during the first 3 months of a year after 2001, or, if the individual first becomes a MedicarePlus eligible individual during a year after 2001, during the first 3 months of such year in which the individual is a MedicarePlus eligible individual, a MedicarePlus eligible individual may change the election under subsection (a)(1).

“(ii) LIMITATION OF ONE CHANGE PER YEAR.—An individual may exercise the right under clause (i) only once a year. The limitation under this clause shall not apply to changes in elections effected during an annual, coordinated election period under paragraph (3) or during a special enrollment period under paragraph (4).

“(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 an annual, coordinated election period.

“(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 2001), the month of October before such year.

“(C) MEDICAREPLUS HEALTH FAIRS.—In the month of October of each year (beginning with 1998), the Secretary shall provide for a nationally coordinated educational and publicity campaign to inform MedicarePlus eligible individuals about MedicarePlus plans and the election process provided under this section.

“(4) SPECIAL ELECTION PERIODS.—Effective as of January 1, 2001, an individual may discontinue an election of a MedicarePlus plan offered by a MedicarePlus organization other than during an annual, coordinated election period and make a new election under this section if—

“(A) the organization’s or plan’s certification under this part has been terminated or the organization has terminated or otherwise discontinued providing the plan;

“(B) the individual is no longer eligible to elect the plan 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 the individual’s enrollment on the basis described in clause (i) or (ii) of subsection (g)(3)(B));

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

“(i) the organization offering the plan substantially violated a material provision of the organization’s contract under this part in relation to the individual (including the failure to provide an enrollee on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide such covered care in accordance with applicable quality standards); or

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

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

“(5) SPECIAL RULES FOR MSA PLANS.—Notwithstanding the preceding provisions of this subsection, an individual—

“(A) may elect an MSA plan only during—

“(i) an initial open enrollment period described in paragraph (1),

“(ii) an annual, coordinated election period described in paragraph (3)(B), or

“(iii) the months of October 1998 and October 1999;

and

“(B) may not discontinue an election of an MSA plan except during the periods described in clause (ii) or (iii) of subparagraph (A) and under paragraph (4).

“(f) EFFECTIVENESS OF ELECTIONS AND CHANGES OF ELECTIONS.—

“(1) DURING INITIAL COVERAGE ELECTION PERIOD.—An election of coverage made during the initial coverage election period under subsection (e)(1) 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 CONTINUOUS OPEN ENROLLMENT PERIODS.—An election or change of coverage made under subsection (e)(2) shall take effect with the first day of the first calendar month following the date on which the election is made.

“(3) ANNUAL, COORDINATED ELECTION PERIOD.—An election or change 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 or change of coverage made during any other period under subsection (e)(4) 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) GUARANTEED ISSUE AND RENEWAL.—

“(1) IN GENERAL.—Except as provided in this subsection, a MedicarePlus organization shall provide that at any time during which elections are accepted under this section with respect to a MedicarePlus plan 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 MedicarePlus organization, in relation to a MedicarePlus plan it offers, has a capacity limit and the number of MedicarePlus eligible individuals who elect the plan under this section exceeds the capacity limit, the organization may limit the election of individuals of the plan under this section but only if priority in election is provided—

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

“(B) then to other such individuals in such a manner that does not discriminate, on a basis described in section 1852(b), among the individuals (who seek to elect the plan).

The preceding sentence shall not apply if it would result in the enrollment of enrollees substantially nonrepresentative, as determined in accordance with regulations of the Secretary, of the medicare population in the service area of the plan.

“(3) LIMITATION ON TERMINATION OF ELECTION.—

“(A) IN GENERAL.—Subject to subparagraph (B), a MedicarePlus organization may not for any reason terminate the election of any individual under this section for a MedicarePlus plan it offers.

“(B) BASIS FOR TERMINATION OF ELECTION.—A MedicarePlus organization may terminate an individual’s election under this section with respect to a MedicarePlus plan it offers if—

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

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

“(iii) the plan is terminated with respect to all individuals under this part in the area in which the individual resides.

“(C) CONSEQUENCE OF TERMINATION.—

“(i) TERMINATIONS FOR CAUSE.—Any individual whose election is terminated under clause (i) or (ii) of subparagraph (B) is deemed to have elected the medicare fee-for-service program option described in subsection (a)(1)(A).

“(ii) TERMINATION BASED ON PLAN TERMINATION OR SERVICE AREA REDUCTION.—Any individual whose election is terminated under subparagraph (B)(iii) shall have a special election period under subsection (e)(4)(A) in which to change coverage to coverage under another MedicarePlus plan. Such an individual who fails to make an election during such period is deemed to have chosen to change coverage to the medicare fee-for-service program option described in subsection (a)(1)(A).

“(D) ORGANIZATION OBLIGATION WITH RESPECT TO ELECTION FORMS.—Pursuant to a contract under section 1857, each MedicarePlus organization receiving an election form under subsection (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.

“(h) APPROVAL OF MARKETING MATERIAL AND APPLICATION FORMS.—

“(1) SUBMISSION.—No marketing material or application form may be distributed by a MedicarePlus organization to (or for the use of) MedicarePlus eligible individuals unless—

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

“(B) the Secretary has not disapproved the distribution of such material or form.

“(2) REVIEW.—The standards established under section 1856 shall include guidelines for the review of all such material or form submitted and under such guidelines the Secretary shall disapprove (or later require the correction of) such material or form if the material or form is materially inaccurate or misleading or otherwise makes a material misrepresentation.

“(3) DEEMED APPROVAL (1-STOP SHOPPING).—In the case of material or form 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 material or form under paragraph (1)(B) with respect to a MedicarePlus plan in an area, the Secretary is deemed not to have disapproved such distribution in all other areas covered by the plan and organization except to the extent that such material or form is specific only to an area involved.

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

“(i) EFFECT OF ELECTION OF MEDICAREPLUS PLAN OPTION.—Subject to sections 1852(a)(5), 1857(f)(2), and 1857(g)—

“(1) payments under a contract with a MedicarePlus organization under section 1853(a) with respect to an individual electing a MedicarePlus plan offered by the organization 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, and

“(2) subject to subsections (e) and (f) of section 1853, only the MedicarePlus organization shall be entitled to receive payments from the Secretary under this title for services furnished to the individual.

“BENEFITS AND BENEFICIARY PROTECTIONS

“SEC. 1852. (a) BASIC BENEFITS.—

“(1) IN GENERAL.—Except as provided in section 1859(b)(2) for MSA plans, each MedicarePlus plan shall provide to members enrolled under this part, through providers and other persons that meet the applicable requirements of this title and part A of title XI—

“(A) those items and services for which benefits are available under parts A and B to individuals residing in the area served by the plan, and

“(B) additional benefits required under section 1854(f)(1)(A).

“(2) SATISFACTION OF REQUIREMENT.—A MedicarePlus plan (other than an MSA plan) offered by a MedicarePlus organization satisfies paragraph (1)(A), with respect to benefits for items and services furnished other than through a provider that has a contract with the organization offering the plan, if the plan provides (in addition to any cost sharing provided for under the plan) for at least the total dollar amount of payment for such items and services as would otherwise be authorized under parts A and B (including any balance billing permitted under such parts).

“(3) SUPPLEMENTAL BENEFITS.—

“(A) BENEFITS INCLUDED SUBJECT TO SECRETARY’S APPROVAL.—Each MedicarePlus organization may provide to individuals enrolled under this part, other than under an MSA plan, (without affording those individuals an option to decline the coverage) supplemental health care benefits that the Secretary may approve. The Secretary shall approve any such supplemental benefits unless the Secretary determines that including such supplemental benefits would substantially discourage enrollment by MedicarePlus eligible individuals with the organization.

“(B) AT ENROLLEES’ OPTION.—A MedicarePlus organization may provide to individuals enrolled under this part, other than under an MSA plan, supplemental health care benefits that the individuals may elect, at their option, to have covered.

“(4) ORGANIZATION AS SECONDARY PAYER.—Notwithstanding any other provision of law, a MedicarePlus organization may (in the case of the provision of items and services to an individual under a MedicarePlus plan 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 a law, plan, 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.

“(5) NATIONAL COVERAGE DETERMINATIONS.—If there is a national coverage determination made in the period beginning on the date of an announcement under section 1853(b) and ending on the date of the next announcement under such section and the Secretary projects that the determination will result in a significant change in the costs to a MedicarePlus organization of providing the benefits that are the subject of such national coverage determination and that such change in costs was not incorporated in the determination of the annual MedicarePlus capitation rate under section 1853 included in the announcement made at the beginning of such period—

“(A) such determination shall not apply to contracts under this part until the first contract year that begins after the end of such period, and

“(B) if such coverage determination provides for coverage of additional benefits or coverage under additional circumstances, section 1851(i) shall not apply to payment for such additional benefits or benefits provided under such additional circumstances until the first contract year that begins after the end of such period,

unless otherwise required by law.

“(b) ANTIDISCRIMINATION.—

“(1) IN GENERAL.—A MedicarePlus organization may not deny, limit, or condition the coverage or provision of benefits under this part, for individuals permitted to be enrolled with the organization under this part, based on any health status-related factor described in section 2702(a)(1) of the Public Health Service Act.

“(2) CONSTRUCTION.—Paragraph (1) shall not be construed as requiring a MedicarePlus organization to enroll individuals who are determined to have end-stage renal disease, except as provided under section 1851(a)(3)(B).

“(c) DETAILED DESCRIPTION OF PLAN PROVISIONS.—A MedicarePlus organization shall disclose, in clear, accurate, and standardized form to each enrollee with a MedicarePlus plan offered by the organization under this part at the time of enrollment and at least annually thereafter, the following information regarding such plan:

“(1) SERVICE AREA.—The plan’s service area.

“(2) BENEFITS.—Benefits offered (and not offered) under the plan offered, including information described in section 1851(d)(3)(A) and exclusions from coverage and, if it is an MSA plan, a comparison of benefits under such a plan with benefits under other MedicarePlus plans.

“(3) ACCESS.—The number, mix, and distribution of plan providers.

“(4) OUT-OF-AREA COVERAGE.—Out-of-area coverage provided by the plan.

“(5) EMERGENCY COVERAGE.—Coverage of emergency services and urgently needed care, including—

“(A) the appropriate use of emergency services, including use of the 911 telephone system or its local equivalent in emergency situations and an explanation of what constitutes an emergency situation;

“(B) the process and procedures of the plan for obtaining emergency services; and

“(C) the locations of (i) emergency departments, and (ii) other settings, in which plan physicians and hospitals provide emergency services and post-stabilization care.

“(6) SUPPLEMENTAL BENEFITS.—Supplemental benefits available from the organization offering the plan, including—

“(A) whether the supplemental benefits are optional,

“(B) the supplemental benefits covered, and

“(C) the premium price for the supplemental benefits.

“(7) PRIOR AUTHORIZATION RULES.—Rules regarding prior authorization or other review requirements that could result in nonpayment.

“(8) PLAN GRIEVANCE AND APPEALS PROCEDURES.—Any appeal or grievance rights and procedures.

“(9) QUALITY ASSURANCE PROGRAM.—A description of the organization’s quality assurance program under subsection (e).

“(d) ACCESS TO SERVICES.—

“(1) IN GENERAL.—A MedicarePlus organization offering a MedicarePlus plan may select the providers from whom the benefits under the plan are provided so long as—

“(A) the organization makes such benefits available and accessible to each individual electing the plan within the plan 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 plan 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 it was not reasonable given the circumstances to obtain the services through the organization,

“(ii) the services were renal dialysis services and were provided other than through the organization because the individual was temporarily out of the plan’s service area, or

“(iii) the services are maintenance care or post-stabilization care covered under the guidelines established under paragraph (2);

“(D) the organization provides access to appropriate providers, including credentialed specialists, for medically necessary treatment and services; and

“(E) coverage is provided for emergency services (as defined in paragraph (3)) without regard to prior authorization or the emergency care provider’s contractual relationship with the organization.

“(2) GUIDELINES RESPECTING COORDINATION OF POST-STABILIZATION CARE.—A MedicarePlus plan shall comply with such guidelines as the Secretary may prescribe relating to promoting efficient and timely coordination of appropriate maintenance and post-stabilization care of an enrollee after the enrollee has been determined to be stable under section 1867.

“(3) DEFINITION OF EMERGENCY SERVICES.—In this subsection—

“(A) IN GENERAL.—The term ‘emergency services’ means, with respect to an individual enrolled with an organization, covered inpatient and outpatient services that—

“(i) are furnished by a provider that is qualified to furnish such services under this title, and

“(ii) are needed to evaluate or stabilize an emergency medical condition (as defined in subparagraph (B)).

“(B) EMERGENCY MEDICAL CONDITION BASED ON PRUDENT LAYPERSON.—The term ‘emergency medical condition’ means a medical condition manifesting itself by acute symptoms of sufficient severity such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in—

“(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,

“(ii) serious impairment to bodily functions, or

“(iii) serious dysfunction of any bodily organ or part.

“(e) QUALITY ASSURANCE PROGRAM.—

“(1) IN GENERAL.—Each MedicarePlus organization must have arrangements, consistent with any regulation, for an ongoing quality assurance program for health care services it provides to individuals enrolled with MedicarePlus plans of the organization.

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

“(A) stress health outcomes and provide for the collection, analysis, and reporting of data (in accordance with a quality measurement system that the Secretary recognizes) that will permit measurement of outcomes and other indices of the quality of MedicarePlus plans and organizations;

“(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) monitor and evaluate high volume and high risk services and the care of acute and chronic conditions;

“(E) evaluate the continuity and coordination of care that enrollees receive;

“(F) have mechanisms to detect both underutilization and overutilization of services;

“(G) after identifying areas for improvement, establish or alter practice parameters;

“(H) take action to improve quality and assesses the effectiveness of such action through systematic followup;

“(I) make 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) be evaluated on an ongoing basis as to its effectiveness;

“(K) include measures of consumer satisfaction; and

“(L) provide the Secretary with such access to information collected as may be appropriate to monitor and ensure the quality of care provided under this part.

“(3) EXTERNAL REVIEW.—Each MedicarePlus organization shall, for each MedicarePlus plan it operates, have an agreement with an independent quality review and improvement organization approved by the Secretary to perform functions of the type described in sections 1154(a)(4)(B) and 1154(a)(14) with respect to services furnished by MedicarePlus plans for which payment is made under this title.

“(4) TREATMENT OF ACCREDITATION.—The Secretary shall provide that a MedicarePlus organization is deemed to meet requirements of paragraphs (1) through (3) of this subsection and subsection (h) (relating to confidentiality and accuracy of enrollee records) if the organization is accredited (and periodically reaccredited) by a private organization under a process that the Secretary has determined assures that the organization, as a condition of accreditation, applies and enforces standards with respect to the requirements involved that are no less stringent than the standards established under section 1856 to carry out the respective requirements.

“(f) COVERAGE DETERMINATIONS.—

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

“(2) RECONSIDERATIONS.—

“(A) IN GENERAL.—Subject to subsection (g)(4), a reconsideration of a determination of an organization denying coverage shall be made within 30 days of the date of receipt of medical information, but not later than 60 days after the date of the determination.

“(B) PHYSICIAN DECISION ON CERTAIN RECONSIDERATIONS.—A reconsideration relating to a determination to deny coverage based on a lack of medical necessity shall be made only by a physician other than a physician involved in the initial determination.

“(g) GRIEVANCES AND APPEALS.—

“(1) GRIEVANCE MECHANISM.—Each MedicarePlus 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 with MedicarePlus plans of the organization under this part.

“(2) APPEALS.—An enrollee with a MedicarePlus plan of a MedicarePlus 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 paragraph, 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) INDEPENDENT REVIEW OF CERTAIN COVERAGE DENIALS.—The Secretary shall contract with an independent, outside entity to review and resolve reconsiderations that affirm denial of coverage.

“(4) EXPEDITED DETERMINATIONS AND RECONSIDERATIONS.—

“(A) RECEIPT OF REQUESTS.—An enrollee in a MedicarePlus plan may request, either in writing or orally, an expedited determination or reconsideration by the MedicarePlus organization regarding a matter described in paragraph (2). The organization shall also permit the acceptance of such requests by physicians.

“(B) ORGANIZATION PROCEDURES.—

“(i) IN GENERAL.—The MedicarePlus organization shall maintain procedures for expediting organization determinations and reconsiderations when, upon request of an enrollee, the organization determines that the application of normal time frames for making a determination (or a reconsideration involving a determination) could seriously jeopardize the life or health of the enrollee or the enrollee’s ability to regain maximum function.

“(ii) TIMELY RESPONSE.—In an urgent case described in clause (i), the organization shall notify the enrollee

(and the physician involved, as appropriate) of the determination (or determination on the reconsideration) as expeditiously as the enrollee's health condition requires, but not later than 72 hours (or 24 hours in the case of a reconsideration) of the time of receipt of the request for the determination or reconsideration (or receipt of the information necessary to make the determination or reconsideration), or such longer period as the Secretary may permit in specified cases.

“(h) CONFIDENTIALITY AND ACCURACY OF ENROLLEE RECORDS.—Each MedicarePlus organization shall establish procedures—

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

“(2) to maintain accurate and timely medical records and other health information for enrollees, and

“(3) to assure timely access of enrollees to their medical information.

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

“(j) RULES REGARDING PHYSICIAN PARTICIPATION.—

“(1) PROCEDURES.—Each MedicarePlus organization shall establish reasonable procedures relating to the participation (under an agreement between a physician and the organization) of physicians under MedicarePlus plans 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 such adverse decisions, including the presentation of information and views of the physician regarding such decision.

“(2) CONSULTATION IN MEDICAL POLICIES.—A MedicarePlus 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) PROHIBITING INTERFERENCE WITH PROVIDER ADVICE TO ENROLLEES.—

“(A) IN GENERAL.—Subject to subparagraphs (B) and (C), a MedicarePlus organization (in relation to an individual enrolled under a MedicarePlus plan offered by the organization under this part) shall not prohibit or otherwise restrict a covered health care professional (as defined in subparagraph (D)) from advising such an individual who is a patient of the professional about the health status of the individual or medical care or treatment for the individual's condition or disease, regardless of whether benefits for such care or treatment are provided under the plan, if the professional is acting within the lawful scope of practice.

“(B) CONSCIENCE PROTECTION.—Subparagraph (A) shall not be construed as requiring a MedicarePlus plan to pro-

vide, reimburse for, or provide coverage of a counseling or referral service if the MedicarePlus organization offering the plan—

“(i) objects to the provision of such service on moral or religious grounds; and

“(ii) in the manner and through the written instrumentalities such MedicarePlus organization deems appropriate, makes available information on its policies regarding such service to prospective enrollees before or during enrollment and to enrollees within 90 days after the date that the organization or plan adopts a change in policy regarding such a counseling or referral service.

“(C) CONSTRUCTION.—Nothing in subparagraph (B) shall be construed to affect disclosure requirements under State law or under the Employee Retirement Income Security Act of 1974.

“(D) HEALTH CARE PROFESSIONAL DEFINED.—For purposes of this paragraph, the term ‘health care professional’ means a physician (as defined in section 1861(r)) or other health care professional if coverage for the professional’s services is provided under the MedicarePlus plan for the services of the professional. Such term includes a podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist and therapy assistant, speech-language pathologist, audiologist, registered or licensed practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified nurse-midwife), licensed certified social worker, registered respiratory therapist, and certified respiratory therapy technician.

“(4) LIMITATIONS ON PHYSICIAN INCENTIVE PLANS.—

“(A) IN GENERAL.—No MedicarePlus organization may 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 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 MedicarePlus 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.

“(5) LIMITATION ON PROVIDER INDEMNIFICATION.—A MedicarePlus organization may not provide (directly or indirectly) for a provider (or group of providers) to indemnify the organization against any liability resulting from a civil action brought for any damage caused to an enrollee with a MedicarePlus plan of the organization under this part by the organization’s denial of medically necessary care.

“(k) TREATMENT OF SERVICES FURNISHED BY CERTAIN PROVIDERS.—A physician or other entity (other than a provider of services) that does not have a contract establishing payment amounts for services furnished to an individual enrolled under this part with a MedicarePlus organization (other than under an MSA plan) shall accept as payment in full for covered services under this title that are furnished to such an individual the amounts that the physician or other entity could collect if the individual were not so enrolled. Any penalty or other provision of law that applies to such a payment with respect to an individual entitled to benefits under this title (but not enrolled with a MedicarePlus organization under this part) also applies with respect to an individual so enrolled.

“(l) DISCLOSURE OF USE OF DSH AND TEACHING HOSPITALS.—Each MedicarePlus organization shall provide the Secretary with information on—

“(1) the extent to which the organization provides inpatient and outpatient hospital benefits under this part—

“(A) through the use of hospitals that are eligible for additional payments under section 1886(d)(5)(F)(i) (relating to so-called DSH hospitals), or

“(B) through the use of teaching hospitals that receive payments under section 1886(h); and

“(2) the extent to which differences between payment rates to different hospitals reflect the disproportionate share percentage of low-income patients and the presence of medical residency training programs in those hospitals.

“PAYMENTS TO MEDICAREPLUS ORGANIZATIONS

“SEC. 1853. (a) PAYMENTS TO ORGANIZATIONS.—

“(1) MONTHLY PAYMENTS.—

“(A) IN GENERAL.—Under a contract under section 1857 and subject to subsections (e) and (f), the Secretary shall make monthly payments under this section in advance to each MedicarePlus organization, with respect to coverage of an individual under this part in a MedicarePlus payment area for a month, in an amount equal to $\frac{1}{12}$ of the annual MedicarePlus capitation rate (as calculated under subsection (c)) with respect to that individual for that area, adjusted for such risk factors as age, disability status, gender, institutional status, 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 factors, if such changes will improve the determination of actuarial equivalence.

“(B) SPECIAL RULE FOR END-STAGE RENAL DISEASE.—The Secretary shall establish separate rates of payment to a MedicarePlus organization with respect to classes of individuals determined to have end-stage renal disease and enrolled in a MedicarePlus plan of the organization. Such rates of payment shall be actuarially equivalent to rates paid to other enrollees in the MedicarePlus payment area (or such other area as specified by the Secretary). In accordance with regulations, the Secretary shall provide for the application of the seventh sentence of section 1881(b)(7) to payments under this section covering the provision of renal dialysis treatment in the same manner as such sentence applies to composite rate payments described in such sentence.

“(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 MedicarePlus organization under a plan 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 information required to be disclosed

under section 1852(c) at the time the individual enrolled with the organization.

“(3) ESTABLISHMENT OF RISK ADJUSTMENT FACTORS.—

“(A) REPORT.—The Secretary shall develop, and submit to Congress by not later than October 1, 1999, a report on a method of risk adjustment of payment rates under this section that accounts for variations in per capita costs based on health status. Such report shall include an evaluation of such method by an outside, independent actuary of the actuarial soundness of the proposal.

“(B) DATA COLLECTION.—In order to carry out this paragraph, the Secretary shall require MedicarePlus organizations (and eligible organizations with risk-sharing contracts under section 1876) to submit, for periods beginning on or after January 1, 1998, data regarding inpatient hospital services and other services and other information the Secretary deems necessary.

“(C) INITIAL IMPLEMENTATION.—The Secretary shall first provide for implementation of a risk adjustment methodology that accounts for variations in per capita costs based on health status and other demographic factors for payments by no later than January 1, 2000.

“(b) ANNUAL ANNOUNCEMENT OF PAYMENT RATES.—

“(1) ANNUAL ANNOUNCEMENT.—The Secretary shall annually determine, and shall announce (in a manner intended to provide notice to interested parties) not later than August 1 before the calendar year concerned—

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

“(B) the risk and other factors to be used in adjusting such rates under subsection (a)(1)(A) for payments for months in that year.

“(2) ADVANCE NOTICE OF METHODOLOGICAL CHANGES.—At least 45 days before making the announcement under paragraph (1) for a year, the Secretary shall provide for notice to MedicarePlus organizations of proposed changes to be made in the methodology from the methodology and assumptions used in the previous announcement and shall provide such organizations an opportunity to comment on such proposed changes.

“(3) EXPLANATION OF ASSUMPTIONS.—In each announcement made under paragraph (1), the Secretary shall include an explanation of the assumptions and changes in methodology used in the announcement in sufficient detail so that MedicarePlus organizations can compute monthly adjusted MedicarePlus capitation rates for individuals in each MedicarePlus payment area which is in whole or in part within the service area of such an organization.

“(c) CALCULATION OF ANNUAL MEDICAREPLUS CAPITATION RATES.—

“(1) IN GENERAL.—For purposes of this part, each annual MedicarePlus capitation rate, for a MedicarePlus payment area for a contract year consisting of a calendar year, is equal to the largest of the amounts specified in the following subparagraphs (A), (B), or (C):

“(A) BLENDED CAPITATION RATE.—The sum of—

“(i) area-specific percentage for the year (as specified under paragraph (2) for the year) of the annual area-specific MedicarePlus capitation rate for the year for the MedicarePlus payment area, as determined under paragraph (3), and

“(ii) national percentage (as specified under paragraph (2) for the year) of the input-price-adjusted annual national MedicarePlus capitation rate for the year, as determined under paragraph (4),

multiplied by the payment adjustment factors described in subparagraphs (A) and (B) of paragraph (5).

“(B) MINIMUM AMOUNT.—12 multiplied by the following amount:

“(i) For 1998, \$350 (but not to exceed, in the case of an area outside the 50 States and the District of Columbia, 150 percent of the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) for the area).

“(ii) For a succeeding year, the minimum amount specified in this clause (or clause (i)) for the preceding year increased by the national per capita MedicarePlus growth percentage, specified under paragraph (6) for that succeeding year.

“(C) MINIMUM PERCENTAGE INCREASE.—

“(i) For 1998, 102 percent of the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) for the MedicarePlus payment area.

“(ii) For a subsequent year, 102 percent of the annual MedicarePlus capitation rate under this paragraph for the area for the previous year.

“(2) AREA-SPECIFIC AND NATIONAL PERCENTAGES.—For purposes of paragraph (1)(A)—

“(A) for 1998, the ‘area-specific percentage’ is 90 percent and the ‘national percentage’ is 10 percent,

“(B) for 1999, the ‘area-specific percentage’ is 80 percent and the ‘national percentage’ is 20 percent,

“(C) for 2000, the ‘area-specific percentage’ is 70 percent and the ‘national percentage’ is 30 percent,

“(D) for 2001, the ‘area-specific percentage’ is 60 percent and the ‘national percentage’ is 40 percent, and

“(E) for a year after 2001, the ‘area-specific percentage’ is 50 percent and the ‘national percentage’ is 50 percent.

“(3) ANNUAL AREA-SPECIFIC MEDICAREPLUS CAPITATION RATE.—For purposes of paragraph (1)(A), the annual area-specific MedicarePlus capitation rate for a MedicarePlus payment area—

“(A) for 1998 is the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) for the area, increased by the national per capita MedicarePlus growth percentage for 1998 (as defined in paragraph (6)); or

“(B) for a subsequent year is the annual area-specific MedicarePlus capitation rate for the previous year deter-

mined under this paragraph for the area, increased by the national per capita MedicarePlus growth percentage for such subsequent year.

“(4) INPUT-PRICE-ADJUSTED ANNUAL NATIONAL MEDICAREPLUS CAPITATION RATE.—

“(A) IN GENERAL.—For purposes of paragraph (1)(A), the input-price-adjusted annual national MedicarePlus capitation rate for a MedicarePlus 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 service) of—

“(i) the national standardized annual MedicarePlus 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 ANNUAL MEDICAREPLUS CAPITATION RATE.—In subparagraph (A)(i), the ‘national standardized annual MedicarePlus capitation rate’ for a year is equal to—

“(i) the sum (for all MedicarePlus payment areas) of the product of—

“(I) the annual area-specific MedicarePlus capitation rate for that year for the area under paragraph (3), and

“(II) the average number of medicare beneficiaries residing in that area in the year, multiplied by the average of the risk factor weights used to adjust payments under subsection (a)(1)(A) for such beneficiaries in such area; divided by

“(ii) the sum of the products described in clause (i)(II) for all areas for that year.

“(C) SPECIAL RULES FOR 1998.—In applying this paragraph for 1998—

“(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)—

“(I) for part A services shall be the ratio (expressed as a percentage) of the national average annual per capita rate of payment for part A for 1997 to the total national average annual per capita rate of payment for parts A and B for 1997, and

“(II) for part B services shall be 100 percent minus the ratio described in subclause (I);

“(iii) for 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, 40 percent shall be adjusted by the index described in clause (iii); and

“(v) the index values shall be computed based only on the beneficiary population who are 65 years of age or older and who are not determined to have end stage renal disease.

The Secretary may continue to apply the rules described in this subparagraph (or similar rules) for 1999.

“(5) PAYMENT ADJUSTMENT BUDGET NEUTRALITY FACTORS.—
For purposes of paragraph (1)(A)—

“(A) BLENDED RATE PAYMENT ADJUSTMENT FACTOR.—For each year, the Secretary shall compute a blended rate payment adjustment factor such that, not taking into account subparagraphs (B) and (C) of paragraph (1) and the application of the payment adjustment factor described in subparagraph (B), the aggregate of the payments that would be made under this part is equal to the aggregate payments that would have been made under this part (not taking into account such subparagraphs and such other adjustment factor) if the area-specific percentage under paragraph (1) for the year had been 100 percent and the national percentage had been 0 percent.

“(B) FLOOR-AND-MINIMUM-UPDATE PAYMENT ADJUSTMENT FACTOR.—For each year, the Secretary shall compute a floor-and-minimum-update payment adjustment factor so that, taking into account the application of the blended rate payment adjustment factor under subparagraph (A) and subparagraphs (B) and (C) of paragraph (1) and the application of the adjustment factor under this subparagraph, the aggregate of the payments under this part shall not exceed the aggregate payments that would have been made under this part if subparagraphs (B) and (C) of paragraph (1) did not apply and if the floor-and-minimum-update payment adjustment factor under this subparagraph was 1.

“(6) NATIONAL PER CAPITA MEDICAREPLUS GROWTH PERCENTAGE DEFINED.—

“(A) IN GENERAL.—In this part, the ‘national per capita MedicarePlus growth percentage’ for a year is the percentage determined by the Secretary, by April 30th before the

beginning of the year involved, to reflect the Secretary's estimate of the projected per capita rate of growth in expenditures under this title for an individual entitled to benefits under part A and enrolled under part B, reduced by the number of percentage points specified in subparagraph (B) for the year. Separate determinations may be made for aged enrollees, disabled enrollees, and enrollees with end-stage renal disease. Such percentage shall include an adjustment for over or under projection in the growth percentage for previous years.

“(B) ADJUSTMENT.—The number of percentage points specified in this subparagraph is—

- “(i) for 1998, 0.5 percentage points,
- “(ii) for 1999, 0.5 percentage points,
- “(iii) for 2000, 0.5 percentage points,
- “(iv) for 2001, 0.5 percentage points,
- “(v) for 2002, 0.5 percentage points, and
- “(vi) for a year after 2002, 0 percentage points.

“(d) MEDICAREPLUS PAYMENT AREA DEFINED.—

“(1) IN GENERAL.—In this part, except as provided in paragraph (3), the term ‘MedicarePlus payment area’ means a county, or equivalent area specified by the Secretary.

“(2) RULE FOR ESRD BENEFICIARIES.—In the case of individuals who are determined to have end stage renal disease, the MedicarePlus payment area shall be a State or such other payment area as the Secretary specifies.

“(3) GEOGRAPHIC ADJUSTMENT.—

“(A) IN GENERAL.—Upon written request of the chief executive officer of a State for a contract year (beginning after 1998) made at least 7 months before the beginning of the year, the Secretary shall make a geographic adjustment to a MedicarePlus payment area in the State otherwise determined under paragraph (1)—

- “(i) to a single statewide MedicarePlus payment area,
- “(ii) to the metropolitan based system described in subparagraph (C), or
- “(iii) to consolidating into a single MedicarePlus payment area noncontiguous counties (or equivalent areas described in paragraph (1)) within a State.

Such adjustment shall be effective for payments for months beginning with January of the year following the year in which the request is received.

“(B) BUDGET NEUTRALITY ADJUSTMENT.—In the case of a State requesting an adjustment under this paragraph, the Secretary shall adjust the payment rates otherwise established under this section for MedicarePlus payment areas in the State in a manner so that the aggregate of the payments under this section in the State shall not exceed the aggregate payments that would have been made under this section for MedicarePlus payment areas in the State in the absence of the adjustment under this paragraph.

“(C) METROPOLITAN BASED SYSTEM.—The metropolitan based system described in this subparagraph is one in which—

“(i) all the portions of each metropolitan statistical area in the State or in the case of a consolidated metropolitan statistical area, all of the portions of each primary metropolitan statistical area within the consolidated area within the State, are treated as a single MedicarePlus payment area, and

“(ii) all areas in the State that do not fall within a metropolitan statistical area are treated as a single MedicarePlus payment area.

“(D) AREAS.—In subparagraph (C), the terms ‘metropolitan statistical area’, ‘consolidated metropolitan statistical area’, and ‘primary metropolitan statistical area’ mean any area designated as such by the Secretary of Commerce.

“(e) SPECIAL RULES FOR INDIVIDUALS ELECTING MSA PLANS.—

“(1) IN GENERAL.—If the amount of the monthly premium for an MSA plan for a MedicarePlus payment area for a year is less than $\frac{1}{12}$ of the annual MedicarePlus capitation rate applied under this section for the area and year involved, the Secretary shall deposit an amount equal to 100 percent of such difference in a MedicarePlus MSA established (and, if applicable, designated) by the individual under paragraph (2).

“(2) ESTABLISHMENT AND DESIGNATION OF MEDICAREPLUS MEDICAL SAVINGS ACCOUNT AS REQUIREMENT FOR PAYMENT OF CONTRIBUTION.—In the case of an individual who has elected coverage under an MSA plan, no payment shall be made under paragraph (1) 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 MedicarePlus MSA (as defined in section 138(b)(2) of the Internal Revenue Code of 1986), and

“(B) if the individual has established more than one such MedicarePlus MSA, has designated one of such accounts as the individual’s MedicarePlus 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 an MSA plan effective beginning with a month in a year, the amount of the contribution to the MedicarePlus 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.

“(f) PAYMENTS FROM TRUST FUND.—The payment to a MedicarePlus organization under this section for individuals enrolled under this part with the organization and payments to a

MedicarePlus MSA under subsection (e)(1) 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. Monthly payments otherwise payable under this section for October 2001 shall be paid on the last business day of September 2001.

“(g) SPECIAL RULE FOR CERTAIN INPATIENT HOSPITAL STAYS.—In the case of an individual who is receiving inpatient hospital services from a subsection (d) hospital (as defined in section 1886(d)(1)(B)) as of the effective date of the individual’s—

“(1) election under this part of a MedicarePlus plan offered by a MedicarePlus organization—

“(A) payment for such services until the date of the individual’s discharge shall be made under this title through the MedicarePlus plan or the medicare fee-for-service program option described in section 1851(a)(1)(A) (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 MedicarePlus 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 MedicarePlus 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.

“PREMIUMS

“SEC. 1854. (a) SUBMISSION AND CHARGING OF PREMIUMS.—

“(1) IN GENERAL.—Subject to paragraph (3), each MedicarePlus 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 premium for coverage for services under section 1852(a) under each MedicarePlus plan it offers under this part in each MedicarePlus payment area (as defined in section 1853(d)) in which the plan is being offered; and

“(B) the enrollment capacity in relation to the plan in each such area.

“(2) TERMINOLOGY.—In this part—

“(A) the term ‘monthly premium’ means, with respect to a MedicarePlus plan offered by a MedicarePlus organization, the monthly premium filed under paragraph (1), not

taking into account the amount of any payment made toward the premium under section 1853; and

“(B) the term ‘net monthly premium’ means, with respect to such a plan and an individual enrolled with the plan, the premium (as defined in subparagraph (A)) for the plan reduced by the amount of payment made toward such premium under section 1853.

“(b) MONTHLY PREMIUM CHARGED.—The monthly amount of the premium charged by a MedicarePlus organization for a MedicarePlus plan offered in a MedicarePlus payment area to an individual under this part shall be equal to the net monthly premium plus any monthly premium charged in accordance with subsection (e)(2) for supplemental benefits.

“(c) UNIFORM PREMIUM.—The monthly premium and monthly amount charged under subsection (b) of a MedicarePlus organization under this part may not vary among individuals who reside in the same MedicarePlus payment area.

“(d) TERMS AND CONDITIONS OF IMPOSING PREMIUMS.—Each MedicarePlus organization shall permit the payment of net monthly premiums on a monthly basis and may terminate election of individuals for a MedicarePlus plan for failure to make premium payments only in accordance with section 1851(g)(3)(B)(i). A MedicarePlus organization is not authorized to provide for cash or other monetary rebates as an inducement for enrollment or otherwise.

“(e) LIMITATION ON ENROLLEE COST-SHARING.—

“(1) FOR BASIC AND ADDITIONAL BENEFITS.—Except as provided in paragraph (2), in no event may—

“(A) the net monthly premium (multiplied by 12) and the actuarial value of the deductibles, coinsurance, and copayments applicable on average to individuals enrolled under this part with a MedicarePlus plan of an organization with respect to required benefits described in section 1852(a)(1) and additional benefits (if any) required under subsection (f)(1) for a year, exceed

“(B) the actuarial value of the deductibles, coinsurance, and copayments that would be applicable on average to individuals entitled to benefits under part A and enrolled under part B if they were not members of a MedicarePlus organization for the year.

“(2) FOR SUPPLEMENTAL BENEFITS.—If the MedicarePlus organization provides to its members enrolled under this part supplemental benefits described in section 1852(a)(3), the sum of the monthly premium rate (multiplied by 12) charged for such supplemental benefits and the actuarial value of its deductibles, coinsurance, and copayments charged with respect to such benefits may not exceed the adjusted community rate for such benefits (as defined in subsection (f)(4)).

“(3) EXCEPTION FOR MSA PLANS.—Paragraphs (1) and (2) do not apply to an MSA plan.

“(4) DETERMINATION ON OTHER BASIS.—If the Secretary determines that adequate data are not available to determine the actuarial value under paragraph (1)(A) or (2), the Secretary may determine such amount with respect to all individuals in

the MedicarePlus payment area, the State, or in the United States, eligible to enroll in the MedicarePlus plan involved under this part or on the basis of other appropriate data.

“(f) REQUIREMENT FOR ADDITIONAL BENEFITS.—

“(1) REQUIREMENT.—

“(A) IN GENERAL.—Each MedicarePlus organization (in relation to a MedicarePlus plan it offers) shall provide that if there is an excess amount (as defined in subparagraph (B)) for the plan 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) in a 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 plan, is the amount (if any) by which—

“(i) the average of the capitation payments made to the organization under section 1853 for the plan at the beginning of contract year, exceeds

“(ii) the actuarial value of the required benefits described in section 1852(a)(1) under the plan for individuals under this part, as determined based upon an adjusted community rate described in paragraph (4) (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 plan, is the excess amount reduced to reflect any amount withheld and reserved for the organization for the year under paragraph (2).

“(D) NO APPLICATION TO MSA PLANS.—Subparagraph (A) shall not apply to an MSA plan.

“(E) UNIFORM APPLICATION.—This paragraph shall be applied uniformly for all enrollees for a plan in a MedicarePlus payment area.

“(F) CONSTRUCTION.—Nothing in this subsection shall be construed as preventing a MedicarePlus 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) STABILIZATION FUND.—A MedicarePlus organization may provide that a part of the value of an excess 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 offered in those subsequent periods by the organization in accordance with such paragraph. Any of such value of the amount reserved which is not provided as additional benefits described in paragraph (1)(A) to individuals electing the

MedicarePlus plan of the organization in accordance with such paragraph prior to the end of such periods, shall revert for the use of such trust funds.

“(3) 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.

“(4) 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 MedicarePlus organization, either—

“(i) the rate of payment for that service or services which the Secretary annually determines would apply to an individual electing a MedicarePlus plan 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 plan (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 MedicarePlus coverage, or MedicarePlus eligible individuals in the area, in the State, or in the United States, eligible to elect MedicarePlus 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 MedicarePlus organization that is a provider-sponsored organization, the adjusted community rate under subparagraph (A) for a MedicarePlus plan of the organization 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 plan.

“(g) PERIODIC AUDITING.—The Secretary shall provide for the annual auditing of the financial records (including data relating to medicare utilization, costs, and computation of the adjusted community rate) of at least one-third of the MedicarePlus organizations offering MedicarePlus plans under this part. The Comptroller Gen-

eral shall monitoring auditing activities conducted under this subsection.

“(h) PROHIBITION OF STATE IMPOSITION OF PREMIUM TAXES.—No State may impose a premium tax or similar tax with respect to premiums on MedicarePlus plans or the offering of such plans.

“ORGANIZATIONAL AND FINANCIAL REQUIREMENTS FOR MEDICAREPLUS ORGANIZATIONS; PROVIDER-SPONSORED ORGANIZATIONS

“SEC. 1855. (a) ORGANIZED AND LICENSED UNDER STATE LAW.—

“(1) IN GENERAL.—Subject to paragraphs (2) and (3), a MedicarePlus organization shall be organized and licensed under State law as a risk-bearing entity eligible to offer health insurance or health benefits coverage in each State in which it offers a MedicarePlus plan.

“(2) SPECIAL EXCEPTION FOR PROVIDER-SPONSORED ORGANIZATIONS.—

“(A) IN GENERAL.—In the case of a provider-sponsored organization that seeks to offer a MedicarePlus plan in a State, the Secretary shall waive the requirement of paragraph (1) that the organization be licensed in that State if—

“(i) the organization files an application for such waiver with the Secretary, and

“(ii) the Secretary determines, based on the application and other evidence presented to the Secretary, that any of the grounds for approval of the application described in subparagraph (B), (C), or (D) has been met.

“(B) FAILURE TO ACT ON LICENSURE APPLICATION ON A TIMELY BASIS.—A ground for approval of such a waiver application is that the State has failed to complete action on a licensing application of the organization within 90 days of the date of the State’s receipt of the completed application. No period before the date of the enactment of this section shall be included in determining such 90-day period.

“(C) DENIAL OF APPLICATION BASED ON DISCRIMINATORY TREATMENT.—A ground for approval of such a waiver application is that the State has denied such a licensing application and—

“(i) the State has imposed documentation or information requirements not related to solvency requirements that are not generally applicable to other entities engaged in substantially similar business, or

“(ii) the standards or review process imposed by the State as a condition of approval of the license imposes any material requirements, procedures, or standards (other than requirements and standards relating to solvency) to such organizations that are not generally applicable to other entities engaged in substantially similar business.

“(D) DENIAL OF APPLICATION BASED ON APPLICATION OF SOLVENCY REQUIREMENTS.—A ground for approval of such

a waiver application is that the State has denied such a licensing application based (in whole or in part) on the organization's failure to meet applicable solvency requirements and—

“(i) such requirements are not the same as the solvency standards established under section 1856(a); or

“(ii) the State has imposed as a condition of approval of the license any documentation or information requirements relating to solvency or other material requirements, procedures, or standards relating to solvency that are different from the requirements, procedures, and standards applied by the Secretary under subsection (d)(2).

For purposes of this subparagraph, the term ‘solvency requirements’ means requirements relating to solvency and other matters covered under the standards established under section 1856(a).

“(E) TREATMENT OF WAIVER.—In the case of a waiver granted under this paragraph for a provider-sponsored organization—

“(i) the waiver shall be effective for a 36-month period, except it may be renewed based on a subsequent application filed during the last 6 months of such period, and

“(ii) any provisions of State law which relate to the licensing of the organization and which prohibit the organization from providing coverage pursuant to a contract under this part shall be superseded.

Nothing in this subparagraph shall be construed as limiting the number of times such a waiver may be renewed.

“(F) PROMPT ACTION ON APPLICATION.—The Secretary shall grant or deny such a waiver application within 60 days after the date the Secretary determines that a substantially complete application has been filed. Nothing in this section shall be construed as preventing an organization which has had such a waiver application denied from submitting a subsequent waiver application.

“(3) EXCEPTION IF REQUIRED TO OFFER MORE THAN MEDICAREPLUS PLANS.—Paragraph (1) shall not apply to a MedicarePlus organization in a State if the State requires the organization, as a condition of licensure, to offer any product or plan other than a MedicarePlus plan.

“(4) LICENSURE DOES NOT SUBSTITUTE FOR OR CONSTITUTE CERTIFICATION.—The fact that an organization is licensed in accordance with paragraph (1) does not deem the organization to meet other requirements imposed under this part.

“(b) PREPAID PAYMENT.—A MedicarePlus organization shall be compensated (except for premiums, deductibles, coinsurance, and copayments) for the provision of health care services to enrolled members under the contract under this part 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.

“(c) ASSUMPTION OF FULL FINANCIAL RISK.—The MedicarePlus organization shall assume full financial risk on a prospective basis for the provision of the health care services (except, at the election of the organization, 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.

“(d) CERTIFICATION OF PROVISION AGAINST RISK OF INSOLVENCY FOR UNLICENSED PSOS.—

“(1) IN GENERAL.—Each MedicarePlus organization that is a provider-sponsored organization, that is not licensed by a State under subsection (a), and for which a waiver application has been approved under subsection (a)(2), shall meet standards established under section 1856(a) relating to the financial solvency and capital adequacy of the organization.

“(2) CERTIFICATION PROCESS FOR SOLVENCY STANDARDS FOR PSOS.—The Secretary shall establish a process for the receipt and approval of applications of a provider-sponsored organization described in paragraph (1) for certification (and periodic recertification) of the organization as meeting such solvency standards. Under such process, the Secretary shall act upon such an application not later than 60 days after the date the application has been received.

“(e) PROVIDER-SPONSORED ORGANIZATION DEFINED.—

“(1) IN GENERAL.—In this part, the term ‘provider-sponsored organization’ means a public or private entity—

“(A) that is established or organized by a health care provider, or group of affiliated health care providers,

“(B) that provides a substantial proportion (as defined by the Secretary in accordance with paragraph (2)) of the health care items and services under the contract under this part directly through the provider or affiliated group of providers, and

“(C) with respect to which those affiliated providers that share, directly or indirectly, substantial financial risk with respect to the provision of such items and services have at least a majority financial interest in the entity.

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

“(A) shall take into account (i) the need for such an organization to assume responsibility for a substantial proportion of services in order to assure financial stability and (ii) 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) both providers are part of a controlled group of corporations under section 1563 of the Internal Revenue Code of 1986, or

“(C) 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.

“(5) HEALTH CARE PROVIDER DEFINED.—In this subsection, the term ‘health care provider’ means—

“(A) any individual who is engaged in the delivery of health care services in a State and who 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, and

“(B) any entity that is engaged in the delivery of health care services in a State and that, if it 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, is so licensed.

“(6) REGULATIONS.—The Secretary shall issue regulations to carry out this subsection.

“ESTABLISHMENT OF STANDARDS

“SEC. 1856. (a) ESTABLISHMENT OF SOLVENCY STANDARDS FOR PROVIDER-SPONSORED ORGANIZATIONS.—

“(1) ESTABLISHMENT.—

“(A) IN GENERAL.—The Secretary shall establish, on an expedited basis and using a negotiated rulemaking process under subchapter III of chapter 5 of title 5, United States Code, standards described in section 1855(d)(1) (relating to the financial solvency and capital adequacy of the organization) that entities must meet to qualify as provider-sponsored organizations under this part.

“(B) FACTORS TO CONSIDER FOR SOLVENCY STANDARDS.—In establishing solvency standards under subparagraph (A) for provider-sponsored organizations, the Secretary shall

consult with interested parties and shall take into account—

“(i) the delivery system assets of such an organization and ability of such an organization to provide services directly to enrollees through affiliated providers, and

“(ii) alternative means of protecting against insolvency, including reinsurance, unrestricted surplus, letters of credit, guarantees, organizational insurance coverage, partnerships with other licensed entities, and valuation attributable to the ability of such an organization to meet its service obligations through direct delivery of care.

“(C) ENROLLEE PROTECTION AGAINST INSOLVENCY.—Such standards shall include provisions to prevent enrollees from being held liable to any person or entity for the MedicarePlus organization’s debts in the event of the organization’s insolvency.

“(2) PUBLICATION OF NOTICE.—In carrying out the rule-making process under this subsection, the Secretary, after consultation with the National Association of Insurance Commissioners, the American Academy of Actuaries, organizations representative of medicare beneficiaries, and other interested parties, shall publish the notice provided for under section 564(a) of title 5, United States Code, by not later than 45 days after the date of the enactment of this section.

“(3) TARGET DATE FOR PUBLICATION OF RULE.—As part of the notice under paragraph (2), and for purposes of this subsection, the ‘target date for publication’ (referred to in section 564(a)(5) of such title) shall be April 1, 1998.

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

“(5) APPOINTMENT OF NEGOTIATED RULEMAKING COMMITTEE AND FACILITATOR.—The Secretary shall provide for—

“(A) the appointment of a negotiated rulemaking committee under section 565(a) of such title by not later than 30 days after the end of the comment period provided for under section 564(c) of such title (as shortened under paragraph (4)), and

“(B) the nomination of a facilitator under section 566(c) of such title by not later than 10 days after the date of appointment of the committee.

“(6) PRELIMINARY COMMITTEE REPORT.—The negotiated rule-making committee appointed under paragraph (5) shall report to the Secretary, by not later than January 1, 1998, regarding the committee’s progress on achieving a consensus with regard to the rulemaking proceeding and whether such consensus is likely to occur before one month before the target date for publication of the rule. If the committee reports that the committee has failed to make significant progress towards such consensus or is unlikely to reach such consensus by the target date, the Secretary may terminate such process and provide for

the publication of a rule under this subsection through such other methods as the Secretary may provide.

“(7) FINAL COMMITTEE REPORT.—If the committee is not terminated under paragraph (6), the rulemaking committee shall submit a report containing a proposed rule by not later than one month before the target date of publication.

“(8) INTERIM, FINAL EFFECT.—The Secretary shall publish a rule under this subsection in the Federal Register by not later than the target date of publication. Such rule shall be effective and final immediately on an interim basis, but is subject to change and revision after public notice and opportunity for a period (of not less than 60 days) for public comment. In connection with such rule, the Secretary shall specify the process for the timely review and approval of applications of entities to be certified as provider-sponsored organizations pursuant to such rules and consistent with this subsection.

“(9) PUBLICATION OF RULE AFTER PUBLIC COMMENT.—The Secretary shall provide for consideration of such comments and republication of such rule by not later than 1 year after the target date of publication.

“(b) ESTABLISHMENT OF OTHER STANDARDS.—

“(1) IN GENERAL.—The Secretary shall establish by regulation other standards (not described in subsection (a)) for MedicarePlus organizations and plans consistent with, and to carry out, this part.

“(2) USE OF CURRENT STANDARDS.—Consistent with the requirements of this part, standards established under this subsection shall be based on standards established under section 1876 to carry out analogous provisions of such section.

“(3) USE OF INTERIM STANDARDS.—For the period in which this part is in effect and standards are being developed and established under the preceding provisions of this subsection, the Secretary shall provide by not later than June 1, 1998, for the application of such interim standards (without regard to any requirements for notice and public comment) as may be appropriate to provide for the expedited implementation of this part. Such interim standards shall not apply after the date standards are established under the preceding provisions of this subsection.

“(4) APPLICATION OF NEW STANDARDS TO ENTITIES WITH A CONTRACT.—In the case of a MedicarePlus 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).

“(5) RELATION TO STATE LAWS.—The standards established under this subsection shall supersede any State law or regulation with respect to MedicarePlus plans which are offered by MedicarePlus organizations under this part to the extent such law or regulation is inconsistent with such standards.

“CONTRACTS WITH MEDICAREPLUS ORGANIZATIONS

“SEC. 1857. (a) IN GENERAL.—The Secretary shall not permit the election under section 1851 of a MedicarePlus plan offered by a MedicarePlus organization under this part, and no payment shall be made under section 1853 to an organization, unless the Secretary has entered into a contract under this section with the organization with respect to the offering of such plan. Such a contract with an organization may cover more than one MedicarePlus plan. 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) MINIMUM ENROLLMENT REQUIREMENTS.—

“(1) IN GENERAL.—Subject to paragraphs (2) and (3), the Secretary may not enter into a contract under this section with a MedicarePlus organization 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.

“(2) EXCEPTION FOR MSA PLAN.—Paragraph (1) shall not apply with respect to a contract that relates only to an MSA plan.

“(3) ALLOWING TRANSITION.—The Secretary may waive the requirement of paragraph (1) during the first 3 contract years with respect to an organization.

“(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 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; or

“(C) 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, except that in no case shall a contract under this section which provides for coverage under an MSA plan be effective before January 1999 with respect to such coverage.

“(4) PREVIOUS TERMINATIONS.—The Secretary may not enter into a contract with a MedicarePlus 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) 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 MedicarePlus 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 MedicarePlus 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 MedicarePlus 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 MedicarePlus 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 MedicarePlus 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.

“(e) ADDITIONAL CONTRACT TERMS.—

“(1) IN GENERAL.—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.

“(2) COST-SHARING IN ENROLLMENT-RELATED COSTS.—The contract with a MedicarePlus organization shall require the payment to the Secretary for the organization’s pro rata share (as determined by the Secretary) of the estimated costs to be incurred by the Secretary in carrying out section 1851 (relating to enrollment and dissemination of information). Such payments are appropriated to defray the costs described in the preceding sentence, to remain available until expended.

“(f) PROMPT PAYMENT BY MEDICAREPLUS ORGANIZATION.—

“(1) REQUIREMENT.—A contract under this part shall require a MedicarePlus organization to provide prompt payment (consistent with the provisions of sections 1816(c)(2) and 1842(c)(2)) of claims submitted for services and supplies furnished to individuals pursuant to the contract, if the services or supplies are not furnished under a contract between the organization and the provider or supplier.

“(2) SECRETARY’S OPTION TO BYPASS NONCOMPLYING ORGANIZATION.—In the case of a MedicarePlus eligible organization which the Secretary determines, after notice and opportunity for a hearing, has failed to make payments of amounts in compliance with paragraph (1), the Secretary may provide for direct payment of the amounts owed to providers and suppliers for covered services and supplies furnished to individuals enrolled under this part under the contract. If the Secretary provides for the direct payments, the Secretary shall provide for an appropriate reduction in the amount of payments otherwise made to the organization under this part to reflect the amount of the Secretary’s payments (and the Secretary’s costs in making the payments).

“(g) INTERMEDIATE SANCTIONS.—

“(1) IN GENERAL.—If the Secretary determines that a MedicarePlus 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 net monthly premiums on individuals enrolled under this part in excess of the net monthly 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(j)(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 MedicarePlus 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 (g) during which the deficiency that is the basis of a determination under subsection (c)(2) exists.

“(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.

“(h) PROCEDURES FOR TERMINATION.—

“(1) IN GENERAL.—The Secretary may terminate a contract with a MedicarePlus organization under this section in accordance with formal investigation and compliance procedures established by the Secretary under which—

“(A) the Secretary provides the organization with the reasonable 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);

“(B) the Secretary provides the organization with reasonable notice and opportunity for hearing (including the right to appeal an initial decision) before terminating the contract.

“(2) CIVIL MONEY PENALTIES.—The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under subsection (f) or under paragraph (2) or (3) of subsection (g) in the same manner as they apply to a civil money penalty or proceeding under section 1128A(a).

“(3) EXCEPTION FOR IMMINENT AND SERIOUS RISK TO HEALTH.—Paragraph (1) shall not apply if the Secretary determines that a delay in termination, resulting from compliance with the procedures specified in such paragraph prior to termination, would pose an imminent and serious risk to the health of individuals enrolled under this part with the organization.

“DEFINITIONS; MISCELLANEOUS PROVISIONS

“SEC. 1859. (a) DEFINITIONS RELATING TO MEDICAREPLUS ORGANIZATIONS.—In this part—

“(1) MEDICAREPLUS ORGANIZATION.—The term ‘MedicarePlus organization’ means a public or private entity that is certified under section 1856 as meeting the requirements and standards of this part for such an organization.

“(2) PROVIDER-SPONSORED ORGANIZATION.—The term ‘provider-sponsored organization’ is defined in section 1855(e)(1).

“(b) DEFINITIONS RELATING TO MEDICAREPLUS PLANS.—

“(1) MEDICAREPLUS PLAN.—The term ‘MedicarePlus plan’ means health benefits coverage offered under a policy, contract, or plan by a MedicarePlus organization pursuant to and in accordance with a contract under section 1857.

“(2) MSA PLAN.—

“(A) IN GENERAL.—The term ‘MSA plan’ means a MedicarePlus plan that—

“(i) 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 plan) equal to the amount of an annual deductible (described in subparagraph (B));

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

“(iii) provides, after such deductible is met for a year and for all subsequent expenses for items and services referred to in clause (i) 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.

“(B) DEDUCTIBLE.—The amount of annual deductible under an MSA plan—

“(i) for contract year 1999 shall be not more than \$6,000; and

“(ii) for a subsequent contract year shall be not more than the maximum amount of such deductible for the previous contract year under this subparagraph increased by the national per capita MedicarePlus growth percentage under section 1853(c)(6) for the year.

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

“(c) OTHER REFERENCES TO OTHER TERMS.—

“(1) MEDICAREPLUS ELIGIBLE INDIVIDUAL.—The term ‘MedicarePlus eligible individual’ is defined in section 1851(a)(3).

“(2) MEDICAREPLUS PAYMENT AREA.—The term ‘MedicarePlus payment area’ is defined in section 1853(d).

“(3) NATIONAL PER CAPITA MEDICAREPLUS GROWTH PERCENTAGE.—The ‘national per capita MedicarePlus growth percentage’ is defined in section 1853(c)(6).

“(4) MONTHLY PREMIUM; NET MONTHLY PREMIUM.—The terms ‘monthly premium’ and ‘net monthly premium’ are defined in section 1854(a)(2).

“(d) COORDINATED ACUTE AND LONG-TERM CARE BENEFITS UNDER A MEDICAREPLUS PLAN.—Nothing in this part shall be construed as preventing a State from coordinating benefits under a medicaid plan under title XIX with those provided under a MedicarePlus plan 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 plan.

“(e) RESTRICTION ON ENROLLMENT FOR CERTAIN MEDICAREPLUS PLANS.—

“(1) IN GENERAL.—In the case of a MedicarePlus religious fraternal benefit society plan described in paragraph (2), notwithstanding any other provision of this part to the contrary

and in accordance with regulations of the Secretary, the society offering the plan may restrict the enrollment of individuals under this part to individuals who are members of the church, convention, or group described in paragraph (3)(B) with which the society is affiliated.

“(2) **MEDICAREPLUS RELIGIOUS FRATERNAL BENEFIT SOCIETY PLAN DESCRIBED.**—For purposes of this subsection, a MedicarePlus religious fraternal benefit society plan described in this paragraph is a MedicarePlus plan described in section 1851(a)(2)(A) that—

“(A) is offered by a religious fraternal benefit society described in paragraph (3) only to members of the church, convention, or group described in paragraph (3)(B); and

“(B) permits all such members to enroll under the plan without regard to health status-related factors.

Nothing in this subsection shall be construed as waiving any plan requirements relating to financial solvency. In developing solvency standards under section 1856, the Secretary shall take into account open contract and assessment features characteristic of fraternal insurance certificates.

“(3) **RELIGIOUS FRATERNAL BENEFIT SOCIETY DEFINED.**—For purposes of paragraph (2)(A), a ‘religious fraternal benefit society’ described in this section is an organization that—

“(A) is exempt from Federal income taxation under section 501(c)(8) of the Internal Revenue Code of 1986;

“(B) is affiliated with, carries out the tenets of, and shares a religious bond with, a church or convention or association of churches or an affiliated group of churches;

“(C) offers, in addition to a MedicarePlus religious fraternal benefit society plan, health coverage to individuals not entitled to benefits under this title who are members of such church, convention, or group; and

“(D) does not impose any limitation on membership in the society based on any health status-related factor.

“(4) **PAYMENT ADJUSTMENT.**—Under regulations of the Secretary, in the case of individuals enrolled under this part under a MedicarePlus religious fraternal benefit society plan described in paragraph (2), the Secretary shall provide for such adjustment to the payment amounts otherwise established under section 1854 as may be appropriate to assure an appropriate payment level, taking into account the actuarial characteristics and experience of such individuals.”

(b) **REPORT ON COVERAGE OF BENEFICIARIES WITH END-STAGE RENAL DISEASE.**—The Secretary of Health and Human Services shall provide for a study on the feasibility and impact of removing the limitation under section 1851(b)(3)(B) of the Social Security Act (as inserted by subsection (a)) on eligibility of most individuals medically determined to have end-stage renal disease to enroll in MedicarePlus plans. By not later than October 1, 1998, the Secretary shall submit to Congress a report on such study and shall include in the report such recommendations regarding removing or restricting the limitation as may be appropriate.

(c) **REPORT ON MEDICAREPLUS TEACHING PROGRAMS AND USE OF DSH AND TEACHING HOSPITALS.**—Based on the information pro-

vided to the Secretary of Health and Human Services under section 1852(k) of the Social Security Act and such information as the Secretary may obtain, by not later than October 1, 1999, the Secretary shall submit to Congress a report on graduate medical education programs operated by MedicarePlus organizations and the extent to which MedicarePlus organizations are providing for payments to hospitals described in such section.

SEC. 10002. TRANSITIONAL RULES FOR CURRENT MEDICARE HMO PROGRAM.

(a) AUTHORIZING TRANSITIONAL WAIVER OF 50:50 RULE.—Section 1876(f) (42 U.S.C. 1395mm(f)) is amended—

(1) in paragraph (2), by striking “The Secretary” and inserting “Subject to paragraph (4), the Secretary”, and

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

“(4) Effective for contract periods beginning after December 31, 1996, the Secretary may waive or modify the requirement imposed by paragraph (1) to the extent the Secretary finds that it is in the public interest.”.

(b) TRANSITION.—Section 1876 (42 U.S.C. 1395mm) is amended by adding at the end the following new subsection:

“(k)(1) Except as provided in paragraph (3), the Secretary shall not enter into, renew, or continue any risk-sharing contract under this section with an eligible organization for any contract year beginning on or after—

“(A) the date standards for MedicarePlus organizations and plans are first established under section 1856 with respect to MedicarePlus organizations that are insurers or health maintenance organizations, or

“(B) in the case of such an organization with such a contract in effect as of the date such standards were first established, 1 year after such date.

“(2) The Secretary shall not enter into, renew, or continue any risk-sharing contract under this section with an eligible organization for any contract year beginning on or after January 1, 2000.

“(3) An individual who is enrolled in part B only and is enrolled in an eligible organization with a risk-sharing contract under this section on December 31, 1998, may continue enrollment in such organization in accordance with regulations issued by not later than July 1, 1998.

“(4) Notwithstanding subsection (a), the Secretary shall provide that payment amounts under risk-sharing contracts under this section for months in a year (beginning with January 1998) shall be computed—

“(A) with respect to individuals entitled to benefits under both parts A and B, by substituting payment rates under section 1853(a) for the payment rates otherwise established under subsection 1876(a), and

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

For purposes of carrying out this paragraph for payments for months in 1998, the Secretary shall compute, announce, and apply

the payment rates under section 1853(a) (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 under this section not in accordance with such rates.”.

(c) ENROLLMENT TRANSITION RULE.—An individual who is enrolled on December 31, 1998, with an eligible organization under section 1876 of the Social Security Act (42 U.S.C. 1395mm) shall be considered to be enrolled with that organization on January 1, 1999, under part C of title XVIII of such Act if that organization has a contract under that part for providing services on January 1, 1999 (unless the individual has disenrolled effective on that date).

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

(1) in paragraph (1)—

(A) by inserting “1855(i),” after “1833(s),” and

(B) by inserting “, MedicarePlus organization,” after “provider of services”; and

(2) in paragraph (2)(E), by inserting “or a MedicarePlus organization” after “section 1833(a)(1)(A)”.

(e) EXTENSION OF PROVIDER REQUIREMENT.—Section 1866(a)(1)(O) (42 U.S.C. 1395cc(a)(1)(O)) is amended—

(1) by striking “in the case of hospitals and skilled nursing facilities,”;

(2) by striking “inpatient hospital and extended care”;

(3) by inserting “with a MedicarePlus organization under part C or” after “any individual enrolled”; and

(4) by striking “(in the case of hospitals) or limits (in the case of skilled nursing facilities)”.

(f) ADDITIONAL CONFORMING CHANGES.—

(1) 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).

(2) SECRETARIAL SUBMISSION OF LEGISLATIVE PROPOSAL.—Not later than 90 days after the date of the enactment of this Act, the Secretary of Health and Human Services shall submit to the appropriate committees of Congress a legislative proposal providing for such technical and conforming amendments in the law as are required by the provisions of this chapter.

(g) IMMEDIATE EFFECTIVE DATE FOR CERTAIN REQUIREMENTS FOR DEMONSTRATIONS.—Section 1857(e)(2) of the Social Security Act (requiring contribution to certain costs related to the enrollment process comparative materials) applies to demonstrations with respect to which enrollment is effected or coordinated under section 1851 of such Act.

(h) USE OF INTERIM, FINAL REGULATIONS.—In order to carry out the amendments made by this chapter 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.

(i) **TRANSITION RULE FOR PSO ENROLLMENT.**—In applying subsection (g)(1) of section 1876 of the Social Security Act (42 U.S.C. 1395mm) to a risk-sharing contract entered into with an eligible organization that is a provider-sponsored organization (as defined in section 1855(e)(1) of such Act, as inserted by section 10001) for a contract year beginning on or after January 1, 1998, there shall be substituted for the minimum number of enrollees provided under such section the minimum number of enrollees permitted under section 1857(b)(1) of such Act (as so inserted).

SEC. 10003. CONFORMING CHANGES IN MEDIGAP PROGRAM.

(a) **CONFORMING AMENDMENTS TO MEDICAREPLUS CHANGES.**—

(1) **IN GENERAL.**—Section 1882(d)(3)(A)(i) (42 U.S.C. 1395ss(d)(3)(A)(i)) is amended—

(A) in the matter before subclause (I), by inserting “including an individual electing a MedicarePlus plan under section 1851” after “of this title”; and

(B) in subclause (II)—

(i) by inserting “in the case of an individual not electing a MedicarePlus plan” after “(II)”, and

(ii) by inserting before the comma at the end the following: “or in the case of an individual electing a MedicarePlus plan, a medicare supplemental policy with knowledge that the policy duplicates health benefits to which the individual is otherwise entitled under the MedicarePlus plan or under another medicare supplemental policy”.

(2) **CONFORMING AMENDMENTS.**—Section 1882(d)(3)(B)(i)(I) (42 U.S.C. 1395ss(d)(3)(B)(i)(I)) is amended by inserting “including any MedicarePlus plan” after “health insurance policies”.

(3) **MEDICAREPLUS PLANS NOT TREATED AS MEDICARE SUPPLEMENTARY POLICIES.**—Section 1882(g)(1) (42 U.S.C. 1395ss(g)(1)) is amended by inserting “or a MedicarePlus plan or” after “does not include”

(b) **ADDITIONAL RULES RELATING TO INDIVIDUALS ENROLLED IN MSA PLANS.**—Section 1882 (42 U.S.C. 1395ss) is further amended by adding at the end the following new subsection:

“(u)(1) It is unlawful for a person to sell or issue a policy described in paragraph (2) to an individual with knowledge that the individual has in effect under section 1851 an election of an MSA plan.

“(2) A policy described in this subparagraph is a health insurance policy that provides for coverage of expenses that are otherwise required to be counted toward meeting the annual deductible amount provided under the MSA plan.”.

Subchapter B—Special Rules for MedicarePlus Medical Savings Accounts

SEC. 10006. MEDICAREPLUS MSA.

(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 138

as section 139 and by inserting after section 137 the following new section:

“SEC. 138. MEDICAREPLUS MSA.

“(a) EXCLUSION.—Gross income shall not include any payment to the MedicarePlus MSA of an individual by the Secretary of Health and Human Services under part C of title XVIII of the Social Security Act.

“(b) MEDICAREPLUS MSA.—For purposes of this section, the term ‘MedicarePlus MSA’ means a medical savings account (as defined in section 220(d))—

“(1) which is designated as a MedicarePlus MSA,

“(2) with respect to which no contribution may be made other than—

“(A) a contribution made by the Secretary of Health and Human Services pursuant to part C of title XVIII of the Social Security Act, or

“(B) a trustee-to-trustee transfer described in subsection (c)(4),

“(3) the governing instrument of which provides that trustee-to-trustee transfers described in subsection (c)(4) may be made to and from such account, and

“(4) which is established in connection with an MSA plan described in section 1859(b)(2) of the Social Security Act.

“(c) SPECIAL RULES FOR DISTRIBUTIONS.—

“(1) DISTRIBUTIONS FOR QUALIFIED MEDICAL EXPENSES.—In applying section 220 to a MedicarePlus MSA—

“(A) qualified medical expenses shall not include amounts paid for medical care for any individual other than the account holder, and

“(B) section 220(d)(2)(C) shall not apply.

“(2) PENALTY FOR DISTRIBUTIONS FROM MEDICAREPLUS MSA 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 MedicarePlus 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 such 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 MedicarePlus MSA plan covering the account holder as of January 1 of the calendar year in which the taxable year begins.

Section 220(f)(2) shall not apply to any payment or distribution from a MedicarePlus MSA.

“(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 MedicarePlus MSAs 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.—Section 220(f)(2) and paragraph (2) of this subsection shall not apply to any payment or distribution from a MedicarePlus MSA to the Secretary of Health and Human Services of an erroneous contribution to such MSA and of the net income attributable to such contribution.

“(4) TRUSTEE-TO-TRUSTEE TRANSFERS.—Section 220(f)(2) and paragraph (2) of this subsection shall not apply to any trustee-to-trustee transfer from a MedicarePlus MSA of an account holder to another MedicarePlus MSA of such account holder.

“(d) SPECIAL RULES FOR TREATMENT OF ACCOUNT AFTER DEATH OF ACCOUNT HOLDER.—In applying section 220(f)(8)(A) to an account which was a MedicarePlus MSA of a decedent, the rules of section 220(f) shall apply in lieu of the rules of subsection (c) of this section with respect to the spouse as the account holder of such MedicarePlus MSA.

“(e) REPORTS.—In the case of a MedicarePlus MSA, the report under section 220(h)—

“(1) shall include the fair market value of the assets in such MedicarePlus MSA as of the close of each calendar year, and

“(2) shall be furnished to the account holder—

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

“(B) in such manner as the Secretary prescribes in such regulations.

“(f) COORDINATION WITH LIMITATION ON NUMBER OF TAXPAYERS HAVING MEDICAL SAVINGS ACCOUNTS.—Subsection (i) of section 220 shall not apply to an individual with respect to a MedicarePlus MSA, and MedicarePlus MSA’s shall not be taken into account in determining whether the numerical limitations under section 220(j) are exceeded.”

(b) TECHNICAL AMENDMENTS.—

(1) The last sentence of section 4973(d) of such Code is amended by inserting “or section 138(c)(3)” after “section 220(f)(3)”.

(2) Subsection (b) of section 220 of such Code is amended by adding at the end the following new paragraph:

“(7) MEDICARE ELIGIBLE INDIVIDUALS.—The limitation under this subsection for any month with respect to an individual shall be zero for the first month such individual is entitled to

benefits under title XVIII of the Social Security Act and for each month thereafter.”

(3) 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. 138. MedicarePlus MSA.

“Sec. 139. Cross references to other Acts.”

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

CHAPTER 2—INTEGRATED LONG-TERM CARE PROGRAMS

Subchapter A—Programs of All-inclusive Care for the Elderly (PACE)

SEC. 10011. COVERAGE OF PACE UNDER THE MEDICARE PROGRAM.

Title XVIII (42 U.S.C. 1395 et seq.) is amended by adding at the end the following new section:

“PAYMENTS TO, AND COVERAGE OF BENEFITS UNDER, PROGRAMS OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)

“SEC. 1894. (a) RECEIPT OF BENEFITS THROUGH ENROLLMENT IN PACE PROGRAM; DEFINITIONS FOR PACE PROGRAM RELATED TERMS.—

“(1) BENEFITS THROUGH ENROLLMENT IN A PACE PROGRAM.—In accordance with this section, in the case of an individual who is entitled to benefits under part A or enrolled under part B and who is a PACE program eligible individual (as defined in paragraph (5)) with respect to a PACE program offered by a PACE provider under a PACE program agreement—

“(A) the individual may enroll in the program under this section; and

“(B) so long as the individual is so enrolled and in accordance with regulations—

“(i) the individual shall receive benefits under this title solely through such program, and

“(ii) the PACE provider is entitled to payment under and in accordance with this section and such agreement for provision of such benefits.

“(2) PACE PROGRAM DEFINED.—For purposes of this section and section 1932, the term ‘PACE program’ means a program of all-inclusive care for the elderly that meets the following requirements:

“(A) OPERATION.—The entity operating the program is a PACE provider (as defined in paragraph (3)).

“(B) COMPREHENSIVE BENEFITS.—The program provides comprehensive health care services to PACE program eligible individuals in accordance with the PACE program agreement and regulations under this section.

“(C) TRANSITION.—In the case of an individual who is enrolled under the program under this section and whose enrollment ceases for any reason (including the individual no longer qualifies as a PACE program eligible individual, the

termination of a PACE program agreement, or otherwise), the program provides assistance to the individual in obtaining necessary transitional care through appropriate referrals and making the individual's medical records available to new providers.

“(3) PACE PROVIDER DEFINED.—

“(A) IN GENERAL.—For purposes of this section, the term ‘PACE provider’ means an entity that—

“(i) subject to subparagraph (B), is (or is a distinct part of) a public entity or a private, nonprofit entity organized for charitable purposes under section 501(c)(3) of the Internal Revenue Code of 1986, and

“(ii) has entered into a PACE program agreement with respect to its operation of a PACE program.

“(B) TREATMENT OF PRIVATE, FOR-PROFIT PROVIDERS.—Clause (i) of subparagraph (A) shall not apply—

“(i) to entities subject to a demonstration project waiver under subsection (h); and

“(ii) after the date the report under section 10014(b) of the Balanced Budget Act of 1997 is submitted, unless the Secretary determines that any of the findings described in subparagraph (A), (B), (C) or (D) of paragraph (2) of such section are true.

“(4) PACE PROGRAM AGREEMENT DEFINED.—For purposes of this section, the term ‘PACE program agreement’ means, with respect to a PACE provider, an agreement, consistent with this section, section 1932 (if applicable), and regulations promulgated to carry out such sections, between the PACE provider and the Secretary, or an agreement between the PACE provider and a State administering agency for the operation of a PACE program by the provider under such sections.

“(5) PACE PROGRAM ELIGIBLE INDIVIDUAL DEFINED.—For purposes of this section, the term ‘PACE program eligible individual’ means, with respect to a PACE program, an individual who—

“(A) is 55 years of age or older;

“(B) subject to subsection (c)(4), is determined under subsection (c) to require the level of care required under the State medicaid plan for coverage of nursing facility services;

“(C) resides in the service area of the PACE program; and

“(D) meets such other eligibility conditions as may be imposed under the PACE program agreement for the program under subsection (e)(2)(A)(ii).

“(6) PACE PROTOCOL.—For purposes of this section, the term ‘PACE protocol’ means the Protocol for the Program of All-inclusive Care for the Elderly (PACE), as published by On Lok, Inc., as of April 14, 1995.

“(7) PACE DEMONSTRATION WAIVER PROGRAM DEFINED.—For purposes of this section, the term ‘PACE demonstration waiver program’ means a demonstration program under either of the following sections (as in effect before the date of their repeal):

“(A) Section 603(c) of the Social Security Amendments of 1983 (Public Law 98–21), as extended by section 9220 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99–272).

“(B) Section 9412(b) of the Omnibus Budget Reconciliation Act of 1986 (Public Law 99–509).

“(8) STATE ADMINISTERING AGENCY DEFINED.—For purposes of this section, the term ‘State administering agency’ means, with respect to the operation of a PACE program in a State, the agency of that State (which may be the single agency responsible for administration of the State plan under title XIX in the State) responsible for administering PACE program agreements under this section and section 1932 in the State.

“(9) TRIAL PERIOD DEFINED.—

“(A) IN GENERAL.—For purposes of this section, the term ‘trial period’ means, with respect to a PACE program operated by a PACE provider under a PACE program agreement, the first 3 contract years under such agreement with respect to such program.

“(B) TREATMENT OF ENTITIES PREVIOUSLY OPERATING PACE DEMONSTRATION WAIVER PROGRAMS.—Each contract year (including a year occurring before the effective date of this section) during which an entity has operated a PACE demonstration waiver program shall be counted under subparagraph (A) as a contract year during which the entity operated a PACE program as a PACE provider under a PACE program agreement.

“(10) REGULATIONS.—For purposes of this section, the term ‘regulations’ refers to interim final or final regulations promulgated under subsection (f) to carry out this section and section 1932.

“(b) SCOPE OF BENEFITS; BENEFICIARY SAFEGUARDS.—

“(1) IN GENERAL.—Under a PACE program agreement, a PACE provider shall—

“(A) provide to PACE program eligible individuals, regardless of source of payment and directly or under contracts with other entities, at a minimum—

“(i) all items and services covered under this title (for individuals enrolled under this section) and all items and services covered under title XIX, but without any limitation or condition as to amount, duration, or scope and without application of deductibles, copayments, coinsurance, or other cost-sharing that would otherwise apply under this title or such title, respectively; and

“(ii) all additional items and services specified in regulations, based upon those required under the PACE protocol;

“(B) provide such enrollees access to necessary covered items and services 24 hours per day, every day of the year;

“(C) provide services to such enrollees through a comprehensive, multidisciplinary health and social services delivery system which integrates acute and long-term care services pursuant to regulations; and

“(D) specify the covered items and services that will not be provided directly by the entity, and to arrange for delivery of those items and services through contracts meeting the requirements of regulations.

“(2) QUALITY ASSURANCE; PATIENT SAFEGUARDS.—The PACE program agreement shall require the PACE provider to have in effect at a minimum—

“(A) a written plan of quality assurance and improvement, and procedures implementing such plan, in accordance with regulations, and

“(B) written safeguards of the rights of enrolled participants (including a patient bill of rights and procedures for grievances and appeals) in accordance with regulations and with other requirements of this title and Federal and State law designed for the protection of patients.

“(c) ELIGIBILITY DETERMINATIONS.—

“(1) IN GENERAL.—The determination of whether an individual is a PACE program eligible individual—

“(A) shall be made under and in accordance with the PACE program agreement, and

“(B) who is entitled to medical assistance under title XIX, shall be made (or who is not so entitled, may be made) by the State administering agency.

“(2) CONDITION.—An individual is not a PACE program eligible individual (with respect to payment under this section) unless the individual’s health status has been determined, in accordance with regulations, to be comparable to the health status of individuals who have participated in the PACE demonstration waiver programs. Such determination shall be based upon information on health status and related indicators (such as medical diagnoses and measures of activities of daily living, instrumental activities of daily living, and cognitive impairment) that are part of a uniform minimum data set collected by PACE providers on potential eligible individuals.

“(3) ANNUAL ELIGIBILITY RECERTIFICATIONS.—

“(A) IN GENERAL.—Subject to subparagraph (B), the determination described in subsection (a)(5)(B) for an individual shall be reevaluated at least once a year.

“(B) EXCEPTION.—The requirement of annual reevaluation under subparagraph (A) may be waived during a period in accordance with regulations in those cases where the State administering agency determines that there is no reasonable expectation of improvement or significant change in an individual’s condition during the period because of the advanced age, severity of the advanced age, severity of chronic condition, or degree of impairment of functional capacity of the individual involved.

“(4) CONTINUATION OF ELIGIBILITY.—An individual who is a PACE program eligible individual may be deemed to continue to be such an individual notwithstanding a determination that the individual no longer meets the requirement of subsection (a)(5)(B) if, in accordance with regulations, in the absence of continued coverage under a PACE program the individual rea-

sonably would be expected to meet such requirement within the succeeding 6-month period.

“(5) ENROLLMENT; DISENROLLMENT.—The enrollment and disenrollment of PACE program eligible individuals in a PACE program shall be pursuant to regulations and the PACE program agreement and shall permit enrollees to voluntarily disenroll without cause at any time.

“(d) PAYMENTS TO PACE PROVIDERS ON A CAPITATED BASIS.—

“(1) IN GENERAL.—In the case of a PACE provider with a PACE program agreement under this section, except as provided in this subsection or by regulations, the Secretary shall make prospective monthly payments of a capitation amount for each PACE program eligible individual enrolled under the agreement under this section in the same manner and from the same sources as payments are made to a MedicarePlus organization under section 1854 (or, for periods beginning before January 1, 1999, to an eligible organization under a risk-sharing contract under section 1876). Such payments shall be subject to adjustment in the manner described in section 1854(a)(2) or section 1876(a)(1)(E), as the case may be.

“(2) CAPITATION AMOUNT.—The capitation amount to be applied under this subsection for a provider for a contract year shall be an amount specified in the PACE program agreement for the year. Such amount shall be based upon payment rates established for purposes of payment under section 1854 (or, for periods before January 1, 1999, for purposes of risk-sharing contracts under section 1876) and shall be adjusted to take into account the comparative frailty of PACE enrollees and such other factors as the Secretary determines to be appropriate. Such amount under such an agreement shall be computed in a manner so that the total payment level for all PACE program eligible individuals enrolled under a program is less than the projected payment under this title for a comparable population not enrolled under a PACE program.

“(e) PACE PROGRAM AGREEMENT.—

“(1) REQUIREMENT.—

“(A) IN GENERAL.—The Secretary, in close cooperation with the State administering agency, shall establish procedures for entering into, extending, and terminating PACE program agreements for the operation of PACE programs by entities that meet the requirements for a PACE provider under this section, section 1932, and regulations.

“(B) NUMERICAL LIMITATION.—

“(i) IN GENERAL.—The Secretary shall not permit the number of PACE providers with which agreements are in effect under this section or under section 9412(b) of the Omnibus Budget Reconciliation Act of 1986 to exceed—

“(I) 40 as of the date of the enactment of this section, or

“(II) as of each succeeding anniversary of such date, the numerical limitation under this subparagraph for the preceding year plus 20.

Subclause (II) shall apply without regard to the actual number of agreements in effect as of a previous anniversary date.

“(ii) TREATMENT OF CERTAIN PRIVATE, FOR-PROFIT PROVIDERS.—The numerical limitation in clause (i) shall not apply to a PACE provider that—

“(I) is operating under a demonstration project waiver under subsection (h), or

“(II) was operating under such a waiver and subsequently qualifies for PACE provider status pursuant to subsection (a)(3)(B)(ii).

“(2) SERVICE AREA AND ELIGIBILITY.—

“(A) IN GENERAL.—A PACE program agreement for a PACE program—

“(i) shall designate the service area of the program;

“(ii) may provide additional requirements for individuals to qualify as PACE program eligible individuals with respect to the program;

“(iii) shall be effective for a contract year, but may be extended for additional contract years in the absence of a notice by a party to terminate and is subject to termination by the Secretary and the State administering agency at any time for cause (as provided under the agreement);

“(iv) shall require a PACE provider to meet all applicable State and local laws and requirements; and

“(v) shall have such additional terms and conditions as the parties may agree to consistent with this section and regulations.

“(B) SERVICE AREA OVERLAP.—In designating a service area under a PACE program agreement under subparagraph (A)(i), the Secretary (in consultation with the State administering agency) may exclude from designation an area that is already covered under another PACE program agreement, in order to avoid unnecessary duplication of services and avoid impairing the financial and service viability of an existing program.

“(3) DATA COLLECTION.—

“(A) IN GENERAL.—Under a PACE program agreement, the PACE provider shall—

“(i) collect data;

“(ii) maintain, and afford the Secretary and the State administering agency access to, the records relating to the program, including pertinent financial, medical, and personnel records; and

“(iii) make to the Secretary and the State administering agency reports that the Secretary finds (in consultation with State administering agencies) necessary to monitor the operation, cost, and effectiveness of the PACE program under this title and title XIX.

“(B) REQUIREMENTS DURING TRIAL PERIOD.—During the first three years of operation of a PACE program (either under this section or under a PACE demonstration waiver program), the PACE provider shall provide such additional

data as the Secretary specifies in regulations in order to perform the oversight required under paragraph (4)(A).

“(4) OVERSIGHT.—

“(A) ANNUAL, CLOSE OVERSIGHT DURING TRIAL PERIOD.—

During the trial period (as defined in subsection (a)(9)) with respect to a PACE program operated by a PACE provider, the Secretary (in cooperation with the State administering agency) shall conduct a comprehensive annual review of the operation of the PACE program by the provider in order to assure compliance with the requirements of this section and regulations. Such a review shall include—

- “(i) an on-site visit to the program site;
- “(ii) comprehensive assessment of a provider’s fiscal soundness;
- “(iii) comprehensive assessment of the provider’s capacity to provide all PACE services to all enrolled participants;
- “(iv) detailed analysis of the entity’s substantial compliance with all significant requirements of this section and regulations; and
- “(v) any other elements the Secretary or State agency considers necessary or appropriate.

“(B) CONTINUING OVERSIGHT.—After the trial period, the Secretary (in cooperation with the State administering agency) shall continue to conduct such review of the operation of PACE providers and PACE programs as may be appropriate, taking into account the performance level of a provider and compliance of a provider with all significant requirements of this section and regulations.

“(C) DISCLOSURE.—The results of reviews under this paragraph shall be reported promptly to the PACE provider, along with any recommendations for changes to the provider’s program, and shall be made available to the public upon request.

“(5) TERMINATION OF PACE PROVIDER AGREEMENTS.—

“(A) IN GENERAL.—Under regulations—

- “(i) the Secretary or a State administering agency may terminate a PACE program agreement for cause, and
- “(ii) a PACE provider may terminate such an agreement after appropriate notice to the Secretary, the State agency, and enrollees.

“(B) CAUSES FOR TERMINATION.—In accordance with regulations establishing procedures for termination of PACE program agreements, the Secretary or a State administering agency may terminate a PACE program agreement with a PACE provider for, among other reasons, the fact that—

- “(i) the Secretary or State administering agency determines that—
 - “(I) there are significant deficiencies in the quality of care provided to enrolled participants; or

“(II) the provider has failed to comply substantially with conditions for a program or provider under this section or section 1932; and

“(ii) the entity has failed to develop and successfully initiate, within 30 days of the date of the receipt of written notice of such a determination, and continue implementation of a plan to correct the deficiencies.

“(C) TERMINATION AND TRANSITION PROCEDURES.—An entity whose PACE provider agreement is terminated under this paragraph shall implement the transition procedures required under subsection (a)(2)(C).

“(6) SECRETARY’S OVERSIGHT; ENFORCEMENT AUTHORITY.—

“(A) IN GENERAL.—Under regulations, if the Secretary determines (after consultation with the State administering agency) that a PACE provider is failing substantially to comply with the requirements of this section and regulations, the Secretary (and the State administering agency) may take any or all of the following actions:

“(i) Condition the continuation of the PACE program agreement upon timely execution of a corrective action plan.

“(ii) Withhold some or all further payments under the PACE program agreement under this section or section 1932 with respect to PACE program services furnished by such provider until the deficiencies have been corrected.

“(iii) Terminate such agreement.

“(B) APPLICATION OF INTERMEDIATE SANCTIONS.—Under regulations, the Secretary may provide for the application against a PACE provider of remedies described in section 1857(f)(2) (or, for periods before January 1, 1999, section 1876(i)(6)(B)) or 1903(m)(5)(B) in the case of violations by the provider of the type described in section 1857(f)(1) (or 1876(i)(6)(A) for such periods) or 1903(m)(5)(A), respectively (in relation to agreements, enrollees, and requirements under this section or section 1932, respectively).

“(7) PROCEDURES FOR TERMINATION OR IMPOSITION OF SANCTIONS.—Under regulations, the provisions of section 1857(g) (or for periods before January 1, 1999, section 1876(i)(9)) shall apply to termination and sanctions respecting a PACE program agreement and PACE provider under this subsection in the same manner as they apply to a termination and sanctions with respect to a contract and a MedicarePlus organization under part C (or for such periods an eligible organization under section 1876).

“(8) TIMELY CONSIDERATION OF APPLICATIONS FOR PACE PROGRAM PROVIDER STATUS.—In considering an application for PACE provider program status, the application shall be deemed approved unless the Secretary, within 90 days after the date of the submission of the application to the Secretary, either denies such request in writing or informs the applicant in writing with respect to any additional information that is needed in order to make a final determination with respect to the application. After the date the Secretary receives such ad-

ditional information, the application shall be deemed approved unless the Secretary, within 90 days of such date, denies such request.

“(f) REGULATIONS.—

“(1) IN GENERAL.—The Secretary shall issue interim final or final regulations to carry out this section and section 1932.

“(2) USE OF PACE PROTOCOL.—

“(A) IN GENERAL.—In issuing such regulations, the Secretary shall, to the extent consistent with the provisions of this section, incorporate the requirements applied to PACE demonstration waiver programs under the PACE protocol.

“(B) FLEXIBILITY.—The Secretary (in close consultation with State administering agencies) may modify or waive such provisions of the PACE protocol in order to provide for reasonable flexibility in adapting the PACE service delivery model to the needs of particular organizations (such as those in rural areas or those that may determine it appropriate to use non-staff physicians accordingly to State licensing law requirements) under this section and section 1932 where such flexibility is not inconsistent with and would not impair the essential elements, objectives, and requirements of the this section, including—

“(i) the focus on frail elderly qualifying individuals who require the level of care provided in a nursing facility;

“(ii) the delivery of comprehensive, integrated acute and long-term care services;

“(iii) the interdisciplinary team approach to care management and service delivery;

“(iv) capitated, integrated financing that allows the provider to pool payments received from public and private programs and individuals; and

“(v) the assumption by the provider over time of full financial risk.

“(3) APPLICATION OF CERTAIN ADDITIONAL BENEFICIARY AND PROGRAM PROTECTIONS.—

“(A) IN GENERAL.—In issuing such regulations and subject to subparagraph (B), the Secretary may apply with respect to PACE programs, providers, and agreements such requirements of part C (or, for periods before January 1, 1999, section 1876) and section 1903(m) relating to protection of beneficiaries and program integrity as would apply to MedicarePlus organizations under part C (or for such periods eligible organizations under risk-sharing contracts under section 1876) and to health maintenance organizations under prepaid capitation agreements under section 1903(m).

“(B) CONSIDERATIONS.—In issuing such regulations, the Secretary shall—

“(i) take into account the differences between populations served and benefits provided under this section and under part C (or, for periods before January 1, 1999, section 1876) and section 1903(m);

“(ii) not include any requirement that conflicts with carrying out PACE programs under this section; and
 “(iii) not include any requirement restricting the proportion of enrollees who are eligible for benefits under this title or title XIX.

“(g) **WAIVERS OF REQUIREMENTS.**—With respect to carrying out a PACE program under this section, the following requirements of this title (and regulations relating to such requirements) are waived and shall not apply:

“(1) Section 1812, insofar as it limits coverage of institutional services.

“(2) Sections 1813, 1814, 1833, and 1886, insofar as such sections relate to rules for payment for benefits.

“(3) Sections 1814(a)(2)(B), 1814(a)(2)(C), and 1835(a)(2)(A), insofar as they limit coverage of extended care services or home health services.

“(4) Section 1861(i), insofar as it imposes a 3-day prior hospitalization requirement for coverage of extended care services.

“(5) Sections 1862(a)(1) and 1862(a)(9), insofar as they may prevent payment for PACE program services to individuals enrolled under PACE programs.

“(h) **DEMONSTRATION PROJECT FOR FOR-PROFIT ENTITIES.**—

“(1) **IN GENERAL.**—In order to demonstrate the operation of a PACE program by a private, for-profit entity, the Secretary (in close consultation with State administering agencies) shall grant waivers from the requirement under subsection (a)(3) that a PACE provider may not be a for-profit, private entity.

“(2) **SIMILAR TERMS AND CONDITIONS.**—

“(A) **IN GENERAL.**—Except as provided under subparagraph (B), and paragraph (1), the terms and conditions for operation of a PACE program by a provider under this subsection shall be the same as those for PACE providers that are nonprofit, private organizations.

“(B) **NUMERICAL LIMITATION.**—The number of programs for which waivers are granted under this subsection shall not exceed 10. Programs with waivers granted under this subsection shall not be counted against the numerical limitation specified in subsection (e)(1)(B).

“(i) **CONSTRUCTION.**—Nothing in this section or section 1932 shall be construed as preventing a PACE provider from entering into contracts with other governmental or nongovernmental payers for the care of PACE program eligible individuals who are not eligible for benefits under part A, or enrolled under part B, or eligible for medical assistance under title XIX.”

SEC. 10012. ESTABLISHMENT OF PACE PROGRAM AS MEDICAID STATE OPTION.

(a) **IN GENERAL.**—Title XIX is amended—

(1) in section 1905(a) (42 U.S.C. 1396d(a))—

(A) by striking “and” at the end of paragraph (24);

(B) by redesignating paragraph (25) as paragraph (26);
 and

(C) by inserting after paragraph (24) the following new paragraph:

“(25) services furnished under a PACE program under section 1932 to PACE program eligible individuals enrolled under the program under such section; and”;

(2) by redesignating section 1932, as redesignated by section 114(a) of Public Law 104–193, as section 1933, and

(3) by inserting after section 1931 the following new section:

“SEC. 1932. PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE).

“(a) OPTION.—

“(1) IN GENERAL.—A State may elect to provide medical assistance under this section with respect to PACE program services to PACE program eligible individuals who are eligible for medical assistance under the State plan and who are enrolled in a PACE program under a PACE program agreement. Such individuals need not be eligible for benefits under part A, or enrolled under part B, of title XVIII to be eligible to enroll under this section.

“(2) BENEFITS THROUGH ENROLLMENT IN PACE PROGRAM.—In the case of an individual enrolled with a PACE program pursuant to such an election—

“(A) the individual shall receive benefits under the plan solely through such program, and

“(B) the PACE provider shall receive payment in accordance with the PACE program agreement for provision of such benefits.

“(3) APPLICATION OF DEFINITIONS.—The definitions of terms under section 1894(a) shall apply under this section in the same manner as they apply under section 1894.

“(b) APPLICATION OF MEDICARE TERMS AND CONDITIONS.—Except as provided in this section, the terms and conditions for the operation and participation of PACE program eligible individuals in PACE programs offered by PACE providers under PACE program agreements under section 1894 shall apply for purposes of this section.

“(c) ADJUSTMENT IN PAYMENT AMOUNTS.—In the case of individuals enrolled in a PACE program under this section, the amount of payment under this section shall not be the amount calculated under section 1894(d), but shall be an amount, specified under the PACE agreement, which is less than the amount that would otherwise have been made under the State plan if the individuals were not so enrolled. The payment under this section shall be in addition to any payment made under section 1894 for individuals who are enrolled in a PACE program under such section.

“(d) WAIVERS OF REQUIREMENTS.—With respect to carrying out a PACE program under this section, the following requirements of this title (and regulations relating to such requirements) shall not apply:

“(1) Section 1902(a)(1), relating to any requirement that PACE programs or PACE program services be provided in all areas of a State.

“(2) Section 1902(a)(10), insofar as such section relates to comparability of services among different population groups.

“(3) Sections 1902(a)(23) and 1915(b)(4), relating to freedom of choice of providers under a PACE program.

“(4) Section 1903(m)(2)(A), insofar as it restricts a PACE provider from receiving prepaid capitation payments.

“(e) POST-ELIGIBILITY TREATMENT OF INCOME.—A State may provide for post-eligibility treatment of income for individuals enrolled in PACE programs under this section in the same manner as a State treats post-eligibility income for individuals receiving services under a waiver under section 1915(c).”

(b) CONFORMING AMENDMENTS.—

(1) Section 1902(j) (42 U.S.C. 1396a(j)) is amended by striking “(25)” and inserting “(26)”.

(2) Section 1924(a)(5) (42 U.S.C. 1396r-5(a)(5)) is amended—

(A) in the heading, by striking “FROM ORGANIZATIONS RECEIVING CERTAIN WAIVERS” and inserting “UNDER PACE PROGRAMS”, and

(B) by striking “from any organization” and all that follows and inserting “under a PACE demonstration waiver program (as defined in subsection (a)(7) of section 1894) or under a PACE program under section 1932.”

(3) Section 1903(f)(4)(C) (42 U.S.C. 1396b(f)(4)(C)) is amended by inserting “or who is a PACE program eligible individual enrolled in a PACE program under section 1932,” after “section 1902(a)(10)(A),”.

SEC. 10013. EFFECTIVE DATE; TRANSITION.

(a) TIMELY ISSUANCE OF REGULATIONS; EFFECTIVE DATE.—The Secretary of Health and Human Services shall promulgate regulations to carry out this subchapter in a timely manner. Such regulations shall be designed so that entities may establish and operate PACE programs under sections 1894 and 1932 for periods beginning not later than 1 year after the date of the enactment of this Act.

(b) EXPANSION AND TRANSITION FOR PACE DEMONSTRATION PROJECT WAIVERS.—

(1) EXPANSION IN CURRENT NUMBER AND EXTENSION OF DEMONSTRATION PROJECTS.—Section 9412(b) of the Omnibus Budget Reconciliation Act of 1986, as amended by section 4118(g) of the Omnibus Budget Reconciliation Act of 1987, is amended—

(A) in paragraph (1), by inserting before the period at the end the following: “, except that the Secretary shall grant waivers of such requirements to up to the applicable numerical limitation specified in section 1894(e)(1)(B) of the Social Security Act”; and

(B) in paragraph (2)—

(i) in subparagraph (A), by striking “, including permitting the organization to assume progressively (over the initial 3-year period of the waiver) the full financial risk”; and

(ii) in subparagraph (C), by adding at the end the following: “In granting further extensions, an organization shall not be required to provide for reporting of information which is only required because of the demonstration nature of the project.”

(2) ELIMINATION OF REPLICATION REQUIREMENT.—Subparagraph (B) of paragraph (2) of such section shall not apply to

waivers granted under such section after the date of the enactment of this Act.

(3) **TIMELY CONSIDERATION OF APPLICATIONS.**—In considering an application for waivers under such section before the effective date of repeals under subsection (c), subject to the numerical limitation under the amendment made by paragraph (1), the application shall be deemed approved unless the Secretary of Health and Human Services, within 90 days after the date of its submission to the Secretary, either denies such request in writing or informs the applicant in writing with respect to any additional information which is needed in order to make a final determination with respect to the application. After the date the Secretary receives such additional information, the application shall be deemed approved unless the Secretary, within 90 days of such date, denies such request.

(c) **PRIORITY AND SPECIAL CONSIDERATION IN APPLICATION.**—During the 3-year period beginning on the date of the enactment of this Act:

(1) **PROVIDER STATUS.**—The Secretary of Health and Human Services shall give priority, in processing applications of entities to qualify as PACE programs under section 1894 or 1932 of the Social Security Act—

(A) first, to entities that are operating a PACE demonstration waiver program (as defined in section 1894(a)(7) of such Act), and

(B) then entities that have applied to operate such a program as of May 1, 1997.

(2) **NEW WAIVERS.**—The Secretary shall give priority, in the awarding of additional waivers under section 9412(b) of the Omnibus Budget Reconciliation Act of 1986—

(A) to any entities that have applied for such waivers under such section as of May 1, 1997; and

(B) to any entity that, as of May 1, 1997, has formally contracted with a State to provide services for which payment is made on a capitated basis with an understanding that the entity was seeking to become a PACE provider.

(3) **SPECIAL CONSIDERATION.**—The Secretary shall give special consideration, in the processing of applications described in paragraph (1) and the awarding of waivers described in paragraph (2), to an entity which as of May 1, 1997 through formal activities (such as entering into contracts for feasibility studies) has indicated a specific intent to become a PACE provider.

(d) **REPEAL OF CURRENT PACE DEMONSTRATION PROJECT WAIVER AUTHORITY.**—

(1) **IN GENERAL.**—Subject to paragraph (2), the following provisions of law are repealed:

(A) Section 603(c) of the Social Security Amendments of 1983 (Public Law 98–21).

(B) Section 9220 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99–272).

(C) Section 9412(b) of the Omnibus Budget Reconciliation Act of 1986 (Public Law 99–509).

(2) **DELAY IN APPLICATION.**—

(A) IN GENERAL.—Subject to subparagraph (B), the repeals made by paragraph (1) shall not apply to waivers granted before the initial effective date of regulations described in subsection (a).

(B) APPLICATION TO APPROVED WAIVERS.—Such repeals shall apply to waivers granted before such date only after allowing such organizations a transition period (of up to 24 months) in order to permit sufficient time for an orderly transition from demonstration project authority to general authority provided under the amendments made by this subchapter.

SEC. 10014. STUDY AND REPORTS.

(a) STUDY.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in close consultation with State administering agencies, as defined in section 1894(a)(8) of the Social Security Act) shall conduct a study of the quality and cost of providing PACE program services under the medicare and medicaid programs under the amendments made by this subchapter.

(2) STUDY OF PRIVATE, FOR-PROFIT PROVIDERS.—Such study shall specifically compare the costs, quality, and access to services by entities that are private, for-profit entities operating under demonstration projects waivers granted under section 1894(h) of the Social Security Act with the costs, quality, and access to services of other PACE providers.

(b) REPORT.—

(1) IN GENERAL.—Not later than 4 years after the date of the enactment of this Act, the Secretary shall provide a report to Congress on the impact of such amendments on quality and cost of services. The Secretary shall include in such report such recommendations for changes in the operation of such amendments as the Secretary deems appropriate.

(2) TREATMENT OF PRIVATE, FOR-PROFIT PROVIDERS.—The report shall include specific findings on whether any of the following findings is true:

(A) The number of covered lives enrolled with entities operating under demonstration project waivers under section 1894(h) of the Social Security Act is fewer than 800 (or such lesser number as the Secretary may find statistically sufficient to make determinations respecting findings described in the succeeding subparagraphs).

(B) The population enrolled with such entities is less frail than the population enrolled with other PACE providers.

(C) Access to or quality of care for individuals enrolled with such entities is lower than such access or quality for individuals enrolled with other PACE providers.

(D) The application of such section has resulted in an increase in expenditures under the medicare or medicaid programs above the expenditures that would have been made if such section did not apply.

(c) INFORMATION INCLUDED IN ANNUAL RECOMMENDATIONS.—The Medicare Payment Advisory Commission shall include in its annual report under section 1805(b)(1)(B) of the Social Security Act

recommendations on the methodology and level of payments made to PACE providers under section 1894(d) of such Act and on the treatment of private, for-profit entities as PACE providers.

Subchapter B—Social Health Maintenance Organizations

SEC. 10015. SOCIAL HEALTH MAINTENANCE ORGANIZATIONS (SHMOS).

(a) **EXTENSION OF DEMONSTRATION PROJECT AUTHORITIES.**—Section 4018(b) of the Omnibus Budget Reconciliation Act of 1987 is amended—

(1) in paragraph (1), by striking “1997” and inserting “2000”, and

(2) in paragraph (4), by striking “1998” and inserting “2001”.

(b) **EXPANSION OF CAP.**—Section 13567(c) of the Omnibus Budget Reconciliation Act of 1993 is amended by striking “12,000” and inserting “36,000”.

(b) **REPORT ON INTEGRATION AND TRANSITION.**—

(1) **IN GENERAL.**—The Secretary of Health and Human Services shall submit to Congress, by not later than January 1, 1999, a plan for the integration of health plans offered by social health maintenance organizations (including SHMO I and SHMO II sites developed under section 2355 of the Deficit Reduction Act of 1984 and under the amendment made by section 4207(b)(3)(B)(i) of OBRA–1990, respectively) and similar plans as an option under the MedicarePlus program under part C of title XVIII of the Social Security Act.

(2) **PROVISION FOR TRANSITION.**—Such plan shall include a transition for social health maintenance organizations operating under demonstration project authority under such section.

(3) **PAYMENT POLICY.**—The report shall also include recommendations on appropriate payment levels for plans offered by such organizations, including an analysis of the application of risk adjustment factors appropriate to the population served by such organizations.

Subchapter C—Other Programs

SEC. 10018. ORDERLY TRANSITION OF MUNICIPAL HEALTH SERVICE DEMONSTRATION PROJECTS.

Section 9215 of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended by section 6135 of OBRA–1989 and section 13557 of OBRA–1993, is further amended—

(1) by inserting “(a)” before “The Secretary”, and

(2) by adding at the end the following: “Subject to subsection (c), the Secretary may further extend such demonstration projects through December 31, 2000, but only with respect to individuals are enrolled with such projects before January 1, 1998.

“(b) The Secretary shall work with each such demonstration project to develop a plan, to be submitted to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate by March 31, 1998, for the orderly transition of demonstration projects and the project enrollees to a non-demonstration project health care delivery system, such as

through integration with private or public health plan, including a medicaid managed care or MedicarePlus plan.

“(c) A demonstration project under subsection (a) which does not develop and submit a transition plan under subsection (b) by March 31, 1998, or, if later, 6 months after the date of the enactment of this Act, shall be discontinued as of December 31, 1998. The Secretary shall provide appropriate technical assistance to assist in the transition so that disruption of medical services to project enrollees may be minimized.”

SEC. 10019. EXTENSION OF CERTAIN MEDICARE COMMUNITY NURSING ORGANIZATION DEMONSTRATION PROJECTS.

Notwithstanding any other provision of law, demonstration projects conducted under section 4079 of the Omnibus Budget Reconciliation Act of 1987 may be conducted for an additional period of 2 years, and the deadline for any report required relating to the results of such projects shall be not later than 6 months before the end of such additional period.

CHAPTER 3—MEDICARE PAYMENT ADVISORY COMMISSION

SEC. 10021. MEDICARE PAYMENT ADVISORY COMMISSION.

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

“MEDICARE PAYMENT ADVISORY COMMISSION

“SEC. 1805. (a) ESTABLISHMENT.—There is hereby established the Medicare Payment Advisory Commission (in this section referred to as the ‘Commission’).

“(b) DUTIES.—

“(1) REVIEW OF PAYMENT POLICIES AND ANNUAL REPORTS.—
The Commission shall—

“(A) review payment policies under this title, including the topics described in paragraph (2);

“(B) make recommendations to Congress concerning such payment policies;

“(C) by not later than March 1 of each year (beginning with 1998), submit a report to Congress containing the results of such reviews and its recommendations concerning such policies; and

“(D) by not later than June 1 of each year (beginning with 1998), submit a report to Congress containing an examination of issues affecting the medicare program, including the implications of changes in health care delivery in the United States and in the market for health care services on the medicare program.

“(2) SPECIFIC TOPICS TO BE REVIEWED.—

“(A) MEDICAREPLUS PROGRAM.—Specifically, the Commission shall review, with respect to the MedicarePlus program under part C, the following:

“(i) The methodology for making payment to plans under such program, including the making of differential payments and the distribution of differential updates among different payment areas.

“(ii) The mechanisms used to adjust payments for risk and the need to adjust such mechanisms to take into account health status of beneficiaries.

“(iii) The implications of risk selection both among MedicarePlus organizations and between the MedicarePlus option and the medicare fee-for-service option.

“(iv) The development and implementation of mechanisms to assure the quality of care for those enrolled with MedicarePlus organizations.

“(v) The impact of the MedicarePlus program on access to care for medicare beneficiaries.

“(vi) Other major issues in implementation and further development of the MedicarePlus program.

“(B) FEE-FOR-SERVICE SYSTEM.—Specifically, the Commission shall review payment policies under parts A and B, including—

“(i) the factors affecting expenditures for services in different sectors, including the process for updating hospital, skilled nursing facility, physician, and other fees,

“(ii) payment methodologies, and

“(iii) their relationship to access and quality of care for medicare beneficiaries.

“(C) INTERACTION OF MEDICARE PAYMENT POLICIES WITH HEALTH CARE DELIVERY GENERALLY.—Specifically, the Commission shall review the effect of payment policies under this title on the delivery of health care services other than under this title and assess the implications of changes in health care delivery in the United States and in the general market for health care services on the medicare program.

“(3) COMMENTS ON CERTAIN SECRETARIAL REPORTS.—If the Secretary submits to Congress (or a committee of Congress) a report that is required by law and that relates to payment policies under this title, the Secretary shall transmit a copy of the report to the Commission. The Commission shall review the report and, not later than 6 months after the date of submittal of the Secretary’s report to Congress, shall submit to the appropriate committees of Congress written comments on such report. Such comments may include such recommendations as the Commission deems appropriate.

“(4) AGENDA AND ADDITIONAL REVIEWS.—The Commission shall consult periodically with the chairmen and ranking minority members of the appropriate committees of Congress regarding the Commission’s agenda and progress towards achieving the agenda. The Commission may conduct additional reviews, and submit additional reports to the appropriate committees of Congress, from time to time on such topics relating to the program under this title as may be requested by such chairmen and members and as the Commission deems appropriate.

“(5) AVAILABILITY OF REPORTS.—The Commission shall transmit to the Secretary a copy of each report submitted under this subsection and shall make such reports available to the public.

“(6) APPROPRIATE COMMITTEES.—For purposes of this section, the term ‘appropriate committees of Congress’ means the Committees on Ways and Means and Commerce of the House of Representatives and the Committee on Finance of the Senate.

“(c) MEMBERSHIP.—

“(1) NUMBER AND APPOINTMENT.—The Commission shall be composed of 19 members appointed by the Comptroller General.

“(2) QUALIFICATIONS.—

“(A) IN GENERAL.—The membership of the Commission shall include individuals with national recognition for their expertise in health finance and economics, actuarial science, health facility management, health plans and integrated delivery systems, reimbursement of health facilities, allopathic and osteopathic physicians, and other providers of health services, and other related fields, who provide a mix of different professionals, broad geographic representation, and a balance between urban and rural representatives.

“(B) INCLUSION.—The membership of the Commission shall include (but not be limited to) physicians and other health professionals, employers, third party payers, 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.

“(C) MAJORITY NONPROVIDERS.—Individuals who are directly involved in the provision, or management of the delivery, of items and services covered under this title shall not constitute a majority of the membership of the Commission.

“(D) ETHICAL DISCLOSURE.—The Comptroller General shall establish a system for public disclosure by members of the Commission of financial and other potential conflicts of interest relating to such members.

“(3) TERMS.—

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

“(4) COMPENSATION.—While serving on the business of the Commission (including traveltime), a member of the Commis-

sion 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.

"(5) 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.

"(6) 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—

“(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 nonproprietary data of the Commission, immediately upon request.

“(4) PERIODIC AUDIT.—The Commission shall be subject to periodic audit by the Comptroller General.

“(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 appropriated 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. Sixty 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 Advisory Commission”.

(2) PPRC.—

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

(B) ELIMINATION OF CERTAIN REPORTS.—Section 1848 (42 U.S.C. 1395w-4) is amended—

(i) by striking subparagraph (F) of subsection (d)(2),

(ii) by striking subparagraph (B) of subsection (f)(1), and

(iii) in subsection (f)(3), by striking “Physician Payment Review Commission.”.

(C) CONFORMING AMENDMENTS.—Section 1848 (42 U.S.C. 1395w-4) is amended by striking “Physician Payment Review Commission” and inserting “Medicare Payment Advi-

sory Commission” each place it appears in subsections (c)(2)(B)(iii), (g)(6)(C), and (g)(7)(C).

(c) EFFECTIVE DATE; TRANSITION.—

(1) IN GENERAL.—The Comptroller General shall first provide for appointment of members to the Medicare Payment Advisory Commission (in this subsection referred to as “MedPAC”) by not later than September 30, 1997.

(2) TRANSITION.—As quickly as possible after the date a majority of members of MedPAC are first appointed, the Comptroller General, in consultation with 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”), shall provide for the termination of the ProPAC and the PPRC. As of the date of termination of the respective Commissions, the amendments made by paragraphs (1) and (2), respectively, of subsection (b) become effective. The Comptroller General, to the extent feasible, shall provide for the transfer to the MedPAC of assets and staff of the ProPAC and the PPRC, without any loss of benefits or seniority by virtue of such transfers. Fund balances available to the ProPAC or the PPRC for any period shall be available to the MedPAC for such period for like purposes.

(3) CONTINUING RESPONSIBILITY FOR REPORTS.—The MedPAC 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 MedPAC) by the ProPAC and the PPRC, and, for this purpose, any reference in law to either such Commission is deemed, after the appointment of the MedPAC, to refer to the MedPAC.

CHAPTER 4—MEDIGAP PROTECTIONS

SEC. 10031. MEDIGAP PROTECTIONS.

(a) GUARANTEEING ISSUE WITHOUT PREEXISTING CONDITIONS FOR CONTINUOUSLY COVERED INDIVIDUALS.—Section 1882(s) (42 U.S.C. 1395ss(s)) is amended—

(1) in paragraph (3), by striking “paragraphs (1) and (2)” and inserting “this subsection”,

(2) by redesignating paragraph (3) as paragraph (4), and

(3) by inserting after paragraph (2) the following new paragraph:

“(3)(A) The issuer of a medicare supplemental policy—

“(i) may not deny or condition the issuance or effectiveness of a medicare supplemental policy described in subparagraph (C) that is offered and is available for issuance to new enrollees by such issuer;

“(ii) may not discriminate in the pricing of such policy, because of health status, claims experience, receipt of health care, or medical condition; and

“(iii) may not impose an exclusion of benefits based on a pre-existing condition under such policy,

in the case of an individual described in subparagraph (B) who seeks to enroll under the policy not later than 63 days after the date of the termination of enrollment described in such subparagraph and who submits evidence of the date of termination or

disenrollment along with the application for such medicare supplemental policy.

“(B) An individual described in this subparagraph is an individual described in any of the following clauses:

“(i) The individual is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under this title and the plan terminates or ceases to provide all such supplemental health benefits to the individual.

“(ii) The individual is enrolled with a MedicarePlus organization under a MedicarePlus plan under part C, and there are circumstances permitting discontinuance of the individual’s election of the plan under section 1851(c)(4).

“(iii) The individual is enrolled with an eligible organization under a contract under section 1876, a similar organization operating under demonstration project authority, with an organization under an agreement under section 1833(a)(1)(A), or with an organization under a policy described in subsection (t), and such enrollment ceases under the same circumstances that would permit discontinuance of an individual’s election of coverage under section 1851(c)(4) and, in the case of a policy described in subsection (t), there is no provision under applicable State law for the continuation of coverage under such policy.

“(iv) The individual is enrolled under a medicare supplemental policy under this section and such enrollment ceases because—

“(I) of the bankruptcy or insolvency of the issuer or because of other involuntary termination of coverage or enrollment under such policy and there is no provision under applicable State law for the continuation of such coverage;

“(II) the issuer of the policy substantially violated a material provision of the policy; or

“(III) the issuer (or an agent or other entity acting on the issuer’s behalf) materially misrepresented the policy’s provisions in marketing the policy to the individual.

“(v) The individual—

“(I) was enrolled under a medicare supplemental policy under this section,

“(II) subsequently terminates such enrollment and enrolls, for the first time, with any MedicarePlus organization under a MedicarePlus plan under part C, any eligible organization under a contract under section 1876, any similar organization operating under demonstration project authority, any organization under an agreement under section 1833(a)(1)(A), or any policy described in subsection (t), and

“(III) the subsequent enrollment under subclause (II) is terminated by the enrollee during the first 6 months (or 3 months for terminations occurring on or after January 1, 2003) of such enrollment.

“(C)(i) Subject to clauses (ii) and (iii), a medicare supplemental policy described in this subparagraph has a benefit package classified as ‘A’, ‘B’, ‘C’, or ‘F’ under the standards established under subsection (p)(2).

“(ii) Only for purposes of an individual described in subparagraph (B)(v), a medicare supplemental policy described in this subparagraph also includes (if available from the same issuer) the same medicare supplemental policy referred to in such subparagraph in which the individual was most recently previously enrolled.

“(iii) For purposes of applying this paragraph in the case of a State that provides for offering of benefit packages other than under the classification referred to in clause (i), the references to benefit packages in such clause are deemed references to comparable benefit packages offered in such State.

“(D) At the time of an event described in subparagraph (B) because of which an individual ceases enrollment or loses coverage or benefits under a contract or agreement, policy, or plan, the organization that offers the contract or agreement, the insurer offering the policy, or the administrator of the plan, respectively, shall notify the individual of the rights of the individual, and obligations of issuers of medicare supplemental policies, under subparagraph (A).”.

(b) LIMITATION ON IMPOSITION OF PREEXISTING CONDITION EXCLUSION DURING INITIAL OPEN ENROLLMENT PERIOD.—Section 1882(s)(2) (42 U.S.C. 1395ss(s)(2)) is amended—

(1) in subparagraph (B), by striking “subparagraph (C)” and inserting “subparagraphs (C) and (D)”, and

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

“(D) In the case of a policy issued during the 6-month period described in subparagraph (A) to an individual who is 65 years of age or older as of the date of issuance and who as of the date of the application for enrollment has a continuous period of creditable coverage (as defined in 2701(c) of the Public Health Service Act) of—

“(i) at least 6 months, the policy may not exclude benefits based on a pre-existing condition; or

“(ii) of less than 6 months, if the policy excludes benefits based on a preexisting condition, the policy shall reduce the period of any preexisting condition exclusion by the aggregate of the periods of creditable coverage (if any, as so defined) applicable to the individual as of the enrollment date.

The Secretary shall specify the manner of the reduction under clause (ii), based upon the rules used by the Secretary in carrying out section 2701(a)(3) of such Act.”.

(c) EFFECTIVE DATES.—

(1) GUARANTEED ISSUE.—The amendment made by subsection (a) shall take effect on July 1, 1998.

(2) LIMIT ON PREEXISTING CONDITION EXCLUSIONS.—The amendment made by subsection (b) shall apply to policies issued on or after July 1, 1998.

(d) TRANSITION PROVISIONS.—

(1) IN GENERAL.—If the Secretary of Health and Human Services identifies a State as requiring a change to its statutes or regulations to conform its regulatory program to the changes made by this section, the State regulatory program shall not be considered to be out of compliance with the requirements of section 1882 of the Social Security Act due solely

to failure to make such change until the date specified in paragraph (4).

(2) NAIC STANDARDS.—If, within 9 months after the date of the enactment of this Act, the National Association of Insurance Commissioners (in this subsection referred to as the “NAIC”) modifies its NAIC Model Regulation relating to section 1882 of the Social Security Act (referred to in such section as the 1991 NAIC Model Regulation, as modified pursuant to section 171(m)(2) of the Social Security Act Amendments of 1994 (Public Law 103–432) and as modified pursuant to section 1882(d)(3)(A)(vi)(IV) of the Social Security Act, as added by section 271(a) of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104–191) to conform to the amendments made by this section, such revised regulation incorporating the modifications shall be considered to be the applicable NAIC model regulation (including the revised NAIC model regulation and the 1991 NAIC Model Regulation) for the purposes of such section.

(3) SECRETARY STANDARDS.—If the NAIC does not make the modifications described in paragraph (2) within the period specified in such paragraph, the Secretary of Health and Human Services shall make the modifications described in such paragraph and such revised regulation incorporating the modifications shall be considered to be the appropriate Regulation for the purposes of such section.

(4) DATE SPECIFIED.—

(A) IN GENERAL.—Subject to subparagraph (B), the date specified in this paragraph for a State is the earlier of—

(i) the date the State changes its statutes or regulations to conform its regulatory program to the changes made by this section, or

(ii) 1 year after the date the NAIC or the Secretary first makes the modifications under paragraph (2) or (3), respectively.

(B) ADDITIONAL LEGISLATIVE ACTION REQUIRED.—In the case of a State which the Secretary identifies as—

(i) requiring State legislation (other than legislation appropriating funds) to conform its regulatory program to the changes made in this section, but

(ii) having a legislature which is not scheduled to meet in 1999 in a legislative session in which such legislation may be considered,

the date specified in this paragraph is the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after July 1, 1999. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

SEC. 10032. MEDICARE PREPAID COMPETITIVE PRICING DEMONSTRATION PROJECT.

(a) ESTABLISHMENT OF PROJECT.—The Secretary of Health and Human Services shall provide, beginning not later than 1 year after the date of the enactment of this Act, for implementation of

a project (in this section referred to as the “project”) to demonstrate the application of, and the consequences of applying, a market-oriented pricing system for the provision of a full range of medicare benefits in a geographic area.

(b) RESEARCH DESIGN ADVISORY COMMITTEE.—

(1) IN GENERAL.—Before implementing the project under this section, the Secretary shall appoint a national advisory committee, including independent actuaries and individuals with expertise in competitive health plan pricing, to make recommendations to the Secretary concerning the appropriate research design for implementing the project.

(2) INITIAL RECOMMENDATIONS.—The committee initially shall submit recommendations respecting the method for area selection, benefit design among plans offered, structuring choice among health plans offered, methods for setting the price to be paid to plans, collection of plan information (including information concerning quality and access to care), information dissemination, and methods of evaluating the results of the project.

(3) ADVICE DURING IMPLEMENTATION.—Upon implementation of the project, the committee shall continue to advise the Secretary on the application of the design in different areas and changes in the project based on experience with its operations.

(c) AREA SELECTION.—

(1) IN GENERAL.—Taking into account the recommendations of the advisory committee submitted under subsection (b), the Secretary shall designate areas in which the project will operate.

(2) APPOINTMENT OF AREA ADVISORY COMMITTEE.—Upon the designation of an area for inclusion in the project, the Secretary shall appoint an area advisory committee, composed of representatives of health plans, providers, and medicare beneficiaries in the area, to advise the Secretary concerning how the project will actually be implemented in the area. Such advice may include advice concerning the marketing and pricing of plans in the area and other salient factors relating.

(d) MONITORING AND REPORT.—

(1) MONITORING IMPACT.—Taking into consideration the recommendations of the general advisory committee (appointed under subsection (b)), the Secretary shall closely monitor the impact of projects in areas on the price and quality of, and access to, medicare covered services, choice of health plan, changes in enrollment, and other relevant factors.

(2) REPORT.—The Secretary shall periodically report to Congress on the progress under the project under this section.

(e) WAIVER AUTHORITY.—The Secretary of Health and Human Services may waive such requirements of section 1876 (and such requirements of part C of title XVIII, as amended by chapter 1), of the Social Security Act as may be necessary for the purposes of carrying out the project.

CHAPTER 5—TAX TREATMENT OF HOSPITALS PARTICIPATING IN PROVIDER-SPONSORED ORGANIZATIONS

SEC. 10041. TAX TREATMENT OF HOSPITALS WHICH PARTICIPATE IN PROVIDER-SPONSORED ORGANIZATIONS.

(a) IN GENERAL.—Section 501 of the Internal Revenue Code of 1986 (relating to exemption from tax on corporations, certain trusts, etc.) is amended by redesignating subsection (o) as subsection (p) and by inserting after subsection (n) the following new subsection:

“(o) TREATMENT OF HOSPITALS PARTICIPATING IN PROVIDER-SPONSORED ORGANIZATIONS.—An organization shall not fail to be treated as organized and operated exclusively for a charitable purpose for purposes of subsection (c)(3) solely because a hospital which is owned and operated by such organization participates in a provider-sponsored organization (as defined in section 1853(e) of the Social Security Act), whether or not the provider-sponsored organization is exempt from tax. For purposes of subsection (c)(3), any person with a material financial interest in such a provider-sponsored organization shall be treated as a private shareholder or individual with respect to the hospital.”

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on the date of the enactment of this Act.

Subtitle B—Prevention Initiatives

SEC. 10101. SCREENING MAMMOGRAPHY.

(a) PROVIDING ANNUAL SCREENING MAMMOGRAPHY FOR WOMEN OVER AGE 39.—Section 1834(c)(2)(A) (42 U.S.C. 1395m(c)(2)(A)) is amended—

(1) in clause (iii), to read as follows:

“(iii) In the case of a woman over 39 years of age, payment may not be made under this part for screening mammography performed within 11 months following the month in which a previous screening mammography was performed.”; and

(2) by striking clauses (iv) and (v).

(b) WAIVER OF DEDUCTIBLE.—The first sentence of section 1833(b) (42 U.S.C. 1395l(b)) is amended—

(1) by striking “and” before “(4)”, and

(2) by inserting before the period at the end the following: “, and (5) such deductible shall not apply with respect to screening mammography (as described in section 1861(jj))”.

(c) CONFORMING AMENDMENT.—Section 1834(c)(1)(C) of such Act (42 U.S.C. 1395m(c)(1)(C)) is amended by striking “, subject to the deductible established under section 1833(b),”.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after January 1, 1998.

SEC. 10102. SCREENING PAP SMEAR AND PELVIC EXAMS.

(a) COVERAGE OF PELVIC EXAM; INCREASING FREQUENCY OF COVERAGE OF PAP SMEAR.—Section 1861(nn) (42 U.S.C. 1395x(nn)) is amended—

(1) in the heading, by striking “Smear” and inserting “Smear; Screening Pelvic Exam”;

(2) by inserting “or vaginal” after “cervical” each place it appears;

(3) by striking “(nn)” and inserting “(nn)(1)”;

(4) 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

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

“(2) The term ‘screening pelvic exam’ means a 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 or vaginal cancer; or

“(B) is at high risk of developing cervical or vaginal cancer (as determined pursuant to factors identified by the Secretary).”.

(b) **WAIVER OF DEDUCTIBLE.**—The first sentence of section 1833(b) (42 U.S.C. 1395l(b)), as amended by section 10101(b), is amended—

(1) by striking “and” before “(5)”, and

(2) by inserting before the period at the end 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))”.

(c) **CONFORMING AMENDMENTS.**—Sections 1861(s)(14) and 1862(a)(1)(F) (42 U.S.C. 1395x(s)(14), 1395y(a)(1)(F)) are each amended by inserting “and screening pelvic exam” after “screening pap smear”.

(d) **PAYMENT UNDER PHYSICIAN FEE SCHEDULE.**—Section 1848(j)(3) (42 U.S.C. 1395w-4(j)(3)) is amended by striking “and (4)” and inserting “(4) and (14) (with respect to services described in section 1861(nn)(2))”.

(e) **EFFECTIVE DATE.**—The amendments made by this section shall apply to items and services furnished on or after January 1, 1998.

SEC. 10103. PROSTATE CANCER SCREENING TESTS.

(a) **COVERAGE.**—Section 1861 (42 U.S.C. 1395x) is amended—

(1) in subsection (s)(2)—

(A) by striking “and” at the end of subparagraphs (N) and (O), and

(B) by inserting after subparagraph (O) the following new subparagraph:

“(P) prostate cancer screening tests (as defined in subsection (oo)); and”;

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

“Prostate Cancer Screening Tests

“(oo)(1) The term ‘prostate cancer screening test’ means a test that consists of any (or all) of the procedures described in paragraph (2) provided for the purpose of early detection of prostate cancer to a man over 50 years of age who has not had such a test during the preceding year.

“(2) The procedures described in this paragraph are as follows:

“(A) A digital rectal examination.

“(B) A prostate-specific antigen blood test.

“(C) For years beginning after 2001, such other procedures as the Secretary finds appropriate for the purpose of early detection of prostate cancer, taking into account changes in technology and standards of medical practice, availability, effectiveness, costs, and such other factors as the Secretary considers appropriate.”.

(b) 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)”.

(c) CONFORMING AMENDMENT.—Section 1862(a) (42 U.S.C. 1395y(a)) is amended—

(1) in paragraph (1)—

(A) in subparagraph (E), by striking “and” at the end,

(B) in subparagraph (F), by striking the semicolon at the end and inserting “, and”, and

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

“(G) in the case of prostate cancer screening tests (as defined in section 1861(oo)), which are performed more frequently than is covered under such section;” and

(2) in paragraph (7), by striking “paragraph (1)(B) or under paragraph (1)(F)” and inserting “subparagraph (B), (F), or (G) of paragraph (1)”.

(d) PAYMENT UNDER PHYSICIAN FEE SCHEDULE.—Section 1848(j)(3) (42 U.S.C. 1395w-4(j)(3)), as amended by section 10102, is amended by inserting “, (2)(P) (with respect to services described in subparagraphs (A) and (C) of section 1861(oo)” after “(2)(G)”

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after January 1, 1998.

SEC. 10104. COVERAGE OF COLORECTAL SCREENING.

(a) COVERAGE.—

(1) IN GENERAL.—Section 1861 (42 U.S.C. 1395x), as amended by section 10103(a), is amended—

(A) in subsection (s)(2)—

(i) by striking “and” at the end of subparagraph (P);

(ii) by adding “and” at the end of subparagraph (Q);

and

(iii) by adding at the end the following new subparagraph:

“(R) colorectal cancer screening tests (as defined in subsection (pp)); and”;

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

“Colorectal Cancer Screening Tests

“(pp)(1) The term ‘colorectal cancer screening test’ means any of the following procedures furnished to an individual for the purpose of early detection of colorectal cancer:

“(A) Screening fecal-occult blood test.

“(B) Screening flexible sigmoidoscopy.

“(C) In the case of an individual at high risk for colorectal cancer, screening colonoscopy.

“(D) Screening barium enema, if found by the Secretary to be an appropriate alternative to screening flexible sigmoidoscopy under subparagraph (B) or screening colonoscopy under subparagraph (C).

“(E) For years beginning after 2002, such other procedures as the Secretary finds appropriate for the purpose of early detection of colorectal cancer, taking into account changes in technology and standards of medical practice, availability, effectiveness, costs, and such other factors as the Secretary considers appropriate.

“(2) In paragraph (1)(C), an ‘individual at high risk for colorectal cancer’ is an individual who, because of family history, prior experience of cancer or precursor neoplastic polyps, a history of chronic digestive disease condition (including inflammatory bowel disease, Crohn’s Disease, or ulcerative colitis), the presence of any appropriate recognized gene markers for colorectal cancer, or other predisposing factors, faces a high risk for colorectal cancer.”.

(2) DEADLINE FOR DECISION ON COVERAGE OF SCREENING BARIUM ENEMA.—Not later than 2 years after the date of the enactment of this section, the Secretary of Health and Human Services shall issue and publish a determination on the treatment of screening barium enema as a colorectal cancer screening test under section 1861(pp) (as added by subparagraph (B)) as an alternative procedure to a screening flexible sigmoidoscopy or screening colonoscopy.

(b) FREQUENCY AND PAYMENT LIMITS.—

(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 COLORECTAL CANCER SCREENING TESTS.—

“(1) SCREENING FECAL-OCCULT BLOOD TESTS.—

“(A) PAYMENT LIMIT.—In establishing fee schedules under section 1833(h) with respect to colorectal cancer screening tests consisting of screening fecal-occult blood tests, except as provided by the Secretary under paragraph (4)(A), the payment amount established for tests performed—

“(i) in 1998 shall not exceed \$5; and

“(ii) in a subsequent year, shall not exceed the limit on the payment amount established under this subsection for such tests for the preceding year, adjusted

by the applicable adjustment under section 1833(h) for tests performed in such year.

“(B) FREQUENCY LIMIT.—Subject to revision by the Secretary under paragraph (4)(B), no payment may be made under this part for colorectal cancer screening test consisting of a screening fecal-occult blood test—

“(i) if the individual is under 50 years of age; or

“(ii) if the test is performed within the 11 months after a previous screening fecal-occult blood test.

“(2) SCREENING FLEXIBLE SIGMOIDOSCOPIES.—

“(A) FEE SCHEDULE.—The Secretary shall establish a payment amount under section 1848 with respect to colorectal cancer screening tests consisting of screening flexible sigmoidoscopies 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) PAYMENT LIMIT.—In the case of screening flexible sigmoidoscopy services—

“(i) the payment amount may not exceed such amount as the Secretary specifies, based upon the rates recognized under this part for diagnostic flexible sigmoidoscopy services; and

“(ii) that, in accordance with regulations, may be performed in an ambulatory surgical center and for which the Secretary permits ambulatory surgical center payments under this part and that are performed in an ambulatory surgical center or hospital outpatient department, the payment amount under this part may not exceed the lesser of (I) the payment rate that would apply to such services if they were performed in a hospital outpatient department, or (II) the payment rate that would apply to such services if they were performed in an ambulatory surgical center.

“(C) SPECIAL RULE FOR DETECTED LESIONS.—If, during the course of such screening flexible sigmoidoscopy, a lesion or growth is detected which results in a biopsy or removal of the lesion or growth, payment under this part shall not be made for the screening flexible sigmoidoscopy but shall be made for the procedure classified as a flexible sigmoidoscopy with such biopsy or removal.

“(D) FREQUENCY LIMIT.—Subject to revision by the Secretary under paragraph (4)(B), no payment may be made under this part for a colorectal cancer screening test consisting of a screening flexible sigmoidoscopy—

“(i) if the individual is under 50 years of age; or

“(ii) if the procedure is performed within the 47 months after a previous screening flexible sigmoidoscopy.

“(3) SCREENING COLONOSCOPY FOR INDIVIDUALS AT HIGH RISK FOR COLORECTAL CANCER.—

“(A) FEE SCHEDULE.—The Secretary shall establish a payment amount under section 1848 with respect to colorectal cancer screening test consisting of a screening

colonoscopy for individuals at high risk for colorectal cancer (as defined in section 1861(pp)(2)) 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) PAYMENT LIMIT.—In the case of screening colonoscopy services—

“(i) the payment amount may not exceed such amount as the Secretary specifies, based upon the rates recognized under this part for diagnostic colonoscopy services; and

“(ii) that are performed in an ambulatory surgical center or hospital outpatient department, the payment amount under this part may not exceed the lesser of (I) the payment rate that would apply to such services if they were performed in a hospital outpatient department, or (II) the payment rate that would apply to such services if they were performed in an ambulatory surgical center.

“(C) SPECIAL RULE FOR DETECTED LESIONS.—If during the course of such screening colonoscopy, a lesion or growth is detected which results in a biopsy or removal of the lesion or growth, payment under this part shall not be made for the screening colonoscopy but shall be made for the procedure classified as a colonoscopy with such biopsy or removal.

“(D) FREQUENCY LIMIT.—Subject to revision by the Secretary under paragraph (4)(B), no payment may be made under this part for a colorectal cancer screening test consisting of a screening colonoscopy for individuals at high risk for colorectal cancer if the procedure is performed within the 23 months after a previous screening colonoscopy.

“(4) REDUCTIONS IN PAYMENT LIMIT AND REVISION OF FREQUENCY.—

“(A) REDUCTIONS IN PAYMENT LIMIT FOR SCREENING FECAL-OCCULT BLOOD TESTS.—The Secretary shall review from time to time the appropriateness of the amount of the payment limit established for screening fecal-occult blood tests under paragraph (1)(A). The Secretary may, with respect to tests performed in a year after 2000, reduce the amount of such limit as it applies nationally or in any area to the amount that the Secretary estimates is required to assure that such tests of an appropriate quality are readily and conveniently available during the year.

“(B) REVISION OF FREQUENCY.—

“(i) REVIEW.—The Secretary shall review periodically the appropriate frequency for performing colorectal cancer screening tests based on age and such other factors as the Secretary believes to be pertinent.

“(ii) 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 may be paid for under this subsection, but no such revision shall apply to tests performed before January 1, 2001.

“(5) LIMITING CHARGES OF NONPARTICIPATING PHYSICIANS.—

“(A) IN GENERAL.—In the case of a colorectal cancer screening test consisting of a screening flexible sigmoidoscopy or a screening colonoscopy provided to an individual at high risk for colorectal cancer for which payment may be made under this part, if a nonparticipating physician provides the procedure to an individual enrolled under this part, the physician may not charge the individual more than the limiting charge (as defined in section 1848(g)(2)).

“(B) ENFORCEMENT.—If a physician or supplier knowing and willfully imposes a charge in violation of subparagraph (A), the Secretary may apply sanctions against such physician or supplier in accordance with section 1842(j)(2).”.

(2) SPECIAL RULE FOR SCREENING BARIUM ENEMA.—If the Secretary of Health and Human Services issues a determination under subsection (a)(2) that screening barium enema should be covered as a colorectal cancer screening test under section 1861(pp) (as added by subsection (a)(1)(B)), the Secretary shall establish frequency limits (including revisions of frequency limits) for such procedure consistent with the frequency limits for other colorectal cancer screening tests under section 1834(d) (as added by subsection (b)(1)), and shall establish payment limits (including limits on charges of nonparticipating physicians) for such procedure consistent with the payment limits under part B of title XVIII for diagnostic barium enema procedures.

(c) CONFORMING AMENDMENTS.—(1) Paragraphs (1)(D) and (2)(D) of section 1833(a) (42 U.S.C. 1395l(a)) are each amended by inserting “or section 1834(d)(1)” after “subsection (h)(1)”.

(2) Section 1833(h)(1)(A) (42 U.S.C. 1395l(h)(1)(A)) is amended by striking “The Secretary” and inserting “Subject to paragraphs (1) and (4)(A) of section 1834(d), the Secretary”.

(3) Clauses (i) and (ii) of section 1848(a)(2)(A) (42 U.S.C. 1395w-4(a)(2)(A)) are each amended by inserting after “a service” the following: “(other than a colorectal cancer screening test consisting of a screening colonoscopy provided to an individual at high risk for colorectal cancer or a screening flexible sigmoidoscopy)”.

(4) Section 1862(a) (42 U.S.C. 1395y(a)), as amended by section 10103(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 colorectal cancer screening tests, which are performed more frequently than is covered under section 1834(d);” and

(B) in paragraph (7), by striking “or (G)” and inserting “(G), or (H)”.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after January 1, 1998.

SEC. 10105. DIABETES SCREENING TESTS.

(a) COVERAGE OF DIABETES OUTPATIENT SELF-MANAGEMENT TRAINING SERVICES.—

(1) IN GENERAL.—Section 1861 (42 U.S.C. 1395x), as amended by sections 10103(a) and 10104(a), is amended—

(A) in subsection (s)(2)—

(i) by striking “and” at the end of subparagraph (Q);

(ii) by adding “and” at the end of subparagraph (R);

and

(iii) by adding at the end the following new subparagraph:

“(S) diabetes outpatient self-management training services (as defined in subsection (qq)); and”;

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

“Diabetes Outpatient Self-Management Training Services

“(qq)(1) The term ‘diabetes outpatient self-management training services’ means educational and training services furnished to an individual with diabetes by 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 a physician, or other individual or entity designated by the Secretary, 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) a physician, or such other individual or entity, meets the quality standards described in this paragraph if the physician, or individual or entity, meets quality standards established by the Secretary, except that the physician or other individual or entity shall be deemed to have met such standards if the physician or other 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 an organization that represents individuals (including individuals under this title) with diabetes as meeting standards for furnishing the services.”.

(2) PAYMENT UNDER PHYSICIAN FEE SCHEDULE.—Section 1848(j)(3)(42 U.S.C. 1395w-4(j)(3)) as amended in sections

10102 and 10103, is amended by inserting “(2)(S),” before “(3).”

(3) CONSULTATION WITH ORGANIZATIONS IN ESTABLISHING PAYMENT AMOUNTS FOR SERVICES PROVIDED BY PHYSICIANS.—In establishing payment amounts under section 1848 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 such organizations representing individuals or medicare beneficiaries with diabetes, in determining the relative value for such services under section 1848(c)(2) of such Act.

(b) BLOOD-TESTING STRIPS FOR INDIVIDUALS WITH DIABETES.—

(1) INCLUDING STRIPS AND MONITORS AS DURABLE MEDICAL EQUIPMENT.—The first sentence of section 1861(n) (42 U.S.C. 1395x(n)) is amended by inserting before the semicolon the following: “, and includes blood-testing strips and blood glucose monitors for individuals with diabetes without regard to whether the individual has Type I or Type II diabetes or to the individual’s use of insulin (as determined under standards established by the Secretary in consultation with the appropriate organizations)”.

(2) 10 PERCENT REDUCTION IN PAYMENTS FOR TESTING STRIPS.—Section 1834(a)(2)(B)(iv) (42 U.S.C. 1395m(a)(2)(B)(iv)) is amended by adding before the period the following: “(reduced by 10 percent, in the case of a blood glucose testing strip furnished after 1997 for an individual with diabetes)”.

(c) ESTABLISHMENT OF OUTCOME MEASURES FOR BENEFICIARIES WITH DIABETES.—

(1) IN GENERAL.—The Secretary of Health and Human Services, in consultation with appropriate organizations, shall establish outcome measures, including glycosolated hemoglobin (past 90-day average blood sugar levels), for purposes of evaluating the improvement of the health status of medicare beneficiaries with diabetes mellitus.

(2) RECOMMENDATIONS FOR MODIFICATIONS TO SCREENING BENEFITS.—Taking into account information on the health status of medicare beneficiaries with diabetes mellitus as measured under the outcome measures established under subparagraph (A), the Secretary shall from time to time submit recommendations to Congress regarding modifications to the coverage of services for such beneficiaries under the medicare program.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after January 1, 1998.

SEC. 10106. STANDARDIZATION OF MEDICARE COVERAGE OF BONE MASS MEASUREMENTS.

(a) IN GENERAL.—Section 1861 (42 U.S.C. 1395x), as amended by sections 10103(a), 10104(a), 10105(a), is amended—

(1) in subsection (s)—

(A) in paragraph (12)(C), by striking “and” at the end,

(B) by striking the period at the end of paragraph (14) and inserting “; and”,

(C) by redesignating paragraphs (15) and (16) as paragraphs (16) and (17), respectively, and

(D) by inserting after paragraph (14) the following new paragraph:

“(15) bone mass measurement (as defined in subsection (rr)).”; and

(2) by inserting after subsection (qq) the following new subsection:

“Bone Mass Measurement

“(rr)(1) The term ‘bone mass measurement’ means a radiologic or radioisotopic procedure or other procedure approved by the Food and Drug Administration performed on a qualified individual (as defined in paragraph (2)) for the purpose of identifying bone mass or detecting bone loss or determining bone quality, and includes a physician’s interpretation of the results of the procedure.

“(2) For purposes of this subsection, the term ‘qualified individual’ means an individual who is (in accordance with regulations prescribed by the Secretary)—

“(A) an estrogen-deficient woman at clinical risk for osteoporosis;

“(B) an individual with vertebral abnormalities;

“(C) an individual receiving long-term glucocorticoid steroid therapy;

“(D) an individual with primary hyperparathyroidism; or

“(E) an individual being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy.

“(3) The Secretary shall establish such standards regarding the frequency with which a qualified individual shall be eligible to be provided benefits for bone mass measurement under this title.”.

(b) PAYMENT UNDER PHYSICIAN FEE SCHEDULE.—Section 1848(j)(3) (42 U.S.C. 1395w-4(j)(3)), as amended by sections 10102, 10103, and 10105, is amended—

(1) by striking “(4) and (14)” and inserting “(4), (14)” and

(2) by inserting “ and (15)” after “1861(nn)(2)”).

(c) CONFORMING AMENDMENTS.—Sections 1864(a), 1902(a)(9)(C), and 1915(a)(1)(B)(ii)(I) (42 U.S.C. 1395aa(a), 1396a(a)(9)(C), and 1396n(a)(1)(B)(ii)(I)) are amended by striking “paragraphs (15) and (16)” each place it appears and inserting “paragraphs (16) and (17)”.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to bone mass measurements performed on or after July 1, 1998.

SEC. 10107. VACCINES OUTREACH EXPANSION.

(a) EXTENSION OF INFLUENZA AND PNEUMOCOCCAL VACCINATION CAMPAIGN.—In order to increase utilization of pneumococcal and influenza vaccines in medicare beneficiaries, the Influenza and Pneumococcal Vaccination Campaign carried out by the Health Care Financing Administration in conjunction with the Centers for Disease Control and Prevention and the National Coalition for Adult Immunization, is extended until the end of fiscal year 2002.

(b) AUTHORIZATION OF APPROPRIATION.—There are hereby authorized to be appropriated for each of fiscal years 1998 through

2002, \$8,000,000 for the Campaign described in subsection (a). Of the amount so authorized to be appropriated in each fiscal year, 60 percent of the amount so appropriated shall be payable from the Federal Hospital Insurance Trust Fund, and 40 percent shall be payable from the Federal Supplementary Medical Insurance Trust Fund.

SEC. 10108. STUDY ON PREVENTIVE BENEFITS.

(a) **STUDY.**—The Secretary of Health and Human Services shall request the National Academy of Sciences, in conjunction with the United States Preventive Services Task Force, to analyze the expansion or modification of preventive benefits provided to medicare beneficiaries under title XVIII of the Social Security Act. The analysis shall consider both the short term and long term benefits, and costs to the medicare program, of such expansion or modification,

(b) **REPORT.**—

(1) **INITIAL REPORT.**—Not later than 2 years after the date of the enactment of this Act, the Secretary shall submit a report on the findings of the analysis conducted under subsection (a) to the Committee on Ways and Means and the Committee on Commerce of the House of Representatives and the Committee on Finance of the Senate.

(2) **CONTENTS.**—Such report shall include specific findings with respect to coverage of the following preventive benefits:

(A) Nutrition therapy, including parenteral and enteral nutrition.

(B) Medically necessary dental care.

(C) Routine patient care costs for beneficiaries enrolled in approved clinical trial programs.

(D) Elimination of time limitation for coverage of immunosuppressive drugs for transplant patients.

(3) **FUNDING.**—From funds appropriated to the Department of Health and Human Services for fiscal years 1998 and 1999, the Secretary shall provide for such funding as may be necessary for the conduct of the analysis by the National Academy of Sciences under this section.

Subtitle C—Rural Initiatives

SEC. 10201. RURAL PRIMARY CARE HOSPITAL PROGRAM.

(a) **RURAL PRIMARY CARE HOSPITAL PROGRAM.**—Section 1820 (42 U.S.C. 1395i–4) is amended to read as follows:

“MEDICARE RURAL PRIMARY CARE HOSPITAL PROGRAM

“SEC. 1820. (a) **STATE DESIGNATION OF FACILITIES.**—

“(1) **IN GENERAL.**—A State may designate one or more facilities as a rural primary care hospital in accordance with paragraph (2).

“(2) **CRITERIA FOR DESIGNATION AS RURAL PRIMARY CARE HOSPITAL.**—A State may designate a facility as a rural primary care hospital if the facility—

“(A) is a nonprofit or public hospital, and is located in a county (or equivalent unit of local government) in a rural area (as defined in section 1886(d)(2)(D)) that—

“(i) is located a distance that corresponds to a travel time of greater than 30 minutes (using the guidelines specified under part IB1(b) of Appendix A to part 5 of title 42, Code of Federal Regulations, as in effect on October 1, 1996), from a hospital, or another facility described in this subsection, or

“(ii) is certified by the State as being a necessary provider of health care services to residents in the area because of local geography or service patterns;

“(B) makes available 24-hour emergency care services;

“(C) provides at any time not more than 15 acute care inpatient beds (meeting such standards as the Secretary may establish) for providing inpatient care for a period not to exceed 96 hours (unless a longer period is required because transfer to a hospital is precluded because of inclement weather or other emergency conditions), except that a peer review organization or equivalent entity may, on request, waive the 96-hour restriction on a case-by-case basis;

“(D) 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 and fully staffed, except insofar as the facility is required to make available emergency care services as determined under subparagraph (B) and must have nursing services available on a 24-hour basis, but need not otherwise staff the facility except when an inpatient is present,

“(ii) the facility may provide any services otherwise required to be provided by a full-time, on-site dietician, pharmacist, laboratory technician, medical technologist, and radiological technologist on a part-time, off-site basis under arrangements as defined in section 1861(w)(1), and

“(iii) the inpatient care described in subparagraph (C) may be provided by a physician’s assistant, nurse practitioner, or clinical nurse specialist subject to the oversight of a physician who need not be present in the facility;

“(E) meets the requirements of subparagraph (I) of paragraph (2) of section 1861(aa); and

“(F) has executed and in effect an agreement described in subsection (b)(1).

“(b) AGREEMENTS.—

“(1) IN GENERAL.—Each rural primary care hospital shall have an agreement with respect to each item described in paragraph (2) with at least 1 hospital (as defined in section 1861(e)).

“(2) ITEMS DESCRIBED.—The items described in this paragraph are the following:

“(A) Patient referral and transfer.

“(B) The development and use of communications systems including (where feasible)—

“(i) telemetry systems, and

“(ii) systems for electronic sharing of patient data.

“(C) The provision of emergency and non-emergency transportation between the facility and the hospital.

“(3) CREDENTIALING AND QUALITY ASSURANCE.—Each rural primary care hospital shall have an agreement with respect to credentialing and quality assurance with at least 1—

“(A) hospital,

“(B) peer review organization or equivalent entity, or

“(C) other appropriate and qualified entity identified by the State.

“(c) CERTIFICATION BY THE SECRETARY.—The Secretary shall certify a facility as a rural primary care hospital if the facility—

“(1) is designated as a rural primary care hospital by the State in which it is located; and

“(2) meets such other criteria as the Secretary may require.

“(d) PERMITTING MAINTENANCE OF SWING BEDS.—Nothing in this section shall be construed to prohibit a State from designating or the Secretary from certifying a facility as a rural primary care hospital solely because, at the time the facility applies to the State for designation as a rural primary care hospital, there is in effect an agreement between the facility and the Secretary under section 1883 under which the facility’s inpatient hospital facilities are used for the provision of extended care services, so long as the total number of beds that may be used at any time for the furnishing of either such services or acute care inpatient services does not exceed 25 beds and the number of beds used at any time for acute care inpatient services does not exceed 15 beds. For purposes of the previous sentence, any bed of a unit of the facility that is licensed as a distinct-part skilled nursing facility at the time the facility applies to the State for designation as a rural primary care hospital shall not be counted.

“(e) WAIVER OF CONFLICTING PART A PROVISIONS.—The Secretary is authorized to waive such provisions of this part and part C as are necessary to conduct the program established under this section.”

(b) PAYMENT ON A REASONABLE COST BASIS.—

(1) MEDICARE PART A.—Section 1814(l) (42 U.S.C. 1395f(l)) is amended to read as follows:

“(l) PAYMENT FOR INPATIENT RURAL PRIMARY CARE HOSPITAL SERVICES.—The amount of payment under this part for inpatient rural primary care hospital services is the reasonable costs of the rural primary care hospital in providing such services.”

(2) MEDICARE PART B.—Section 1834(g) (42 U.S.C. 1395m(g)) is amended to read as follows:

“(g) PAYMENT FOR OUTPATIENT RURAL PRIMARY CARE HOSPITAL SERVICES.—The amount of payment under this part for outpatient rural primary care hospital services is the reasonable costs of the rural primary care hospital in providing such services.”

(c) LENGTHENING MAXIMUM PERIOD OF PERMITTED INPATIENT STAY.—Section 1814(a)(8) (42 U.S.C. 1395f(a)(8)) is amended by striking “72 hours” and inserting “96 hours”.

(d) **PAYMENT CONTINUED TO DESIGNATED ESSENTIAL ACCESS COMMUNITY HOSPITALS AND DESIGNATED RURAL PRIMARY CARE HOSPITALS.**—

(1) **ESSENTIAL ACCESS COMMUNITY HOSPITALS.**—Section 1886(d)(5)(D) (42 U.S.C. 1395ww(d)(5)(D)) is amended—

(A) in clause (iii)(III), by inserting “as in effect on September 30, 1997” before the period at the end; and

(B) in clause (v), by inserting “as in effect on September 30, 1997” after “1820(i)(1)” and after “1820(g)”.

(2) **RURAL PRIMARY CARE HOSPITALS.**—Section 1861(mm)(1) (42 U.S.C. 1395x(mm)(1)) is amended by striking “1820(i)(2).” and inserting “1820(c), and includes a facility designated by the Secretary under section 1820(i)(2) as in effect on September 30, 1997.”.

(3) **MEDICAL ASSISTANCE FACILITY.**—Any facility that, as of March 1, 1997, operated as a limited service rural hospital under a demonstration described in section 4008(i)(1) of the Omnibus Budget Reconciliation Act of 1990 (42 U.S.C. 1395b–1 note) shall be treated as a rural primary care hospital for the purposes of title XVIII of the Social Security Act so long as it continues to meet the requirements of the demonstration protocol relating to staffing, services, quality assurance, and related factors.

(e) **CONFORMING AMENDMENT.**—Section 1883(a)(1) (42 U.S.C. 1395tt(a)(1)) is amended by inserting “or rural primary care hospital” after “Any hospital”.

(f) **EFFECTIVE DATE.**—The amendments made by this section shall apply to services furnished in cost reporting periods beginning on or after October 1, 1997.

SEC. 10202. PROHIBITING DENIAL OF REQUEST BY RURAL REFERRAL CENTERS FOR RECLASSIFICATION ON BASIS OF COMPARABILITY OF WAGES.

(a) **IN GENERAL.**—Section 1886(d)(10)(D) (42 U.S.C. 1395ww(d)(10)(D)) is amended—

(1) by redesignating clause (iii) as clause (iv); and

(2) by inserting after clause (ii) the following new clause:

“(iii) Under the guidelines published by the Secretary under clause (i), in the case of a hospital which has ever been classified by the Secretary as a rural referral center under paragraph (5)(C), the Board may not reject the application of the hospital under this paragraph on the basis of any comparison between the average hourly wage of the hospital and the average hourly wage of hospitals in the area in which it is located.”.

(b) **CONTINUING TREATMENT OF PREVIOUSLY DESIGNATED CENTERS.**—

(1) **IN GENERAL.**—Any hospital classified as a rural referral center by the Secretary of Health and Human Services under section 1886(d)(5)(C) of the Social Security Act for fiscal year 1991 shall be classified as such a rural referral center for fiscal year 1998 and each subsequent fiscal year.

(2) **BUDGET NEUTRALITY.**—The provisions of section 1886(d)(8)(D) of the Social Security Act shall apply to reclassifications made pursuant to paragraph (1) in the same manner

as such provisions apply to a reclassification under section 1886(d)(10) of such Act.

SEC. 10203. HOSPITAL GEOGRAPHIC RECLASSIFICATION PERMITTED FOR PURPOSES OF DISPROPORTIONATE SHARE PAYMENT ADJUSTMENTS.

(a) **IN GENERAL.**—Section 1886(d)(10)(C)(i) (42 U.S.C. 1395ww(d)(10)(C)(i)) is amended—

- (1) by striking “or” at the end of subclause (I);
- (2) by striking the period at the end of subclause (II) and inserting “, or”; and
- (3) by inserting after subclause (II) the following:

“(III) eligibility for and amount of additional payment amounts under paragraph (5)(F).”

(b) **APPLICABLE GUIDELINES.**—Such Board shall apply the guidelines established for reclassification under subclause (I) of section 1886(d)(10)(C)(i) of such Act to reclassification under subclause (III) of such section until the Secretary of Health and Human Services promulgates separate guidelines for reclassification under such subclause (III).

SEC. 10204. MEDICARE-DEPENDENT, SMALL RURAL HOSPITAL PAYMENT EXTENSION.

(a) **SPECIAL TREATMENT EXTENDED.**—

(1) **PAYMENT METHODOLOGY.**—Section 1886(d)(5)(G) (42 U.S.C. 1395ww(d)(5)(G)) is amended—

(A) in clause (i), by striking “October 1, 1994,” and inserting “October 1, 1994, or beginning on or after October 1, 1997, and before October 1, 2001,”; and

(B) in clause (ii)(II), by striking “October 1, 1994,” and inserting “October 1, 1994, or beginning on or after October 1, 1997, and before October 1, 2001,”.

(2) **EXTENSION OF TARGET AMOUNT.**—Section 1886(b)(3)(D) (42 U.S.C. 1395ww(b)(3)(D)) is amended—

(A) in the matter preceding clause (i), by striking “September 30, 1994,” and inserting “September 30, 1994, and for cost reporting periods beginning on or after October 1, 1997, and before October 1, 2001,”;

(B) in clause (ii), by striking “and” at the end;

(C) in clause (iii), by striking the period at the end and inserting “, and”; and

(D) by adding after clause (iii) the following new clause:

“(iv) with respect to discharges occurring during fiscal year 1998 through fiscal year 2000, the target amount for the preceding year increased by the applicable percentage increase under subparagraph (B)(iv).”

(3) **PERMITTING HOSPITALS TO DECLINE RECLASSIFICATION.**—Section 13501(e)(2) of OBRA-93 (42 U.S.C. 1395ww note) is amended by striking “or fiscal year 1994” and inserting “, fiscal year 1994, fiscal year 1998, fiscal year 1999, or fiscal year 2000”.

(b) **EFFECTIVE DATE.**—The amendments made by subsection (a) shall apply with respect to discharges occurring on or after October 1, 1997.

**SEC. 10205. GEOGRAPHIC RECLASSIFICATION FOR CERTAIN DIS-
PROPORTIONATELY LARGE HOSPITALS.**

(a) **NEW GUIDELINES FOR RECLASSIFICATION.**—Notwithstanding the guidelines published under subparagraph (D)(i)(I) of section 1886(d)(10) of the Social Security Act (42 U.S.C. 1395ww(d)(10)), the Secretary of Health and Human Services shall publish and use alternative guidelines under which a hospital described in subsection (b) qualifies for geographic reclassification under such section for a fiscal year beginning with fiscal year 1998.

(b) **HOSPITALS COVERED.**—A hospital described in this subsection is a hospital that demonstrates that—

(1) the average hourly wage paid by the hospital is not less than 108 percent of the average hourly wage paid by all other hospitals located in the Metropolitan Statistical Area (or the New England County Metropolitan Area) in which the hospital is located; and

(2) not less than 40 percent of the adjusted uninflated wages paid by all hospitals located in such Area is attributable to wages paid by the hospital.

SEC. 10206. FLOOR ON AREA WAGE INDEX.

(a) **IN GENERAL.**—For purposes of section 1886(d)(3)(E) of the Social Security Act for discharges occurring on or after October 1, 1997, the area wage index applicable under such section to any hospital which is not located in a rural area (as defined in section 1886(d)(2)(D) of such Act) may not be less than the area wage indices applicable under such section to hospitals located in rural areas in the State in which the hospital is located.

(b) **IMPLEMENTATION.**—The Secretary of Health and Human Services shall adjust the area wage indices referred to in subsection (a) for hospitals not described in such subsection in a manner which assures that the aggregate payments made under section 1886(d) of the Social Security Act in a fiscal year for the operating costs of inpatient hospital services are not greater or less than those which would have been made in the year if this section did not apply.

SEC. 10207. INFORMATICS, TELEMEDICINE, AND EDUCATION DEMONSTRATION PROJECT.

(a) **PURPOSE AND AUTHORIZATION.**—

(1) **IN GENERAL.**—Not later than 9 months after the date of enactment of this section, the Secretary of Health and Human Services shall provide for a demonstration project described in paragraph (2).

(2) **DESCRIPTION OF PROJECT.**—

(A) **IN GENERAL.**—The demonstration project described in this paragraph is a single demonstration project to use eligible health care provider telemedicine networks to apply high-capacity computing and advanced networks to improve primary care (and prevent health care complications) to medicare beneficiaries with diabetes mellitus who are residents of medically underserved rural areas or residents of medically underserved inner-city areas.

(B) **MEDICALLY UNDERSERVED DEFINED.**—As used in this paragraph, the term “medically underserved” has the

meaning given such term in section 330(b)(3) of the Public Health Service Act (42 U.S.C. 254b(b)(3)).

(3) **WAIVER.**—The Secretary shall waive such provisions of title XVIII of the Social Security Act as may be necessary to provide for payment for services under the project in accordance with subsection (d).

(4) **DURATION OF PROJECT.**—The project shall be conducted over a 4-year period.

(b) **OBJECTIVES OF PROJECT.**—The objectives of the project include the following:

(1) Improving patient access to and compliance with appropriate care guidelines for individuals with diabetes mellitus through direct telecommunications link with information networks in order to improve patient quality-of-life and reduce overall health care costs.

(2) Developing a curriculum to train, and providing standards for credentialing and licensure of, health professionals (particularly primary care health professionals) in the use of medical informatics and telecommunications.

(3) Demonstrating the application of advanced technologies, such as video-conferencing from a patient's home, remote monitoring of a patient's medical condition, interventional informatics, and applying individualized, automated care guidelines, to assist primary care providers in assisting patients with diabetes in a home setting.

(4) Application of medical informatics to residents with limited English language skills.

(5) Developing standards in the application of telemedicine and medical informatics.

(6) Developing a model for the cost-effective delivery of primary and related care both in a managed care environment and in a fee-for-service environment.

(c) **ELIGIBLE HEALTH CARE PROVIDER TELEMEDICINE NETWORK DEFINED.**—For purposes of this section, the term “eligible health care provider telemedicine network” means a consortium that includes at least one tertiary care hospital (but no more than 2 such hospitals), at least one medical school, no more than 4 facilities in rural or urban areas, and at least one regional telecommunications provider and that meets the following requirements:

(1) The consortium is located in an area with one of the highest concentrations of medical schools and tertiary care facilities in the United States and has appropriate arrangements (within or outside the consortium) with such schools and facilities, universities, and telecommunications providers, in order to conduct the project.

(2) The consortium submits to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require, including a description of the use to which the consortium would apply any amounts received under the project and the source and amount of non-Federal funds used in the project.

(3) The consortium guarantees that it will be responsible for payment for all costs of the project that are not paid under this section and that the maximum amount of payment that may

be made to the consortium under this section shall not exceed the amount specified in subsection (d)(3).

(d) COVERAGE AS MEDICARE PART B SERVICES.—

(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, services related to the treatment or management of (including prevention of complications from) diabetes for medicare beneficiaries furnished under the project shall be considered to be services covered under part B of title XVIII of the Social Security Act.

(2) PAYMENTS.—

(A) IN GENERAL.—Subject to paragraph (3), payment for such services shall be made at a rate of 50 percent of the costs that are reasonable and related to the provision of such services. In computing such costs, the Secretary shall include costs described in subparagraph (B), but may not include costs described in subparagraph (C).

(B) COSTS THAT MAY BE INCLUDED.—The costs described in this subparagraph are the permissible costs (as recognized by the Secretary) for the following:

(i) The acquisition of telemedicine equipment for use in patients' homes (but only in the case of patients located in medically underserved areas).

(ii) Curriculum development and training of health professionals in medical informatics and telemedicine.

(iii) Payment of telecommunications costs (including salaries and maintenance of equipment), including costs of telecommunications between patients' homes and the eligible network and between the network and other entities under the arrangements described in subsection (c)(1).

(iv) Payments to practitioners and providers under the medicare programs.

(C) COSTS NOT INCLUDED.—The costs described in this subparagraph are costs for any of the following:

(i) The purchase or installation of transmission equipment (other than such equipment used by health professionals to deliver medical informatics services under the project).

(ii) The establishment or operation of a telecommunications common carrier network.

(iii) Construction (except for minor renovations related to the installation of reimbursable equipment) or the acquisition or building of real property.

(3) LIMITATION.—The total amount of the payments that may be made under this section shall not exceed \$30,000,000.

(4) LIMITATION ON COST-SHARING.—The project may not impose cost sharing on a medicare beneficiary for the receipt of services under the project in excess of 20 percent of the recognized costs of the project attributable to such services.

(e) REPORTS.—The Secretary shall submit to the Committees on Ways and Means and Commerce of the House of Representatives and the Committee on Finance of the Senate interim reports on the project and a final report on the project within 6 months after the conclusion of the project. The final report shall include an evalua-

tion of the impact of the use of telemedicine and medical informatics on improving access of medicare beneficiaries to health care services, on reducing the costs of such services, and on improving the quality of life of such beneficiaries.

(f) DEFINITIONS.—For purposes of this section:

(1) INTERVENTIONAL INFORMATICS.—The term “interventional informatics” means using information technology and virtual reality technology to intervene in patient care.

(2) MEDICAL INFORMATICS.—The term “medical informatics” means the storage, retrieval, and use of biomedical and related information for problem solving and decision-making through computing and communications technologies.

(3) PROJECT.—The term “project” means the demonstration project under this section.

Subtitle D—Anti-Fraud and Abuse Provisions

SEC. 10301. PERMANENT EXCLUSION FOR THOSE CONVICTED OF 3 HEALTH CARE RELATED CRIMES.

Section 1128(c)(3) (42 U.S.C. 1320a–7(c)(3)) is amended—

(1) in subparagraph (A), by inserting “or in the case described in subparagraph (G)” after “subsection (b)(12)”;

(2) in subparagraphs (B) and (D), by striking “In the case” and inserting “Subject to subparagraph (G), in the case”; and

(3) by adding at the end the following new subparagraph:

“(G) In the case of an exclusion of an individual under subsection (a) based on a conviction occurring on or after the date of the enactment of this subparagraph, if the individual has (before, on, or after such date and before the date of the conviction for which the exclusion is imposed) been convicted—

“(i) on one previous occasion of one or more offenses for which an exclusion may be effected under such subsection, the period of the exclusion shall be not less than 10 years, or

“(ii) on 2 or more previous occasions of one or more offenses for which an exclusion may be effected under such subsection, the period of the exclusion shall be permanent.”.

SEC. 10302. AUTHORITY TO REFUSE TO ENTER INTO MEDICARE AGREEMENTS WITH INDIVIDUALS OR ENTITIES CONVICTED OF FELONIES.

(a) MEDICARE PART A.—Section 1866(b)(2) (42 U.S.C. 1395cc(b)(2)) is amended—

(1) by striking “or” at the end of subparagraph (B);

(2) by striking the period at the end of subparagraph (C) and inserting “, or”; and

(3) by adding after subparagraph (C) the following new subparagraph:

“(D) has ascertained that the provider has been convicted of a felony under Federal or State law for an offense which the Secretary determines is inconsistent with the best interests of program beneficiaries.”.

(b) MEDICARE PART B.—Section 1842 (42 U.S.C. 1395u) is amended by adding after subsection (r) the following new subsection:

“(s) The Secretary may refuse to enter into an agreement with a physician or supplier under subsection (h) or may terminate or refuse to renew such agreement, in the event that such physician or supplier has been convicted of a felony under Federal or State law for an offense which the Secretary determines is inconsistent with the best interests of program beneficiaries.”.

(c) **MEDICAID.**—For provisions amending title XIX of the Social Security Act to provide similar treatment under the medicaid program, see section ____.

(d) **EFFECTIVE DATE.**—The amendments made by this section shall take effect on the date of the enactment of this Act and apply to the entry and renewal of contracts on or after such date.

SEC. 10303. INCLUSION OF TOLL-FREE NUMBER TO REPORT MEDICARE WASTE, FRAUD, AND ABUSE IN EXPLANATION OF BENEFITS FORMS.

(a) **IN GENERAL.**—Section 1842(h)(7) (42 U.S.C. 1395u(h)(7)) is amended—

- (1) by striking “and” at the end of subparagraph (C),
- (2) by striking the period at the end of subparagraph (D) and inserting “; and”, and
- (3) by adding at the end the following new subparagraph:

“(E) a toll-free telephone number maintained by the Inspector General in the Department of Health and Human Services for the receipt of complaints and information about waste, fraud, and abuse in the provision or billing of services under this title.”.

(b) **EFFECTIVE DATE.**—The amendments made by subsection (a) shall apply to explanations of benefits provided on or after such date (not later than January 1, 1999) as the Secretary of Health and Human Services shall provide.

SEC. 10304. LIABILITY OF MEDICARE CARRIERS AND FISCAL INTERMEDIARIES FOR CLAIMS SUBMITTED BY EXCLUDED PROVIDERS.

(a) **REIMBURSEMENT TO THE SECRETARY FOR AMOUNTS PAID TO EXCLUDED PROVIDERS.**—

(1) **REQUIREMENTS FOR FISCAL INTERMEDIARIES.**—

(A) **IN GENERAL.**—Section 1816 (42 U.S.C. 1395h) is amended by adding at the end the following new subsection:

“(m) An agreement with an agency or organization under this section shall require that such agency or organization reimburse the Secretary for any amounts paid by the agency or organization for a service under this title which is furnished, directed, or prescribed by an individual or entity during any period for which the individual or entity is excluded pursuant to section 1128, 1128A, or 1156, from participation in the program under this title, if the amounts are paid after the Secretary notifies the agency or organization of the exclusion.”.

(B) **CONFORMING AMENDMENT.**—Subsection (i) of such section is amended by adding at the end the following new paragraph:

“(4) Nothing in this subsection shall be construed to prohibit reimbursement by an agency or organization under subsection (m).”.

(2) REQUIREMENTS FOR CARRIERS.—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 reimburse the Secretary for any amounts paid by the carrier for an item or service under this part which is furnished, directed, or prescribed by an individual or entity during any period for which the individual or entity is excluded pursuant to section 1128, 1128A, or 1156, from participation in the program under this title, if the amounts are paid after the Secretary notifies the carrier of the exclusion, and”.

(3) REFERENCE TO MEDICAID PROVISION.—For provision imposing similar restrictions on States under the medicaid program under title XIX of the Social Security Act, see section

(b) CONFORMING REPEAL OF MANDATORY PAYMENT RULE.—Paragraph (2) of section 1862(e) (42 U.S.C. 1395y(e)) is amended to read as follows:

“(2) No individual or entity may bill (or collect any amount from) any individual for any item or service for which payment is denied under paragraph (1). No person is liable for payment of any amounts billed for such an item or service in violation of the previous sentence.”.

(c) EFFECTIVE DATES.—The amendments made by this section shall apply to contracts and agreements entered into, renewed, or extended after the date of the enactment of this Act, but only with respect to claims submitted on or after the later of January 1, 1998, or the date such entry, renewal, or extension becomes effective.

SEC. 10305. EXCLUSION OF ENTITY CONTROLLED BY FAMILY MEMBER OF A SANCTIONED INDIVIDUAL.

(a) IN GENERAL.—Section 1128 (42 U.S.C. 1320a–7) is amended—

- (1) in subsection (b)(8)(A)—
 - (A) by striking “or” at the end of clause (i), and
 - (B) by striking the dash at the end of clause (ii) and inserting “; or”, and
 - (C) by inserting after clause (ii) the following:

“(iii) who was described in clause (i) but is no longer so described because of a transfer of ownership or control interest, in anticipation of (or following) a conviction, assessment, or exclusion described in subparagraph (B) against the person, to an immediate family member (as defined in subsection (j)(1)) or a member of the household of the person (as defined in subsection (j)(2)) who continues to maintain an interest described in such clause—”; and

(2) by adding after subsection (i) the following new subsection:

“(j) DEFINITION OF IMMEDIATE FAMILY MEMBER AND MEMBER OF HOUSEHOLD.—For purposes of subsection (b)(8)(A)(iii):

“(1) The term ‘immediate family member’ means, with respect to a person—

- “(A) the husband or wife of the person;

“(B) the natural or adoptive parent, child, or sibling of the person;

“(C) the stepparent, stepchild, stepbrother, or stepsister of the person;

“(D) the father-, mother-, daughter-, son-, brother-, or sister-in-law of the person;

“(E) the grandparent or grandchild of the person; and

“(F) the spouse of a grandparent or grandchild of the person.

“(2) The term ‘member of the household’ means, with respect to a person, any individual sharing a common abode as part of a single family unit with the person, including domestic employees and others who live together as a family unit, but not including a roomer or boarder.”.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall take effect on the date that is 45 days after the date of the enactment of this Act.

SEC. 10306. IMPOSITION OF CIVIL MONEY PENALTIES.

(a) CIVIL MONEY PENALTIES FOR PERSONS THAT CONTRACT WITH EXCLUDED INDIVIDUALS.—Section 1128A(a) (42 U.S.C. 1320a–7a(a)) is amended—

(1) by striking “or” at the end of paragraph (4);

(2) by adding “or” at the end of paragraph (5); and

(3) by adding after paragraph (5) the following new paragraph:

“(6) arranges or contracts (by employment or otherwise) with an individual or entity that the person knows or should know is excluded from participation in a Federal health care program (as defined in section 1128B(f)), for the provision of items or services for which payment may be made under such a program;”.

(b) CIVIL MONEY PENALTIES FOR SERVICES ORDERED OR PRESCRIBED BY AN EXCLUDED INDIVIDUAL OR ENTITY.—Section 1128A(a)(1) (42 U.S.C. 1320a–7a(a)(1)) is amended—

(1) in subparagraph (D)—

(A) by inserting “, ordered, or prescribed by such person” after “other item or service furnished”;

(B) by inserting “(pursuant to this title or title XVIII)” after “period in which the person was excluded”; and

(C) by striking “pursuant to a determination by the Secretary” and all that follows through “the provisions of section 1842(j)(2)”; and

(D) by striking “or” at the end;

(2) by redesignating subparagraph (E) as subparagraph (F); and

(3) by inserting after subparagraph (D) the following new subparagraph:

“(E) is for a medical or other item or service ordered or prescribed by a person excluded (pursuant to this title or title XVIII) from the program under which the claim was made, and the person furnishing such item or service knows or should know of such exclusion, or”.

(c) EFFECTIVE DATES.—

(1) **CONTRACTS WITH EXCLUDED PERSONS.**—The amendments made by subsection (a) shall apply to arrangements and contracts entered into after the date of the enactment of this Act.

(2) **SERVICES ORDERED OR PRESCRIBED.**—The amendments made by subsection (b) shall apply to items and services furnished ordered or prescribed after the date of the enactment of this Act.

SEC. 10307. DISCLOSURE OF INFORMATION AND SURETY BONDS.

(a) **DISCLOSURE OF INFORMATION AND SURETY BOND REQUIREMENT FOR SUPPLIERS OF DURABLE MEDICAL EQUIPMENT.**—Section 1834(a) (42 U.S.C. 1395m(a)) is amended by inserting after paragraph (15) the following new paragraph:

“(16) **CONDITIONS FOR ISSUANCE OF PROVIDER NUMBER.**—The Secretary shall not provide for the issuance (or renewal) of a provider number for a supplier of durable medical equipment, for purposes of payment under this part for durable medical equipment furnished by the supplier, unless the supplier provides the Secretary on a continuing basis with—

“(A)(i) full and complete information as to the identity of each person with an ownership or control interest (as defined in section 1124(a)(3)) in the supplier or in any subcontractor (as defined by the Secretary in regulations) in which the supplier directly or indirectly has a 5 percent or more ownership interest, and

“(ii) to the extent determined to be feasible under regulations of the Secretary, the name of any disclosing entity (as defined in section 1124(a)(2)) with respect to which a person with such an ownership or control interest in the supplier is a person with such an ownership or control interest in the disclosing entity; and

“(B) a surety bond in a form specified by the Secretary and in an amount that is not less than \$50,000.

The Secretary may waive the requirement of a bond under subparagraph (B) in the case of a supplier that provides a comparable surety bond under State law.”.

(b) **SURETY BOND REQUIREMENT FOR HOME HEALTH AGENCIES.**—(1) **IN GENERAL.**—Section 1861(o) (42 U.S.C. 1395x(o)) is amended—

(A) in paragraph (7), by inserting “and including providing the Secretary on a continuing basis with a surety bond in a form specified by the Secretary and in an amount that is not less than \$50,000” after “financial security of the program”, and

(B) by adding at the end the following: “The Secretary may waive the requirement of a bond under paragraph (7) in the case of an agency or organization that provides a comparable surety bond under State law.”.

(2) **CONFORMING AMENDMENTS.**—Section 1861(v)(1)(H) (42 U.S.C. 1395x(v)(1)(H)) is amended—

(A) in clause (i), by striking “the financial security requirement” and inserting “the financial security and surety bond requirements”; and

(B) in clause (ii), by striking “the financial security requirement described in subsection (o)(7) applies” and in-

serting “the financial security and surety bond requirements described in subsection (o)(7) apply”.

(3) REFERENCE TO CURRENT DISCLOSURE REQUIREMENT.—For provision of current law requiring home health agencies to disclose information on ownership and control interests, see section 1124 of the Social Security Act.

(c) AUTHORIZING APPLICATION OF DISCLOSURE AND SURETY BOND REQUIREMENTS TO AMBULANCE SERVICES AND CERTAIN CLINICS.—Section 1834(a)(16) (42 U.S.C. 1395m(a)(16)), as added by subsection (a), is amended by adding at the end the following: “The Secretary, in the Secretary’s discretion, may impose the requirements of the previous sentence with respect to some or all classes of suppliers of ambulance services described in section 1861(s)(7) and clinics that furnish medical and other health services (other than physicians’ services) under this part.”.

(d) APPLICATION TO COMPREHENSIVE OUTPATIENT REHABILITATION FACILITIES (CORFs).—Section 1861(cc)(2) (42 U.S.C. 1395x(cc)(2)) is amended—

(1) in subparagraph (I), by inserting before the period at the end the following: “and providing the Secretary on a continuing basis with a surety bond in a form specified by the Secretary and in an amount that is not less than \$50,000”, and

(2) by adding after and below subparagraph (I) the following: “The Secretary may waive the requirement of a bond under subparagraph (I) in the case of a facility that provides a comparable surety bond under State law.”.

(e) APPLICATION TO REHABILITATION AGENCIES.—Section 1861(p) (42 U.S.C. 1395x(p)) is amended—

(1) in paragraph (4)(A)(v), by inserting after “as the Secretary may find necessary,” the following: “and provides the Secretary, to the extent required by the Secretary, on a continuing basis with a surety bond in a form specified by the Secretary and in an amount that is not less than \$50,000,”, and

(2) by adding at the end the following: “The Secretary may waive the requirement of a bond under paragraph (4)(A)(v) in the case of a clinic or agency that provides a comparable surety bond under State law.”.

(f) EFFECTIVE DATES.—(1) The amendment made by subsection (a) shall apply to suppliers of durable medical equipment with respect to such equipment furnished on or after January 1, 1998.

(2) The amendments made by subsection (b) shall apply to home health agencies with respect to services furnished on or after such date. The Secretary of Health and Human Services shall modify participation agreements under section 1866(a)(1) of the Social Security Act with respect to home health agencies to provide for implementation of such amendments on a timely basis.

(3) The amendments made by subsections (c) through (e) shall take effect on the date of the enactment of this Act and may be applied with respect to items and services furnished on or after the date specified in paragraph (1).

SEC. 10308. PROVISION OF CERTAIN IDENTIFICATION NUMBERS.

(a) REQUIREMENTS TO DISCLOSE EMPLOYER IDENTIFICATION NUMBERS (EINS) AND SOCIAL SECURITY ACCOUNT NUMBERS (SSNs).—Section 1124(a)(1) (42 U.S.C. 1320a–3(a)(1)) is amended by insert-

ing before the period at the end the following: “and supply the Secretary with both the employer identification number (assigned pursuant to section 6109 of the Internal Revenue Code of 1986) and social security account number (assigned under section 205(c)(2)(B)) of the disclosing entity, each person with an ownership or control interest (as defined in subsection (a)(3)), and any subcontractor in which the entity directly or indirectly has a 5 percent or more ownership interest”.

(b) OTHER MEDICARE PROVIDERS.—Section 1124A (42 U.S.C. 1320a–3a) is amended—

(1) in subsection (a)—

(A) by striking “and” at the end of paragraph (1);

(B) by striking the period at the end of paragraph (2) and inserting “; and”; and

(C) by adding at the end the following new paragraph:
 “(3) including the employer identification number (assigned pursuant to section 6109 of the Internal Revenue Code of 1986) and social security account number (assigned under section 205(c)(2)(B)) of the disclosing part B provider and any person, managing employee, or other entity identified or described under paragraph (1) or (2).”; and

(2) in subsection (c) by inserting “(or, for purposes of subsection (a)(3), any entity receiving payment)” after “on an assignment-related basis”.

(c) VERIFICATION BY SOCIAL SECURITY ADMINISTRATION (SSA).—Section 1124A (42 U.S.C. 1320a–3a) is amended—

(1) by redesignating subsection (c) as subsection (d); and

(2) by inserting after subsection (b) the following new subsection:

“(c) VERIFICATION.—

“(1) TRANSMITTAL BY HHS.—The Secretary shall transmit—

“(A) to the Commissioner of Social Security information concerning each social security account number (assigned under section 205(c)(2)(B)), and

“(B) to the Secretary of the Treasury information concerning each employer identification number (assigned pursuant to section 6109 of the Internal Revenue Code of 1986),

supplied to the Secretary pursuant to subsection (a)(3) or section 1124(c) to the extent necessary for verification of such information in accordance with paragraph (2).

“(2) VERIFICATION.—The Commissioner of Social Security and the Secretary of the Treasury shall verify the accuracy of, or correct, the information supplied by the Secretary to such official pursuant to paragraph (1), and shall report such verifications or corrections to the Secretary.

“(3) FEES FOR VERIFICATION.—The Secretary shall reimburse the Commissioner and Secretary of the Treasury, at a rate negotiated between the Secretary and such official, for the costs incurred by such official in performing the verification and correction services described in this subsection.”.

(d) REPORT.—The Secretary of Health and Human Services shall submit to Congress a report on steps the Secretary has taken to assure the confidentiality of social security account numbers that will

be provided to the Secretary under the amendments made by this section.

(e) EFFECTIVE DATES.—

(1) The amendment made by subsection (a) shall apply to the application of conditions of participation, and entering into and renewal of contracts and agreements, occurring more than 90 days after the date of submission of the report under subsection (d).

(2) The amendments made by subsection (b) shall apply to payment for items and services furnished more than 90 days after the date of submission of such report.

SEC. 10309. ADVISORY OPINIONS REGARDING CERTAIN PHYSICIAN SELF-REFERRAL PROVISIONS.

Section 1877(g) (42 U.S.C. 1395nn(g)) is amended by adding at the end the following new paragraph:

“(6) ADVISORY OPINIONS.—

“(A) IN GENERAL.—The Secretary shall issue written advisory opinions concerning whether a referral relating to designated health services (other than clinical laboratory services) is prohibited under this section.

“(B) BINDING AS TO SECRETARY AND PARTIES INVOLVED.—Each advisory opinion issued by the Secretary shall be binding as to the Secretary and the party or parties requesting the opinion.

“(C) APPLICATION OF CERTAIN PROCEDURES.—The Secretary shall, to the extent practicable, apply the regulations promulgated under section 1128D(b)(5) to the issuance of advisory opinions under this paragraph.

“(D) APPLICABILITY.—This paragraph shall apply to requests for advisory opinions made during the period described in section 1128D(b)(6).”.

SEC. 10310. OTHER FRAUD AND ABUSE RELATED PROVISIONS.

(a) REFERENCE CORRECTION.—(1) Section 1128D(b)(2)(D) (42 U.S.C. 1320a–7d(b)(2)(D)), as added by section 205 of the Health Insurance Portability and Accountability Act of 1996, is amended by striking “1128B(b)” and inserting “1128A(b)”.

(2) Section 1128E(g)(3)(C) (42 U.S.C. 1320a–7e(g)(3)(C)) is amended by striking “Veterans’ Administration” and inserting “Department of Veterans Affairs”.

(b) LANGUAGE IN DEFINITION OF CONVICTION.—Section 1128E(g)(5) (42 U.S.C. 1320a–7e(g)(5)), as inserted by section 221(a) of the Health Insurance Portability and Accountability Act of 1996, is amended by striking “paragraph (4)” and inserting “paragraphs (1) through (4)”.

(c) IMPLEMENTATION OF EXCLUSIONS.—Section 1128 (42 U.S.C. 1320a–7) is amended—

(1) in subsection (a), by striking “any program under title XVIII and shall direct that the following individuals and entities be excluded from participation in any State health care program (as defined in subsection (h))” and inserting “any Federal health care program (as defined in section 1128B(f))”; and

(2) in subsection (b), by striking “any program under title XVIII and may direct that the following individuals and enti-

ties be excluded from participation in any State health care program” and inserting “any Federal health care program (as defined in section 1128B(f))”.

(d) **SANCTIONS FOR FAILURE TO REPORT.**—Section 1128E(b) (42 U.S.C. 1320a–7e(b)), as inserted by section 221(a) of the Health Insurance Portability and Accountability Act of 1996, is amended by adding at the end the following:

“(6) **SANCTIONS FOR FAILURE TO REPORT.**—

“(A) **HEALTH PLANS.**—Any health plan that fails to report information on an adverse action required to be reported under this subsection shall be subject to a civil money penalty of not more than \$25,000 for each such adverse action not reported. Such penalty shall be imposed and collected in the same manner as civil money penalties under subsection (a) of section 1128A are imposed and collected under that section.

“(B) **GOVERNMENTAL AGENCIES.**—The Secretary shall provide for a publication of a public report that identifies those Government agencies that have failed to report information on adverse actions as required to be reported under this subsection.”.

(e) **EFFECTIVE DATES.**—

(1) **IN GENERAL.**—Except as provided in this subsection, the amendments made by this section shall be effective as if included in the enactment of the Health Insurance Portability and Accountability Act of 1996.

(2) **FEDERAL HEALTH PROGRAM.**—The amendments made by subsection (c) shall take effect on the date of the enactment of this Act.

(3) **SANCTION FOR FAILURE TO REPORT.**—The amendment made by subsection (d) shall apply to failures occurring on or after the date of the enactment of this Act.

Subtitle E—Prospective Payment Systems

CHAPTER 1—PAYMENT UNDER PART A

SEC. 10401. PROSPECTIVE PAYMENT FOR SKILLED NURSING FACILITY SERVICES.

(a) **IN GENERAL.**—Section 1888 (42 U.S.C. 1395yy) is amended by adding at the end the following new subsection:

“(e) **PROSPECTIVE PAYMENT.**—

“(1) **PAYMENT PROVISION.**—Notwithstanding any other provision of this title, subject to paragraph (7), the amount of the payment for all costs (as defined in paragraph (2)(B)) of covered skilled nursing facility services (as defined in paragraph (2)(A)) for each day of such services furnished—

“(A) in a cost reporting period during the transition period (as defined in paragraph (2)(E)), is equal to the sum of—

“(i) the non-Federal percentage of the facility-specific per diem rate (computed under paragraph (3)), and

“(ii) the Federal percentage of the adjusted Federal per diem rate (determined under paragraph (4)) applicable to the facility; and

“(B) after the transition period is equal to the adjusted Federal per diem rate applicable to the facility.

“(2) DEFINITIONS.—For purposes of this subsection:

“(A) COVERED SKILLED NURSING FACILITY SERVICES.—

“(i) IN GENERAL.—The term ‘covered skilled nursing facility services’—

“(I) means post-hospital extended care services as defined in section 1861(i) for which benefits are provided under part A; and

“(II) includes all items and services (other than services described in clause (ii)) for which payment may be made under part B and which are furnished to an individual who is a resident of a skilled nursing facility during the period in which the individual is provided covered post-hospital extended care services.

“(ii) SERVICES EXCLUDED.—Services described in this clause are physicians’ services, services described by clauses (i) through (iii) of section 1861(s)(2)(K), certified nurse-midwife services, qualified psychologist services, services of a certified registered nurse anesthetist, items and services described in subparagraphs in (F) and (O) of section 1861(s)(2), and, only with respect to services furnished during 1998, the transportation costs of electrocardiogram equipment for electrocardiogram tests services (HCPCS Code R0076). Services described in this clause do not include any physical, occupational, or speech-language therapy services regardless of whether or not the services are furnished by, or under the supervision of, a physician or other health care professional.

“(B) ALL COSTS.—The term ‘all costs’ means routine service costs, ancillary costs, and capital-related costs of covered skilled nursing facility services, but does not include costs associated with approved educational activities.

“(C) NON-FEDERAL PERCENTAGE; FEDERAL PERCENTAGE.—For—

“(i) the first cost reporting period (as defined in subparagraph (D)) of a facility, the ‘non-Federal percentage’ is 75 percent and the ‘Federal percentage’ is 25 percent;

“(ii) the next cost reporting period of such facility, the ‘non-Federal percentage’ is 50 percent and the ‘Federal percentage’ is 50 percent; and

“(iii) the subsequent cost reporting period of such facility, the ‘non-Federal percentage’ is 25 percent and the ‘Federal percentage’ is 75 percent.

“(D) FIRST COST REPORTING PERIOD.—The term ‘first cost reporting period’ means, with respect to a skilled nursing facility, the first cost reporting period of the facility beginning on or after July 1, 1998.

“(E) TRANSITION PERIOD.—

“(i) IN GENERAL.—The term ‘transition period’ means, with respect to a skilled nursing facility, the 3 cost reporting periods of the facility beginning with the first cost reporting period.

“(ii) TREATMENT OF NEW SKILLED NURSING FACILITIES.—In the case of a skilled nursing facility that does not have a settled cost report for a cost reporting period before July 1, 1998, payment for such services shall be made under this subsection as if all services were furnished after the transition period.

“(3) DETERMINATION OF FACILITY SPECIFIC PER DIEM RATES.—The Secretary shall determine a facility-specific per diem rate for each skilled nursing facility for a cost reporting period as follows:

“(A) DETERMINING BASE PAYMENTS.—The Secretary shall determine, on a per diem basis, the total of—

“(i) the allowable costs of extended care services for the facility for cost reporting periods beginning in 1995 with appropriate adjustments (as determined by the Secretary) to non-settled cost reports, and

“(ii) an estimate of the amounts that would be payable under part B (disregarding any applicable deductibles, coinsurance and copayments) for covered skilled nursing facility services described in paragraph (2)(A)(i)(II) furnished during such period to an individual who is a resident of the facility, regardless of whether or not the payment was made to the facility or to another entity.

“(B) UPDATE TO COST REPORTING PERIOD BEFORE FIRST COST REPORTING PERIOD.—The Secretary shall update the amount determined under subparagraph (A), for each cost reporting period after the cost reporting period described in subparagraph (A)(i) and up to the cost reporting period immediately preceding the first cost reporting period, by the skilled nursing facility historical trend factor.

“(C) UPDATING TO APPLICABLE COST REPORTING PERIOD.—The Secretary shall further update such amount for each cost reporting period beginning with the first cost reporting period and up to and including the cost reporting period involved by a factor equal to the skilled nursing facility market basket percentage increase.

“(4) FEDERAL PER DIEM RATE.—

“(A) DETERMINATION OF HISTORICAL PER DIEM FOR FREESTANDING FACILITIES.—For each freestanding skilled nursing facility that received payments for post-hospital extended care services during a cost reporting period beginning in fiscal year 1995 and that was subject to (and not exempted from) the per diem limits referred to in paragraph (1) or (2) of subsection (a) (and facilities described in subsection (d), if appropriate), the Secretary shall estimate, on a per diem basis for such cost reporting period, the total of—

“(i) the allowable costs of extended care services for the facility for cost reporting periods beginning in 1995 with appropriate adjustments (as determined by the Secretary) to non-settled cost reports, and

“(ii) an estimate of the amounts that would be payable under part B (disregarding any applicable deductibles, coinsurance and copayments) for covered skilled nursing facility services described in paragraph (2)(A)(i)(II) furnished during such period to an individual who is a resident of the facility, regardless of whether or not the payment was made to the facility or to another entity.

“(B) UPDATE TO FISCAL YEAR 1998.—The Secretary shall update the amount determined under subparagraph (A), for each cost reporting period after the cost reporting period described in subparagraph (A)(i) and up to the cost reporting period immediately preceding the first cost reporting period, by the skilled nursing facility historical trend factor for such period.

“(C) COMPUTATION OF STANDARDIZED PER DIEM RATE.—The Secretary shall standardize the amount updated under subparagraph (B) for each facility by—

“(i) adjusting for variations among facility by area in the average facility wage level per diem, and

“(ii) adjusting for variations in case mix per diem among facilities.

“(D) COMPUTATION OF WEIGHTED AVERAGE PER DIEM RATE.—The Secretary shall compute a weighted average per diem rate by computing an average of the standardized amounts computed under subparagraph (C), weighted for each facility by number of days of extended care services furnished during the cost reporting period referred to in subparagraph (A). The Secretary may compute and apply such average separately for facilities located in urban and rural areas (as defined in section 1886(d)(2)(D)).

“(E) UPDATING.—

“(i) FISCAL YEAR 1998.—For fiscal year 1998, the Secretary shall compute for each skilled nursing facility an unadjusted Federal per diem rate equal to the weighted average per diem rate computed under subparagraph (D) and applicable to the facility increased by skilled nursing facility market basket percentage change for the fiscal year involved.

“(ii) SUBSEQUENT FISCAL YEARS.—For each subsequent fiscal year the Secretary shall compute for each skilled nursing facility an unadjusted Federal per diem rate equal to the Federal per diem rate computed under this subparagraph for the previous fiscal year and applicable to the facility increased by the skilled nursing facility market basket percentage change for the fiscal year involved.

“(F) ADJUSTMENT FOR CASE MIX CREEP.—Insofar as the Secretary determines that such adjustments under subparagraph (G)(i) for a previous fiscal year (or esti-

mates that such adjustments for a future fiscal year did (or are likely to) result in a change in aggregate payments under this subsection during the fiscal year that are a result of changes in the coding or classification of residents that do not reflect real changes in case mix, the Secretary may adjust unadjusted Federal per diem rates for subsequent years so as to discount the effect of such coding or classification changes.

“(G) APPLICATION TO SPECIFIC FACILITIES.—The Secretary shall compute for each skilled nursing facility for each fiscal year (beginning with fiscal year 1998) an adjusted Federal per diem rate equal to the unadjusted Federal per diem rate determined under subparagraph (E), as adjusted under subparagraph (F), and as further adjusted as follows:

“(i) ADJUSTMENT FOR CASE MIX.—The Secretary shall provide for an appropriate adjustment to account for case mix. Such adjustment shall be based on a resident classification system, established by the Secretary, that accounts for the relative resource utilization of different patient types. The case mix adjustment shall be based on resident assessment data and other data that the Secretary considers appropriate.

“(ii) ADJUSTMENT FOR GEOGRAPHIC VARIATIONS IN LABOR COSTS.—The Secretary shall adjust the portion of such per diem rate attributable to wages and wage-related costs for the area in which the facility is located compared to the national average of such costs using an appropriate wage index as determined by the Secretary. Such adjustment shall be done in a manner that does not result in aggregate payments under this subsection that are greater or less than those that would otherwise be made if such adjustment had not been made.

“(H) PUBLICATION OF INFORMATION ON PER DIEM RATES.—The Secretary shall provide for publication in the Federal Register, before the July 1 preceding each fiscal year (beginning with fiscal year 1999), of—

“(i) the unadjusted Federal per diem rates to be applied to days of covered skilled nursing facility services furnished during the fiscal year,

“(ii) the case mix classification system to be applied under subparagraph (G)(i) with respect to such services during the fiscal year, and

“(iii) the factors to be applied in making the area wage adjustment under subparagraph (G)(ii) with respect to such services.

“(5) SKILLED NURSING FACILITY MARKET BASKET INDEX, PERCENTAGE, AND HISTORICAL TREND FACTOR.—For purposes of this subsection:

“(A) SKILLED NURSING FACILITY MARKET BASKET INDEX.—The Secretary shall establish a skilled nursing facility market basket index that reflects changes over time in the

prices of an appropriate mix of goods and services included in covered skilled nursing facility services.

“(B) SKILLED NURSING FACILITY MARKET BASKET PERCENTAGE.—The term ‘skilled nursing facility market basket percentage’ means, for a fiscal year or other annual period and as calculated by the Secretary, the percentage change in the skilled nursing facility market basket index (established under subparagraph (A)) from the midpoint of the prior fiscal year (or period) to the midpoint of the fiscal year (or other period) involved.

“(C) SKILLED NURSING FACILITY HISTORICAL TREND FACTOR.—The term ‘skilled nursing facility historical trend factor’ means, for a fiscal year or other annual period and as calculated by the Secretary, the percentage change in the skilled nursing facility routine cost index (used in applying per diem routine cost limits under subsection (a)) from the midpoint of the prior fiscal year (or period) to the midpoint of the fiscal year (or other period) involved, reduced (on an annualized basis) by 1 percentage point.

“(6) SUBMISSION OF RESIDENT ASSESSMENT DATA.—A skilled nursing facility shall provide the Secretary, in a manner and within the timeframes prescribed by the Secretary, the resident assessment data necessary to develop and implement the rates under this subsection. For purposes of meeting such requirement, a skilled nursing facility may submit the resident assessment data required under section 1819(b)(3), using the standard instrument designated by the State under section 1819(e)(5).

“(7) TRANSITION FOR MEDICARE LOW VOLUME SKILLED NURSING FACILITIES AND SWING BED HOSPITALS.—

“(A) IN GENERAL.—The Secretary shall determine an appropriate manner in which to apply this subsection to the facilities described in subparagraph (B), taking into account the purposes of this subsection, and shall provide that at the end of the transition period (as defined in paragraph (2)(E)) such facilities shall be paid only under this subsection. Payment shall not be made under this subsection to such facilities for cost reporting periods beginning before such date (not earlier than July 1, 1999) as the Secretary specifies.

“(B) FACILITIES DESCRIBED.—The facilities described in this subparagraph are—

“(i) skilled nursing facilities for which payment is made for routine service costs during a cost reporting period, ending prior to the date of the implementation of this paragraph, on the basis of prospective payments under section 1888(d), or

“(ii) facilities that have in effect an agreement described in section 1883, for which payment is made for the furnishing of extended care services on a reasonable cost basis under section 1814(l) (as in effect on and after such date).

“(8) LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1869, 1878, or otherwise of—

“(A) the establishment of facility specific per diem rates under paragraph (3);

“(B) the establishment of Federal per diem rates under paragraph (4), including the computation of the standardized per diem rates under paragraph (4)(C), adjustments and corrections for case mix under paragraphs (4)(F) and (4)(G)(i), and adjustments for variations in labor-related costs under paragraph (4)(G)(ii); and

“(C) the establishment of transitional amounts under paragraph (7).”.

(b) CONSOLIDATED BILLING.—

(1) FOR SNF SERVICES.—Section 1862(a) (42 U.S.C. 1395y(a)) is amended—

(A) by striking “or” at the end of paragraph (15),

(B) by striking the period at the end of paragraph (16) and inserting “; or”, and

(C) by inserting after paragraph (16) the following new paragraph:

“(17) which are covered skilled nursing facility services described in section 1888(e)(2)(A)(i) and which are furnished to an individual who is a resident of a skilled nursing facility by an entity other than the skilled nursing facility, unless the services are furnished under arrangements (as defined in section 1861(w)(1)) with the entity made by the skilled nursing facility.”.

(2) REQUIRING PAYMENT FOR ALL PART B ITEMS AND SERVICES TO BE MADE TO FACILITY.—The first sentence of section 1842(b)(6) (42 U.S.C. 1395u(b)(6)) is amended—

(A) by striking “and (D)” and inserting “(D)”; and

(B) by striking the period at the end and inserting the following: “, and (E) in the case of an item or service (other than services described in section 1888(e)(2)(A)(ii)) furnished to an individual who (at the time the item or service is furnished) is a resident of a skilled nursing facility, payment shall be made to the facility (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).”.

(3) PAYMENT RULES.—Section 1888(e) (42 U.S.C. 1395yy(e)), as added by subsection (a), is amended by adding at the end the following:

“(9) PAYMENT FOR CERTAIN SERVICES.—In the case of an item or service furnished by a skilled nursing facility (or by others under arrangement with them made by a skilled nursing facility or under any other contracting or consulting arrangement or otherwise) for which payment would otherwise (but for this paragraph) be made under part B in an amount determined in accordance with section 1833(a)(2)(B), the amount of the payment under such part shall be based on such existing or other fee schedules as the Secretary establishes.

“(10) REQUIRED CODING.—No payment may be made under part B for items and services (other than services described in paragraph (2)(A)(ii)) furnished to an individual who is a resident of a skilled nursing facility unless the claim for such payment includes a code (or codes) under a uniform coding system specified by the Secretary that identifies the items or services delivered.”.

(4) CONFORMING AMENDMENTS.—

(A) Section 1819(b)(3)(C)(i) (42 U.S.C. 1395i–3(b)(3)(C)(i)) is amended by striking “Such” and inserting “Subject to the timeframes prescribed by the Secretary under section 1888(t)(6), such”.

(B) Section 1832(a)(1) (42 U.S.C. 1395k(a)(1)) is amended by striking “(2);” and inserting “(2) and section 1842(b)(6)(E);”.

(C) Section 1833(a)(2)(B) (42 U.S.C. 1395l(a)(2)(B)) is amended by inserting “or section 1888(e)(9)” after “section 1886”.

(D) Section 1861(h) (42 U.S.C. 1395x(h)) is amended—

(i) in the opening paragraph, by striking “paragraphs (3) and (6)” and inserting “paragraphs (3), (6), and (7)”, and

(ii) in paragraph (7), after “skilled nursing facilities”, by inserting “, or by others under arrangements with them made by the facility”.

(E) Section 1866(a)(1)(H) (42 U.S.C. 1395cc(a)(1)(H)) is amended—

(i) by redesignating clauses (i) and (ii) as subclauses (I) and (II) respectively,

(ii) by inserting “(i)” after “(H)”, and

(iii) by adding after clause (i), as so redesignated, the following new clause:

“(ii) in the case of skilled nursing facilities which provide covered skilled nursing facility services—

“(I) that are furnished to an individual who is a resident of the skilled nursing facility, and

“(II) for which the individual is entitled to have payment made under this title,

to have items and services (other than services described in section 1888(e)(2)(A)(ii)) furnished by the skilled nursing facility or otherwise under arrangements (as defined in section 1861(w)(1)) made by the skilled nursing facility.”.

(c) MEDICAL REVIEW PROCESS.—In order to ensure that medicare beneficiaries are furnished appropriate services in skilled nursing facilities, the Secretary of Health and Human Services shall establish and implement a thorough medical review process to examine the effects of the amendments made by this section on the quality of covered skilled nursing facility services furnished to medicare beneficiaries. In developing such a medical review process, the Secretary shall place a particular emphasis on the quality of non-routine covered services and physicians’ services for which payment is made under title XVIII of the Social Security Act for which payment is made under section 1848 of such Act.

(d) **EFFECTIVE DATE.**—The amendments made by this section are effective for cost reporting periods beginning on or after July 1, 1998; except that the amendments made by subsection (b) shall apply to items and services furnished on or after July 1, 1998.

SEC. 10402. PROSPECTIVE PAYMENT FOR INPATIENT REHABILITATION HOSPITAL SERVICES.

(a) **IN GENERAL.**—Section 1886 (42 U.S.C. 1395ww) is amended by adding at the end the following new subsection:

“(j) **PROSPECTIVE PAYMENT FOR INPATIENT REHABILITATION SERVICES.**—

“(1) **PAYMENT DURING TRANSITION PERIOD.**—

“(A) **IN GENERAL.**—Notwithstanding section 1814(b), but subject to the provisions of section 1813, the amount of the payment with respect to the operating and capital costs of inpatient hospital services of a rehabilitation hospital or a rehabilitation unit (in this subsection referred to as a ‘rehabilitation facility’), in a cost reporting period beginning on or after October 1, 2000, and before October 1, 2003, is equal to the sum of—

“(i) the TEFRA percentage (as defined in subparagraph (C)) of the amount that would have been paid under part A with respect to such costs if this subsection did not apply, and

“(ii) the prospective payment percentage (as defined in subparagraph (C)) of the product of (I) the per unit payment rate established under this subsection for the fiscal year in which the payment unit of service occurs, and (II) the number of such payment units occurring in the cost reporting period.

“(B) **FULLY IMPLEMENTED SYSTEM.**—Notwithstanding section 1814(b), but subject to the provisions of section 1813, the amount of the payment with respect to the operating and capital costs of inpatient hospital services of a rehabilitation facility for a payment unit in a cost reporting period beginning on or after October 1, 2003, is equal to the per unit payment rate established under this subsection for the fiscal year in which the payment unit of service occurs.

“(C) **TEFRA AND PROSPECTIVE PAYMENT PERCENTAGES SPECIFIED.**—For purposes of subparagraph (A), for a cost reporting period beginning—

“(i) on or after October 1, 2000, and before October 1, 2001, the ‘TEFRA percentage’ is 75 percent and the ‘prospective payment percentage’ is 25 percent;

“(ii) on or after October 1, 2001, and before October 1, 2002, the ‘TEFRA percentage’ is 50 percent and the ‘prospective payment percentage’ is 50 percent; and

“(iii) on or after October 1, 2002, and before October 1, 2003, the ‘TEFRA percentage’ is 25 percent and the ‘prospective payment percentage’ is 75 percent.

“(D) **PAYMENT UNIT.**—For purposes of this subsection, the term ‘payment unit’ means a discharge, day of inpatient hospital services, or other unit of payment defined by the Secretary.

“(2) PATIENT CASE MIX GROUPS.—

“(A) ESTABLISHMENT.—The Secretary shall establish—

“(i) classes of patients of rehabilitation facilities (each in this subsection referred to as a ‘case mix group’), based on such factors as the Secretary deems appropriate, which may include impairment, age, related prior hospitalization, comorbidities, and functional capability of the patient; and

“(ii) a method of classifying specific patients in rehabilitation facilities within these groups.

“(B) WEIGHTING FACTORS.—For each case mix group the Secretary shall assign an appropriate weighting which reflects the relative facility resources used with respect to patients classified within that group compared to patients classified within other groups.

“(C) ADJUSTMENTS FOR CASE MIX.—

“(i) IN GENERAL.—The Secretary shall from time to time adjust the classifications and weighting factors established under this paragraph as appropriate to reflect changes in treatment patterns, technology, case mix, number of payment units for which payment is made under this title, and other factors which may affect the relative use of resources. Such adjustments shall be made in a manner so that changes in aggregate payments under the classification system are a result of real changes and are not a result of changes in coding that are unrelated to real changes in case mix.

“(ii) ADJUSTMENT.—Insofar as the Secretary determines that such adjustments for a previous fiscal year (or estimates that such adjustments for a future fiscal year) did (or are likely to) result in a change in aggregate payments under the classification system during the fiscal year that are a result of changes in the coding or classification of patients that do not reflect real changes in case mix, the Secretary shall adjust the per payment unit payment rate for subsequent years so as to discount the effect of such coding or classification changes.

“(D) DATA COLLECTION.—The Secretary is authorized to require rehabilitation facilities that provide inpatient hospital services to submit such data as the Secretary deems necessary to establish and administer the prospective payment system under this subsection.

“(3) PAYMENT RATE.—

“(A) IN GENERAL.—The Secretary shall determine a prospective payment rate for each payment unit for which such rehabilitation facility is entitled to receive payment under this title. Subject to subparagraph (B), such rate for payment units occurring during a fiscal year shall be based on the average payment per payment unit under this title for inpatient operating and capital costs of rehabilitation facilities using the most recent data available (as

estimated by the Secretary as of the date of establishment of the system) adjusted—

“(i) by updating such per-payment-unit amount to the fiscal year involved by the weighted average of the applicable percentage increases provided under subsection (b)(3)(B)(ii) (for cost reporting periods beginning during the fiscal year) covering the period from the midpoint of the period for such data through the midpoint of fiscal year 2000 and by an increase factor (described in subparagraph (C)) specified by the Secretary for subsequent fiscal years up to the fiscal year involved;

“(ii) by reducing such rates by a factor equal to the proportion of payments under this subsection (as estimated by the Secretary) based on prospective payment amounts which are additional payments described in paragraph (4) (relating to outlier and related payments) or paragraph (7);

“(iii) for variations among rehabilitation facilities by area under paragraph (6);

“(iv) by the weighting factors established under paragraph (2)(B); and

“(v) by such other factors as the Secretary determines are necessary to properly reflect variations in necessary costs of treatment among rehabilitation facilities.

“(B) BUDGET NEUTRAL RATES.—The Secretary shall establish the prospective payment amounts under this subsection for payment units during fiscal years 2001 through 2004 at levels such that, in the Secretary’s estimation, the amount of total payments under this subsection for such fiscal years (including any payment adjustments pursuant to paragraphs (4), (6), and (7)) shall be equal to 99 percent of the amount of payments that would have been made under this title during the fiscal years for operating and capital costs of rehabilitation facilities had this subsection not been enacted. In establishing such payment amounts, the Secretary shall consider the effects of the prospective payment system established under this subsection on the total number of payment units from rehabilitation facilities and other factors described in subparagraph (A).

“(C) INCREASE FACTOR.—For purposes of this subsection for payment units in each fiscal year (beginning with fiscal year 2001), the Secretary shall establish an increase factor. Such factor shall be based on an appropriate percentage increase in a market basket of goods and services comprising services for which payment is made under this subsection, which may be the market basket percentage increase described in subsection (b)(3)(B)(iii).

“(4) OUTLIER AND SPECIAL PAYMENTS.—

“(A) OUTLIERS.—

“(i) IN GENERAL.—The Secretary may provide for an additional payment to a rehabilitation facility for patients in a case mix group, based upon the patient

being classified as an outlier based on an unusual length of stay, costs, or other factors specified by the Secretary.

“(ii) PAYMENT BASED ON MARGINAL COST OF CARE.—The amount of such additional payment under clause (i) shall be determined by the Secretary and shall approximate the marginal cost of care beyond the cutoff point applicable under clause (i).

“(iii) TOTAL PAYMENTS.—The total amount of the additional payments made under this subparagraph for payment units in a fiscal year may not exceed 5 percent of the total payments projected or estimated to be made based on prospective payment rates for payment units in that year.

“(B) ADJUSTMENT.—The Secretary may provide for such adjustments to the payment amounts under this subsection as the Secretary deems appropriate to take into account the unique circumstances of rehabilitation facilities located in Alaska and Hawaii.

“(5) PUBLICATION.—The Secretary shall provide for publication in the Federal Register, on or before September 1 before each fiscal year (beginning with fiscal year 2001, of the classification and weighting factors for case mix groups under paragraph (2) for such fiscal year and a description of the methodology and data used in computing the prospective payment rates under this subsection for that fiscal year.

“(6) AREA WAGE ADJUSTMENT.—The Secretary shall adjust the proportion, (as estimated by the Secretary from time to time) of rehabilitation facilities’ costs which are attributable to wages and wage-related costs, of the prospective payment rates computed under paragraph (3) for area differences in wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the rehabilitation facility compared to the national average wage level for such facilities. Not later than October 1, 2001 (and at least every 36 months thereafter), the Secretary shall update the factor under the preceding sentence on the basis of a survey conducted by the Secretary (and updated as appropriate) of the wages and wage-related costs incurred in furnishing rehabilitation services. Any adjustments or updates made under this paragraph for a fiscal year shall be made in a manner that assures that the aggregated payments under this subsection in the fiscal year are not greater or less than those that would have been made in the year without such adjustment.

“(7) ADDITIONAL ADJUSTMENTS.—The Secretary may provide by regulation for—

“(A) an additional payment to take into account indirect costs of medical education and the special circumstances of hospitals that serve a significantly disproportionate number of low-income patients in a manner similar to that provided under subparagraphs (B) and (F), respectively, of subsection (d)(5); and

“(B) such other exceptions and adjustments to payment amounts under this subsection in a manner similar to that

provided under subsection (d)(5)(I) in relation to payments under subsection (d).

“(8) LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1869, 1878, or otherwise of—

“(A) the establishment of case mix groups, of the methodology for the classification of patients within such groups, and of the appropriate weighting factors thereof under paragraph (2),

“(B) the establishment of the prospective payment rates under paragraph (3),

“(C) the establishment of outlier and special payments under paragraph (4),

“(D) the establishment of area wage adjustments under paragraph (6), and

“(E) the establishment of additional adjustments under paragraph (7).”.

(b) CONFORMING AMENDMENTS.—Section 1886(b) of such Act (42 U.S.C. 1395ww(b)) is amended—

(1) in paragraph (1), by inserting “and other than a rehabilitation facility described in subsection (j)(1)” after “subsection (d)(1)(B)”, and

(2) in paragraph (3)(B)(i), by inserting “and subsection (j)” after “For purposes of subsection (d)”.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to cost reporting periods beginning on or after October 1, 2000, except that the Secretary of Health and Human Services may require the submission of data under section 1886(j)(2)(D) of the Social Security Act (as added by subsection (a)) on and after the date of the enactment of this section.

CHAPTER 2—PAYMENT UNDER PART B

Subchapter A—Payment for Hospital Outpatient Department Services

SEC. 10411. ELIMINATION OF FORMULA-DRIVEN OVERPAYMENTS (FDO) FOR CERTAIN OUTPATIENT HOSPITAL SERVICES.

(a) ELIMINATION OF FDO FOR 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) ELIMINATION OF FDO FOR RADIOLOGY SERVICES AND DIAGNOSTIC PROCEDURES.—Section 1833(n)(1)(B)(i) (42 U.S.C. 1395l(n)(1)(B)(i)) is amended—

(1) by striking “of 80 percent”, and

(2) by inserting before the period at the end 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 October 1, 1997.

SEC. 10412. EXTENSION OF REDUCTIONS IN PAYMENTS FOR COSTS OF HOSPITAL OUTPATIENT SERVICES.

(a) **REDUCTION IN PAYMENTS FOR CAPITAL-RELATED COSTS.**—Section 1861(v)(1)(S)(ii)(I) (42 U.S.C. 1395x(v)(1)(S)(ii)(I)) is amended by striking “through 1998” and inserting “through 1999 and during fiscal year 2000 before January 1, 2000”.

(b) **REDUCTION IN PAYMENTS FOR OTHER COSTS.**—Section 1861(v)(1)(S)(ii)(II) (42 U.S.C. 1395x(v)(1)(S)(ii)(II)) is amended by striking “through 1998” and inserting “through 1999 and during fiscal year 2000 before January 1, 2000”.

SEC. 10413. PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES.

(a) **IN GENERAL.**—Section 1833 (42 U.S.C. 1395l) is amended by adding at the end the following:

“(t) **PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES.**—

“(1) **IN GENERAL.**—With respect to hospital outpatient services designated by the Secretary (in this section referred to as ‘covered OPD services’) and furnished during a year beginning with 1999, the amount of payment under this part shall be determined under a prospective payment system established by the Secretary in accordance with this subsection.

“(2) **SYSTEM REQUIREMENTS.**—Under the payment system—

“(A) the Secretary shall develop a classification system for covered OPD services;

“(B) the Secretary may establish groups of covered OPD services, within the classification system described in subparagraph (A), so that services classified within each group are comparable clinically and with respect to the use of resources;

“(C) the Secretary shall, using data on claims from 1996 and using data from the most recent available cost reports, establish relative payment weights for covered OPD services (and any groups of such services described in subparagraph (B)) based on median hospital costs and shall determine projections of the frequency of utilization of each such service (or group of services) in 1999;

“(D) the Secretary shall determine a wage adjustment factor to adjust the portion of payment and coinsurance attributable to labor-related costs for relative differences in labor and labor-related costs across geographic regions in a budget neutral manner;

“(E) the Secretary shall establish other adjustments, in a budget neutral manner, as determined to be necessary to ensure equitable payments, such as outlier adjustments, adjustments to account for variations in coinsurance payments for procedures with similar resource costs, or adjustments for certain classes of hospitals; and

“(F) the Secretary shall develop a method for controlling unnecessary increases in the volume of covered OPD services.

“(3) **CALCULATION OF BASE AMOUNTS.**—

“(A) **AGGREGATE AMOUNTS THAT WOULD BE PAYABLE IF DEDUCTIBLES WERE DISREGARDED.**—The Secretary shall es-

estimate the total amounts that would be payable from the Trust Fund under this part for covered OPD services in 1999, determined without regard to this subsection, as though the deductible under section 1833(b) did not apply, and as though the coinsurance described in section 1866(a)(2)(A)(ii) (as in effect before the date of the enactment of this subsection) continued to apply.

“(B) UNADJUSTED COPAYMENT AMOUNT.—

“(i) IN GENERAL.—For purposes of this subsection, subject to clause (ii), the ‘unadjusted copayment amount’ applicable to a covered OPD service (or group of such services) is 20 percent of national median of the charges for the service (or services within the group) furnished during 1996, updated to 1999 using the Secretary’s estimate of charge growth during the period.

“(ii) ADJUSTED TO BE 20 PERCENT WHEN FULLY PHASED IN.—If the pre-deductible payment percentage for a covered OPD service (or group of such services) furnished in a year would be equal to or exceed 80 percent, then the unadjusted copayment amount shall be 25 percent of amount determined under subparagraph (D)(i).

“(iii) RULES FOR NEW SERVICES.—The Secretary shall establish rules for establishment of an unadjusted copayment amount for a covered OPD service not furnished during 1996, based upon its classification within a group of such services.

“(C) CALCULATION OF CONVERSION FACTORS.—

“(i) FOR 1999.—

“(I) IN GENERAL.—The Secretary shall establish a 1999 conversion factor for determining the medicare pre-deductible OPD fee payment amounts for each covered OPD service (or group of such services) furnished in 1999. Such conversion factor shall be established on the basis of the weights and frequencies described in paragraph (2)(C) and in a manner such that the sum for all services and groups of the products (described in subclause (II) for each such service or group) equals the total projected amount described in subparagraph (A).

“(II) PRODUCT DESCRIBED.—The product described in this subclause, for a service or group, is the product of the medicare pre-deductible OPD fee payment amounts (taking into account appropriate adjustments described in paragraphs (2)(D) and (2)(E)) and the frequencies for such service or group.

“(ii) SUBSEQUENT YEARS.—Subject to paragraph (8)(B), the Secretary shall establish a conversion factor for covered OPD services furnished in subsequent years in an amount equal to the conversion factor established under this subparagraph and applicable to

such services furnished in the previous year increased by the OPD payment increase factor specified under clause (iii) for the year involved.

“(iii) OPD PAYMENT INCREASE FACTOR.—For purposes of this subparagraph, the ‘OPD payment increase factor’ for services furnished in a year is equal to the sum of—

“(I) market basket percentage increase (applicable under section 1886(b)(3)(B)(iii) to hospital discharges occurring during the fiscal year ending in such year, and

“(II) in the case of a covered OPD service (or group of such services) furnished in a year in which the pre-deductible payment percentage would not exceed 80 percent, 3.5 percentage points, but in no case greater than such number of percentage points as will result in the pre-deductible payment percentage exceeding 80 percent.

In applying the previous sentence for years beginning with 2000, the Secretary may substitute for the market basket percentage increase under subclause (I) an annual percentage increase that is computed and applied with respect to covered OPD services furnished in a year in the same manner as the market basket percentage increase is determined and applied to inpatient hospital services for discharges occurring in a fiscal year.

“(D) PRE-DEDUCTIBLE PAYMENT PERCENTAGE.—The pre-deductible payment percentage for a covered OPD service (or group of such services) furnished in a year is equal to the ratio of—

“(i) the conversion factor established under subparagraph (C) for the year, multiplied by the weighting factor established under paragraph (2)(C) for the service (or group), to

“(ii) the sum of the amount determined under clause (i) and the unadjusted copayment amount determined under subparagraph (B) for such service or group.

“(E) CALCULATION OF MEDICARE OPD FEE SCHEDULE AMOUNTS.—The Secretary shall compute a medicare OPD fee schedule amount for each covered OPD service (or group of such services) furnished in a year, in an amount equal to the product of—

“(i) the conversion factor computed under subparagraph (C) for the year, and

“(ii) the relative payment weight (determined under paragraph (2)(C)) for the service or group.

“(4) MEDICARE PAYMENT AMOUNT.—The amount of payment made from the Trust Fund under this part for a covered OPD service (and such services classified within a group) furnished in a year is determined as follows:

“(A) FEE SCHEDULE AND COPAYMENT AMOUNT.—Add (i) the medicare OPD fee schedule amount (computed under

paragraph (3)(E)) for the service or group and year, and (ii) the unadjusted copayment amount (determined under paragraph (3)(B)) for the service or group.

“(B) SUBTRACT APPLICABLE DEDUCTIBLE.—Reduce the sum determined under subparagraph (A) by the amount of the deductible under section 1833(b), to the extent applicable.

“(C) APPLY PAYMENT PROPORTION TO REMAINDER.—Multiply the amount so determined under subparagraph (B) by the pre-deductible payment percentage (as determined under paragraph (3)(D)) for the service or group and year involved.

“(D) LABOR-RELATED ADJUSTMENT.—The amount of payment is the product determined under subparagraph (C) with the labor-related portion of such product adjusted for relative differences in the cost of labor and other factors determined by the Secretary, as computed under paragraph (2)(D).

“(5) COPAYMENT AMOUNT.—

“(A) IN GENERAL.—Except as provided in subparagraph (B), the copayment amount under this subsection is determined as follows:

“(i) UNADJUSTED COPAYMENT.—Compute the amount by which the amount described in paragraph (4)(B) exceeds the amount of payment determined under paragraph (4)(C).

“(ii) LABOR ADJUSTMENT.—The copayment amount is the difference determined under clause (i) with the labor-related portion of such difference adjusted for relative differences in the cost of labor and other factors determined by the Secretary, as computed under paragraphs (2)(D). The adjustment under this clause shall be made in a manner that does not result in any change in the aggregate copayments made in any year if the adjustment had not been made.

“(B) ELECTION TO OFFER REDUCED COPAYMENT AMOUNT.—The Secretary shall establish a procedure under which a hospital, before the beginning of a year (beginning with 1999), may elect to reduce the copayment amount otherwise established under subparagraph (A) for some or all covered OPD services to an amount that is not less than 25 percent of the medicare OPD fee schedule amount (computed under paragraph (3)(E)) for the service involved, adjusted for relative differences in the cost of labor and other factors determined by the Secretary, as computed under subparagraphs (D) and (E) of paragraph (2). Under such procedures, such reduced copayment amount may not be further reduced or increased during the year involved and the hospital may disseminate information on the reduction of copayment amount effected under this subparagraph.

“(C) NO IMPACT ON DEDUCTIBLES.—Nothing in this paragraph shall be construed as affecting a hospital’s authority

to waive the charging of a deductible under section 1833(b).

“(6) PERIODIC REVIEW AND ADJUSTMENTS COMPONENTS OF PROSPECTIVE PAYMENT SYSTEM.—

“(A) PERIODIC REVIEW.—The Secretary may periodically review and revise the groups, the relative payment weights, and the wage and other adjustments described in paragraph (2) to take into account changes in medical practice, changes in technology, the addition of new services, new cost data, and other relevant information and factors.

“(B) BUDGET NEUTRALITY ADJUSTMENT.—If the Secretary makes adjustments under subparagraph (A), then the adjustments for a year may not cause the estimated amount of expenditures under this part for the year to increase or decrease from the estimated amount of expenditures under this part that would have been made if the adjustments had not been made.

“(C) UPDATE FACTOR.—If the Secretary determines under methodologies described in subparagraph (2)(F) that the volume of services paid for under this subsection increased beyond amounts established through those methodologies, the Secretary may appropriately adjust the update to the conversion factor otherwise applicable in a subsequent year.

“(7) SPECIAL RULE FOR AMBULANCE SERVICES.—The Secretary shall pay for hospital outpatient services that are ambulance services on the basis described in the matter in subsection (a)(1) preceding subparagraph (A).

“(8) SPECIAL RULES FOR CERTAIN HOSPITALS.—In the case of hospitals described in section 1886(d)(1)(B)(v)—

“(A) the system under this subsection shall not apply to covered OPD services furnished before January 1, 2000; and

“(B) the Secretary may establish a separate conversion factor for such services in a manner that specifically takes into account the unique costs incurred by such hospitals by virtue of their patient population and service intensity.

“(9) LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1869, 1878, or otherwise of—

“(A) the development of the classification system under paragraph (2), including the establishment of groups and relative payment weights for covered OPD services, of wage adjustment factors, other adjustments, and methods described in paragraph (2)(F);

“(B) the calculation of base amounts under paragraph (3);

“(C) periodic adjustments made under paragraph (6); and

“(D) the establishment of a separate conversion factor under paragraph (8)(B).”.

(b) COINSURANCE.—Section 1866(a)(2)(A)(ii) (42 U.S.C. 1395cc(a)(2)(A)(ii)) is amended by adding at the end the following:

“In the case of items and services for which payment is made under part B under the prospective payment system established under section 1833(t), clause (ii) of the first sentence shall be applied by substituting for 20 percent of the reasonable charge, the applicable copayment amount established under section 1833(t)(5).”

(c) TREATMENT OF REDUCTION IN COPAYMENT AMOUNT.—Section 1128A(i)(6) (42 U.S.C. 1320a-7a(i)(6)) is amended—

- (1) by striking “or” at the end of subparagraph (B),
- (2) by striking the period at the end of subparagraph (C) and inserting “; or”, and
- (3) by adding at the end the following new subparagraph:
 “(D) a reduction in the copayment amount for covered OPD services under section 1833(t)(5)(B).”

(d) CONFORMING AMENDMENTS.—

(1) APPROVED ASC PROCEDURES PERFORMED IN HOSPITAL OUTPATIENT DEPARTMENTS.—

(A)(i) Section 1833(i)(3)(A) (42 U.S.C. 13951(i)(3)(A)) is amended—

(I) by inserting “before January 1, 1999,” after “furnished”, and

(II) by striking “in a cost reporting period”.

(ii) The amendment made by clause (i) shall apply to services furnished on or after January 1, 1999.

(B) Section 1833(a)(4) (42 U.S.C. 13951(a)(4)) is amended by inserting “or subsection (t)” before the semicolon.

(2) RADIOLOGY AND OTHER DIAGNOSTIC PROCEDURES.—

(A) Section 1833(n)(1)(A) (42 U.S.C. 13951(n)(1)(A)) is amended by inserting “and before January 1, 1999,” after “October 1, 1988,” and after “October 1, 1989.”

(B) Section 1833(a)(2)(E) (42 U.S.C. 13951(a)(2)(E)) is amended by inserting “or, for services or procedures performed on or after January 1, 1999, (t)” before the semicolon.

(3) OTHER HOSPITAL OUTPATIENT SERVICES.—Section 1833(a)(2)(B) (42 U.S.C. 13951(a)(2)(B)) is amended—

(A) in clause (i), by inserting “furnished before January 1, 1999,” after “(i)”,

(B) in clause (ii), by inserting “before January 1, 1999,” after “furnished”,

(C) by redesignating clause (iii) as clause (iv), and

(D) by inserting after clause (ii), the following new clause:

“(iii) if such services are furnished on or after January 1, 1999, the amount determined under subsection (t), or”.

Subchapter B—Rehabilitation Services

SEC. 10421. REHABILITATION AGENCIES AND SERVICES.

(a) PAYMENT BASED ON FEE SCHEDULE.—

(1) SPECIAL PAYMENT RULES.—Section 1833(a) (42 U.S.C. 13951(a)) is amended—

(A) in paragraph (2) in the matter before subparagraph (A), by inserting “(C),” before “(D)”;

(B) in paragraph (6), by striking “and” at the end;

(C) in paragraph (7), by striking the period at the end and inserting “; and”;

(D) by adding at the end the following new paragraph:
 “(8) in the case of services described in section 1832(a)(2)(C) (that are not described in section 1832(a)(2)(B)), the amounts described in section 1834(k).”

(2) PAYMENT RATES.—Section 1834 (42 U.S.C. 1395m) is amended by adding at the end the following new subsection:

“(k) PAYMENT FOR OUTPATIENT THERAPY SERVICES.—

“(1) IN GENERAL.—With respect to outpatient physical therapy services (which includes outpatient speech-language pathology services) and outpatient occupational therapy services for which payment is determined under this subsection, the payment basis shall be—

“(A) for services furnished during 1998, the amount determined under paragraph (2); or

“(B) for services furnished during a subsequent year, 80 percent of the lesser of—

“(i) the actual charge for the services, or

“(ii) the applicable fee schedule amount (as defined in paragraph (3)) for the services.

“(2) PAYMENT IN 1998 BASED UPON ADJUSTED REASONABLE COSTS.—The amount under this paragraph for services is the lesser of—

“(A) the charges imposed for the services, or

“(B) the adjusted reasonable costs (as defined in paragraph (4)) for the services,

less 20 percent of the amount of the charges imposed for such services.

“(3) APPLICABLE FEE SCHEDULE AMOUNT.—In this paragraph, the term ‘applicable fee schedule amount’ means, with respect to services furnished in a year, the fee schedule amount established under section 1848 for such services furnished during the year or, if there is no such fee schedule amount established for such services, for such comparable services as the Secretary specifies.

“(4) ADJUSTED REASONABLE COSTS.—In paragraph (2), the term ‘adjusted reasonable costs’ means reasonable costs determined reduced by—

“(A) 5.8 percent of the reasonable costs for operating costs, and

“(B) 10 percent of the reasonable costs for capital costs.

“(5) UNIFORM CODING.—For claims for services submitted on or after April 1, 1998, for which the amount of payment is determined under this subsection, the claim shall include a code (or codes) under a uniform coding system specified by the Secretary that identifies the services furnished.

“(6) RESTRAINT ON BILLING.—The provisions of subparagraphs (A) and (B) of section 1842(b)(18) shall apply to therapy services for which payment is made under this subsection in the same manner as they apply to services provided by a practitioner described in section 1842(b)(18)(C).”

(b) APPLICATION OF STANDARDS TO OUTPATIENT OCCUPATIONAL AND PHYSICAL THERAPY SERVICES PROVIDED AS AN INCIDENT TO A

PHYSICIAN'S PROFESSIONAL SERVICES.—Section 1862(a), as amended by section 10401(b), (42 U.S.C. 1395y(a)) is amended—

- (1) by striking “or” at the end of paragraph (16);
- (2) by striking the period at the end of paragraph (17) and inserting “; or”; and
- (3) by inserting after paragraph (17) the following:

“(18) in the case of outpatient occupational therapy services or outpatient physical therapy services furnished as an incident to a physician's professional services (as described in section 1861(s)(2)(A)), that do not meet the standards and conditions under the second sentence of section 1861(g) or 1861(p) as such standards and conditions would apply to such therapy services if furnished by a therapist.”.

(c) APPLYING FINANCIAL LIMITATION TO ALL REHABILITATION SERVICES.—Section 1833(g) (42 U.S.C. 1395l(g)) is amended—

- (1) in the first sentence, by striking “services described in the second sentence of section 1861(p)” and inserting “physical therapy services of the type described in section 1861(p) (regardless of who furnishes the services or whether the services may be covered as physicians' services so long as the services are furnished other than in a hospital setting)”, and
- (2) in the second sentence, by striking “outpatient occupational therapy services which are described in the second sentence of section 1861(p) through the operation of section 1861(g)” and inserting “occupational therapy services (of the type that are described in section 1861(p) through the operation of section 1861(g)), regardless of who furnishes the services or whether the services may be covered as physicians' services so long as the services are furnished other than in a hospital setting”.

(d) INDEXING LIMITATION.—Section 1833(g) (42 U.S.C. 1395l(g)), as amended by subsection (c), is further amended—

- (1) by striking “\$900” each place it appears and inserting “the amount specified in paragraph (2) for the year”,
- (2) by inserting “(1)” after “(g)”,
- (3) by designating the last sentence as a paragraph (3), and
- (4) by inserting before paragraph (3), as so designated, the following:

“(2) The amount specified in this paragraph—

“(A) for 1999, and each preceding year, is \$900, and

“(B) for a subsequent year is the amount specified in this paragraph for the preceding year increased by the Secretary's estimate of the projected percentage growth in real gross domestic product per capita from the fiscal year ending in the preceding year to the fiscal year ending in such subsequent year.”.

(e) EFFECTIVE DATE.—The amendments made by this section apply to services furnished on or after January 1, 1998; except that the amendments made by subsection (c) apply to services furnished on or after January 1, 1999.

SEC. 10422. COMPREHENSIVE OUTPATIENT REHABILITATION FACILITIES (CORF).

- (a) PAYMENT BASED ON FEE SCHEDULE.—

(1) SPECIAL PAYMENT RULES.—Section 1833(a) (42 U.S.C. 1395l(a)), as amended by section 10421(a), is amended—

(A) in paragraph (3), by striking “subparagraphs (D) and (E) of section 1832(a)(2)” and inserting “section 1832(a)(2)(E)”;

(B) in paragraph (7), by striking “and” at the end;

(C) in paragraph (8), by striking the period at the end and inserting “; and”;

(D) by adding at the end the following new paragraph: “(9) in the case of services described in section 1832(a)(2)(E), the amounts described in section 1834(k).”

(2) PAYMENT RATES.—Section 1834(k) (42 U.S.C. 1395m(k)), as added by section 10421(a), is amended—

(A) in the heading, by inserting “AND COMPREHENSIVE OUTPATIENT REHABILITATION FACILITY SERVICES” after “THERAPY SERVICES”; and

(B) in paragraph (1), by inserting “and with respect to comprehensive outpatient rehabilitation facility services” after “occupational therapy services”.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to services furnished on or after January 1, 1998, and to portions of cost reporting periods occurring on or after such date.

Subchapter C—Ambulance Services

SEC. 10431. PAYMENTS FOR AMBULANCE SERVICES.

(a) INTERIM REDUCTIONS.—

(1) PAYMENTS DETERMINED ON REASONABLE COST BASIS.—Section 1861(v)(1) (42 U.S.C. 1395x(v)(1)) is amended by adding at the end the following new subparagraph:

“(U) In determining the reasonable cost of ambulance services (as described in subsection (s)(7)) provided during a fiscal year (beginning with fiscal year 1998 and ending with fiscal year 2002), the Secretary shall not recognize any costs in excess of costs recognized as reasonable for ambulance services provided during the previous fiscal year after application of this subparagraph, increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) as estimated by the Secretary for the 12-month period ending with the midpoint of the fiscal year involved reduced (in the case of each of fiscal years 1998 and 1999) by 1 percentage point.”

(2) PAYMENTS DETERMINED ON REASONABLE CHARGE BASIS.—Section 1842(b) (42 U.S.C. 1395u(b)) is amended by adding at the end the following new paragraph:

“(19) For purposes of section 1833(a)(1), the reasonable charge for ambulance services (as described in section 1861(s)(7)) provided during a fiscal year (beginning with fiscal year 1998 and ending with fiscal year 2002) may not exceed the reasonable charge for such services provided during the previous fiscal year after the application of this paragraph, increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) as estimated by the Secretary for the 12-month period ending with the midpoint of the year involved reduced (in the case of each of fiscal years 1998 and 1999) by 1 percentage point.”

(b) ESTABLISHMENT OF PROSPECTIVE FEE SCHEDULE.—

(1) PAYMENT IN ACCORDANCE WITH FEE SCHEDULE.—Section 1833(a)(1) (42 U.S.C. 1395l(a)(1)), as amended by section 10619(b)(1), is amended—

(A) by striking “and (P)” and inserting “(P)”; and

(B) by striking the semicolon at the end and inserting the following: “, and (Q) with respect to ambulance service, the amounts paid shall be 80 percent of the lesser of the actual charge for the services or the amount determined by a fee schedule established by the Secretary under section 1834(1);”.

(2) ESTABLISHMENT OF SCHEDULE.—Section 1834 (42 U.S.C. 1395m), as amended by section 10421(a)(2), is amended by adding at the end the following new subsection:

“(1) ESTABLISHMENT OF FEE SCHEDULE FOR AMBULANCE SERVICES.—

“(1) IN GENERAL.—The Secretary shall establish a fee schedule for payment for ambulance services under this part through a negotiated rulemaking process described in title 5, United States Code, and in accordance with the requirements of this subsection.

“(2) CONSIDERATIONS.—In establishing such fee schedule the Secretary shall—

“(A) establish mechanisms to control increases in expenditures for ambulance services under this part;

“(B) establish definitions for ambulance services which link payments to the type of services provided;

“(C) consider appropriate regional and operational differences;

“(D) consider adjustments to payment rates to account for inflation and other relevant factors; and

“(E) phase in the application of the payment rates under the fee schedule in an efficient and fair manner.

“(3) SAVINGS.—In establishing such fee schedule the Secretary shall—

“(A) ensure that the aggregate amount of payments made for ambulance services under this part during 2000 does not exceed the aggregate amount of payments which would have been made for such services under this part during such year if the amendments made by section 10431 of the Balanced Budget Act of 1997 had not been made; and

“(B) set the payment amounts provided under the fee schedule for services furnished in 2001 and each subsequent year at amounts equal to the payment amounts under the fee schedule for service furnished during the previous year, increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 12-month period ending with June of the previous year.

“(4) CONSULTATION.—In establishing the fee schedule for ambulance services under this subsection, the Secretary shall consult with various national organizations representing individuals and entities who furnish and regulate ambulance services

and share with such organizations relevant data in establishing such schedule.

“(5) **LIMITATION ON REVIEW.**—There shall be no administrative or judicial review under section 1869 or otherwise of the amounts established under the fee schedule for ambulance services under this subsection, including matters described in paragraph (2).

“(6) **RESTRAINT ON BILLING.**—The provisions of subparagraphs (A) and (B) of section 1842(b)(18) shall apply to ambulance services for which payment is made under this subsection in the same manner as they apply to services provided by a practitioner described in section 1842(b)(18)(C).”.

(3) **EFFECTIVE DATE.**—The amendments made by this section apply to ambulance services furnished on or after January 1, 2000.

(c) **AUTHORIZING PAYMENT FOR PARAMEDIC INTERCEPT SERVICE PROVIDERS IN RURAL COMMUNITIES.**—In promulgating regulations to carry out section 1861(s)(7) of the Social Security Act (42 U.S.C. 1395x(s)(7)) with respect to the coverage of ambulance service, the Secretary of Health and Human Services may include coverage of advanced life support services (in this subsection referred to as “ALS intercept services”) provided by a paramedic intercept service provider in a rural area if the following conditions are met:

(1) The ALS intercept services are provided under a contract with one or more volunteer ambulance services and are medically necessary based on the health condition of the individual being transported.

(2) The volunteer ambulance service involved—

(A) is certified as qualified to provide ambulance service for purposes of such section,

(B) provides only basic life support services at the time of the intercept, and

(C) is prohibited by State law from billing for any services.

(3) The entity supplying the ALS intercept services—

(A) is certified as qualified to provide such services under the medicare program under title XVIII of the Social Security Act, and

(B) bills all recipients who receive ALS intercept services from the entity, regardless of whether or not such recipients are medicare beneficiaries.

SEC. 10432. DEMONSTRATION OF COVERAGE OF AMBULANCE SERVICES UNDER MEDICARE THROUGH CONTRACTS WITH UNITS OF LOCAL GOVERNMENT.

(a) **DEMONSTRATION PROJECT CONTRACTS WITH LOCAL GOVERNMENTS.**—The Secretary of Health and Human Services shall establish up to 3 demonstration projects under which, at the request of a county or parish, the Secretary enters into a contract with the county or parish under which—

(1) the county or parish furnishes (or arranges for the furnishing) of ambulance services for which payment may be made under part B of title XVIII of the Social Security Act for individuals residing in the county or parish who are enrolled under such part, except that the county or parish may not

enter into the contract unless the contract covers at least 80 percent of the individuals residing in the county or parish who are enrolled under such part;

(2) any individual or entity furnishing ambulance services under the contract meets the requirements otherwise applicable to individuals and entities furnishing such services under such part; and

(3) for each month during which the contract is in effect, the Secretary makes a capitated payment to the county or parish in accordance with subsection (b).

The projects may extend over a period of not to exceed 3 years each.

(b) AMOUNT OF PAYMENT.—

(1) IN GENERAL.—The amount of the monthly payment made for months occurring during a calendar year to a county or parish under a demonstration project contract under subsection (a) shall be equal to the product of—

(A) the Secretary's estimate of the number of individuals covered under the contract for the month; and

(B) $\frac{1}{12}$ of the capitated payment rate for the year established under paragraph (2).

(2) CAPITATED PAYMENT RATE DEFINED.—In this subsection, the "capitated payment rate" applicable to a contract under this subsection for a calendar year is equal to 95 percent of—

(A) for the first calendar year for which the contract is in effect, the average annual per capita payment made under part B of title XVIII of the Social Security Act with respect to ambulance services furnished to such individuals during the 3 most recent calendar years for which data on the amount of such payment is available; and

(B) for a subsequent year, the amount provided under this paragraph for the previous year increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 12-month period ending with June of the previous year.

(c) OTHER TERMS OF CONTRACT.—The Secretary and the county or parish may include in a contract under this section such other terms as the parties consider appropriate, including—

(1) covering individuals residing in additional counties or parishes (under arrangements entered into between such counties or parishes and the county or parish involved);

(2) permitting the county or parish to transport individuals to non-hospital providers if such providers are able to furnish quality services at a lower cost than hospital providers; or

(3) implementing such other innovations as the county or parish may propose to improve the quality of ambulance services and control the costs of such services.

(d) CONTRACT PAYMENTS IN LIEU OF OTHER BENEFITS.—Payments under a contract to a county or parish under this section shall be instead of the amounts which (in the absence of the contract) would otherwise be payable under part B of title XVIII of the Social Security Act for the services covered under the contract which are furnished to individuals who reside in the county or parish.

(e) REPORT ON EFFECTS OF CAPITATED CONTRACTS.—

(1) STUDY.—The Secretary shall evaluate the demonstration projects conducted under this section. Such evaluation shall include an analysis of the quality and cost-effectiveness of ambulance services furnished under the projects.

(2) REPORT.—Not later than January 1, 2000, the Secretary shall submit a report to Congress on the study conducted under paragraph (1), and shall include in the report such recommendations as the Secretary considers appropriate, including recommendations regarding modifications to the methodology used to determine the amount of payments made under such contracts and extending or expanding such projects.

CHAPTER 3—PAYMENT UNDER PARTS A AND B**SEC. 10441. PROSPECTIVE PAYMENT FOR HOME HEALTH SERVICES.**

(a) IN GENERAL.—Title XVIII (42 U.S.C. 1395 et seq.), as amended by section 10011, is amended by adding at the end the following new section:

“PROSPECTIVE PAYMENT FOR HOME HEALTH SERVICES

“SEC. 1895. (a) IN GENERAL.—Notwithstanding section 1861(v), the Secretary shall provide, for cost reporting periods beginning on or after October 1, 1999, for payments for home health services in accordance with a prospective payment system established by the Secretary under this section.

“(b) SYSTEM OF PROSPECTIVE PAYMENT FOR HOME HEALTH SERVICES.—

“(1) IN GENERAL.—The Secretary shall establish under this subsection a prospective payment system for payment for all costs of home health services. Under the system under this subsection all services covered and paid on a reasonable cost basis under the medicare home health benefit as of the date of the enactment of this section, including medical supplies, shall be paid for on the basis of a prospective payment amount determined under this subsection and applicable to the services involved. In implementing the system, the Secretary may provide for a transition (of not longer than 4 years) during which a portion of such payment is based on agency-specific costs, but only if such transition does not result in aggregate payments under this title that exceed the aggregate payments that would be made if such a transition did not occur.

“(2) UNIT OF PAYMENT.—In defining a prospective payment amount under the system under this subsection, the Secretary shall consider an appropriate unit of service and the number, type, and duration of visits provided within that unit, potential changes in the mix of services provided within that unit and their cost, and a general system design that provides for continued access to quality services.

“(3) PAYMENT BASIS.—

“(A) INITIAL BASIS.—

“(i) IN GENERAL.—Under such system the Secretary shall provide for computation of a standard prospective payment amount (or amounts). Such amount (or

amounts) shall initially be based on the most current audited cost report data available to the Secretary and shall be computed in a manner so that the total amounts payable under the system for fiscal year 2000 shall be equal to the total amount that would have been made if the system had not been in effect but if the reduction in limits described in clause (ii) had been in effect. Such amount shall be standardized in a manner that eliminates the effect of variations in relative case mix and wage levels among different home health agencies in a budget neutral manner consistent with the case mix and wage level adjustments provided under paragraph (4)(A). Under the system, the Secretary may recognize regional differences or differences based upon whether or not the services or agency are in an urbanized area.

“(ii) REDUCTION.—The reduction described in this clause is a reduction by 15 percent in the cost limits and per beneficiary limits described in section 1861(v)(1)(L), as those limits are in effect on September 30, 1999.

“(B) ANNUAL UPDATE.—

“(i) IN GENERAL.—The standard prospective payment amount (or amounts) shall be adjusted for each fiscal year (beginning with fiscal year 2001) in a prospective manner specified by the Secretary by the home health market basket percentage increase applicable to the fiscal year involved.

“(ii) HOME HEALTH MARKET BASKET PERCENTAGE INCREASE.—For purposes of this subsection, the term ‘home health market basket percentage increase’ means, with respect to a fiscal year, a percentage (estimated by the Secretary before the beginning of the fiscal year) determined and applied with respect to the mix of goods and services included in home health services in the same manner as the market basket percentage increase under section 1886(b)(3)(B)(iii) is determined and applied to the mix of goods and services comprising inpatient hospital services for the fiscal year.

“(C) ADJUSTMENT FOR OUTLIERS.—The Secretary shall reduce the standard prospective payment amount (or amounts) under this paragraph applicable to home health services furnished during a period by such proportion as will result in an aggregate reduction in payments for the period equal to the aggregate increase in payments resulting from the application of paragraph (5) (relating to outliers).

“(4) PAYMENT COMPUTATION.—

“(A) IN GENERAL.—The payment amount for a unit of home health services shall be the applicable standard prospective payment amount adjusted as follows:

“(i) CASE MIX ADJUSTMENT.—The amount shall be adjusted by an appropriate case mix adjustment factor (established under subparagraph (B)).

“(ii) AREA WAGE ADJUSTMENT.—The portion of such amount that the Secretary estimates to be attributable to wages and wage-related costs shall be adjusted for geographic differences in such costs by an area wage adjustment factor (established under subparagraph (C)) for the area in which the services are furnished or such other area as the Secretary may specify.

“(B) ESTABLISHMENT OF CASE MIX ADJUSTMENT FACTORS.—The Secretary shall establish appropriate case mix adjustment factors for home health services in a manner that explains a significant amount of the variation in cost among different units of services.

“(C) ESTABLISHMENT OF AREA WAGE ADJUSTMENT FACTORS.—The Secretary shall establish area wage adjustment factors that reflect the relative level of wages and wage-related costs applicable to the furnishing of home health services in a geographic area compared to the national average applicable level. Such factors may be the factors used by the Secretary for purposes of section 1886(d)(3)(E).

“(5) OUTLIERS.—The Secretary may provide for an addition or adjustment to the payment amount otherwise made in the case of outliers because of unusual variations in the type or amount of medically necessary care. The total amount of the additional payments or payment adjustments made under this paragraph with respect to a fiscal year may not exceed 5 percent of the total payments projected or estimated to be made based on the prospective payment system under this subsection in that year.

“(6) PRORATION OF PROSPECTIVE PAYMENT AMOUNTS.—If a beneficiary elects to transfer to, or receive services from, another home health agency within the period covered by the prospective payment amount, the payment shall be prorated between the home health agencies involved.

“(c) REQUIREMENTS FOR PAYMENT INFORMATION.—With respect to home health services furnished on or after October 1, 1998, no claim for such a service may be paid under this title unless—

“(1) the claim has the unique identifier (provided under section 1842(r)) for the physician who prescribed the services or made the certification described in section 1814(a)(2) or 1835(a)(2)(A); and

“(2) in the case of a service visit described in paragraph (1), (2), (3), or (4) of section 1861(m), the claim has information (coded in an appropriate manner) on the length of time of the service visit, as measured in 15 minute increments.

“(d) LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1869, 1878, or otherwise of—

“(1) the establishment of a transition period under subsection (b)(1);

“(2) the definition and application of payment units under subsection (b)(2);

“(3) the computation of initial standard prospective payment amounts under subsection (b)(3)(A) (including the reduction described in clause (ii) of such subsection);

“(4) the establishment of the adjustment for outliers under subsection (b)(3)(C);

“(5) the establishment of case mix and area wage adjustments under subsection (b)(4);

“(6) the establishment of any adjustments for outliers under subsection (b)(5); and

“(7) the amounts or types of adjustments under subsection (b)(7).”.

(b) ELIMINATION OF PERIODIC INTERIM PAYMENTS FOR HOME HEALTH AGENCIES.—Section 1815(e)(2) (42 U.S.C. 1395g(e)(2)) is amended—

(1) by inserting “and” at the end of subparagraph (C),

(2) by striking subparagraph (D), and

(3) by redesignating subparagraph (E) as subparagraph (D).

(c) CONFORMING AMENDMENTS.—

(1) PAYMENTS UNDER PART A.—Section 1814(b) (42 U.S.C. 1395f(b)) is amended in the matter preceding paragraph (1) by striking “and 1886” and inserting “1886, and 1895”.

(2) TREATMENT OF ITEMS AND SERVICES PAID UNDER PART B.—

(A) PAYMENTS UNDER PART B.—Section 1833(a)(2) (42 U.S.C. 1395l(a)(2)) is amended—

(i) by amending subparagraph (A) to read as follows:

“(A) with respect to home health services (other than a covered osteoporosis drug) (as defined in section 1861(kk)), the amount determined under the prospective payment system under section 1895;”;

(ii) by striking “and” at the end of subparagraph (E);

(iii) by adding “and” at the end of subparagraph (F);

and

(iv) by adding at the end the following new subparagraph:

“(G) with respect to items and services described in section 1861(s)(10)(A), the lesser of—

“(i) the reasonable cost of such services, as determined under section 1861(v), or

“(ii) the customary charges with respect to such services,

or, if such services are furnished by a public provider of services, or by another provider which demonstrates to the satisfaction of the Secretary that a significant portion of its patients are low-income (and requests that payment be made under this provision), free of charge or at nominal charges to the public, the amount determined in accordance with section 1814(b)(2);”.

(B) REQUIRING PAYMENT FOR ALL ITEMS AND SERVICES TO BE MADE TO AGENCY.—

(i) IN GENERAL.—The first sentence of section 1842(b)(6) (42 U.S.C. 1395u(b)(6)), as amended by section 10401(b)(2), is amended—

(I) by striking “and (E)” and inserting “(E)”; and

(II) by striking the period at the end and inserting the following: “, and (F) in the case of home health services furnished to an individual who (at the time the item or service is furnished) is under a plan of care of a home health agency, payment shall be made to the agency (without regard to whether or not the item or service was furnished by the agency, by others under arrangement with them made by the agency, or when any other contracting or consulting arrangement, or otherwise).”.

(ii) CONFORMING AMENDMENT.—Section 1832(a)(1) (42 U.S.C. 1395k(a)(1)), as amended by section 10401(b), is amended by striking “and section 1842(b)(6)(E)” and inserting “, section 1842(b)(6)(E), and section 1842(b)(6)(F)”.

(C) EXCLUSIONS FROM COVERAGE.—Section 1862(a) (42 U.S.C. 1395y(a)), as amended by sections 10401(b) and 10421(b), is amended—

- (i) by striking “or” at the end of paragraph (17);
- (ii) by striking the period at the end of paragraph (18) and inserting “; or”; and
- (iii) inserting after paragraph (18) the following new paragraph:

“(19) where such expenses are for home health services furnished to an individual who is under a plan of care of the home health agency if the claim for payment for such services is not submitted by the agency.”.

(d) EFFECTIVE DATE.—Except as otherwise provided, the amendments made by this section shall apply to cost reporting periods beginning on or after October 1, 1999.

Subtitle F—Provisions Relating to Part A

CHAPTER 1—PAYMENT OF PPS HOSPITALS

SEC. 10501. PPS HOSPITAL PAYMENT UPDATE.

Section 1886(b)(3)(B)(i) (42 U.S.C. 1395ww(b)(3)(B)(i)) is amended—

- (1) by striking “and” at the end of subclause (XII), and
- (2) by striking subclause (XIII) and inserting the following:
 - “(XIII) for fiscal year 1998, 0 percent,
 - “(XIV) for each of the fiscal years 1999 through 2002, the market basket percentage increase minus 1.0 percentage point for hospitals in all areas, and
 - “(XV) for fiscal year 2003 and each subsequent fiscal year, the market basket percentage increase for hospitals in all areas.”.

SEC. 10502. CAPITAL PAYMENTS FOR PPS HOSPITALS.

(a) MAINTAINING SAVINGS FROM TEMPORARY REDUCTION IN PPS CAPITAL RATES.—Section 1886(g)(1)(A) (42 U.S.C. 1395ww(g)(1)(A)) is amended by adding at the end the following: “In addition to the reduction described in the preceding sentence, for discharges occur-

ring on or after October 1, 1997, the Secretary shall apply the budget neutrality adjustment factor used to determine the Federal capital payment rate in effect on September 30, 1995 (as described in section 412.352 of title 42 of the Code of Federal Regulations), to (i) the unadjusted standard Federal capital payment rate (as described in section 412.308(c) of that title, as in effect on September 30, 1997), and (ii) the unadjusted hospital-specific rate (as described in section 412.328(e)(1) of that title, as in effect on September 30, 1997).”.

(b) REVISION OF EXCEPTIONS PROCESS UNDER PROSPECTIVE PAYMENT SYSTEM FOR CERTAIN PROJECTS.—

(1) IN GENERAL.—Section 1886(g)(1) (42 U.S.C. 1395ww(g)(1)) is amended—

(A) by redesignating subparagraph (C) as subparagraph (F), and

(B) by inserting after subparagraph (B) the following subparagraphs:

“(C) The exceptions under the system provided by the Secretary under subparagraph (B)(iii) shall include the provision of exception payments under the special exceptions process provided under section 412.348(g) of title 42, Code of Federal Regulations (as in effect on September 1, 1995), except that the Secretary shall revise such process, effective for discharges occurring after September 30, 1997, as follows:

“(i) A hospital with at least 100 beds which is located in an urban area shall be eligible under such process without regard to its disproportionate patient percentage under subsection (d)(5)(F) or whether it qualifies for additional payment amounts under such subsection.

“(ii) The minimum payment level for qualifying hospitals shall be 85 percent (or such lower percentage, but no lower than 75 percent, as the Secretary may provide to comply with subparagraph (D)).

“(iii) A hospital shall be considered to meet the requirement that it complete the project involved no later than the end of the hospital’s last cost reporting period beginning before October 1, 2001, if—

“(I) the hospital has obtained a certificate of need for the project approved by the State or a local planning authority by September 1, 1995, and

“(II) by September 1, 1995, the hospital has expended on the project at least \$750,000 or 10 percent of the estimated cost of the project.

“(iv) Offsetting amounts, as described in section 412.348(g)(8)(ii) of title 42, Code of Federal Regulations, shall apply except that subparagraph (B) of such section shall be revised to require that the additional payment that would otherwise be payable for the cost reporting period shall be reduced by the amount (if any) by which the hospital’s current year medicare capital payments (excluding, if applicable, 75 percent of the hospital’s capital-related disproportionate share payments) exceeds its medicare capital costs for such year.

“(D) The Secretary may reduce the percent specified under subparagraph (C)(ii) (but not below 75 percent) and shall reduce the

Federal capital rate for a fiscal year by such percentage as the Secretary determines to be necessary to ensure that the application of subparagraph (C) does not result in an increase in the total amount that would have been paid under this subsection in the fiscal year if such subparagraph did not apply.

“(E) The Secretary shall provide for publication in the Federal Register each year (beginning with 1999) a description of the distributional impact of the application of subparagraph (C) on hospitals which receive, and do not receive, an exception payment under such subparagraph.”

(2) CONFORMING AMENDMENT.—Section 1886(g)(1)(B)(iii) (42 U.S.C. 1395ww(g)(1)(B)(iii)) is amended by striking “may provide” and inserting “shall provide (in accordance with subparagraph (C))”.

SEC. 10503. FREEZE IN DISPROPORTIONATE SHARE.

(a) NO UPDATE IN DISPROPORTIONATE SHARE FOR FISCAL YEARS 1998 AND 1999.—Section 1886(d)(5)(F) (42 U.S.C. 1395ww(d)(5)(F)) is amended in clause (ii) by adding at the end the following new sentence: “For discharges occurring on or after October 1, 1997, the sum described in subclause (I) shall be determined as if the applicable percentage increase described in subsection (b)(3)(B)(i) for discharges for fiscal years 1998 and 1999 were zero percent.”

(b) DEVELOPMENT OF REVISED QUALIFYING CRITERIA AND PAYMENT METHODOLOGY FOR HOSPITALS THAT SERVE A DISPROPORTIONATE SHARE OF LOW-INCOME PATIENTS.—

(1) DEVELOPMENT OF PROPOSAL.—The Secretary of Health and Human Services shall develop a proposal to modify the current qualifying criteria and payment methodology under which hospitals that are paid under section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)) receive an additional payment because they serve a disproportionate share of low-income patients.

(2) REPORT.—Not later than April 1, 1999, the Secretary shall transmit the proposal developed under paragraph (1) to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate.

SEC. 10504. MEDICARE CAPITAL ASSET SALES PRICE EQUAL TO BOOK VALUE.

(a) IN GENERAL.—Section 1861(v)(1)(O) (42 U.S.C. 1395x(v)(1)(O)) is amended—

(1) in clause (i)—

(A) by striking “and (if applicable) a return on equity capital”;

(B) by striking “hospital or skilled nursing facility” and inserting “provider of services”;

(C) by striking “clause (iv)” and inserting “clause (iii)”;

and

(D) by striking “the lesser of the allowable acquisition cost” and all that follows and inserting “the historical cost of the asset, as recognized under this title, less depreciation allowed, to the owner of record as of the date of enactment of the Balanced Budget Act of 1997 (or, in the case

- of an asset not in existence as of that date, the first owner of record of the asset after that date.”;
- (2) by striking clause (ii); and
- (3) by redesignating clauses (iii) and (iv) as clauses (ii) and (iii), respectively.

(b) **EFFECTIVE DATE.**—The amendments made by subsection (a) apply to changes of ownership that occur after the third month beginning after the date of enactment of this section.

SEC. 10505. ELIMINATION OF IME AND DSH PAYMENTS ATTRIBUTABLE TO OUTLIER PAYMENTS.

(a) **INDIRECT MEDICAL EDUCATION.**—Section 1886(d)(5)(B)(i)(I) (42 U.S.C. 1395ww(d)(5)(B)(i)(I)) is amended by inserting “, for cases qualifying for additional payment under subparagraph (A)(i),” before “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 by inserting “, for cases qualifying for additional payment under subparagraph (A)(i),” before “the amount paid to the hospital under subparagraph (A)”.

(c) **COST OUTLIER PAYMENTS.**—Section 1886(d)(5)(A)(ii) (42 U.S.C. 1395ww(d)(5)(A)(ii)) is amended by striking “exceed the applicable DRG prospective payment rate” and inserting “exceed the sum of the applicable DRG prospective payment rate plus any amounts payable under paragraphs (d)(5)(B) and (d)(5)(F)”.

(d) **EFFECTIVE DATE.**—The amendments made by this section apply to discharges occurring after September 30, 1997.

SEC. 10506. REDUCTION IN ADJUSTMENT FOR INDIRECT MEDICAL EDUCATION.

(a) **IN GENERAL.**—Section 1886(d)(5)(B)(ii) (42 U.S.C. 1395ww(d)(5)(B)(ii)) is amended to read as follows:

“(ii) For purposes of clause (i)(II), the indirect teaching adjustment factor for discharges occurring—

“(I) on or after October 1, 1988 and before October 1, 1997, is equal to $1.89 \times (((1+r) \text{ to the } n\text{th power}) - 1)$,

“(II) during fiscal year 1998, is equal to $1.62 \times (((1+r) \text{ to the } n\text{th power}) - 1)$, and

“(III) during or after fiscal year 1999, is equal to $1.35 \times (((1+r) \text{ to the } n\text{th power}) - 1)$,

where ‘r’ is the ratio of the hospital’s full-time equivalent interns and residents to beds and ‘n’ equals 0.405, subject to clause (vi).”.

(b) **CONFORMING AMENDMENT RELATING TO DETERMINATION OF STANDARDIZED AMOUNTS.**—Section 1886(d)(2)(C)(i) (42 U.S.C. 1395ww(d)(2)(C)(i)) is amended by adding at the end the following: “except that the Secretary shall not take into account any reductions in the amount of additional payments under paragraph (5)(B)(ii) resulting from the amendments made by section 10506(a) of the Balanced Budget Act of 1997.”.

(c) **LIMITATION ON NUMBER OF RESIDENTS FOR CERTAIN FISCAL YEARS.**—Section 1886(d)(5)(B) (42 U.S.C. 1395ww(d)(5)(B)), as amended by subsection (a), is amended by adding at the end the following new clauses:

“(v) In determining the adjustment with respect to a hospital for discharges occurring on or after October 1, 1997, the total

number of interns and residents in either a hospital or non-hospital setting may not exceed the number of interns and residents in the hospital with respect to the hospital's cost reporting period beginning on or before December 31, 1996.

“(vi) For purposes of clause (ii)—

“(I) ‘r’ may not exceed the ratio of the number of interns and residents as determined under clause (v) with respect to the hospital for its most recent cost reporting period, to the hospital's available beds (as defined by the Secretary) during that cost reporting period,

“(II) for the hospital's first cost reporting period beginning on or after October 1, 1997, subject to the limits described in clauses (iv) and (v), the total number of full-time equivalent residents for payment purposes shall equal the average of the actual full-time equivalent resident count for the hospital's most recent cost reporting period and the preceding cost reporting period, and

“(III) for the cost reporting period beginning on or after October 1, 1998, and each subsequent cost reporting period, subject to the limits described in clauses (iv) and (v), the total number of full-time equivalent residents for payment purposes shall equal the average of the actual full-time equivalent resident count for the cost reporting period and the preceding two cost reporting periods.

“(vii) If the hospital's fiscal year 1998 or later cost reporting period is not equal to twelve months, the Secretary shall make appropriate modifications to ensure that the average full-time equivalent residency count pursuant to subclauses (II) and (III) of clause (vi) is based on the equivalent of full twelve month cost reporting periods.

“(viii) The Secretary may establish rules, consistent with the policies in clauses (v) through (vii) and in subsection (h)(6)(A)(ii), with respect to the application of clauses (v) through (vii) in the case of medical residency training programs established on or after January 1, 1997.”.

SEC. 10507. TREATMENT OF TRANSFER CASES.

(a) TRANSFERS TO PPS EXEMPT HOSPITALS AND SKILLED NURSING FACILITIES.—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 carrying out this subparagraph, the Secretary shall treat the term ‘transfer case’ as including the case of an individual who, upon discharge from a subsection (d) hospital—

“(I) is admitted as an inpatient to a hospital or hospital unit that is not a subsection (d) hospital for the receipt of inpatient hospital services; or

“(II) is admitted to a skilled nursing facility or facility described in section 1861(y)(1) for the receipt of extended care services.”.

(b) TRANSFERS FOR PURPOSES OF HOME HEALTH SERVICES.—Section 1886(d)(5)(I)(iii) (42 U.S.C. 1395ww(d)(5)(I)(iii)), as amended by subsection (a), is amended—

(1) in subclause (I), by striking “or”;

(2) in subclause (II), by striking the period at the end and inserting “; or” and

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

“(III) receives home health services from a home health agency, if such services relate to the condition or diagnosis for which such individual received inpatient hospital services from the subsection (d) hospital, and if such services are provided within an appropriate period as determined by the Secretary in regulations promulgated not later than September 1, 1998.”.

(c) EFFECTIVE DATES.—

(1) The amendment made by subsection (a) shall apply with respect to discharges occurring on or after October 1, 1997.

(2) The amendment made by subsection (b) shall apply with respect to discharges occurring on or after October 1, 1998.

SEC. 10508. INCREASE BASE PAYMENT RATE TO PUERTO RICO HOSPITALS.

Section 1886(d)(9)(A) (42 U.S.C. 1395ww(d)(9)(A)) is amended—

(1) in the matter preceding clause (i), by striking “in a fiscal year beginning on or after October 1, 1987,”,

(2) in clause (i), by striking “75 percent” and inserting “for discharges beginning on or after October 1, 1997, 50 percent (and for discharges between October 1, 1987, and September 30, 1997, 75 percent)”, and

(3) in clause (ii), by striking “25 percent” and inserting “for discharges beginning in a fiscal year beginning on or after October 1, 1997, 50 percent (and for discharges between October 1, 1987 and September 30, 1997, 25 percent)”.

CHAPTER 2—PAYMENT OF PPS EXEMPT HOSPITALS

SEC. 10511. PAYMENT UPDATE.

(a) IN GENERAL.—Section 1886(b)(3)(B) (42 U.S.C. 1395ww(b)(3)(B)) is amended—

(1) in clause (ii)—

(A) by striking “and” at the end of subclause (V),

(B) by redesignating subclause (VI) as subclause (VIII);

and

(C) by inserting after subclause (V), the following new subclauses:

“(VI) for fiscal year 1998, is 0 percent;

“(VII) for fiscal years 1999 through 2002, is the applicable update factor specified under clause (vi) for the fiscal year; and”;

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

“(vi) For purposes of clause (ii)(VII) for a fiscal year, if a hospital’s allowable operating costs of inpatient hospital services recognized under this title for the most recent cost reporting period for which information is available—

“(I) is equal to, or exceeds, 110 percent of the hospital’s target amount (as determined under subparagraph (A)) for such cost reporting period, the applicable update factor specified under this clause is the market basket percentage;

“(II) exceeds 100 percent, but is less than 110 percent, of such target amount for the hospital, the applicable update factor specified under this clause is 0 percent or, if greater, the market basket percentage minus 0.25 percentage points for

each percentage point by which such allowable operating costs (expressed as a percentage of such target amount) is less than 110 percent of such target amount;

“(III) is equal to, or less than 100 percent, but exceeds $\frac{2}{3}$ of such target amount for the hospital, the applicable update factor specified under this clause is 0 percent or, if greater, the market basket percentage minus 2.5 percentage points; or

“(IV) does not exceed $\frac{2}{3}$ of such target amount for the hospital, the applicable update factor specified under this clause is 0 percent.”.

(b) NO EFFECT OF PAYMENT REDUCTION ON EXCEPTIONS AND ADJUSTMENTS.—Section 1886(b)(4)(A)(ii) (42 U.S.C. 1395ww(b)(4)(A)(ii)) is amended by adding at the end the following new sentence: “In making such reductions, the Secretary shall treat the applicable update factor described in paragraph (3)(B)(vi) for a fiscal year as being equal to the market basket percentage for that year.”.

SEC. 10512. REDUCTIONS TO CAPITAL PAYMENTS FOR CERTAIN PPS-EXEMPT HOSPITALS AND UNITS.

Section 1886(g) (42 U.S.C. 1395ww(g)) is amended by adding at the end the following new paragraph:

“(4) In determining the amount of the payments that are attributable to portions of cost reporting periods occurring during fiscal years 1998 through 2002 and that may be made under this title with respect to capital-related costs of inpatient hospital services of a hospital which is described in clause (i), (ii), or (iv) of subsection (d)(1)(B) or a unit described in the matter after clause (v) of such subsection, the Secretary shall reduce the amounts of such payments otherwise determined under this title by 10 percent.”.

SEC. 10513. CAP ON TEFRA LIMITS.

Section 1886(b)(3) (42 U.S.C. 1395ww(b)(3)) is amended—

(1) in subparagraph (A) by striking “subparagraphs (C), (D), and (E)” and inserting “subparagraph (C) and succeeding subparagraphs”, and

(2) by adding at the end the following:

“(F)(i) In the case of a hospital or unit that is within a class of hospital described in clause (ii), for cost reporting periods beginning on or after October 1, 1997, and before October 1, 2002, such target amount may not be greater than the 90th percentile of the target amounts for such hospitals within such class for cost reporting periods beginning during that fiscal year.

“(ii) For purposes of this subparagraph, each of the following shall be treated as a separate class of hospital:

“(I) Hospitals described in clause (i) of subsection (d)(1)(B) and psychiatric units described in the matter following clause (v) of such subsection.

“(II) Hospitals described in clause (ii) of such subsection and rehabilitation units described in the matter following clause (v) of such subsection.

“(III) Hospitals described in clause (iv) of such subsection.”.

SEC. 10514. CHANGE IN BONUS AND RELIEF PAYMENTS.

(a) CHANGE IN BONUS PAYMENT.—Section 1886(b)(1)(A) (42 U.S.C. 1395ww(b)(1)(A)) is amended by striking all that follows “plus—” and inserting the following:

- “(i) 10 percent of the amount by which the target amount exceeds the amount of the operating costs, or
 - “(ii) 1 percent of the operating costs,
- whichever is less;”.

(b) CHANGE IN RELIEF PAYMENTS.—Section 1886(b)(1) (42 U.S.C. 1395ww(b)(1)) is amended—

(1) in subparagraph (B)—

(A) by striking “greater than the target amount” and inserting “greater than 110 percent of the target amount”,

(B) by striking “exceed the target amount” and inserting “exceed 110 percent of the target amount”,

(C) by striking “10 percent” and inserting “20 percent”,

and

(D) by redesignating such subparagraph as subparagraph (C); and

(2) by inserting after subparagraph (A) the following new subparagraph:

“(B) are greater than the target amount but do not exceed 110 percent of the target amount, the amount of the payment with respect to those operating costs payable under part A on a per discharge basis shall equal the target amount; or”.

SEC. 10515. CHANGE IN PAYMENT AND TARGET AMOUNT FOR NEW PROVIDERS.

Section 1886(b) (42 U.S.C. 1395ww(b)) is amended—

(1) by inserting after paragraph (1) the following new paragraph:

“(2)(A) Notwithstanding paragraph (1), in the case of a hospital or unit that is within a class of hospital described in subparagraph (B) which first receives payments under this section on or after October 1, 1997—

“(i) for each of the first 2 full or partial cost reporting periods, the amount of the payment with respect to operating costs described in paragraph (1) under part A on a per discharge or per admission basis (as the case may be) is equal to the lesser of—

“(I) the amount of operating costs for such respective period, or

“(II) 150 percent of the national median of the operating costs for hospitals in the same class as the hospital for cost reporting periods beginning during the same fiscal year, as adjusted under subparagraph (C); and

“(ii) for purposes of computing the target amount for the subsequent cost reporting period, the target amount for the preceding cost reporting period is equal to the amount determined under clause (i) for such preceding period.

“(B) For purposes of this paragraph, each of the following shall be treated as a separate class of hospital:

“(i) Hospitals described in clause (i) of subsection (d)(1)(B) and psychiatric units described in the matter following clause (v) of such subsection.

“(ii) Hospitals described in clause (ii) of such subsection and rehabilitation units described in the matter following clause (v) of such subsection.

“(iii) A class of hospitals described in subsection (d)(1)(B)(iv) that the Secretary shall establish based upon a measure of case mix that takes into account acuity.

“(iv) Hospitals described in subsection (d)(1)(B)(iv) that are not within the class described in clause (iii).

“(C) In applying subparagraph (A)(i)(II) in the case of a hospital or unit, the Secretary shall provide for an appropriate adjustment to the labor-related portion of the amount determined under such subparagraph to take into account differences between average wage-related costs in the area of the hospital and the national average of such costs within the same class of hospital.”; and

(2) in paragraph (3)(A), as amended in section 10513, by inserting “and in paragraph (2)(A)(ii),” before “for purposes of”.

SEC. 10516. REBASING.

(a) OPTION OF REBASING FOR HOSPITALS IN OPERATION BEFORE 1990.—Section 1886(b)(3)(42 U.S.C. 1395ww(b)(3)), as amended in section 10513, is amended by adding at the end the following new subparagraph:

“(G)(i) In the case of a hospital (or unit described in the matter following clause (v) of subsection (d)(1)(B)) that received payment under this subsection for inpatient hospital services furnished during cost reporting periods before October 1, 1990, that is within a class of hospital described in clause (iii), and that elects (in a form and manner determined by the Secretary) this subparagraph to apply to the hospital, the target amount for the hospital’s 12-month cost reporting period beginning during fiscal year 1998 is equal to the average described in clause (ii).

“(ii) The average described in this clause for a hospital or unit shall be determined by the Secretary as follows:

“(I) The Secretary shall determine the allowable operating costs for inpatient hospital services for the hospital or unit for each of the 5 cost reporting periods for which the Secretary has the most recent settled cost reports as of the date of the enactment of this subparagraph.

“(II) The Secretary shall increase the amount determined under subclause (I) for each cost reporting period by the applicable percentage increase under subparagraph (B)(ii) for each subsequent cost reporting period up to the cost reporting period described in clause (i).

“(III) The Secretary shall identify among such 5 cost reporting periods the cost reporting periods for which the amount determined under subclause (II) is the highest, and the lowest.

“(IV) The Secretary shall compute the averages of the amounts determined under subclause (II) for the 3 cost reporting periods not identified under subclause (III).

“(iii) For purposes of this subparagraph, each of the following shall be treated as a separate class of hospital:

“(I) Hospitals described in clause (i) of subsection (d)(1)(B) and psychiatric units described in the matter following clause (v) of such subsection.

“(II) Hospitals described in clause (ii) of such subsection and rehabilitation units described in the matter following clause (v) of such subsection.

“(III) Hospitals described in clause (iii) of such subsection.

“(IV) Hospitals described in clause (iv) of such subsection.

“(V) Hospitals described in clause (v) of such subsection.”.

(b) CERTAIN LONG-TERM CARE HOSPITALS.—Section 1886(b)(3) (42 U.S.C. 1395ww(b)(3)), as amended by subsection (a), is amended by adding at the end the following new subparagraph:

“(H)(i) In the case of a qualified long-term care hospital (as defined in clause (ii)) that elects (in a form and manner determined by the Secretary) this subparagraph to apply to the hospital, the target amount for the hospital’s 12-month cost reporting period beginning during fiscal year 1998 is equal to the allowable operating costs of inpatient hospital services (as defined in subsection (a)(4)) recognized under this title for the hospital for the 12-month cost reporting period beginning during fiscal year 1996, increased by the applicable percentage increase for the cost reporting period beginning during fiscal year 1997.

“(ii) In clause (i), a ‘qualified long-term care hospital’ means, with respect to a cost reporting period, a hospital described in clause (iv) of subsection (d)(1)(B) during each of the 2 cost reporting periods for which the Secretary has the most recent settled cost reports as of the date of the enactment of this subparagraph for each of which—

“(I) the hospital’s allowable operating costs of inpatient hospital services recognized under this title exceeded 115 percent of the hospital’s target amount, and

“(II) the hospital would have a disproportionate patient percentage of at least 70 percent (as determined by the Secretary under subsection (d)(5)(F)(vi)) if the hospital were a subsection (d) hospital.”.

(c) CERTAIN LONG-TERM CARE CANCER HOSPITALS.—

(1) IN GENERAL.—Section 1886(d)(1)(B)(iv) (42 U.S.C. 1395ww(d)(1)(B)(iv)) is amended by adding at the end the following: “a hospital that first received payment under this subsection in 1986 which has an average inpatient length of stay (as determined by the Secretary) of greater than 20 days and that has 80 percent or more of its annual total inpatient discharges with a principal diagnosis that reflects a finding of neoplastic disease, or”.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to cost reporting periods beginning on or after the date of the enactment of this Act.

SEC. 10517. TREATMENT OF CERTAIN LONG-TERM CARE HOSPITALS.

(a) IN GENERAL.—Section 1886(d)(1)(B) (42 U.S.C. 1395ww(d)(1)(B)) is amended by adding at the end the following new sentence: “A hospital that was classified by the Secretary on or before September 30, 1995, as a hospital described in clause (iv) shall continue to be so classified notwithstanding that it is located in the same building as, or on the same campus as, another hospital.”.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to discharges occurring on or after October 1, 1995.

SEC. 10518. ELIMINATION OF EXEMPTIONS; REPORT ON EXCEPTIONS AND ADJUSTMENTS.

(a) **ELIMINATION OF EXEMPTIONS.**—

(1) **IN GENERAL.**—Section 1886(b)(4)(A)(i) (42 U.S.C. 1395ww(b)(4)(A)(i)) is amended by striking “exemption from, or an exception and adjustment to,” and inserting “an exception and adjustment to” each place it appears.

(2) **EFFECTIVE DATE.**—The amendments made by paragraph (1) shall apply to hospitals or units that first qualify as a hospital or unit described in section 1886(d)(1)(B) (42 U.S.C. 1395ww(d)(1)(B)) on or after October 1, 1997.

(b) **REPORT.**—The Secretary of Health and Human Services shall publish annually in the Federal Register a report describing the total amount of payments made to hospitals by reason of section 1886(b)(4) of the Social Security Act (42 U.S.C. 1395ww(b)(4)), as amended by subsection (a), for cost reporting periods ending during the previous fiscal year.

CHAPTER 3—PROVISIONS RELATED TO HOSPICE SERVICES

SEC. 10521. PAYMENTS FOR HOSPICE SERVICES.

(a) **PAYMENT UPDATE.**—Section 1814(i)(1)(C)(ii) (42 U.S.C. 1395f(i)(1)(C)(ii)) is amended—

(1) in subclause (V), by striking “and” at the end;

(2) by redesignating subclause (VI) as subclause (VII); and

(3) by inserting after subclause (V) the following new subclause:

“(VI) for each of fiscal years 1998 through 2002, the market basket percentage increase for the fiscal year involved minus 1.0 percentage points; and”.

(b) **REPORT.**—Section 1814(i) (42 U.S.C. 1395f(i)) is amended by adding at the end the following new paragraph:

“(3) The Secretary shall provide for the collection of data, from hospice programs providing hospice care for which payment is made under this subsection, with respect to the costs for providing such care for each fiscal year beginning with fiscal year 1999.”.

SEC. 10522. PAYMENT FOR HOME HOSPICE CARE BASED ON LOCATION WHERE CARE IS FURNISHED.

(a) **IN GENERAL.**—Section 1814(i)(2) (42 U.S.C. 1395f(i)(2)) is amended by adding at the end the following:

“(D) A hospice program shall submit claims for payment for hospice care furnished in an individual’s home under this title only on the basis of the geographic location at which the service is furnished, as determined by the Secretary.”.

(b) **EFFECTIVE DATE.**—The amendment made by subsection (a) applies to cost reporting periods beginning on or after October 1, 1997.

SEC. 10523. HOSPICE CARE BENEFITS PERIODS.

(a) **RESTRUCTURING OF BENEFIT PERIOD.**—Section 1812 (42 U.S.C. 1395d) is amended, in subsections (a)(4) and (d)(1), by striking “, a subsequent period of 30 days, and a subsequent extension period” and inserting “and an unlimited number of subsequent periods of 60 days each”.

(b) CONFORMING AMENDMENTS.—(1) Section 1812 (42 U.S.C. 1395d) is amended in subsection (d)(2)(B) by striking “90- or 30-day period or a subsequent extension period” and inserting “90-day period or a subsequent 60-day period”.

(2) Section 1814(a)(7)(A) (42 U.S.C. 1395f(a)(7)(A)) is amended—

(A) in clause (i), by inserting “and” at the end;

(B) in clause (ii)—

(i) by striking “30-day” and inserting “60-day”; and

(ii) by striking “, and” at the end and inserting a period;

and

(C) by striking clause (iii).

SEC. 10524. OTHER ITEMS AND SERVICES INCLUDED IN HOSPICE CARE.

Section 1861(dd)(1) (42 U.S.C. 1395x(dd)(1)) is amended—

(1) in subparagraph (G), by striking “and” at the end;

(2) in subparagraph (H), by striking the period at the end and inserting “, and”; and

(3) by inserting after subparagraph (H) the following:

“(I) any other item or service which is specified in the plan and for which payment may otherwise be made under this title.”.

SEC. 10525. CONTRACTING WITH INDEPENDENT PHYSICIANS OR PHYSICIAN GROUPS FOR HOSPICE CARE SERVICES PERMITTED.

Section 1861(dd)(2) (42 U.S.C. 1395x(dd)(2)) is amended—

(1) in subparagraph (A)(ii)(I), by striking “(F),”; and

(2) in subparagraph (B)(i), by inserting “or, in the case of a physician described in subclause (I), under contract with” after “employed by”.

SEC. 10526. WAIVER OF CERTAIN STAFFING REQUIREMENTS FOR HOSPICE CARE PROGRAMS IN NON-URBANIZED AREAS.

Section 1861(dd)(5) (42 U.S.C. 1395x(dd)(5)) is amended—

(1) in subparagraph (B), by inserting “or (C)” after “subparagraph (A)” each place it appears; and

(2) by adding at the end the following:

“(C) The Secretary may waive the requirements of paragraph (2)(A)(i) and (2)(A)(ii) for an agency or organization with respect to the services described in paragraph (1)(B) and, with respect to dietary counseling, paragraph (1)(H), if such agency or organization—

“(i) is located in an area which is not an urbanized area (as defined by the Bureau of Census), and

“(ii) demonstrates to the satisfaction of the Secretary that the agency or organization has been unable, despite diligent efforts, to recruit appropriate personnel.”.

SEC. 10527. LIMITATION ON LIABILITY OF BENEFICIARIES FOR CERTAIN HOSPICE COVERAGE DENIALS.

Section 1879(g) (42 U.S.C. 1395pp(g)) is amended—

(1) by redesignating paragraphs (1) and (2) as subparagraphs (A) and (B), respectively, and moving such subparagraphs 2 ems to the right;

(2) by striking “is,” and inserting “is—”;

(3) by making the remaining text of subsection (g), as amended, that follows “is—” a new paragraph (1) and indenting such paragraph 2 ems to the right;

(4) by striking the period at the end and inserting “; and”; and

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

“(2) with respect to the provision of hospice care to an individual, a determination that the individual is not terminally ill.”.

SEC. 10528. EXTENDING THE PERIOD FOR PHYSICIAN CERTIFICATION OF AN INDIVIDUAL’S TERMINAL ILLNESS.

Section 1814(a)(7)(A)(i) (42 U.S.C. 1395f(a)(7)(A)(i)) is amended, in the matter following subclause (II), by striking “, not later than 2 days after hospice care is initiated (or, if each certify verbally not later than 2 days after hospice care is initiated, not later than 8 days after such care is initiated)” and inserting “at the beginning of the period”.

SEC. 10529. EFFECTIVE DATE.

Except as otherwise provided in this chapter, the amendments made by this chapter apply to benefits provided on or after the date of the enactment of this chapter, regardless of whether or not an individual has made an election under section 1812(d) of the Social Security Act (42 U.S.C. 1395d(d)) before such date.

CHAPTER 4—MODIFICATION OF PART A HOME HEALTH BENEFIT

SEC. 10531. MODIFICATION OF PART A HOME HEALTH BENEFIT FOR INDIVIDUALS ENROLLED UNDER PART B.

(a) IN GENERAL.—Section 1812 (42 U.S.C. 1395d) is amended—

(1) in subsection (a)(3), by striking “home health services” and inserting “for individuals not enrolled in part B, home health services, and for individuals so enrolled, part A home health services (as defined in subsection (g))”;

(2) by redesignating subsection (g) as subsection (h); and

(3) by inserting after subsection (f) the following new subsection:

“(g)(1) For purposes of this section, the term ‘part A home health services’ means—

“(A) for services furnished during each year beginning with 1998 and ending with 2002, home health services subject to the transition reduction applied under paragraph (2)(C) for services furnished during the year, and

“(B) for services furnished on or after January 1, 2003, post-institutional home health services for up to 100 visits during a home health spell of illness.

“(2) For purposes of paragraph (1)(B), the Secretary shall specify, before the beginning of each year beginning with 1998 and ending with 2002, a transition reduction in the home health services benefit under this part as follows:

“(A) The Secretary first shall estimate the amount of payments that would have been made under this part for home health services furnished during the year if—

“(i) part A home health services were all home health services, and

“(ii) part A home health services were limited to services described in paragraph (1)(B).

“(B)(i) The Secretary next shall compute a transfer reduction amount equal to the appropriate proportion (specified under clause (ii)) of the amount by which the amount estimated under subparagraph (A)(i) for the year exceeds the amount estimated under subparagraph (A)(ii) for the year.

“(ii) For purposes of clause (i), the ‘appropriate proportion’ is equal to—

- “(I) $\frac{1}{6}$ for 1998,
- “(II) $\frac{2}{6}$ for 1999,
- “(III) $\frac{3}{6}$ for 2000,
- “(IV) $\frac{4}{6}$ for 2001, and
- “(V) $\frac{5}{6}$ for 2002.

“(C) The Secretary shall establish a transition reduction by specifying such a visit limit (during a home health spell of illness) or such a post-institutional limitation on home health services furnished under this part during the year as the Secretary estimates will result in a reduction in the amount of payments that would otherwise be made under this part for home health services furnished during the year equal to the transfer amount computed under subparagraph (B)(i) for the year.

“(3) Payment under this part for home health services furnished an individual enrolled under part B—

“(A) during a year beginning with 1998 and ending with 2003, may not be made for services that are not within the visit limit or other limitation specified by the Secretary under the transition reduction under paragraph (3)(C) for services furnished during the year; or

“(B) on or after January 1, 2004, may not be made for home health services that are not post-institutional home health services or for post-institutional furnished to the individual after such services have been furnished to the individual for a total of 100 visits during a home health spell of illness.

“(4) With respect to computing the monthly actuarial rate for enrollees age 65 and over for purposes of applying section 1839, such rate shall be computed as though any reference in a previous provision of this subsection to 2002 or 2003 is a reference to the succeeding year and as through the appropriate proportion described in paragraph (3)(B)(ii) were equal to—

- “(A) $\frac{1}{7}$ for 1998,
- “(B) $\frac{2}{7}$ for 1999,
- “(C) $\frac{3}{7}$ for 2000,
- “(D) $\frac{4}{7}$ for 2001,
- “(E) $\frac{5}{7}$ for 2002, and
- “(F) $\frac{6}{7}$ for 2003.”

(b) POST-INSTITUTIONAL HOME HEALTH SERVICES DEFINED.—Section 1861 (42 U.S.C. 1395x), as amended by section 10105(a)(1)(B) is amended by adding at the end the following:

“Post-Institutional Home Health Services; Home Health Spell of
Illness

“(rr)(1) The term ‘post-institutional home health services’ means home health services furnished to an individual—

“(A) after discharge from a hospital or rural primary care hospital in which the individual was an inpatient for not less than 3 consecutive days before such discharge if such home health services were initiated within 14 days after the date of such discharge; or

“(B) after discharge from a skilled nursing facility in which the individual was provided post-hospital extended care services if such home health services were initiated within 14 days after the date of such discharge.

“(2) The term ‘home health spell of illness’ with respect to any individual means a period of consecutive days—

“(A) beginning with the first day (not included in a previous home health spell of illness) (i) on which such individual is furnished post-institutional home health services, and (B) which occurs in a month for which the individual is entitled to benefits under part A, and

“(B) ending with the close of the first period of 60 consecutive days thereafter on each of which the individual is neither an inpatient of a hospital or rural primary care hospital nor an inpatient of a facility described in section 1819(a)(1) or subsection (y)(1) nor provided home health services.”.

(c) MAINTAINING APPEAL RIGHTS FOR HOME HEALTH SERVICES.—Section 1869(b)(2)(B) (42 U.S.C. 1395ff(b)(2)(B)) is amended by inserting “(or \$100 in the case of home health services)” after “\$500”.

(d) MAINTAINING SEAMLESS ADMINISTRATION THROUGH FISCAL INTERMEDIARIES.—Section 1842(b)(2) (42 U.S.C. 1395u(b)(2)) is amended by adding at the end the following:

“(E) With respect to the payment of claims for home health services under this part that, but for the amendments made by section 10531 of the Balanced Budget Act of 1997, would be payable under part A instead of under this part, the Secretary shall continue administration of such claims through fiscal intermediaries under section 1816.”.

(e) EFFECTIVE DATE.—The amendments made by this section apply to services furnished on or after January 1, 1998. For purpose of applying such amendments, any home health spell of illness that began, but not end, before such date shall be considered to have begun as of such date.

CHAPTER 5—OTHER PAYMENT PROVISIONS

SEC. 10541. REDUCTIONS IN PAYMENTS FOR ENROLLEE BAD DEBT.

Section 1861(v)(1) (42 U.S.C. 1395x(v)(1)) is amended by adding at the end the following new subparagraph:

“(T) In determining such reasonable costs for hospitals, the amount of bad debts otherwise treated as allowable costs which are attributable to the deductibles and coinsurance amounts under this title shall be reduced—

“(i) for cost reporting periods beginning during fiscal year 1998, by 25 percent of such amount otherwise allowable,

“(ii) for cost reporting periods beginning during fiscal year 1999, by 40 percent of such amount otherwise allowable, and
 “(iii) for cost reporting periods beginning during a subsequent fiscal year, by 50 percent of such amount otherwise allowable.”.

SEC. 10542. PERMANENT EXTENSION OF HEMOPHILIA PASS-THROUGH.

Effective October 1, 1997, section 6011(d) of OBRA-1989 (as amended by section 13505 of OBRA-1993) is amended by striking “and shall expire September 30, 1994”.

SEC. 10543. REDUCTION IN PART A MEDICARE PREMIUM FOR CERTAIN PUBLIC RETIREES.

(a) IN GENERAL.—Section 1818(d) (42 U.S.C. 1395i-2(d)) is amended—

(1) in paragraph (2), by striking “paragraph (4)” and inserting “paragraphs (4) and (5)”; and

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

“(5)(A) The amount of the monthly premium shall be zero in the case of an individual who is a person described in subparagraph (B) for a month, if—

“(i) the individual’s premium under this section for the month is not (and will not be) paid for, in whole or in part, by a State (under title XIX or otherwise), a political subdivision of a State, or an agency or instrumentality of one or more States or political subdivisions thereof; and

“(ii) in each of 60 months before such month, the individual was enrolled in this part under this section and the payment of the individual’s premium under this section for the month was not paid for, in whole or in part, by a State (under title XIX or otherwise), a political subdivision of a State, or an agency or instrumentality of one or more States or political subdivisions thereof.

“(B) A person described in this subparagraph for the month is a person who establishes to the satisfaction of the Secretary that, as of the last day of the previous month—

“(i)(I) the person was receiving cash benefits under a qualified State or local government retirement system (as defined in subparagraph (C)) on the basis of the person’s employment in one or more positions covered under any such system, and (II) the person would have at least 40 quarters of coverage under title II if remuneration for medicare qualified government employment (as defined in paragraph (1) of section 210(p), but determined without regard to paragraph (3) of such section) paid to such person were treated as wages paid to such person and credited for purposes of determining quarters of coverage under section 213;

“(ii)(I) the person was married (and had been married for the previous 1-year period) to an individual who is described in clause (i), or (II) the person met the requirement of clause (i)(II) and was married (and had been married for the previous 1-year period) to an individual described in clause (i)(I);

“(iii) the person had been married to an individual for a period of at least 1 year (at the time of such individual’s death) if (I) the individual was described in clause (i) at the time of

the individual's death, or (II) the person met the requirement of clause (i)(II) and the individual was described in clause (i)(I) at the time of the individual's death; or

“(iv) the person is divorced from an individual and had been married to the individual for a period of at least 10 years (at the time of the divorce) if (I) the individual was described in clause (i) at the time of the divorce, or (II) the person met the requirement of clause (i)(II) and the individual was described in clause (i)(I) at the time of the divorce.

“(C) For purposes of subparagraph (B)(i)(I), the term ‘qualified State or local government retirement system’ means a retirement system that—

“(i) is established or maintained by a State or political subdivision thereof, or an agency or instrumentality of one or more States or political subdivisions thereof;

“(ii) covers positions of some or all employees of such a State, subdivision, agency, or instrumentality; and

“(iii) does not adjust cash retirement benefits based on eligibility for a reduction in premium under this paragraph.”.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to premiums for months beginning with January 1998, and months before such month may be taken into account for purposes of meeting the requirement of section 1818(d)(5)(B)(iii) of the Social Security Act, as added by subsection (a).

Subtitle G—Provisions Relating to Part B Only

CHAPTER 1—PHYSICIANS’ SERVICES

SEC. 10601. ESTABLISHMENT OF SINGLE CONVERSION FACTOR FOR 1998.

(a) IN GENERAL.—Section 1848(d)(1) (42 U.S.C. 1395w–4(d)(1)) is amended—

(1) by redesignating subparagraph (C) as subparagraph (D), and

(2) by inserting after subparagraph (B) the following:

“(C) SPECIAL RULES FOR 1998.—The single conversion factor for 1998 under this subsection shall be the conversion factor for primary care services for 1997, increased by the Secretary's estimate of the weighted average of the three separate updates that would otherwise occur were it not for the enactment of chapter 1 of subtitle G of title X of the Balanced Budget Act of 1997.”.

(b) CONFORMING AMENDMENTS.—Section 1848 (42 U.S.C. 1395w–4) is amended—

(1) by striking “(or factors)” each place it appears in subsection (d)(1)(A) and (d)(1)(D)(ii) (as redesignated by subsection (a)(1)),

(2) in subsection (d)(1)(A), by striking “or updates”,

(3) in subsection (d)(1)(D) (as redesignated by subsection (a)(1)), by striking “(or updates)” each place it appears, and

(4) in subsection (i)(1)(C), by striking “conversion factors” and inserting “the conversion factor”.

SEC. 10602. ESTABLISHING UPDATE TO CONVERSION FACTOR TO MATCH SPENDING UNDER SUSTAINABLE GROWTH RATE.

(a) UPDATE.—

(1) IN GENERAL.—Section 1848(d)(3) (42 U.S.C. 1395w-4(d)(3)) is amended to read as follows:

“(3) UPDATE.—

“(A) IN GENERAL.—Unless otherwise provided by law, subject to subparagraph (D) and the budget-neutrality factor determined by the Secretary under subsection (c)(2)(B)(ii), the update to the single conversion factor established in paragraph (1)(C) for a year beginning with 1999 is equal to the product of—

“(i) 1 plus the Secretary’s estimate of the percentage increase in the MEI (as defined in section 1842(i)(3)) for the year (divided by 100), and

“(ii) 1 plus the Secretary’s estimate of the update adjustment factor for the year (divided by 100), minus 1 and multiplied by 100.

“(B) UPDATE ADJUSTMENT FACTOR.—For purposes of subparagraph (A)(ii), the ‘update adjustment factor’ for a year is equal to the quotient (as estimated by the Secretary) of—

“(i) the difference between (I) the sum of the allowed expenditures for physicians’ services (as determined under subparagraph (C)) during the period beginning July 1, 1997, and ending on June 30 of the year involved, and (II) the sum of the amount of actual expenditures for physicians’ services furnished during the period beginning July 1, 1997, and ending on June 30 of the preceding year; divided by

“(ii) the actual expenditures for physicians’ services for the 12-month period ending on June 30 of the preceding year, increased by the sustainable growth rate under subsection (f) for the fiscal year which begins during such 12-month period.

“(C) DETERMINATION OF ALLOWED EXPENDITURES.—For purposes of this paragraph, the allowed expenditures for physicians’ services for the 12-month period ending with June 30 of—

“(i) 1997 is equal to the actual expenditures for physicians’ services furnished during such 12-month period, as estimated by the Secretary; or

“(ii) a subsequent year is equal to the allowed expenditures for physicians’ services for the previous year, increased by the sustainable growth rate under subsection (f) for the fiscal year which begins during such 12-month period.

“(D) RESTRICTION ON VARIATION FROM MEDICARE ECONOMIC INDEX.—Notwithstanding the amount of the update adjustment factor determined under subparagraph (B) for a year, the update in the conversion factor under this paragraph for the year may not be—

“(i) greater than 100 times the following amount: $(1.03 + (\text{MEI percentage}/100)) - 1$; or

“(ii) less than 100 times the following amount: $(0.93 + (\text{MEI percentage}/100)) - 1$,

where ‘MEI percentage’ means the Secretary’s estimate of the percentage increase in the MEI (as defined in section 1842(i)(3)) for the year involved.”

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to the update for years beginning with 1999.

(b) ELIMINATION OF REPORT.—Section 1848(d) (42 U.S.C. 1395w-4(d)) is amended by striking paragraph (2).

SEC. 10603. REPLACEMENT OF VOLUME PERFORMANCE STANDARD WITH SUSTAINABLE GROWTH RATE.

(a) IN GENERAL.—Section 1848(f) (42 U.S.C. 1395w-4(f)) is amended by striking paragraphs (2) through (5) and inserting the following:

“(2) SPECIFICATION OF GROWTH RATE.—The sustainable growth rate for all physicians’ services for a fiscal year (beginning with fiscal year 1998) shall be equal to the product of—

“(A) 1 plus the Secretary’s estimate of the weighted average percentage increase (divided by 100) in the fees for all physicians’ services in the fiscal year involved,

“(B) 1 plus the Secretary’s estimate of the percentage change (divided by 100) in the average number of individuals enrolled under this part (other than MedicarePlus plan enrollees) from the previous fiscal year to the fiscal year involved,

“(C) 1 plus the Secretary’s estimate of the projected percentage growth in real gross domestic product per capita (divided by 100) from the previous fiscal year to the fiscal year involved, and

“(D) 1 plus the Secretary’s estimate of the percentage change (divided by 100) in expenditures for all physicians’ services in the fiscal year (compared with the previous fiscal year) which will result from changes in law and regulations, determined without taking into account estimated changes in expenditures due to changes in the volume and intensity of physicians’ services resulting from changes in the update to the conversion factor under subsection (d)(3), minus 1 and multiplied by 100.

“(3) DEFINITIONS.—In this subsection:

“(A) SERVICES INCLUDED IN PHYSICIANS’ SERVICES.—The term ‘physicians’ services’ includes other items and services (such as clinical diagnostic laboratory tests and radiology services), specified by the Secretary, that are commonly performed or furnished by a physician or in a physician’s office, but does not include services furnished to a MedicarePlus plan enrollee.

“(B) MEDICAREPLUS PLAN ENROLLEE.—The term ‘MedicarePlus plan enrollee’ means, with respect to a fiscal year, an individual enrolled under this part who has elected to receive benefits under this title for the fiscal year through a MedicarePlus plan offered under part C, and also includes an individual who is receiving benefits under this part through enrollment with an eligible organization with a risk-sharing contract under section 1876.”

(b) CONFORMING AMENDMENTS.—Section 1848(f) (42 U.S.C. 1395w-4(f)) is amended—

(1) in the heading, by striking “VOLUME PERFORMANCE STANDARD RATES OF INCREASE” and inserting “SUSTAINABLE GROWTH RATE”; and

(2) in paragraph (1)—

(A) in the heading, by striking “VOLUME PERFORMANCE STANDARD RATES OF INCREASE” and inserting “SUSTAINABLE GROWTH RATE”,

(B) by striking subparagraphs (A) and (B); and

(C) in paragraph (1)(C)—

(i) in the heading, by striking “PERFORMANCE STANDARD RATES OF INCREASE” and inserting “SUSTAINABLE GROWTH RATE”;

(ii) in the first sentence, by striking “with 1991), the performance standard rates of increase” and all that follows through the first period and inserting “with 1999), the sustainable growth rate for the fiscal year beginning in that year.”; and

(iii) in the second sentence, by striking “January 1, 1990, the performance standard rate of increase under subparagraph (D) for fiscal year 1990” and inserting “January 1, 1999, the sustainable growth rate for fiscal year 1999”.

SEC. 10604. PAYMENT RULES FOR ANESTHESIA SERVICES.

(a) IN GENERAL.—Section 1848(d)(1) (42 U.S.C. 1395w-4(d)(1)), as amended by section 10601(a), is amended—

(1) in subparagraph (C), striking “The single” and inserting “Except as provided in subparagraph (D), the single”;

(2) by redesignating subparagraph (D) as subparagraph (E); and

(3) by inserting after subparagraph (C) the following new subparagraph:

“(D) SPECIAL RULES FOR ANESTHESIA SERVICES.—The separate conversion factor for anesthesia services for a year shall be equal to 46 percent of the single conversion factor established for other physicians’ services, except as adjusted for changes in work, practice expense, or malpractice relative value units.”.

(b) CLASSIFICATION OF ANESTHESIA SERVICES.—The first sentence of section 1848(j)(1) (42 U.S.C. 1395w-4(j)(1)) is amended—

(1) by striking “and including anesthesia services”; and

(2) by inserting before the period the following: “(including anesthesia services)”.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 1998.

SEC. 10605. IMPLEMENTATION OF RESOURCE-BASED PHYSICIAN PRACTICE EXPENSE.

(a) 1-YEAR DELAY IN IMPLEMENTATION.—Section 1848(c) (42 U.S.C. 1395w-4(c)) is amended—

(1) in paragraph (2)(C)(ii), in the matter before subclause (I) and after subclause (II), by striking “1998” and inserting “1999” each place it appears; and

(2) in paragraph (3)(C)(ii), by striking “1998” and inserting “1999”.

(b) PHASED-IN IMPLEMENTATION.—Section 1848(c)(2)(C)(ii) (42 U.S.C. 1395w-4(c)(2)(C)(ii)) is further amended—

(1) in subparagraph (C)(ii), in the matter following subclause (II), by inserting “, to the extent provided under subparagraph (G),” after “based”, and

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

“(G) TRANSITIONAL RULE FOR RESOURCE-BASED PRACTICE EXPENSE UNITS.—In applying subparagraph (C)(ii) for 1999, 2000, 2001, and any subsequent year, the number of units under such subparagraph shall be based 75 percent, 50 percent, 25 percent, and 0 percent, respectively, on the practice expense relative value units in effect in 1998 (or the Secretary’s imputation of such units for new or revised codes) and the remainder on the relative value expense resources involved in furnishing the service.”.

SEC. 10606. DISSEMINATION OF INFORMATION ON HIGH PER DISCHARGE RELATIVE VALUES FOR IN-HOSPITAL PHYSICIANS’ SERVICES.

(a) DETERMINATION AND NOTICE CONCERNING HOSPITAL-SPECIFIC PER DISCHARGE RELATIVE VALUES.—

(1) IN GENERAL.—For 1999 and 2001 the Secretary of Health and Human Services shall determine for each hospital—

(A) the hospital-specific per discharge relative value under subsection (b); and

(B) whether the hospital-specific relative value is projected to be excessive (as determined based on such value represented as a percentage of the median of hospital-specific per discharge relative values determined under subsection (b)).

(2) NOTICE TO MEDICAL STAFFS AND CARRIERS.—The Secretary shall notify the medical executive committee of each hospital identified under paragraph (1)(B) as having an excessive hospital-specific relative value, of the determinations made with respect to the medical staff under paragraph (1).

(b) DETERMINATION OF HOSPITAL-SPECIFIC PER DISCHARGE RELATIVE VALUES.—

(1) IN GENERAL.—For purposes of this section, the hospital-specific per discharge relative value for the medical staff of a hospital (other than a teaching hospital) for a year, shall be equal to the average per discharge relative value (as determined under section 1848(c)(2) of the Social Security Act) for physicians’ services furnished to inpatients of the hospital by the hospital’s medical staff (excluding interns and residents) during the second year preceding that calendar year, adjusted for variations in case-mix and disproportionate share status among hospitals (as determined by the Secretary under paragraph (3)).

(2) SPECIAL RULE FOR TEACHING HOSPITALS.—The hospital-specific relative value projected for a teaching hospital in a year shall be equal to the sum of—

(A) the average per discharge relative value (as determined under section 1848(c)(2) of such Act) for physicians’

services furnished to inpatients of the hospital by the hospital's medical staff (excluding interns and residents) during the second year preceding that calendar year, and

(B) the equivalent per discharge relative value (as determined under such section) for physicians' services furnished to inpatients of the hospital by interns and residents of the hospital during the second year preceding that calendar year, adjusted for variations in case-mix, disproportionate share status, and teaching status among hospitals (as determined by the Secretary under paragraph (3)).

The Secretary shall determine the equivalent relative value unit per discharge for interns and residents based on the best available data and may make such adjustment in the aggregate.

(3) ADJUSTMENT FOR TEACHING AND DISPROPORTIONATE SHARE HOSPITALS.—The Secretary shall adjust the allowable per discharge relative values otherwise determined under this subsection to take into account the needs of teaching hospitals and hospitals receiving additional payments under subparagraphs (F) and (G) of section 1886(d)(5) of the Social Security Act. The adjustment for teaching status or disproportionate share shall not be less than zero.

(c) DEFINITIONS.—For purposes of this section:

(1) HOSPITAL.—The term “hospital” means a subsection (d) hospital as defined in section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)).

(2) MEDICAL STAFF.—An individual furnishing a physician's service is considered to be on the medical staff of a hospital—

(A) if (in accordance with requirements for hospitals established by the Joint Commission on Accreditation of Health Organizations)—

(i) the individual is subject to bylaws, rules, and regulations established by the hospital to provide a framework for the self-governance of medical staff activities,

(ii) subject to the bylaws, rules, and regulations, the individual has clinical privileges granted by the hospital's governing body, and

(iii) under the clinical privileges, the individual may provide physicians' services independently within the scope of the individual's clinical privileges, or

(B) if the physician provides at least one service to an individual entitled to benefits under this title in that hospital.

(3) PHYSICIANS' SERVICES.—The term “physicians services” means the services described in section 1848(j)(3) of the Social Security Act (42 U.S.C. 1395w-4(j)(3)).

(4) RURAL AREA; URBAN AREA.—The terms “rural area” and “urban area” have the meaning given those terms under section 1886(d)(2)(D) of such Act (42 U.S.C. 1395ww(d)(2)(D)).

(5) SECRETARY.—The term “Secretary” means the Secretary of Health and Human Services .

(6) **TEACHING HOSPITAL.**—The term “teaching hospital” means a hospital which has a teaching program approved as specified in section 1861(b)(6) of the Social Security Act (42 U.S.C. 1395x(b)(6)).

SEC. 10607. NO X-RAY REQUIRED FOR CHIROPRACTIC SERVICES.

(a) **IN GENERAL.**—Section 1861(r)(5) (42 U.S.C. 1395x(r)(5)) is amended by striking “demonstrated by X-ray to exist”.

(b) **EFFECTIVE DATE.**—The amendment made by subsection (a) applies to services furnished on or after January 1, 1998.

SEC. 10608. TEMPORARY COVERAGE RESTORATION FOR PORTABLE ELECTROCARDIOGRAM TRANSPORTATION.

(a) **IN GENERAL.**—Effective for electrocardiogram tests furnished during 1998, the Secretary of Health and Human Services shall restore separate payment, under part B of title XVIII of the Social Security Act, for the transportation of electrocardiogram equipment (HCPCS code R0076) based upon the status code and relative value units established for such service as of December 31, 1996.

(b) **DETERMINATION.**—By not later than July 1, 1998, the Secretary of Health and Human Services shall determine, taking into account the study of coverage of portable electrocardiogram transportation conducted by the Comptroller General and other relevant information, including information submitted by interested parties, whether coverage of portable electrocardiogram transportation should be provided under part B of title XVIII of the Social Security Act.

CHAPTER 2—OTHER PAYMENT PROVISIONS

SEC. 10611. PAYMENTS FOR DURABLE MEDICAL EQUIPMENT.

(a) **REDUCTION IN PAYMENT AMOUNTS FOR ITEMS OF DURABLE MEDICAL EQUIPMENT.**—

(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, 1995, 1996, and 1997”, and

(ii) by striking the period at the end and inserting a semicolon; and

(C) by adding at the end the following:

“(C) for each of the years 1998 through 2002, 0 percentage points; 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) (42 U.S.C. 1395m(h)(4)(A)) is amended—

(A) by striking “, and” at the end of clause (iii) and inserting a semicolon;

(B) in clause (iv), by striking “a subsequent year” and inserting “1996 and 1997”, and

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

“(v) for each of the years 1998 through 2002, 1 percent, and

“(vi) for a subsequent year, the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period ending with June of the previous year;”.

(c) **PAYMENT FREEZE FOR PARENTERAL AND ENTERAL NUTRIENTS, SUPPLIES, AND EQUIPMENT.**—In determining the amount of payment under part B of title XVIII of the Social Security Act with respect to parenteral and enteral nutrients, supplies, and equipment during each of the years 1998 through 2002, the charges determined to be reasonable with respect to such nutrients, supplies, and equipment may not exceed the charges determined to be reasonable with respect to such nutrients, supplies, and equipment during 1995.

SEC. 10612. 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, 1995, 1996, and 1997”, and

(B) by striking the period at the end and inserting a semicolon; and

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

“(v) in each of the years 1998 through 2002, is 80 percent of the national limited monthly payment rate computed under subparagraph (B) for the item for the year; and

“(vi) in a subsequent year, is the national limited monthly payment rate computed under subparagraph (B) for the item for the year.”.

SEC. 10613. REDUCTION IN UPDATES TO PAYMENT AMOUNTS FOR CLINICAL DIAGNOSTIC LABORATORY TESTS.

(a) **CHANGE IN UPDATE.**—Section 1833(h)(2)(A)(ii)(IV) (42 U.S.C. 1395l(h)(2)(A)(ii)(IV)) is amended by inserting “and 1998 through 2002” after “1995”.

(b) **LOWERING CAP ON PAYMENT AMOUNTS.**—Section 1833(h)(4)(B) (42 U.S.C. 1395l(h)(4)(B)) is amended—

(1) in clause (vi), by striking “and” at the end;

(2) in clause (vii)—

(A) by inserting “and before January 1, 1998,” after “1995,” and

(B) by striking the period at the end and inserting “, and”; and

(3) by adding at the end the following new clause:

“(viii) after December 31, 1997, is equal to 72 percent of such median.”.

SEC. 10614. SIMPLIFICATION IN ADMINISTRATION OF LABORATORY TESTS.

(a) **SELECTION OF REGIONAL CARRIERS.**—

(1) **IN GENERAL.**—The Secretary of Health and Human Services (in this section referred to as the “Secretary”) shall—

(A) divide the United States into no more than 5 regions, and

(B) designate a single carrier for each such region, for the purpose of payment of claims under part B of title XVIII of the Social Security Act with respect to clinical diagnostic laboratory tests (other than for independent physician offices) furnished on or after such date (not later than January 1, 1999) as the Secretary specifies.

(2) DESIGNATION.—In designating such carriers, the Secretary shall consider, among other criteria—

(A) a carrier's timeliness, quality, and experience in claims processing, and

(B) a carrier's capacity to conduct electronic data interchange with laboratories and data matches with other carriers.

(3) SINGLE DATA RESOURCE.—The Secretary may select one of the designated carriers to serve as a central statistical resource for all claims information relating to such clinical diagnostic laboratory tests handled by all the designated carriers under such part.

(4) ALLOCATION OF CLAIMS.—The allocation of claims for clinical diagnostic laboratory tests to particular designated carriers shall be based on whether a carrier serves the geographic area where the laboratory specimen was collected or other method specified by the Secretary.

(b) ADOPTION OF UNIFORM POLICIES FOR CLINICAL LABORATORY TESTS.—

(1) IN GENERAL.—Not later than July 1, 1998, the Secretary shall first adopt, consistent with paragraph (2), uniform coverage, administration, and payment policies for clinical diagnostic laboratory tests under part B of title XVIII of the Social Security Act, using a negotiated rulemaking process under subchapter III of chapter 5 of title 5, United States Code.

(2) CONSIDERATIONS IN DESIGN OF UNIFORM POLICIES.—The policies under paragraph (1) shall be designed to promote uniformity and program integrity and reduce administrative burdens with respect to clinical diagnostic laboratory tests payable under such part in connection with the following:

(A) Beneficiary information required to be submitted with each claim or order for laboratory tests.

(B) Physicians' obligations regarding documentation requirements and recordkeeping.

(C) Procedures for filing claims and for providing remittances by electronic media.

(D) The documentation of medical necessity.

(E) Limitation on frequency of coverage for the same tests performed on the same individual.

(3) CHANGES IN CARRIER REQUIREMENTS PENDING ADOPTION OF UNIFORM POLICY.—During the period that begins on the date of the enactment of this Act and ends on the date the Secretary first implements uniform policies pursuant to regulations promulgated under this subsection, a carrier under such part may implement changes relating to requirements for the submission of a claim for clinical diagnostic laboratory tests.

(4) USE OF INTERIM REGIONAL POLICIES.—After the date the Secretary first implements such uniform policies, the Secretary shall permit any carrier to develop and implement interim policies of the type described in paragraph (1), in accordance with guidelines established by the Secretary, in cases in which a uniform national policy has not been established under this subsection and there is a demonstrated need for a policy to respond to aberrant utilization or provision of unnecessary services. Except as the Secretary specifically permits, no policy shall be implemented under this paragraph for a period of longer than 2 years.

(5) INTERIM NATIONAL POLICIES.—After the date the Secretary first designates regional carriers under subsection (a), the Secretary shall establish a process under which designated carriers can collectively develop and implement interim national standards of the type described in paragraph (1). No such policy shall be implemented under this paragraph for a period of longer than 2 years.

(6) BIENNIAL REVIEW PROCESS.—Not less often than once every 2 years, the Secretary shall solicit and review comments regarding changes in the uniform policies established under this subsection. As part of such biennial review process, the Secretary shall specifically review and consider whether to incorporate or supersede interim, regional, or national policies developed under paragraph (4) or (5). Based upon such review, the Secretary may provide for appropriate changes in the uniform policies previously adopted under this subsection.

(7) NOTICE.— Before a carrier implements a change or policy under paragraph (3), (4), or (5), the carrier shall provide for advance notice to interested parties and a 45-day period in which such parties may submit comments on the proposed change.

(c) INCLUSION OF LABORATORY REPRESENTATIVE ON CARRIER ADVISORY COMMITTEES.—The Secretary shall direct that any advisory committee established by such a carrier, to advise with respect to coverage, administration or payment policies under part B of title XVIII of the Social Security Act, shall include an individual to represent the interest and views of independent clinical laboratories and such other laboratories as the Secretary deems appropriate. Such individual shall be selected by such committee from among nominations submitted by national and local organizations that represent independent clinical laboratories.

SEC. 10615. UPDATES FOR AMBULATORY SURGICAL SERVICES.

Section 1833(i)(2)(C) (42 U.S.C. 1395l(i)(2)(C)) is amended by striking all that follows “shall be increased” and inserting the following: “as follows:

“(i) For fiscal years 1996 and 1997, by the percentage increase in the consumer price index for all urban consumers (U.S. city average) as estimated by the Secretary for the 12-month period ending with the midpoint of the year involved.

“(ii) For each of fiscal years 1998 through 2002 by such percentage increase minus 2.0 percentage points.

“(iii) For each succeeding fiscal year by such percentage increase.”.

SEC. 10616. REIMBURSEMENT FOR DRUGS AND BIOLOGICALS.

(a) IN GENERAL.—Section 1842 (42 U.S.C. 1395u) is amended by inserting after subsection (n) the following new subsection:

“(o) If a physician’s, supplier’s, or any other person’s bill or request for payment for services includes a charge for a drug or biological for which payment may be made under this part and the drug or biological is not paid on a cost or prospective payment basis as otherwise provided in this part, the amount payable for the drug or biological is equal to 95 percent of the average wholesale price.”.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) apply to drugs and biologicals furnished on or after January 1, 1998.

SEC. 10617. COVERAGE OF ORAL ANTI-NAUSEA DRUGS UNDER CHEMOTHERAPEUTIC REGIMEN.

(a) IN GENERAL.—Section 1861(s)(2) (42 U.S.C. 1395x(s)(2)), as amended, is further amended—

(1) by striking “and” at the end of subparagraph (R); and

(2) by inserting after subparagraph (S) the following new subparagraph:

“(T) an oral drug (which is approved by the Federal Food and Drug Administration) prescribed for use as an acute anti-emetic used as part of an anticancer chemotherapeutic regimen if the drug is administered by a physician (or under the supervision of a physician)—

“(i) for use immediately before, immediately after, or at the time of the administration of the anticancer chemotherapeutic agent; and

“(ii) as a full replacement for the anti-emetic therapy which would otherwise be administered intravenously.”.

(b) PAYMENT LEVELS.—Section 1834 (42 U.S.C. 1395m), as amended by sections 10421(a)(2) and 10431(b)(2), is amended by adding at the end the following new subsection:

“(m) SPECIAL RULES FOR PAYMENT FOR ORAL ANTI-NAUSEA DRUGS.—

“(1) LIMITATION ON PER DOSE PAYMENT BASIS.—Subject to paragraph (2), the per dose payment basis under this part for oral anti-nausea drugs (as defined in paragraph (3)) administered during a year shall not exceed 90 percent of the average per dose payment basis for the equivalent intravenous antiemetics administered during the year, as computed based on the payment basis applied during 1996.

“(2) AGGREGATE LIMIT.—The Secretary shall make such adjustment in the coverage of, or payment basis for, oral anti-nausea drugs so that coverage of such drugs under this part does not result in any increase in aggregate payments per capita under this part above the levels of such payments per capita that would otherwise have been made if there were no coverage for such drugs under this part.

“(3) ORAL ANTI-NAUSEA DRUGS DEFINED.—For purposes of this subsection, the term ‘oral anti-nausea drugs’ means drugs for which coverage is provided under this part pursuant to section 1861(s)(2)(P).”.

(c) **EFFECTIVE DATE.**—The amendments made by this section shall apply to items and services furnished on or after January 1, 1998.

SEC. 10618. RURAL HEALTH CLINIC SERVICES.

(a) **PER-VISIT PAYMENT LIMITS FOR PROVIDER-BASED CLINICS.**—

(1) **EXTENSION OF LIMIT.**—

(A) **IN GENERAL.**—The matter in section 1833(f) (42 U.S.C. 1395l(f)) preceding paragraph (1) is amended by striking “independent rural health clinics” and inserting “rural health clinics (other than such clinics in rural hospitals with less than 50 beds)”.

(B) **EFFECTIVE DATE.**—The amendment made by subparagraph (A) applies to services furnished after 1997.

(2) **TECHNICAL CLARIFICATION.**—Section 1833(f)(1) (42 U.S.C. 1395l(f)(1)) is amended by inserting “per visit” after “\$46”.

(b) **ASSURANCE OF QUALITY SERVICES.**—

(1) **IN GENERAL.**—Subparagraph (I) of the first sentence of section 1861(aa)(2) (42 U.S.C. 1395x(aa)(2)) is amended to read as follows:

“(I) has a quality assessment and performance improvement program, and appropriate procedures for review of utilization of clinic services, as the Secretary may specify,”.

(2) **EFFECTIVE DATE.**—The amendment made by paragraph (1) shall take effect on January 1, 1998.

(c) **WAIVER OF CERTAIN STAFFING REQUIREMENTS LIMITED TO CLINICS IN PROGRAM.**—

(1) **IN GENERAL.**—Section 1861(aa)(7)(B) (42 U.S.C. 1395x(aa)(7)(B)) is amended by inserting before the period at the end the following: “, or if the facility has not yet been determined to meet the requirements (including subparagraph (J) of the first sentence of paragraph (2)) of a rural health clinic”.

(2) **EFFECTIVE DATE.**—The amendment made by paragraph (1) applies to waiver requests made after 1997.

(d) **REFINEMENT OF SHORTAGE AREA REQUIREMENTS.**—

(1) **DESIGNATION REVIEWED TRIENNIALLY.**—Section 1861(aa)(2) (42 U.S.C. 1395x(aa)(2)) is amended in the second sentence, in the matter in clause (i) preceding subclause (I)—

(A) by striking “and that is designated” and inserting “and that, within the previous three-year period, has been designated”; and

(B) by striking “or that is designated” and inserting “or designated”.

(2) **AREA MUST HAVE SHORTAGE OF HEALTH CARE PRACTITIONERS.**—Section 1861(aa)(2) (42 U.S.C. 1395x(aa)(2)), as amended by paragraph (1), is further amended in the second sentence, in the matter in clause (i) preceding subclause (I)—

(A) by striking the comma after “personal health services”; and

(B) by inserting “and in which there are insufficient numbers of needed health care practitioners (as determined by the Secretary),” after “Bureau of the Census”.

(3) **PREVIOUSLY QUALIFYING CLINICS GRANDFATHERED ONLY TO PREVENT SHORTAGE.**—Section 1861(aa)(2) (42 U.S.C. 1395x(aa)(2)) is amended in the third sentence by inserting be-

fore the period “if it is determined, in accordance with criteria established by the Secretary in regulations, to be essential to the delivery of primary care services that would otherwise be unavailable in the geographic area served by the clinic”.

(4) EFFECTIVE DATES; IMPLEMENTING REGULATIONS.—

(A) IN GENERAL.—Except as otherwise provided, the amendments made by the preceding paragraphs take effect on January 1 of the first calendar year beginning at least one month after enactment of this Act.

(B) CURRENT RURAL HEALTH CLINICS.—The amendments made by the preceding paragraphs take effect, with respect to entities that are rural health clinics under title XVIII of the Social Security Act on the date of enactment of this Act, on January 1 of the second calendar year following the calendar year specified in subparagraph (A).

(C) GRANDFATHERED CLINICS.—

(i) IN GENERAL.—The amendment made by paragraph (3) shall take effect on the effective date of regulations issued by the Secretary under clause (ii).

(ii) REGULATIONS.—The Secretary shall issue final regulations implementing paragraph (3) that shall take effect no later than January 1 of the third calendar year beginning at least one month after enactment of this Act.

SEC. 10619. INCREASED MEDICARE REIMBURSEMENT FOR NURSE PRACTITIONERS AND CLINICAL NURSE SPECIALISTS.

(a) REMOVAL OF RESTRICTIONS ON SETTINGS.—

(1) IN GENERAL.—Clause (ii) of section 1861(s)(2)(K) (42 U.S.C. 1395x(s)(2)(K)) is amended to read as follows:

“(ii) services which would be physicians’ services if furnished by a physician (as defined in subsection (r)(1)) and which are performed by a nurse practitioner or clinical nurse specialist (as defined in subsection (aa)(5)) working in collaboration (as defined in subsection (aa)(6)) with a physician (as defined in subsection (r)(1)) which the nurse practitioner or clinical nurse specialist is legally authorized to perform by the State in which the services are performed, and such services and supplies furnished as an incident to such services as would be covered under subparagraph (A) if furnished incident to a physician’s professional service, but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services;”.

(2) CONFORMING AMENDMENTS.—(A) Section 1861(s)(2)(K) of such Act (42 U.S.C. 1395x(s)(2)(K)) is further amended—

(i) in clause (i), by inserting “and such services and supplies furnished as incident to such services as would be covered under subparagraph (A) if furnished incident to a physician’s professional service,” after “are performed;” and

(ii) by striking clauses (iii) and (iv).

(B) Section 1861(b)(4) (42 U.S.C. 1395x(b)(4)) is amended by striking “clauses (i) or (iii) of subsection (s)(2)(K)” and inserting “subsection (s)(2)(K)”.

(C) Section 1862(a)(14) (42 U.S.C. 1395y(a)(14)) is amended by striking “section 1861(s)(2)(K)(i) or 1861(s)(2)(K)(iii)” and inserting “section 1861(s)(2)(K)”.

(D) Section 1866(a)(1)(H) (42 U.S.C. 1395cc(a)(1)(H)) is amended by striking “section 1861(s)(2)(K)(i) or 1861(s)(2)(K)(iii)” and inserting “section 1861(s)(2)(K)”.

(E) Section 1888(e)(2)(A)(ii) (42 U.S.C. 1395yy(e)(2)(A)(ii)), as added by section 10401(a), is amended by striking “through (iii)” and inserting “and (ii)”.

(b) INCREASED PAYMENT.—

(1) FEE SCHEDULE AMOUNT.—Clause (O) of section 1833(a)(1) (42 U.S.C. 1395l(a)(1)) is amended to read as follows: “(O) with respect to services described in section 1861(s)(2)(K)(ii) (relating to nurse practitioner or clinical nurse specialist services), the amounts paid shall be equal to 80 percent of (i) the lesser of the actual charge or 85 percent of the fee schedule amount provided under section 1848, or (ii) in the case of services as an assistant at surgery, the lesser of the actual charge or 85 percent of the amount that would otherwise be recognized if performed by a physician who is serving as an assistant at surgery; and”.

(2) CONFORMING AMENDMENTS.—(A) Section 1833(r) (42 U.S.C. 1395l(r)) is amended—

(i) in paragraph (1), by striking “section 1861(s)(2)(K)(iii) (relating to nurse practitioner or clinical nurse specialist services provided in a rural area)” and inserting “section 1861(s)(2)(K)(ii) (relating to nurse practitioner or clinical nurse specialist services)”;

(ii) by striking paragraph (2);

(iii) in paragraph (3), by striking “section 1861(s)(2)(K)(iii)” and inserting “section 1861(s)(2)(K)(ii)”;

and

(iv) by redesignating paragraph (3) as paragraph (2).

(B) Section 1842(b)(12)(A) (42 U.S.C. 1395u(b)(12)(A)) is amended, in the matter preceding clause (i), by striking “clauses (i), (ii), or (iv) of section 1861(s)(2)(K) (relating to a physician assistants and nurse practitioners)” and inserting “section 1861(s)(2)(K)(i) (relating to physician assistants)”.

(c) DIRECT PAYMENT FOR NURSE PRACTITIONERS AND CLINICAL NURSE SPECIALISTS.—

(1) IN GENERAL.—Section 1832(a)(2)(B)(iv) (42 U.S.C. 1395k(a)(2)(B)(iv)) is amended by striking “provided in a rural area (as defined in section 1886(d)(2)(D))” and inserting “but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services”.

(2) CONFORMING AMENDMENT.—Section 1842(b)(6)(C) (42 U.S.C. 1395u(b)(6)(C)) is amended—

(A) by striking “clauses (i), (ii), or (iv)” and inserting “clause (i)”;

(B) by striking “or nurse practitioner”.

(d) DEFINITION OF CLINICAL NURSE SPECIALIST CLARIFIED.—Section 1861(aa)(5) (42 U.S.C. 1395x(aa)(5)) is amended—

(1) by inserting “(A)” after “(5)”;

(2) by striking “The term ‘physician assistant’ ” and all that follows through “who performs” and inserting “The term ‘physician assistant’ and the term ‘nurse practitioner’ mean, for purposes of this title, a physician assistant or nurse practitioner who performs”; and

(3) by adding at the end the following new subparagraph:

“(B) The term ‘clinical nurse specialist’ means, for purposes of this title, an individual who—

“(i) is a registered nurse and is licensed to practice nursing in the State in which the clinical nurse specialist services are performed; and

“(ii) holds a master’s degree in a defined clinical area of nursing from an accredited educational institution.”.

(e) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to services furnished and supplies provided on and after January 1, 1998.

SEC. 10620. INCREASED MEDICARE REIMBURSEMENT FOR PHYSICIAN ASSISTANTS.

(a) REMOVAL OF RESTRICTION ON SETTINGS.—Section 1861(s)(2)(K)(i) (42 U.S.C. 1395x(s)(2)(K)(i)) is amended—

(1) by striking “(I) in a hospital” and all that follows through “shortage area,”, and

(2) by adding at the end the following: “but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services,”.

(b) INCREASED PAYMENT.—Paragraph (12) of section 1842(b) (42 U.S.C. 1395u(b)), as amended by section 10619(b)(2)(B), is amended to read as follows:

“(12) With respect to services described in section 1861(s)(2)(K)(i)—

“(A) payment under this part may only be made on an assignment-related basis; and

“(B) the amounts paid under this part shall be equal to 80 percent of (i) the lesser of the actual charge or 85 percent of the fee schedule amount provided under section 1848 for the same service provided by a physician who is not a specialist; or (ii) in the case of services as an assistant at surgery, the lesser of the actual charge or 85 percent of the amount that would otherwise be recognized if performed by a physician who is serving as an assistant at surgery.”.

(c) REMOVAL OF RESTRICTION ON EMPLOYMENT RELATIONSHIP.—Section 1842(b)(6) (42 U.S.C. 1395u(b)(6)) is amended by adding at the end the following new sentence: “For purposes of clause (C) of the first sentence of this paragraph, an employment relationship may include any independent contractor arrangement, and employer status shall be determined in accordance with the law of the State in which the services described in such clause are performed.”.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to services furnished and supplies provided on and after January 1, 1998.

SEC. 10621. RENAL DIALYSIS-RELATED SERVICES.

(a) **AUDITING OF COST REPORTS.**—The Secretary shall audit a sample of cost reports of renal dialysis providers for 1995 and for each third year thereafter.

(b) **IMPLEMENTATION OF QUALITY STANDARDS.**—The Secretary of Health and Human Services shall develop and implement, by not later than January 1, 1999, a method to measure and report quality of renal dialysis services provided under the medicare program under title XVIII of the Social Security Act in order to reduce payments for inappropriate or low quality care.

CHAPTER 3—PART B PREMIUM**SEC. 10631. PART B PREMIUM.**

(a) **IN GENERAL.**—The first, second and third sentences of section 1839(a)(3) (42 U.S.C. 1395r(a)(3)) are amended to read as follows: “The Secretary, during September of each year, shall determine and promulgate a monthly premium rate for the succeeding calendar year. That monthly premium rate shall be equal to 50 percent of the monthly actuarial rate for enrollees age 65 and over, determined according to paragraph (1), for that succeeding calendar year.”.

(b) **CONFORMING AND TECHNICAL AMENDMENTS.**—

(1) **SECTION 1839.**—Section 1839 (42 U.S.C. 1395r) is amended—

(A) in subsection (a)(2), by striking “(b) and (e)” and inserting “(b), (c), and (f)”,

(B) in the last sentence of subsection (a)(3)—

(i) by inserting “rate” after “premium”, and

(ii) by striking “and the derivation of the dollar amounts specified in this paragraph”,

(C) by striking subsection (e), and

(D) by redesignating subsection (g) as subsection (e) and inserting that subsection after subsection (d).

(2) **SECTION 1844.**—Subparagraphs (A)(i) and (B)(i) of section 1844(a)(1) (42 U.S.C. 1395w(a)(1)) are each amended by striking “or 1839(e), as the case may be”.

Subtitle H—Provisions Relating to Parts A and B**CHAPTER 1—PROVISIONS RELATING TO MEDICARE SECONDARY PAYER****SEC. 10701. PERMANENT EXTENSION AND REVISION OF CERTAIN SECONDARY PAYER PROVISIONS.**

(a) **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)”.

(b) INDIVIDUALS WITH END STAGE RENAL DISEASE.—

(1) IN GENERAL.—Section 1862(b)(1)(C) (42 U.S.C. 1395y(b)(1)(C)) is amended—

(A) in the first sentence, by striking “12-month” each place it appears and inserting “30-month”, and

(B) by striking the second sentence.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to items and services furnished on or after the date of the enactment of this Act and with respect to periods beginning on or after the date that is 18 months prior to such date.

(c) IRS—SSA—HCFA DATA MATCH.—

(1) SOCIAL SECURITY ACT.—Section 1862(b)(5)(C) (42 U.S.C. 1395y(b)(5)(C)) is amended by striking clause (iii).

(2) INTERNAL REVENUE CODE.—Section 6103(l)(12) of the Internal Revenue Code of 1986 is amended by striking subparagraph (F).

SEC. 10702. CLARIFICATION OF TIME AND FILING LIMITATIONS.

(a) EXTENSION OF CLAIMS FILING PERIOD.—Section 1862(b)(2)(B) (42 U.S.C. 1395y(b)(2)(B)) is amended by adding at the end the following new clause:

“(v) CLAIMS-FILING PERIOD.—Notwithstanding any other time limits that may exist for filing a claim under an employer group health plan, the United States may seek to recover conditional payments in accordance with this subparagraph where the request for payment is submitted to the entity required or responsible under this subsection to pay with respect to the item or service (or any portion thereof) under a primary plan within the 3-year period beginning on the date on which the item or service was furnished.”.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) applies to items and services furnished after 1990. The previous sentence shall not be construed as permitting any waiver of the 3-year-period requirement (imposed by such amendment) in the case of items and services furnished more than 3 years before the date of the enactment of this Act.

SEC. 10703. PERMITTING RECOVERY AGAINST THIRD PARTY ADMINISTRATORS.

(a) PERMITTING RECOVERY AGAINST THIRD PARTY ADMINISTRATORS OF PRIMARY PLANS.—Section 1862(b)(2)(B)(ii) (42 U.S.C. 1395y(b)(2)(B)(ii)) is amended—

(1) by striking “under this subsection to pay” and inserting “(directly, as a third-party administrator, or otherwise) to make payment”, and

(2) by adding at the end the following: “The United States may not recover from a third-party administrator under this clause in cases where the third-party administrator would not

be able to recover the amount at issue from the employer or group health plan for whom it provides administrative services due to the insolvency or bankruptcy of the employer or plan.”.

(b) **CLARIFICATION OF BENEFICIARY LIABILITY.**—Section 1862(b)(1) (42 U.S.C. 1395y(b)(1)) is amended by adding at the end the following new subparagraph:

“(F) **LIMITATION ON BENEFICIARY LIABILITY.**—An individual who is entitled to benefits under this title and is furnished an item or service for which such benefits are incorrectly paid is not liable for repayment of such benefits under this paragraph unless payment of such benefits was made to the individual.”.

(c) **EFFECTIVE DATE.**—The amendments made by this section apply to items and services furnished on or after the date of the enactment of this Act.

CHAPTER 2—HOME HEALTH SERVICES

SEC. 10711. RECAPTURING SAVINGS RESULTING FROM TEMPORARY FREEZE ON PAYMENT INCREASES FOR HOME HEALTH SERVICES.

(a) **BASING UPDATES TO PER VISIT COST LIMITS ON LIMITS FOR FISCAL YEAR 1993.**—Section 1861(v)(1)(L) (42 U.S.C. 1395x(v)(1)(L)) is amended by adding at the end the following:

“(iv) In establishing limits under this subparagraph for cost reporting periods beginning after September 30, 1997, the Secretary shall not take into account any changes in the home health market basket, as determined by the Secretary, with respect to cost reporting periods which began on or after July 1, 1994, and before July 1, 1996.”.

(b) **NO EXCEPTIONS PERMITTED BASED ON AMENDMENT.**—The Secretary of Health and Human Services shall not consider the amendment made by subsection (a) in making any exemptions and exceptions pursuant to section 1861(v)(1)(L)(ii) of the Social Security Act (42 U.S.C. 1395x(v)(1)(L)(ii)).

SEC. 10712. INTERIM PAYMENTS FOR HOME HEALTH SERVICES.

(a) **REDUCTIONS IN COST LIMITS.**—Section 1861(v)(1)(L)(i) (42 U.S.C. 1395x(v)(1)(L)(i)) is amended—

(1) by moving the indentation of subclauses (I) through (III) 2-ems to the left;

(2) in subclause (I), by inserting “of the mean of the labor-related and nonlabor per visit costs for freestanding home health agencies” before the comma at the end;

(3) in subclause (II), by striking “, or” and inserting “of such mean,”;

(4) in subclause (III)—

(A) by inserting “and before October 1, 1997,” after “July 1, 1987,”, and

(B) by striking the comma at the end and inserting “of such mean, or”; and

(5) by striking the matter following subclause (III) and inserting the following:

“(IV) October 1, 1997, 105 percent of the median of the labor-related and nonlabor per visit costs for freestanding home health agencies.”.

(b) DELAY IN UPDATES.—Section 1861(v)(1)(L)(iii) (42 U.S.C. 1395x(v)(1)(L)(iii)) is amended by inserting “, or on or after July 1, 1997, and before October 1, 1997” after “July 1, 1996”.

(c) ADDITIONS TO COST LIMITS.—Section 1861(v)(1)(L) (42 U.S.C. 1395x(v)(1)(L)), as amended by section 10711(a), is amended by adding at the end the following new clauses:

“(v) For services furnished by home health agencies for cost reporting periods beginning on or after October 1, 1997, the Secretary shall provide for an interim system of limits. Payment shall not exceed the costs determined under the preceding provisions of this subparagraph or, if lower, the product of—

“(I) an agency-specific per beneficiary annual limitation calculated based 75 percent on the reasonable costs (including nonroutine medical supplies) for the agency’s 12-month cost reporting period ending during 1994, and based 25 percent on the standardized regional average of such costs for the agency’s region, as applied to such agency, for cost reporting periods ending during 1994, such costs updated by the home health market basket index; and

“(II) the agency’s unduplicated census count of patients (entitled to benefits under this title) for the cost reporting period subject to the limitation.

“(vi) For services furnished by home health agencies for cost reporting periods beginning on or after October 1, 1997, the following rules apply:

“(I) For new providers and those providers without a 12-month cost reporting period ending in calendar year 1994, the per beneficiary limitation shall be equal to the median of these limits (or the Secretary’s best estimates thereof) applied to other home health agencies as determined by the Secretary. A home health agency that has altered its corporate structure or name shall not be considered a new provider for this purpose.

“(II) For beneficiaries who use services furnished by more than one home health agency, the per beneficiary limitations shall be prorated among the agencies.”.

(d) DEVELOPMENT OF CASE MIX SYSTEM.—The Secretary of Health and Human Services shall expand research on a prospective payment system for home health agencies under the medicare program that ties prospective payments to a unit of service, including an intensive effort to develop a reliable case mix adjuster that explains a significant amount of the variances in costs.

(e) SUBMISSION OF DATA FOR CASE MIX SYSTEM.—Effective for cost reporting periods beginning on or after October 1, 1997, the Secretary of Health and Human Services may require all home health agencies to submit additional information that the Secretary considers necessary for the development of a reliable case mix system.

SEC. 10713. CLARIFICATION OF PART-TIME OR INTERMITTENT NURSING CARE.

(a) IN GENERAL.—Section 1861(m) (42 U.S.C. 1395x(m)) is amended by adding at the end the following: “For purposes of paragraphs (1) and (4), the term ‘part-time or intermittent services’ means skilled nursing and home health aide services furnished any number of days per week as long as they are furnished (combined)

less than 8 hours each day and 28 or fewer hours each week (or, subject to review on a case-by-case basis as to the need for care, less than 8 hours each day and 35 or fewer hours per week). For purposes of sections 1814(a)(2)(C) and 1835(a)(2)(A), ‘intermittent’ means skilled nursing care that is either provided or needed on fewer than 7 days each week, or less than 8 hours of each day for periods of 21 days or less (with extensions in exceptional circumstances when the need for additional care is finite and predictable).”

(b) **EFFECTIVE DATE.**—The amendment made by subsection (a) applies to services furnished on or after October 1, 1997.

SEC. 10714. STUDY ON DEFINITION OF HOMEBOUND.

(a) **STUDY.**—The Secretary of Health and Human Services shall conduct a study of the criteria that should be applied, and the method of applying such criteria, in the determination of whether an individual is homebound for purposes of qualifying for receipt of benefits for home health services under the medicare program. Such criteria shall include the extent and circumstances under which a person may be absent from the home but nonetheless qualify.

(b) **REPORT.**—Not later than October 1, 1998, the Secretary shall submit a report to the Congress on the study conducted under subsection (a). The report shall include specific recommendations on such criteria and methods.

SEC. 10715. PAYMENT BASED ON LOCATION WHERE HOME HEALTH SERVICE IS FURNISHED.

(a) **CONDITIONS OF PARTICIPATION.**—Section 1891 (42 U.S.C. 1395bbb) is amended by adding at the end the following:

“(g) **PAYMENT ON BASIS OF LOCATION OF SERVICE.**—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, as determined by the Secretary.”.

(b) **WAGE ADJUSTMENT.**—Section 1861(v)(1)(L)(iii) (42 U.S.C. 1395x(v)(1)(L)(iii)) is amended by striking “agency is located” and inserting “service is furnished”.

(c) **EFFECTIVE DATE.**—The amendments made by this section apply to cost reporting periods beginning on or after October 1, 1997.

SEC. 10716. NORMATIVE STANDARDS FOR HOME HEALTH CLAIMS DENIALS,

(a) **IN GENERAL.**—Section 1862(a)(1) (42 U.S.C. 1395y(a)(1)), as amended by section 10616(c), is amended—

(1) by striking “and” at the end of subparagraph (G),

(2) by striking the semicolon at the end of subparagraph (H) and inserting “, and”, and

(3) by inserting after subparagraph (H) the following new subparagraph:

“(I) the frequency and duration of home health services which are in excess of normative guidelines that the Secretary shall establish by regulation;”.

(b) **NOTIFICATION.**—The Secretary of Health and Human Services may establish a process for notifying a physician in cases in which the number of home health service visits furnished under the medi-

care program pursuant to a prescription or certification of the physician significantly exceeds such threshold (or thresholds) as the Secretary specifies. The Secretary may adjust such threshold to reflect demonstrated differences in the need for home health services among different beneficiaries.

(c) **EFFECTIVE DATE.**—The amendments made by this section apply to services furnished on or after October 1, 1997.

SEC. 10717. NO HOME HEALTH BENEFITS BASED SOLELY ON DRAWING BLOOD.

(a) **IN GENERAL.**—Sections 1814(a)(2)(C) and 1835(a)(2)(A) (42 U.S.C. 1395f(a)(2)(C), 1395n(a)(2)(A)) are each amended by inserting “(other than solely venipuncture for the purpose of obtaining a blood sample)” after “skilled nursing care”.

(b) **EFFECTIVE DATE.**—The amendments made by subsection (a) apply to home health services furnished after the 6-month period beginning after the date of enactment of this Act.

CHAPTER 3—BABY BOOM GENERATION MEDICARE COMMISSION

SEC. 10721. BIPARTISAN 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 Bipartisan 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,

(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, and

(C) study the feasibility and desirability of establishing—

(i) an independent commission on medicare to make recommendations annually on how best to match the structure of the medicare program to available funding for the program,

(ii) an expedited process for consideration of such recommendations by Congress, and

(iii) a default mechanism to enforce Congressional spending targets for the program if Congress fails to approve such recommendations.

(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) Methods used by other nations to respond to comparable demographic patterns in eligibility for health care benefits for elderly and disabled individuals.
- (C) Modifying age-based eligibility to correspond to changes in age-based eligibility under the OASDI program.
- (D) 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 voting members as follows:
- (A) 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.
- (B) 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.
- (C) The 3 ex officio members of the Board of Trustees of the Federal Hospital Insurance Trust Fund and of the Federal Supplementary Medical Insurance Trust Fund who are Cabinet level officials.
- (2) CHAIRMAN AND VICE CHAIRMAN.—As the first item of business at the Commission's first meeting (described in paragraph (5)(B)), the Commission shall elect a Chairman and Vice Chairman from among its members. The individuals elected as Chairman and Vice Chairman may not be of the same political party and may not have been appointed to the Commission by the same appointing authority.
- (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 (f).
- (5) MEETINGS.—
- (A) The Commission shall meet at the call of its Chairman or a majority of its members.
- (B) The Commission shall hold its first meeting not later than February 1, 1998.
- (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) ADVISORY PANEL.—
- (1) IN GENERAL.—The Chairman, in consultation with the Vice Chairman, may establish a panel (in this section referred to as the "Advisory Panel") consisting of health care experts, consumers, providers, and others to advise and assist the members of the Commission in carrying out the duties described in subsection (b). The panel shall have only those powers that the

Chairman, in consultation with the Vice Chairman, determines are necessary and appropriate to assist the Commission in carrying out such duties.

(2) COMPENSATION.—Members of the Advisory Panel are not entitled to receive compensation for service on the Advisory Panel. Subject to the approval of the chairman of the Commission, members may be reimbursed for travel, subsistence, and other necessary expenses incurred in carrying out the duties of the Advisory Panel.

(e) 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.

(f) 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.

(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) 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.

(g) REPORT.—(1) Not later than May 1, 1999, 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.

(2) Not later than 12 months after the date of the enactment of this Act, the Commission shall report to the Congress on the matters specified in subsection (b)(1)(C). If the Commission determines that it is feasible and desirable to establish the processes described in such subsection, the report under this paragraph shall include specific recommendations on changes in law (such as changes in the Congressional Budget Act of 1974 and the Balanced Budget and Emergency Deficit Control Act of 1985) as are needed to implement its recommendations.

(h) TERMINATION.—The Commission shall terminate 30 days after the date of submission of the report required in subsection (g).

(i) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated \$1,500,000 to carry out 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 under title XVIII of the Social Security Act (42 U.S.C. 1395i, 1395t).

CHAPTER 4—PROVISIONS RELATING TO DIRECT GRADUATE MEDICAL EDUCATION

SEC. 10731. LIMITATION ON PAYMENT BASED ON NUMBER OF RESIDENTS AND IMPLEMENTATION OF ROLLING AVERAGE FTE COUNT.

Section 1886(h)(4) (42 U.S.C. 1395ww(h)(4)) is amended by adding after subparagraph (E) the following:

“(F) LIMITATION ON NUMBER OF RESIDENTS FOR CERTAIN FISCAL YEARS.—Such rules shall provide that for purposes of a cost reporting period beginning on or after October 1, 1997, the total number of full-time equivalent residents before application of weighting factors (as determined under this paragraph) with respect to a hospital’s approved medical residency training program may not exceed the number of full-time equivalent residents with respect to the hospital’s most recent cost reporting period ending on or before December 31, 1996. The Secretary may establish rules, consistent with the policies in the previous sentence and paragraph (6), with respect to the application of the previous sentence in the case of medical residency training programs established on or after January 1, 1997.

“(G) COUNTING INTERNS AND RESIDENTS FOR FY 1998 AND SUBSEQUENT YEARS.—

“(i) FY 1998.—For the hospital’s first cost reporting period beginning during fiscal year 1998, subject to the limit described in subparagraph (F), the total number of full-time equivalent residents, for determining the hospital’s graduate medical education payment, shall equal the average of the full-time equivalent resident counts for the cost reporting period and the preceding cost reporting period.

“(ii) SUBSEQUENT YEARS.—For each subsequent cost reporting period, subject to the limit described in subparagraph (F), the total number of full-time equivalent residents, for determining the hospital’s graduate medical education payment, shall equal the average of the actual full-time equivalent resident counts for the cost reporting period and preceding two cost reporting periods.

“(iii) ADJUSTMENT FOR SHORT PERIODS.—If a hospital’s cost reporting period beginning on or after October 1, 1997, is not equal to twelve months, the Secretary shall make appropriate modifications to ensure that the average full-time equivalent resident counts pursuant to clause (ii) are based on the equivalent of full 12-month cost reporting periods.”

SEC. 10732. PHASED-IN LIMITATION ON HOSPITAL OVERHEAD AND SUPERVISORY PHYSICIAN COMPONENT OF DIRECT MEDICAL EDUCATION COSTS.

(a) IN GENERAL.—Section 1886(h)(3) (42 U.S.C. 1395ww(h)(3)) is amended—

(1) in subparagraph (B), by inserting “subject to subparagraph (D),” after “subparagraph (A),” and

(2) by adding at the end the following:

“(D) PHASED-IN LIMITATION ON HOSPITAL OVERHEAD AND SUPERVISORY PHYSICIAN COMPONENT.—

“(i) IN GENERAL.—In the case of a hospital for which the overhead GME amount (as defined in clause (ii)) for the base period exceeds an amount equal to the 75th percentile of the overhead GME amounts in such period for all hospitals (weighted to reflect the full-

time equivalent resident counts for all approved medical residency training programs), subject to clause (iv), the hospital's approved FTE resident amount (for periods beginning on or after October 1, 1997) shall be reduced from the amount otherwise applicable (as previously reduced under this subparagraph) by an overhead reduction amount. The overhead reduction amount is equal to the lesser of—

“(I) 20 percent of the reference reduction amount (described in clause (iii)) for the period, or

“(II) 15 percent of the hospital's overhead GME amount for the period (as otherwise determined before the reduction provided under this subparagraph for the period involved).

“(ii) OVERHEAD GME AMOUNT.—For purposes of this subparagraph, the term ‘overhead GME amount’ means, for a hospital for a period, the product of—

“(I) the percentage of the hospital's approved FTE resident amount for the base period that is not attributable to resident salaries and fringe benefits, and

“(II) the hospital's approved FTE resident amount for the period involved.

“(iii) REFERENCE REDUCTION AMOUNT.—

“(I) IN GENERAL.—The reference reduction amount described in this clause for a hospital for a cost reporting period is the base difference (described in subclause (II)) updated, in a compounded manner for each period from the base period to the period involved, by the update applied for such period to the hospital's approved FTE resident amount.

“(II) BASE DIFFERENCE.—The base difference described in this subclause for a hospital is the amount by which the hospital's overhead GME amount in the base period exceeded the 75th percentile of such amounts (as described in clause (i)).

“(iv) MAXIMUM REDUCTION TO 75TH PERCENTILE.—In no case shall the reduction under this subparagraph effected for a hospital for a period (below the amount that would otherwise apply for the period if this subparagraph did not apply for any period) exceed the reference reduction amount for the hospital for the period.

“(v) BASE PERIOD.—For purposes of this subparagraph, the term ‘base period’ means the cost reporting period beginning in fiscal year 1984 or the period used to establish the hospital's approved FTE resident amount for hospitals that did not have approved residency training programs in fiscal year 1984.

“(vi) RULES FOR HOSPITALS INITIATING RESIDENCY TRAINING PROGRAMS.—The Secretary shall establish rules for the application of this subparagraph in the

case of a hospital that initiates medical residency training programs during or after the base period.”.

(b) **EFFECTIVE DATE.**—The amendments made by subsection (a) shall apply to per resident payment amounts attributable to periods beginning on or after October 1, 1997.

SEC. 10733. PERMITTING PAYMENT TO NON-HOSPITAL PROVIDERS.

(a) **IN GENERAL.**—Section 1886 (42 U.S.C. 1395ww) is amended by adding at the end the following:

“(k) **PAYMENT TO NON-HOSPITAL PROVIDERS.**—

“(1) **REPORT.**—The Secretary shall submit to Congress, not later than 18 months after the date of the enactment of this subsection, a proposal for payment to qualified non-hospital providers for their direct costs of medical education, if those costs are incurred in the operation of an approved medical residency training program described in subsection (h). Such proposal shall specify the amounts, form, and manner in which such payments will be made and the portion of such payments that will be made from each of the trust funds under this title.

“(2) **EFFECTIVENESS.**—Except as otherwise provided in law, the Secretary may implement such proposal for residency years beginning not earlier than 6 months after the date of submittal of the report under paragraph (1).

“(3) **QUALIFIED NON-HOSPITAL PROVIDERS.**—For purposes of this subsection, the term ‘qualified non-hospital provider’ means—

“(A) a Federally qualified health center, as defined in section 1861(aa)(4);

“(B) a rural health clinic, as defined in section 1861(aa)(2);

“(C) MedicarePlus organizations; and

“(D) such other providers (other than hospitals) as the Secretary determines to be appropriate.”.

(b) **PROHIBITION ON DOUBLE PAYMENTS; BUDGET NEUTRALITY ADJUSTMENT.**—Section 1886(h)(3)(B) (42 U.S.C. 1395ww(h)(3)(B)) is amended by adding at the end the following:

“The Secretary shall reduce the aggregate approved amount to the extent payment is made under subsection (k) for residents included in the hospital’s count of full-time equivalent residents and, in the case of residents not included in any such count, the Secretary shall provide for such a reduction in aggregate approved amounts under this subsection as will assure that the application of subsection (k) does not result in any increase in expenditures under this title in excess of those that would have occurred if subsection (k) were not applicable.”.

SEC. 10734. INCENTIVE PAYMENTS UNDER PLANS FOR VOLUNTARY REDUCTION IN NUMBER OF RESIDENTS.

(a) **IN GENERAL.**—Section 1886(h) (42 U.S.C. 1395ww(h)) is further amended by adding at the end the following new paragraph:

“(6) **INCENTIVE PAYMENT UNDER PLANS FOR VOLUNTARY REDUCTION IN NUMBER OF RESIDENTS.**—

“(A) **IN GENERAL.**—In the case of a voluntary residency reduction plan for which an application is approved under

subparagraph (B), the qualifying entity submitting the plan shall be paid an applicable hold harmless percentage (as specified in subparagraph (E)) of the sum of—

“(i) amount (if any) by which—

“(I) the amount of payment which would have been made under this subsection if there had been a 5 percent reduction in the number of full-time equivalent residents in the approved medical education training programs of the qualifying entity as of June 30, 1997, exceeds

“(II) the amount of payment which is made under this subsection, taking into account the reduction in such number effected under the reduction plan; and

“(ii) the amount of the reduction in payment under 1886(d)(5)(B) (for hospitals participating in the qualifying entity) that is attributable to the reduction in number of residents effected under the plan below 95 percent of the number of full-time equivalent residents in such programs of such entity as of June 30, 1997.

“(B) APPROVAL OF PLAN APPLICATIONS.—The Secretary may not approve the application of a qualifying entity unless—

“(i) the application is submitted in a form and manner specified by the Secretary and by not later than March 1, 2000,

“(ii) the application provides for the operation of a plan for the reduction in the number of full-time equivalent residents in the approved medical residency training programs of the entity consistent with the requirements of subparagraph (D);

“(iii) the entity elects in the application whether such reduction will occur over—

“(I) a period of not longer than 5 residency training years, or

“(II) a period of 6 residency training years, except that a qualifying entity described in subparagraph (C)(i)(III) may not make the election described in subclause (II); and

“(iv) the Secretary determines that the application and the entity and such plan meet such other requirements as the Secretary specifies in regulations.

“(C) QUALIFYING ENTITY.—

“(i) IN GENERAL.—For purposes of this paragraph, any of the following may be a qualifying entity:

“(I) Individual hospitals operating one or more approved medical residency training programs.

“(II) Subject to clause (ii), two or more hospitals that operate such programs and apply for treatment under this paragraph as a single qualifying entity.

“(III) Subject to clause (iii), a qualifying consortium (as described in section 10735 of the Balanced Budget Act of 1997).

“(ii) **ADDITIONAL REQUIREMENT FOR JOINT PROGRAMS.**—In the case of an application by a qualifying entity described in clause (i)(II), the Secretary may not approve the application unless the application represents that the qualifying entity either—

“(I) in the case of an entity that meets the requirements of clause (v) of subparagraph (D) will not reduce the number of full-time equivalent residents in primary care during the period of the plan, or

“(II) in the case of another entity will not reduce the proportion of its residents in primary care (to the total number of residents) below such proportion as in effect as of the applicable time described in subparagraph (D)(vi).

“(iii) **ADDITIONAL REQUIREMENT FOR CONSORTIA.**—In the case of an application by a qualifying entity described in clause (i)(III), the Secretary may not approve the application unless the application represents that the qualifying entity will not reduce the proportion of its residents in primary care (to the total number of residents) below such proportion as in effect as of the applicable time described in subparagraph (D)(vi).

“(D) **RESIDENCY REDUCTION REQUIREMENTS.**—

“(i) **INDIVIDUAL HOSPITAL APPLICANTS.**—In the case of a qualifying entity described in subparagraph (C)(i)(I), the number of full-time equivalent residents in all the approved medical residency training programs operated by or through the entity shall be reduced as follows:

“(I) If base number of residents exceeds 750 residents, by a number equal to at least 20 percent of such base number.

“(II) Subject to subclause (IV), if base number of residents exceeds 500, but is less than 750, residents, by 150 residents.

“(III) Subject to subclause (IV), if base number of residents does not exceed 500 residents, by a number equal to at least 25 percent of such base number.

“(IV) In the case of a qualifying entity which is described in clause (v) and which elects treatment under this subclause, by a number equal to at least 20 percent of such base number.

“(ii) **JOINT APPLICANTS.**—In the case of a qualifying entity described in subparagraph (C)(i)(II), the number of full-time equivalent residents in all the approved medical residency training programs operated by or through the entity shall be reduced as follows:

“(I) Subject to subclause (II), by a number equal to at least 25 percent of such base number.

“(II) In the case of a qualifying entity which is described in clause (v) and which elects treatment

under this subclause, by a number equal to at least 20 percent of such base number.

“(iii) CONSORTIA.—In the case of a qualifying entity described in subparagraph (C)(i)(III), the number of full-time equivalent residents in all the approved medical residency training programs operated by or through the entity shall be reduced by a number equal to at least 20 percent of such base number.

“(iv) MANNER OF REDUCTION.—The reductions specified under the preceding provisions of this subparagraph for a qualifying entity shall be below the base number of residents for that entity and shall be fully effective not later than—

“(I) the 5th residency training year in which the application under subparagraph (B) is effective, in the case of an entity making the election described in subparagraph (B)(iii)(I), or

“(II) the 6th such residency training year, in the case of an entity making the election described in subparagraph (B)(iii)(II).

“(v) ENTITIES PROVIDING ASSURANCE OF MAINTENANCE OF PRIMARY CARE RESIDENTS.—An entity is described in this clause if—

“(I) the base number of residents for the entity is less than 750;

“(II) the number of full-time equivalent residents in primary care included in the base number of residents for the entity is at least 10 percent of such base number; and

“(III) the entity represents in its application under subparagraph (B) that there will be no reduction under the plan in the number of full-time equivalent residents in primary care.

If a qualifying entity fails to comply with the representation described in subclause (III), the entity shall be subject to repayment of all amounts paid under this paragraph, in accordance with procedures established to carry out subparagraph (F).

“(vi) BASE NUMBER OF RESIDENTS DEFINED.—For purposes of this paragraph, the term ‘base number of residents’ means, with respect to a qualifying entity operating approved medical residency training programs, the number of full-time equivalent residents in such programs (before application of weighting factors) of the entity as of the most recent cost reporting period ending before June 30, 1997, or, if less, for any subsequent cost reporting period that ends before the date the entity makes application under this paragraph.

“(E) APPLICABLE HOLD HARMLESS PERCENTAGE.—

“(i) IN GENERAL.—For purposes of subparagraph (A), the ‘applicable hold harmless percentage’ is the percentages specified in clause (ii) or clause (iii), as elect-

ed by the qualifying entity in the application submitted under subparagraph (B).

“(ii) 5-YEAR REDUCTION PLAN.—In the case of an entity making the election described in subparagraph (B)(iii)(I), the percentages specified in this clause are, for the—

“(I) first and second residency training years in which the reduction plan is in effect, 100 percent,

“(II) third such year, 75 percent,

“(III) fourth such year, 50 percent, and

“(IV) fifth such year, 25 percent.

“(iii) 6-YEAR REDUCTION PLAN.—In the case of an entity making the election described in subparagraph (B)(iii)(II), the percentages specified in this clause are, for the—

“(I) first residency training year in which the reduction plan is in effect, 100 percent,

“(II) second such year, 95 percent,

“(III) third such year, 85 percent,

“(IV) fourth such year, 70 percent,

“(V) fifth such year, 50 percent, and

“(VI) sixth such year, 25 percent.

“(F) PENALTY FOR INCREASE IN NUMBER OF RESIDENTS IN SUBSEQUENT YEARS.—If payments are made under this paragraph to a qualifying entity, if the entity (or any hospital operating as part of the entity) increases the number of full-time equivalent residents above the number of such residents permitted under the reduction plan as of the completion of the plan, then, as specified by the Secretary, the entity is liable for repayment to the Secretary of the total amounts paid under this paragraph to the entity.

“(G) TREATMENT OF ROTATING RESIDENTS.—In applying this paragraph, the Secretary shall establish rules regarding the counting of residents who are assigned to institutions the medical residency training programs in which are not covered under approved applications under this paragraph.”

(b) RELATION TO DEMONSTRATION PROJECTS AND AUTHORITY.—

(1) Section 1886(h)(6) of the Social Security Act, added by subsection (a), shall not apply to any residency training program with respect to which a demonstration project described in paragraph (3) has been approved by the Health Care Financing Administration as of May 27, 1997. The Secretary of Health and Human Services shall take such actions as may be necessary to assure that (in the manner described in subparagraph (A) of such section) in no case shall payments be made under such a project with respect to the first 5 percent reduction in the base number of full-time equivalent residents otherwise used under the project.

(2) Effective May 27, 1997, the Secretary of Health and Human Services is not authorized to approve any demonstration project described in paragraph (3) for any residency training year beginning before July 1, 2006.

(3) A demonstration project described in this paragraph is a project that provides for additional payments under title XVIII of the Social Security Act in connection with reduction in the number of residents in a medical residency training program.

(c) 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 first promulgate regulations, that take effect on an interim basis, after notice and pending opportunity for public comment, by not later than 6 months after the date of the enactment of this Act.

SEC. 10735. DEMONSTRATION PROJECT ON USE OF CONSORTIA.

(a) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the Secretary) shall establish a demonstration project under which, instead of making payments to teaching hospitals pursuant to section 1886(h) of the Social Security Act, the Secretary shall make payments under this section to each consortium that meets the requirements of subsection (b).

(b) QUALIFYING CONSORTIA.—For purposes of subsection (a), a consortium meets the requirements of this subsection if the consortium is in compliance with the following:

(1) The consortium consists of an approved medical residency training program in a teaching hospital and one or more of the following entities:

(A) A school of allopathic medicine or osteopathic medicine.

(B) Another teaching hospital, which may be a children's hospital.

(C) Another approved medical residency training program.

(D) A Federally qualified health center.

(E) A medical group practice.

(F) A managed care entity.

(G) An entity furnishing outpatient services.

(H) Such other entity as the Secretary determines to be appropriate.

(2) The members of the consortium have agreed to participate in the programs of graduate medical education that are operated by the entities in the consortium.

(3) With respect to the receipt by the consortium of payments made pursuant to this section, the members of the consortium have agreed on a method for allocating the payments among the members.

(4) The consortium meets such additional requirements as the Secretary may establish.

(c) AMOUNT AND SOURCE OF PAYMENT.—The total of payments to a qualifying consortium for a fiscal year pursuant to subsection (a) shall not exceed the amount that would have been paid under section 1886(h) of the Social Security Act for the teaching hospital (or hospitals) in the consortium. Such payments shall be made in such proportion from each of the trust funds established under title XVIII of such Act as the Secretary specifies.

SEC. 10736. RECOMMENDATIONS ON LONG-TERM PAYMENT POLICIES REGARDING FINANCING TEACHING HOSPITALS AND GRADUATE MEDICAL EDUCATION.

(a) IN GENERAL.—The Medicare Payment Advisory Commission (established under section 1805 of the Social Security Act and in this section referred to as the “Commission”) shall examine and develop recommendations on whether and to what extent medicare payment policies and other Federal policies regarding teaching hospitals and graduate medical education should be reformed. Such recommendations shall include recommendations regarding each of the following:

(1) The financing of graduate medical education, including consideration of alternative broad-based sources of funding for such education and models for the distribution of payments under any all-payer financing mechanism.

(2) The financing of teaching hospitals, including consideration of the difficulties encountered by such hospitals as competition among health care entities increases. Matters considered under this paragraph shall include consideration of the effects on teaching hospitals of the method of financing used for the MedicarePlus program under part C of title XVIII of the Social Security Act.

(3) Possible methodologies for making payments for graduate medical education and the selection of entities to receive such payments. Matters considered under this paragraph shall include—

(A) issues regarding children’s hospitals and approved medical residency training programs in pediatrics, and

(B) whether and to what extent payments are being made (or should be made) for training in the various non-physician health professions.

(4) Federal policies regarding international medical graduates.

(5) The dependence of schools of medicine on service-generated income.

(6) Whether and to what extent the needs of the United States regarding the supply of physicians, in the aggregate and in different specialties, will change during the 10-year period beginning on October 1, 1997, and whether and to what extent any such changes will have significant financial effects on teaching hospitals.

(7) Methods for promoting an appropriate number, mix, and geographical distribution of health professionals.

(c) CONSULTATION.—In conducting the study under subsection (a), the Commission shall consult with the Council on Graduate Medical Education and individuals with expertise in the area of graduate medical education, including—

(1) deans from allopathic and osteopathic schools of medicine;

(2) chief executive officers (or equivalent administrative heads) from academic health centers, integrated health care systems, approved medical residency training programs, and teaching hospitals that sponsor approved medical residency training programs;

(3) chairs of departments or divisions from allopathic and osteopathic schools of medicine, schools of dentistry, and approved medical residency training programs in oral surgery;

(4) individuals with leadership experience from representative fields of non-physician health professionals;

(5) individuals with substantial experience in the study of issues regarding the composition of the health care workforce of the United States; and

(6) individuals with expertise on the financing of health care.

(d) REPORT.—Not later than 2 years after the date of the enactment of this Act, the Commission shall submit to the Congress a report providing its recommendations under this section and the reasons and justifications for such recommendations.

SEC. 10737. MEDICARE SPECIAL REIMBURSEMENT RULE FOR CERTAIN COMBINED RESIDENCY PROGRAMS.

(a) IN GENERAL.—Section 1886(h)(5)(G) (42 U.S.C. 1395ww(h)(5)(G)) is amended—

(1) in clause (i), by striking “and (iii)” and inserting “, (iii), and (iv)”; and

(2) by adding at the end the following:

“(iv) SPECIAL RULE FOR CERTAIN COMBINED RESIDENCY PROGRAMS.—(I) In the case of a resident enrolled in a combined medical residency training program in which all of the individual programs (that are combined) are for training a primary care resident (as defined in subparagraph (H)), the period of board eligibility shall be the minimum number of years of formal training required to satisfy the requirements for initial board eligibility in the longest of the individual programs plus one additional year.

“(II) A resident enrolled in a combined medical residency training program that includes an obstetrics and gynecology program shall qualify for the period of board eligibility under subclause (I) if the other programs such resident combines with such obstetrics and gynecology program are for training a primary care resident.”.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) apply to combined medical residency programs for residency years beginning on or after July 1, 1998.

CHAPTER 5—OTHER PROVISIONS

SEC. 10741. CENTERS OF EXCELLENCE.

(a) IN GENERAL.—Title XVIII is amended by inserting after section 1888 the following:

“CENTERS OF EXCELLENCE

“SEC. 1889. (a) IN GENERAL.—The Secretary shall use a competitive process to contract with specific hospitals or other entities for furnishing services related to surgical procedures, and for furnishing services (unrelated to surgical procedures) to hospital inpatients that the Secretary determines to be appropriate. The services may include any services covered under this title that the Sec-

retary determines to be appropriate, including post-hospital services.

“(b) **QUALITY STANDARDS.**—Only entities that meet quality standards established by the Secretary shall be eligible to contract under this section. Contracting entities shall implement a quality improvement plan approved by the Secretary.

“(c) **PAYMENT.**—Payment under this section shall be made on the basis of negotiated all-inclusive rates. The amount of payment made by the Secretary to an entity under this title for services covered under a contract shall be less than the aggregate amount of the payments that the Secretary would have otherwise made for the services.

“(d) **CONTRACT PERIOD.**—A contract period shall be 3 years (subject to renewal), so long as the entity continues to meet quality and other contractual standards.

“(e) **INCENTIVES FOR USE OF CENTERS.**—Entities under a contract under this section may furnish additional services (at no cost to an individual entitled to benefits under this title) or waive cost-sharing, subject to the approval of the Secretary.

“(f) **LIMIT ON NUMBER OF CENTERS.**—The Secretary shall limit the number of centers in a geographic area to the number needed to meet projected demand for contracted services.”

(b) **EFFECTIVE DATE.**—The amendment made by subsection (a) applies to services furnished on or after October 1, 1997.

SEC. 10742. MEDICARE PART B SPECIAL ENROLLMENT PERIOD AND WAIVER OF PART B LATE ENROLLMENT PENALTY AND MEDIGAP SPECIAL OPEN ENROLLMENT PERIOD FOR CERTAIN MILITARY RETIREES AND DEPENDENTS.

(a) **MEDICARE PART B SPECIAL ENROLLMENT PERIOD; WAIVER OF PART B PENALTY FOR LATE ENROLLMENT.**—

(1) **IN GENERAL.**—In the case of any eligible individual (as defined in subsection (c)), the Secretary of Health and Human Services shall provide for a special enrollment period during which the individual may enroll under part B of title XVIII of the Social Security Act. Such period shall be for a period of 6 months and shall begin with the first month that begins at least 45 days after the date of the enactment of this Act.

(2) **COVERAGE PERIOD.**—In the case of an eligible individual who enrolls during the special enrollment period provided under paragraph (1), the coverage period under part B of title XVIII of the Social Security Act shall begin on the first day of the month following the month in which the individual enrolls.

(3) **WAIVER OF PART B LATE ENROLLMENT PENALTY.**—In the case of an eligible individual who enrolls during the special enrollment period provided under paragraph (1), there shall be no increase pursuant to section 1839(b) of the Social Security Act in the monthly premium under part B of title XVIII of such Act.

(b) **MEDIGAP SPECIAL OPEN ENROLLMENT PERIOD.**—Notwithstanding any other provision of law, an issuer of a medicare supplemental policy (as defined in section 1882(g) of the Social Security Act)—

(1) may not deny or condition the issuance or effectiveness of a medicare supplemental policy that has a benefit package

classified as “A”, “B”, “C”, or “F” under the standards established under section 1882(p)(2) of the Social Security Act (42 U.S.C. 1395rr(p)(2)); and

(2) may not discriminate in the pricing of the policy on the basis of the individual’s health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence), or disability;

in the case of an eligible individual who seeks to enroll (and is enrolled) during the 6-month period described in subsection (a)(1).

(c) ELIGIBLE INDIVIDUAL DEFINED.—In this section, the term “eligible individual” means an individual—

(1) who, as of the date of the enactment of this Act, has attained 65 years of age and was eligible to enroll under part B of title XVIII of the Social Security Act, and

(2) who at the time the individual first satisfied paragraph (1) or (2) of section 1836 of the Social Security Act—

(A) was a covered beneficiary (as defined in section 1072(5) of title 10, United States Code), and

(B) did not elect to enroll (or to be deemed enrolled) under section 1837 of the Social Security Act during the individual’s initial enrollment period.

The Secretary of Health and Human Services shall consult with the Secretary of Defense in the identification of eligible individuals.

SEC. 10743. PROTECTIONS UNDER THE MEDICARE PROGRAM FOR DISABLED WORKERS WHO LOSE BENEFITS UNDER A GROUP HEALTH PLAN.

(a) NO PREMIUM PENALTY FOR LATE ENROLLMENT.—The second sentence of section 1839(b) (42 U.S.C. 1395r(b)) is amended by inserting “and not pursuant to a special enrollment period under section 1837(i)(4)” after “section 1837”.

(b) SPECIAL MEDICARE ENROLLMENT PERIOD.—

(1) IN GENERAL.—Section 1837(i) (42 U.S.C. 1395p(i)) is amended by adding at the end the following new paragraph:

“(4)(A) In the case of an individual who is entitled to benefits under part A pursuant to section 226(b) and—

“(i) who at the time the individual first satisfies paragraph (1) or (2) of section 1836—

“(I) is enrolled in a group health plan described in section 1862(b)(1)(A)(v) by reason of the individual’s (or the individual’s spouse’s) current employment or otherwise, and

“(II) has elected not to enroll (or to be deemed enrolled) under this section during the individual’s initial enrollment period; and

“(ii) whose continuous enrollment under such group health plan is involuntarily terminated at a time when the enrollment under the plan is not by reason of the individual’s (or the individual’s spouse’s) current employment,

there shall be a special enrollment period described in subparagraph (B).

“(B) The special enrollment period referred to in subparagraph (A) is the 6-month period beginning on the date of the enrollment termination described in subparagraph (A)(ii).”.

(2) COVERAGE PERIOD.—Section 1838(e) (42 U.S.C. 1395q(e)) is amended—

(A) by inserting “or 1837(i)(4)(B)” after “1837(i)(3)” the first place it appears, and

(B) by inserting “or specified in section 1837(i)(4)(A)(i)” after “1837(i)(3)” the second place it appears”.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to involuntary terminations of coverage under a group health plan occurring on or after the date of the enactment of this Act.

SEC. 10744. PLACEMENT OF ADVANCE DIRECTIVE IN MEDICAL RECORD.

(a) IN GENERAL.—Section 1866(f)(1)(B) (42 U.S.C. 1395cc(f)(1)(B)) is amended by striking “in the individual’s medical record” and inserting “in a prominent part of the individual’s current medical record”.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to provider agreements entered into, renewed, or extended on or after such date (not later than 1 year after the date of the enactment of this Act) as the Secretary of Health and Human Services specifies.

Subtitle I—Medical Liability Reform

CHAPTER 1—GENERAL PROVISIONS

SEC. 10801. FEDERAL REFORM OF HEALTH CARE LIABILITY ACTIONS.

(a) APPLICABILITY.—This subtitle shall apply with respect to any health care liability action brought in any State or Federal court, except that this subtitle shall not apply to—

(1) an action for damages arising from a vaccine-related injury or death to the extent that title XXI of the Public Health Service Act applies to the action, or

(2) an action under the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 et seq.).

(b) PREEMPTION.—This subtitle shall preempt any State law to the extent such law is inconsistent with the limitations contained in this subtitle. This subtitle 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 subtitle or otherwise imposes greater restrictions than those provided in this subtitle.

(c) EFFECT ON SOVEREIGN IMMUNITY AND CHOICE OF LAW OR VENUE.—Nothing in subsection (b) 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 of inconvenient forum.

(d) AMOUNT IN CONTROVERSY.—In an action to which this subtitle applies and which is brought under section 1332 of title 28, United States Code, the amount of noneconomic damages or punitive damages, and attorneys' fees or costs, shall not be included in determining whether the matter in controversy exceeds the sum or value of \$50,000.

(e) FEDERAL COURT JURISDICTION NOT ESTABLISHED ON FEDERAL QUESTION GROUNDS.—Nothing in this subtitle shall be construed to establish any jurisdiction in the district courts of the United States over health care liability actions on the basis of section 1331 or 1337 of title 28, United States Code.

SEC. 10802. DEFINITIONS.

As used in this subtitle:

(1) ACTUAL DAMAGES.—The term “actual damages” means damages awarded to pay for economic loss.

(2) ALTERNATIVE DISPUTE RESOLUTION SYSTEM; ADR.—The term “alternative dispute resolution system” or “ADR” means a system established under Federal or State law that provides for the resolution of health care liability claims in a manner other than through health care liability actions.

(3) CLAIMANT.—The term “claimant” means any person who brings a health care liability action and any person on whose behalf such an action is brought. If such action is brought through or on behalf of an estate, the term includes the claimant's decedent. If such action is brought through or on behalf of a minor or incompetent, the term includes the claimant's legal guardian.

(4) 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. 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.

(5) COLLATERAL SOURCE PAYMENTS.—The term “collateral source payments” means any amount paid or reasonably likely to be paid in the future to or on behalf of a claimant, or any service, product, or other benefit provided or reasonably likely to be provided in the future to or on behalf of a claimant, as a result of an injury or wrongful death, pursuant to—

(A) any State or Federal health, sickness, income-disability, accident or workers' compensation Act;

(B) any health, sickness, income-disability, or accident insurance that provides health benefits or income-disability coverage;

(C) any contract or agreement of any group, organization, partnership, or corporation to provide, pay for, or reimburse the cost of medical, hospital, dental, or income disability benefits; and

(D) any other publicly or privately funded program.

(6) DRUG.—The term “drug” has the meaning given such term in section 201(g)(1) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321(g)(1)).

(7) ECONOMIC LOSS.—The term “economic loss” means any pecuniary loss resulting from injury (including the loss of earnings or other benefits related to employment, medical expense loss, replacement services loss, loss due to death, burial costs, and loss of business or employment opportunities), to the extent recovery for such loss is allowed under applicable State law.

(8) HARM.—The term “harm” means any legally cognizable wrong or injury for which punitive damages may be imposed.

(9) HEALTH BENEFIT PLAN.—The term “health benefit plan” means—

(A) a hospital or medical expense incurred policy or certificate,

(B) a hospital or medical service plan contract,

(C) a health maintenance subscriber contract, or

(D) a MedicarePlus product (offered under part C of title XVIII of the Social Security Act),

that provides benefits with respect to health care services.

(10) HEALTH CARE LIABILITY ACTION.—The term “health care liability action” means a civil action brought in a State or Federal court against a health care provider, an entity which is obligated to provide or pay for health benefits under any health benefit plan (including any person or entity acting under a contract or arrangement to provide or administer any health benefit), or the manufacturer, distributor, supplier, marketer, promoter, or seller of a medical product, in which the claimant alleges a claim (including third party claims, cross claims, counter claims, or distribution claims) based upon the provision of (or the failure to provide or pay for) health care services or the use of a medical product, regardless of the theory of liability on which the claim is based or the number of plaintiffs, defendants, or causes of action.

(11) HEALTH CARE LIABILITY CLAIM.—The term “health care liability claim” means a claim in which the claimant alleges that injury was caused by the provision of (or the failure to provide) health care services.

(12) HEALTH CARE PROVIDER.—The term “health care provider” means any person that is engaged in the delivery of health care services in a State and that is required by the laws or regulations of the State to be licensed or certified by the State to engage in the delivery of such services in the State.

(13) HEALTH CARE SERVICE.—The term “health care service” means any service for which payment may be made under a health benefit plan including services related to the delivery or administration of such service.

(14) MEDICAL DEVICE.—The term “medical device” has the meaning given such term in section 201(h) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321(h)).

(15) NONECONOMIC DAMAGES.—The term “noneconomic damages” means damages paid to an individual for pain and suffering, inconvenience, emotional distress, mental anguish, loss of

consortium, injury to reputation, humiliation, and other non-pecuniary losses.

(16) **PERSON.**—The term “person” means any individual, corporation, company, association, firm, partnership, society, joint stock company, or any other entity, including any governmental entity.

(17) **PRODUCT SELLER.**—

(A) **IN GENERAL.**—Subject to subparagraph (B), the term “product seller” means a person who, in the course of a business conducted for that purpose—

(i) sells, distributes, rents, leases, prepares, blends, packages, labels, or is otherwise involved in placing, a product in the stream of commerce, or

(ii) installs, repairs, or maintains the harm-causing aspect of a product.

(B) **EXCLUSION.**—Such term does not include—

(i) a seller or lessor of real property;

(ii) a provider of professional services in any case in which the sale or use of a product is incidental to the transaction and the essence of the transaction is the furnishing of judgment, skill, or services; or

(iii) any person who—

(I) acts in only a financial capacity with respect to the sale of a product; or

(II) leases a product under a lease arrangement in which the selection, possession, maintenance, and operation of the product are controlled by a person other than the lessor.

(18) **PUNITIVE DAMAGES.**—The term “punitive damages” means damages awarded against any person not to compensate for actual injury suffered, but to punish or deter such person or others from engaging in similar behavior in the future.

(19) **STATE.**—The term “State” means each of the several States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, the Northern Mariana Islands, and any other territory or possession of the United States.

SEC. 10803. EFFECTIVE DATE.

This subtitle will apply to any health care liability action brought in a Federal or State court and to any health care liability claim subject to an alternative dispute resolution system, that is initiated on or after the date of enactment of this subtitle, except that any health care liability claim or action arising from an injury occurring prior to the date of enactment of this subtitle shall be governed by the applicable statute of limitations provisions in effect at the time the injury occurred.

CHAPTER 2—UNIFORM STANDARDS FOR HEALTH CARE LIABILITY ACTIONS

SEC. 10811. STATUTE OF LIMITATIONS.

A health care liability action may not be brought after the expiration of the 2-year period that begins on the date on which the alleged injury that is the subject of the action was discovered or should reasonably have been discovered, but in no case after the

expiration of the 5-year period that begins on the date the alleged injury occurred.

SEC. 10812. CALCULATION AND PAYMENT OF DAMAGES.

(a) **TREATMENT OF NONECONOMIC DAMAGES.—**

(1) **LIMITATION ON NONECONOMIC DAMAGES.—**The total amount of noneconomic damages that may be awarded to a claimant for losses resulting from the injury which is the subject of a health care 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.

(2) **JOINT AND SEVERAL LIABILITY.—**In any health care liability action brought in State or Federal court, a defendant shall be liable only for the amount of noneconomic damages attributable to such defendant in direct proportion to such defendant's share of fault or responsibility for the claimant's actual damages, as determined by the trier of fact. In all such cases, the liability of a defendant for noneconomic damages shall be several and not joint.

(b) **TREATMENT OF PUNITIVE DAMAGES.—**

(1) **GENERAL RULE.—**Punitive damages may, to the extent permitted by applicable State law, be awarded in any health care liability action for harm in any Federal or State court against a defendant if the claimant establishes by clear and convincing evidence that the harm suffered was the result of conduct—

(A) specifically intended to cause harm, or

(B) conduct manifesting a conscious, flagrant indifference to the rights or safety of others.

(2) **PROPORTIONAL AWARDS.—**The amount of punitive damages that may be awarded in any health care liability action subject to this subtitle shall not exceed 3 times the amount of damages awarded to the claimant for economic loss, or \$250,000, whichever is greater. This paragraph shall be applied by the court and shall not be disclosed to the jury.

(3) **APPLICABILITY.—**This subsection shall apply to any health care liability action brought in any Federal or State court on any theory where punitive damages are sought. This subsection does not create a cause of action for punitive damages. This subsection does not preempt or supersede any State or Federal law to the extent that such law would further limit the award of punitive damages.

(4) **BIFURCATION.—**At the request of any party, the trier of fact shall consider in a separate proceeding whether punitive damages are to be awarded and the amount of such award. If a separate proceeding is requested, evidence relevant only to the claim of punitive damages, as determined by applicable State law, shall be inadmissible in any proceeding to determine whether actual damages are to be awarded.

(5) **DRUGS AND DEVICES.—**

(A) **IN GENERAL.—**(i) Punitive damages shall not be awarded against a manufacturer or product seller of a drug or medical device 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 which caused the harm, and such drug, device, packaging, or labeling 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.

(ii) Clause (i) 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.

(B) PACKAGING.—In a health care liability action for harm which is alleged to relate to the adequacy of the packaging or labeling 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 or product seller of the drug shall not be held liable for punitive damages unless such packaging or labeling is found by the court by clear and convincing evidence to be substantially out of compliance with such regulations.

(c) PERIODIC PAYMENTS FOR FUTURE LOSSES.—

(1) GENERAL RULE.—In any health care liability action in which the damages awarded for future economic and non-economic loss exceeds \$50,000, a person shall not be required to pay such damages in a single, lump-sum payment, but shall be permitted to make such payments periodically based on when the damages are found likely to occur, as such payments are determined by the court.

(2) FINALITY OF JUDGMENT.—The judgment of the court awarding periodic payments under this subsection may not, in the absence of fraud, be reopened at any time to contest, amend, or modify the schedule or amount of the payments.

(3) LUMP-SUM SETTLEMENTS.—This subsection shall not be construed to preclude a settlement providing for a single, lump-sum payment.

(d) TREATMENT OF COLLATERAL SOURCE PAYMENTS.—

(1) INTRODUCTION INTO EVIDENCE.—In any health care liability action, any defendant may introduce evidence of collateral source payments. If any defendant elects to introduce such evidence, the claimant may introduce evidence of any amount paid or contributed or reasonably likely to be paid or contributed in the future by or on behalf of the claimant to secure the right to such collateral source payments.

(2) NO SUBROGATION.—No provider of collateral source payments shall recover any amount against the claimant or receive any lien or credit against the claimant's recovery or be equitably or legally subrogated the right of the claimant in a health care liability action.

(3) APPLICATION TO SETTLEMENTS.—This subsection shall apply to an action that is settled as well as an action that is resolved by a fact finder.

SEC. 10813. ALTERNATIVE DISPUTE RESOLUTION.

Any ADR used to resolve a health care liability action or claim shall contain provisions relating to statute of limitations, non-economic damages, joint and several liability, punitive damages, collateral source rule, and periodic payments which are identical to the provisions relating to such matters in this subtitle.

STATEMENT OF THE HOUSE COMMITTEE ON THE BUDGET
ON THE BALANCED BUDGET ACT OF 1997

The Bipartisan Budget Agreement reached earlier this year represents an historic achievement. It demonstrated that Congress and the administration could commit themselves to major reforms of government programs so that the Federal budget can be balanced in 2002. It also called for a substantial reduction in the tax burden for middle-income Americans.

This legislation—the Balanced Budget Act of 1997—reflects the good faith efforts of House authorizing committees to fulfill the first part of that agreement through systemic, fundamental reforms of government entitlements. A second measure, called the Revenue Reconciliation Act of 1997, provides approximately \$85 billion in net tax relief over 5 years. Together, these twin bills respond to the reconciliation directives of the House Concurrent Resolution on the Budget for Fiscal Year 1998, (H. Con. Res. 84), which embraced the Bipartisan Budget Agreement.

The underlying accomplishments of the budget agreement warrant repeating. They include the following:

- It balances the Federal budget in 2002 and is projected to run surpluses each year thereafter through 2002.
- It provides a total of \$85 billion in net tax relief over the next 5 years and \$250 billion through 2007—the vast majority of it going to middle-income working families.
- It delays Medicare bankruptcy for 10 years.
- It reduces total Federal spending to 18.9 percent of gross domestic product [GDP] by 2002—the first time since 1974 that Federal spending has been below 20 percent of GDP.
- It slows the growth of total Federal spending to 3 percent a year for the next 5 years.
- It achieves roughly \$182 billion in entitlement savings over the next 5 years, and approximately \$700 billion over the next 10 years.
- It slows the growth of nondefense discretionary outlays to less than one-half of 1 percent a year over the next 5 years, compared with an average of 6 percent a year for the past 10 years.
- It saves taxpayers approximately \$13 billion over the next 5 years, and \$142 billion over the next 10 years, through lower interest payments.

- It proves Congress and the administration can achieve common goals without compromising fundamental principles.

Yet as sweeping as these achievements are, they represent only the first step in what must be a long-term commitment to keep Congress' fiscal house in order. The forthcoming retirement of the baby boom generation will bring a massive new wave of challenges for Federal policymakers—challenges that, if left unaddressed, could overwhelm not only the Federal budget, but the entire economy as well.

Still, this budget agreement is an indispensable first step. Congress should swiftly pass this implementing legislation, and the President should sign it, so that we can move on together to face the challenges ahead.

HOUSE OF REPRESENTATIVES,
COMMITTEE ON AGRICULTURE,
Washington, DC, June 16, 1997.

Hon. JOHN KASICH,
Chairman, Committee on the Budget,
Washington, DC.

DEAR CHAIRMAN KASICH: I am transmitting herewith the results of the Committee on Agriculture's consideration of recommendations with respect to the reconciliation bill for fiscal year 1998, provided for under H. Con. Res. 84, the Concurrent Resolution on the Budget—Fiscal Year 1998.

The instructions to this Committee contained in the conference report to H. Con. Res. 84 filed by the Budget Committee (H. Rept. 105-116) on June 4, 1997 related to changes in laws within the Committee on Agriculture's jurisdiction that provide direct spending under provisions of the Food Stamp Act of 1977. The enclosed recommendations adopted by this Committee in a business meeting on June 12, 1997, in the presence of a majority quorum, comply with those instructions.

During the markup of the recommendations several amendments were offered, one of which was adopted, one withdrawn, and one failed adoption. The Ranking Minority Member offered an amendment that it was claimed would reduce a State's food stamp funds only to the extent that States took advantage of an opportunity to attribute costs to the Food Stamp program which were really incurred as part of their administration of their temporary assistance to needy families (TANF) block grant under Title I of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996. Claimed savings from such policy changes that effect shifts in administrative costs from TANF to food stamps were preliminarily estimated to exceed \$1.5 billion in budget authority and outlays in fiscal year 1998 through 2002. The amendment further provided that such savings realized from the amendment were to be used for, among other things, spending for agricultural programs such as nutrition, crop insurance, etc. While the alternative use of the funds for producer-related Department of Agriculture programs was enticing to several Members, it was admitted by the sponsor of the amendment that the Congressional Budget Office had determined that such a shift of funds would constitute an intergovernmental unfunded mandate on States under section 421 of the Congressional Budget Act. The sponsor claimed the CBO determination was technical, but would be subject to a point of order on the House Floor. After considerable debate, the amendment was rejected on a recorded vote of 30 nays to 13 ayes.

I am enclosing a hard copy of the Committee's recommendations on Title I—Agriculture that achieve the spending increases as contained in the instructions contained in H. Con. Res. 84 and as re-

quested in your letter of May 30, 1997. There is also enclosed a hard copy of the Section-by-Section Analysis and a Congressional Budget Office cost estimate of the recommendations, as well as a Microsoft Word 7.0 disk of the recommendations. There are also enclosed a hard copy of the Ramseyer; and the remainder of the contents of the report filed pursuant to Rule XI of the Rules of the House, including the Brief Explanation, Committee Consideration, the Purpose and Need, etc. for the Committee's recommendations, as well as a set of Minority Views.

The Committee staff was advised Friday afternoon that the Committee's recommendations for the reconciliation bill could be forwarded to you Monday morning without affecting your Committee's schedule. Accordingly, this letter with enclosures was held over until this morning for delivery to your office in Room 309 CHOB.

Sincerely,

ROBERT F. (BOB) SMITH,
Chairman.

Enclosures.

BRIEF EXPLANATION

States are permitted to exempt 15% of the number of able bodied, 18 to 50 year old persons subject to the food stamp work requirement, after all other waivers have been approved.

Funding for additional work activity is added to the food stamp employment and training program. The Secretary is directed to allocate funding among states based on the number of able bodied 18 to 50 year old persons in each state, after the Secretary approves waivers requested by states due to high unemployment or insufficient jobs.

States are provided the authority to contract for the delivery of food stamp benefits through the use of any entity (governmental or non-governmental) for the purpose of making food stamp eligibility determinations for individuals and households.

PURPOSE AND NEED

The Concurrent Resolution on the Budget for Fiscal Year 1998 directs the Committee on Agriculture to increase spending for the food stamp program by \$1.5 billion over five years. The Committee on Agriculture is to redirect existing food stamp employment and training funds and to add funding to create additional work activity for able bodied persons between 18 and 50 years, who have no dependents.

SECTION-BY-SECTION ANALYSIS

Section 1001. Exemption

A state agency may provide an exemption for a portion of those individuals subject to the work requirement time limits established under section 6(0).

The average monthly number of exemptions a state agency may grant is limited to 15% of the estimated number of individuals to whom the requirement time limits apply. These "covered individuals" are those: not excepted (because of age, disability, etc.); not

living in an area for which a waiver has been granted for high unemployment or insufficient jobs; not complying with the work requirement; and not in their first (or second) 3 months of eligibility under the work requirement time limits. If a state chooses to provide exemptions under this new rule, it can do so in any way, including defining categories of applicants and recipients who will be exempted, so long as it adheres to the 15% limit.

For FY 1998, the Secretary will determine the estimated number of covered individuals from which a state can exempt 15%, using the FY 1996 recipient survey conducted under the Integrated Quality Control System and other information deemed necessary by the Secretary due to the timing of the survey and its limitations. The estimate will reflect adjustments for those covered by current-law exceptions (e.g., age, disability), those covered by waivers, and those in their first and second 3-month periods of eligibility under the work requirement. In later fiscal years, the number of covered individuals from which a state can exempt 15% will be estimated by adjusting the FY 1998 number to reflect changes in the state's food stamp caseload in the prior year and the Secretary's estimate of changes in the proportion of recipients living in areas covered by waivers.

If a state's food stamp participation, during a fiscal year, varies significantly from the prior year's caseload, the Secretary will adjust, upward or downward, the estimated number of covered individuals from which the state may exempt 15% to reflect the increase or decrease.

If a state exempts more or less than 15% of covered individuals in a fiscal year, the Secretary must decrease or increase the number of allowable exemptions, in the next fiscal year, to correspond to the number of exemptions by which the state was over or under 15% in the previous year.

The Secretary can require documentation from states to ensure compliance with the rules governing the new 15% exemption.

Section 1002. Additional funding for employment and training

New money is added to the existing mandatory unmatched federal grants to states for the employment and training program for food stamp recipients. Current grant levels, totaling \$81 million for FY 1998, \$84 million for FY 1999, \$86 million for FY 2000, \$88 million for FY 2001, and \$90 million for FY 2002, are increased to \$221 million for FY 1998, \$224 million for FY 1999, \$226 million for FY 2000, \$228 million for FY 2001, and \$210 million for FY 2002. The amounts provided are to remain available until expended, so as to facilitate reallocation of any unused funds.

The total grant amounts noted above (including "old" and "new" money) will be allocated to state agencies using a reasonable formula, determined by the Secretary. The formula will reflect each state's proportion of able-bodied adults without dependents subject to the work requirement time limits who are not excepted (e.g. because of age, disability) but not including those residing in areas for which a waiver has been granted for high unemployment or insufficient jobs, unless the state is providing them employment and training services. The current law requiring a minimum unmatched federal grant of \$50,000 per state agency is retained.

State agencies are required to use 75% of their unmatched federal grant allocations (including “old” and “new” money) to serve food stamp recipients subject to work requirement time limits who are not excepted (e.g., by reason of age, disability). They may not use any of their unmatched federal grant allocations for food stamp participants who also receive benefits under the state’s Temporary Assistance for Needy Families (TANF) block grant.

State agencies not expending all of the unmatched federal money allocated them for a fiscal year will notify the Secretary, and, on notification, the Secretary must reallocate these funds as the Secretary considers appropriate and equitable, which may include reallocation in the following fiscal year.

In order to receive the additional unmatched federal grant funding provided in this law (i.e., the amount by which their allocation under the new law exceeds the allocation under prior law), state agencies must maintain their federally matched expenditure for employment and training and workfare program administrative/operating costs at not less than the FY 1996 level.

The Secretary may require documentation from states to ensure compliance with the new rules governing allocation and use of employment and training funds.

Beginning one year after enactment, the Secretary must report to the House and Senate Agriculture Committees on whether the additional unmatched federal grant funding provided in this law has been utilized by state agencies to increase the number of employment and training program work slots (for recipients subject to the work requirement time limits) in the most efficient and effective manner.

Section 1003. Authorizing use of nongovernmental personnel in making determinations of eligibility for benefits under the Food Stamp Program.

States are allowed to contract for the delivery of food stamp benefits with any entity (governmental or non-governmental) for the purpose of making food stamp eligibility determinations for individuals and households. The utilization of any non-Federal entity to make food stamp eligibility determinations will not affect the conditions for eligibility of benefits, the right to challenge determinations regarding eligibility or rights to benefits, or determinations regarding quality control or error rates.

COMMITTEE CONSIDERATION

The Committee on Agriculture met, pursuant to notice, with a majority quorum present, on June 12, 1997, to consider its recommendations to the Budget Committee as provided in the Budget Resolution Instructions contained in the conference report to H. Con. Res. 84 (H. Rept. 105–116) with respect to recommendations for Title I—Agriculture in the Reconciliation Bill for Fiscal Year 1998.

The Chairman called the meeting to order and recognized Ranking Minority Member Stenholm for a brief opening statement and gave all other Members permission to submit statements for the record.

The Chairman recognized professional staff for a brief explanation and then laid before the Committee Members for their consideration his recommendations for Title I—Agriculture of a proposed Budget Reconciliation Bill to be introduced by the Budget Committee.

A brief discussion occurred on the Committee recommendations, and Mr. Smith of Michigan questioned U.S. Department of Agriculture representatives concerning the status of the implementation of the electronic benefit program being implemented by the States.

Without objection, the Committee recommendations for Title I—Agriculture were considered as original text and open for amendment at any point.

Thereafter, Mrs. Clayton was recognized to offer and explain an amendment concerning establishing minimum performance standards for the employment and training programs carried out by the States under the food stamp program. Mrs. Clayton further noted that the amendment was not the Administration's proposal and that it was comparable to a provision adopted the Senate Committee on Agriculture, Nutrition and Forestry.

Discussion occurred on the amendment with Mr. Goodlatte indicating his opposition to the amendment because he wanted to give the States as much flexibility as possible in running the program. Mr. Goodlatte also indicated that he would like to work this matter out in the conference with the Senate and would prefer to leave some room for negotiations on the part of the House conferees.

Further discussion occurred on the bill, with Ranking Minority Member Stenholm noting that concessions had been made in producing the Committee recommendations in that the Committee was requiring the States to maintain 100 percent of effort regarding jobs, which was significantly better than the Senate provisions adopted in the Senate Committee on Agriculture, Nutrition, and Forestry.

Chairman Smith requested that Mrs. Clayton withdraw her amendment and stated that the Committee would work with her on the provision. Given that offer, without objection, Mrs. Clayton withdrew her amendment.

Mr. Stenholm was then recognized to offer and explain an amendment which would make certain changes to the food stamp program that would affect savings in direct spending with the resulting savings therefrom to provide funding for nutrition and other agriculture programs, including the federal crop insurance program. Mr. Stenholm acknowledged that there likely would be a point of order made against the amendment because the Congressional Budget Office had determined the amendment would be considered an unfunded mandate to the States. He urged the Committee to support his amendment and to let the Rules Committee and/or the full House of Representatives determine the unfunded mandate issue, rather than the Committee.

Chairman Smith stated that he had been working continuously with Mr. Stenholm in an effort to make the amendment work. As a Member representing an agricultural Congressional District, he supported the funding of many of the items included in the amendment that helped farmers. The Chairman also noted that in spite

of his wish to support the amendment, the decision of the Congressional Budget Office that the amendment constituted an unfunded mandate for States put a different character on it inasmuch as it would be subject to a point of order.

Lengthy discussion occurred on the amendment with Messrs. Condit, Peterson, and others speaking on the matter of the unfunded mandate and what would happen on the House Floor if a point of order were made. Other discussion occurred on how the Appropriations Committee would interpret whatever action the Committee on Agriculture took with respect to the amendment. Chairman Smith called for a vote and by a voice vote the amendment was ruled as not agreed to. Mr. Stenholm requested a roll call vote and Chairman Smith directed that a roll call vote be taken. By a recorded vote of 30 nays and 13 yeas, the Stenholm amendment was not adopted. See Roll Call Vote No. 1.

Mr. Combest was recognized to offer and explain an amendment which would authorize the use of nongovernmental personnel in making determinations of eligibility for benefits under the food stamp program. Mr. Combest further noted that his amendment, as it related to the food stamp program, was nearly identical to H.R. 1709, which had been introduced by the Chairman of the Ways and Means Committee, and was cosponsored by over 40 Members, including the Chairman and Ranking Minority Member of the Agriculture Committee, and the Chairman of the Commerce Committee. Mr. Combest stated that there was no cost associated with the amendment.

Mr. Combest further stated that the State of Texas had been working with the Administration to receive a waiver which would allow this welfare delivery program, and that after negotiating for ten months that the waiver had been denied.

Discussion occurred on the amendment with Messrs. Holden and Peterson expressing concern that it was premature to consider the amendment and that more study and hearings should be held. Mr. Stenholm indicated that he had tried to bring parties together to forge a compromise on this issue, and that since this had not happened that he would support the Combest amendment.

Chairman Smith called for a vote on the Combest amendment, and by voice vote the Chair ruled that the amendment was adopted. Mr. Holden requested a roll call vote and the Chair directed that a recorded vote be taken. By a recorded vote of 24 yeas to 19 nays, the Combest amendment was adopted. See Roll Call Vote #2.

Mr. Combest moved that the Committee's recommendations, as amended, be adopted and that the Chairman be authorized to forward such recommendations, and other materials as directed to be included by the Speaker, to the Budget Committee. By voice vote, and in the presence of a majority quorum, the Combest motion was adopted.

Chairman Smith noted that Members would have two working days to file Minority, Supplemental, or other Views, but he requested that the Chief Counsel be advised if views would not be available until Saturday, so that the Counsel would be available to receive the views and to file them with the Budget Committee on Saturday, June 14, 1997.

Without objection, staff was given instructions to make such technical, clarifying, or conforming changes as appropriate without changing the substance of the legislation.

The meeting adjourned, subject to the call of the Chair.

REPORTING THE BILL—ROLL CALL VOTES

In compliance with clause 2(1)(2)(b) of rule XI of the House of Representatives, the Committee sets forth the record of the following roll call votes taken with respect to consideration of the recommendations regarding the Reconciliation Bill for Fiscal Year 1998:

ROLL CALL NO. 1

Summary: To prevent states from allocating additional administrative costs to the food stamp program and reallocate the savings to fund certain other agricultural, rural development, research, and nutrition programs.

Offered by: Mr. Stenholm.

Results: Failed by a roll call vote: 13 yeas/30 nays/7 not voting.

Yeas—1. Cong. Smith, MI; 2. Cong. Lewis; 3. Cong. Stenholm; 4. Cong. Peterson; 5. Cong. Dooley; 6. Cong. Minge; 7. Cong. Holden; 8. Cong. Baesler; 9. Cong. Berry; 10. Cong. McIntyre; 11. Cong. Etheridge; 12. Cong. Johnson; 13. Cong. Boswell.

Nays—1. Cong. Smith, OR; 2. Cong. Combest; 3. Cong. Barrett; 4. Cong. Ewing; 5. Cong. Doolittle; 6. Cong. Goodlatte; 7. Cong. Pombo; 8. Cong. Canady; 9. Cong. Everett; 10. Cong. Lucas; 11. Cong. Chenoweth; 12. Cong. Hostettler; 13. Cong. Bryant; 14. Cong. Foley; 15. Cong. Chambliss; 16. Cong. Emerson; 17. Cong. Moran; 18. Cong. Blunt; 19. Cong. Pickering; 20. Cong. Schaffer; 21. Cong. Jenkins; 22. Cong. Cooksey; 23. Cong. Condit; 24. Cong. Clayton; 25. Cong. Hilliard; 26. Cong. Bishop; 27. Cong. Thompson; 28. Cong. Baldacci; 29. Cong. Goode; 30. Cong. Stabenow.

Not Voting—1. Cong. Boehner; 2. Cong. LaHood; 3. Cong. Thune; 4. Cong. Brown; 5. Cong. Pomeroy; 6. Cong. Farr; 7. Cong. John.

ROLL CALL NO. 2

Summary: To authorize use of nongovernmental personnel in making determinations of eligibility for benefits under the food stamp program.

Offered by: Mr. Combest.

Results: Passed by a roll call vote: 24 yeas/19 nays/7 not voting.

Yeas—1. Cong. Smith, OR; 2. Cong. Combest; 3. Cong. Barrett; 4. Cong. Ewing; 5. Cong. Doolittle; 6. Cong. Goodlatte; 7. Cong. Pombo; 8. Cong. Canady; 9. Cong. Smith, MI; 10. Cong. Everett; 11. Cong. Lucas; 12. Cong. Lewis; 13. Cong. Chenoweth; 14. Cong. Hostettler; 15. Cong. Foley; 16. Cong. Chambliss; 17. Cong. Emerson; 18. Cong. Moran; 19. Cong. Pickering; 20. Cong. Thune; 21. Cong. Jenkins; 22. Cong. Cooksey; 23. Cong. Stenholm; 24. Cong. Goode.

Nays—1. Cong. Condit; 2. Cong. Peterson; 3. Cong. Dooley; 4. Cong. Clayton; 5. Cong. Minge; 6. Cong. Hilliard; 7. Cong. Pomeroy; 8. Cong. Holden; 9. Cong. Baesler; 10. Cong. Bishop; 11. Cong. Thompson; 12. Cong. Baldacci; 13. Cong. Berry; 14. Cong. McIn-

tyre; 15. Cong. Stabenow; 16. Cong. Etheridge; 17. Cong. John; 18. Cong. Johnson; 19. Cong. Boswell.

Not Voting—1. Cong. Boehner; 2. Cong. Bryant; 3. Cong. LaHood; 4. Cong. Blunt; 5. Cong. Schaffer; 6. Cong. Brown; 7. Cong. Farr.

BUDGET ACT COMPLIANCE (SECTIONS 308, 403, AND 424)

The provisions of clause 2(1)(3)(B) of rule XI of the Rules of the House of Representatives and section 308(a)(1) of the Congressional Budget Act of 1974 (relating to estimates of new budget authority, new spending authority, new credit authority, or increased or decreased revenues or tax expenditures) are not considered applicable. The estimate and comparison required to be prepared by the Director of the Congressional Budget Office under clause 2(1)(3)(C) of rule XI of the Rules of the House of Representatives and sections 403 and 424 of the Congressional Budget Act of 1974 submitted to the Committee on Agriculture prior to the filing of this report are as follows:

CONSTITUTIONAL AUTHORITY STATEMENT

Pursuant to clause 2(1)(4) of rule XI of the Rules of the House of Representatives, the Committee on Agriculture finds the Constitutional authority for this legislation in Article I, clause 8, section 18, that grants Congress the power to make all laws necessary and proper for carrying out the powers vested by Congress in the Government of the United States or in any department or officer thereof.

OVERSIGHT STATEMENT

No summary of oversight findings and recommendations made by the Committee on Government Reform and Oversight as provided for in clause 2(1)(3)(D) of rule XI, and under clause 4(c)(2) of rule X of the Rules of the House of Representatives was available to the Committee on Agriculture with reference to the subject matter specifically addressed by the Chairman's recommendations of the Committee on Agriculture for Title I—Agriculture to be included in the Budget Reconciliation Bill for Fiscal Year 1998.

COMMITTEE OVERSIGHT FINDINGS

Pursuant to clause 2(1)(3)(A) of rule XI, and clause 2(b)(1) of rule X of the Rules of the House of Representatives, the Committee on Agriculture's oversight findings and recommendations are reflected in the body of this report.

COMMITTEE COST ESTIMATE

Pursuant to clause 7(a) of rule XIII of the rules of the House of Representatives, the Committee report incorporates the cost estimate prepared by the Director of the Congressional Budget Office pursuant to sections 403 and 424 of the Congressional Budget Act of 1974.

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, June 16, 1997.

Hon. ROBERT F. SMITH,
*Chairman, Committee on Agriculture,
House of Representatives, Washington, DC.*

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the enclosed cost estimate for the reconciliation recommendations of the House Committee on Agriculture, as approved on June 12, 1997.

The estimate shows the budgetary effects of the committee's proposals over the 1998–2007 period. CBO understands that the Committee on the Budget will be responsible for interpreting how these proposals compare with the reconciliation instructions in the budget resolution. The estimate assumes that the reconciliation bill will be enacted by August 15; the estimate could change if the bill is enacted later.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contact is Dorothy Rosenbaum.

Sincerely,

JUNE E. O'NEILL, *Director.*

Enclosure.

CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

Reconciliation Recommendations of the House Committee on Agriculture (Title I)

Summary: The House Agriculture Committee reconciliation recommendations would increase federal Food Stamp spending by \$1.5 billion over the 1998–2002 period.

The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 limited Food Stamp receipt to a period of three months in any 36-month period for able-bodied adults who do not have dependent children and who are not working or participating in an appropriate training or work activity. The title would allow states to exempt some individuals from this limitation and would provide additional federal Food Stamp Employment and Training funds to states.

The title does not contain any intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act of 1995 (UMRA) and would impose no costs on state, local, or tribal governments.

Estimated cost to the Federal Government: The estimated budgetary impact of the title for the 1998–2002 period is shown in the following table. The appendix table shows the budgetary impacts through 2007.

The effects of this legislation fall within budget function 600 (Income Security).

ESTIMATED BUDGETARY IMPACT OF THE RECONCILIATION RECOMMENDATIONS OF THE HOUSE
COMMITTEE ON AGRICULTURE

	Outlays by fiscal years in millions of dollars					
	1997	1998	1999	2000	2001	2002
DIRECT SPENDING						
Food Stamp Spending Under Current Law	23,794	24,450	25,884	27,226	28,645	29,417
Proposed Changes:						
Section 1001: Exemptions	0	110	110	110	120	130
Section 1002: Additional funding for employment and training	0	160	190	200	200	170
Total Changes	0	270	300	310	320	300
Spending Under Title I	23,794	24,720	26,814	27,536	28,965	29,717

Basis of estimate: The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 limited Food Stamp receipt to a period of three months in any 36-month period for able-bodied adults who do not have dependent children and who are not working or participating in an appropriate training or work activity. An individual can reestablish eligibility for another three-month period after a month of working or participating in an allowable employment or training program. The Secretary of Agriculture can provide a waiver from the provision for areas that have an unemployment rate greater than ten percent or insufficient jobs. The Department of Agriculture estimates that currently about 35 percent of the people who otherwise would be affected by this provision live in areas that are covered by a waiver.

Title I contains two provisions that address this component of current law. The first would allow states to exempt a certain number of individuals from the requirements. The second would provide additional federal money for Food Stamp Employment and Training. A third provision would allow states to use nongovernmental personnel to make eligibility determinations in the Food Stamp Program.

Section 1001. Exemption

Under this provision, each state would be allowed to continue food stamp benefits past the three month limit for 15 percent of the state's covered individuals, as estimated annually by the Secretary of Agriculture based on Food Stamp Program administrative data. Covered individuals would be defined as individuals who are covered by the time-limit provision by virtue of their age, work status, and household circumstances, do not live in an area that is covered by a waiver, and are not receiving benefits under a three-month period of eligibility.

Based on CBO's analysis of the Food Stamp administrative data and projections of Food Stamp participation, CBO assumes that approximately 1.1 million Food Stamp recipients would, in fiscal year 1998, be able-bodied, between the ages of 18 and 50 with no children in the home, and not working or complying with an appropriate work activity. Of these individuals, CBO assumes that 75 percent would not be in a three-month period of eligibility and, of the remainder, 65 percent would not reside in a waiver area.

Under these assumptions, the Secretary would identify approximately 550,000 individuals nationwide as covered individuals, and would distribute the number among the states. States could, therefore, allow a total of about 82,000 people (15 percent) to receive food stamps each month who would otherwise be ineligible. CBO assumes that only about 74,000 people would actually continue to receive benefits because a few states would choose not to implement the exemption. Continuing food stamps for these newly exempt individuals (at an average cost of about \$120 a month) would increase Food Stamp outlays by \$110 million in 1998, \$130 million in 2002, and \$580 million over the 1998–2002 period.

Section 1002. Additional funding for employment and training

Under current law, the Food Stamp Employment and Training component of the Food Stamp Program has two federal funding sources. The federal government provides a stated amount annually in funds that do not require a state match. States may also draw down an unlimited amount of additional funds at a 50 percent match rate. In 1996, the federal government provided about \$75 million dollars in federal-only funds and about the same amount as a match to state funds.

Section 1002 would increase the federal-only Food Stamp Employment and Training funds by \$140 million in each of fiscal years 1998 to 2001 and by \$120 million in fiscal year 2002. The bill would require that states spend at least 75 percent of the federal-only money on employment and training services for people who are potentially subject to the three-month time limit based on their age and other characteristics, regardless of whether they live in a waiver area or a non-waiver area. Furthermore, in order to receive the additional amounts of federal funds a state must continue to spend state funds at its fiscal year 1996 level. In addition to the increase in federal-only employment and training funds, CBO estimates that this section would increase Food Stamp benefits and slightly reduce federal matching funds for employment and training. In total, CBO estimates that Section 1002 would increase federal outlays by \$920 million over the 1998–2002 period.

CBO expects that states will spend some of the new money on the types of employment and training services that the Food Stamp Act outlines as appropriate for meeting the work requirement. CBO estimates that it costs states an average of about \$100 a month in 1997 to serve someone in an appropriate employment or training activity. If an individual resides in an area that is not covered by a waiver and receives an appropriate service, that person would remain eligible for Food Stamps past the three-month limit. CBO assumes that states will spend 75 percent of the new money in areas that are not covered by a waiver. Of this amount, CBO further assumes that in fiscal year 1998 states would spend 25 percent of the money that they spend in non-waiver areas on appropriate services, resulting in 20,000 individuals remaining eligible for Food Stamps at a cost of \$28 million in that year. By 2001, CBO expects that states would spend 65 percent of the money that they spend in non-waiver area on appropriate services, resulting in 45,000 individuals remaining eligible at a cost of about \$70 million. In 2002 the amount of new federal funds is somewhat lower, so slightly

fewer people would remain eligible (40,000) at a lower cost (\$60 million).

CBO also assumes that under current law states would have increased their own spending modestly over the years to account for inflation. Because the bill would require states to maintain their effort on their own funds at a flat amount and provides such a large amount of new federal funds, CBO expects that in the aggregate states would withdraw a small amount of their own spending on employment and training services. Because these funds would have received a federal match, CBO estimates that federal outlays would be lower by \$4 million in 1998 and \$9 million in 2002.

Section 1003: Authorizing use of nongovernmental personnel in making determinations of eligibility for benefits

Section 1003 would allow states to employ nongovernmental personnel to make eligibility determinations in the Food Stamp Program. Although the provision could either increase or decrease spending for the Food Stamp Program, CBO estimates that it would have no net effect on federal spending compared with current law.

Intergovernmental and private-sector impact: This title contains no intergovernmental or private-sector mandates as defined in UMRA. This title would provide states with additional funds for Food Stamp employment and training programs totaling \$140 million in fiscal year 1998 and \$680 million over the 1998–2002 period if they meet certain maintenance-of-effort requirements. This title would also allow states the option to use nongovernmental personnel in making eligibility determinations under the Food Stamp Program.

Estimate prepared by: Federal Cost: Dorothy Rosenbaum (226–2820). Impact on State, Local, and Tribal Governments: Marc Nicole (225–3220). Impact on the Private Sector: Ralph Smith (226–2659).

Estimate approved by: Paul N. Van de Water, Assistant Director for Budget Analysis.

APPENDIX TABLE—FEDERAL BUDGETARY EFFECTS OF TITLE I

[By fiscal year, in millions of dollars]

	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	1998– 2002 Total	1998– 2007 Total
DIRECT SPENDING												
Section 1001. Exemption:												
Budget Authority	110	110	110	120	130	130	130	140	140	140	580	1,260
Outlays	110	110	110	120	130	130	130	140	140	140	580	1,260
Section 1002. Additional fund- ing for Employment and Training:												
Budget Authority	160	190	200	200	170	170	180	180	180	180	920	1,810
Outlays	160	190	200	200	170	170	180	180	180	180	920	1,810
Total, Direct Spending:												
Budget Authority	270	300	310	320	300	300	310	320	320	320	1,500	3,070
Outlays	270	300	310	320	300	300	310	320	320	320	1,500	3,070

ADVISORY COMMITTEE STATEMENT

No advisory committee within the meaning of section 5(b) of the Federal Advisory Committee Act was created by this legislation.

APPLICABILITY TO THE LEGISLATIVE BRANCH

The Committee finds that the legislation does not relate to the terms and conditions of employment or access to public services or accommodations within the meaning of section 102(b)(3) of the Congressional Accountability Act (Public Law 104-1).

CHANGES IN EXISTING LAW MADE BY TITLE I OF THE BILL, AS REPORTED

In compliance with clause 3 of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

FOOD STAMP ACT OF 1977

* * * * *

ELIGIBILITY DISQUALIFICATIONS

SEC. 6. (a) * * *

* * * * *

(o) WORK REQUIREMENT.—

(1) * * *

(2) WORK REQUIREMENT.—Subject to the other provisions of this subsection, no individual shall be eligible to participate in the food stamp program as a member of any household if, during the preceding 36-month period, the individual received food stamp benefits for not less than 3 months (consecutive or otherwise) during which the individual did not—

(A) * * *

(D) receive benefits pursuant to paragraph (3), (4), [or (5)] (5), or (6).

* * * * *

(5) 15-PERCENT EXEMPTION.—

(A) DEFINITIONS.—*In this paragraph:*

(i) CASELOAD.—*The term “caseload” means the average monthly number of individuals receiving food stamps during the 12-month period ending the preceding June 30.*

(ii) COVERED INDIVIDUAL.—*The term “covered individual” means a food stamp recipient, or an individual denied eligibility for food stamp benefits solely due to paragraph (2), who—*

(I) is not eligible for an exception under paragraph (3);

(II) does not reside in an area covered by a waiver granted under paragraph (4);

(III) is not complying with subparagraph (A), (B), or (C) of paragraph (2);

(IV) is not in the first 3 months of eligibility under paragraph (2); and

(V) is not receiving benefits under paragraph (6).

(B) *GENERAL RULE.*—Subject to subparagraphs (C) through (F), a State agency may provide an exemption from the requirements of paragraph (2) for covered individuals.

(C) *FISCAL YEAR 1998.*—Subject to subparagraph (E), for fiscal year 1998, a State agency may provide a number of exemptions such that the average monthly number of the exemptions in effect during the fiscal year does not exceed 15 percent of the number of covered individuals in the State in fiscal year 1998, as estimated by the Secretary, based on the survey conducted to carry out section 16(c) for fiscal year 1996 and such other factors as the Secretary considers appropriate due to the timing and limitations of the survey.

(D) *SUBSEQUENT FISCAL YEARS.*—Subject to subparagraphs (E) and (F), for fiscal year 1999 and each subsequent fiscal year, a State agency may provide a number of exemptions such that the average monthly number of the exemptions in effect during the fiscal year does not exceed 15 percent of the number of covered individuals in the State, as estimated by the Secretary under subparagraph (C), adjusted by the Secretary to reflect changes in the State's caseload and the Secretary's estimate of changes in the proportion of food stamp recipients covered by waivers granted under paragraph (4).

(E) *CASELOAD ADJUSTMENTS.*—The Secretary shall adjust the number of individuals estimated for a State under subparagraph (C) or (D) during a fiscal year if the number of food stamp recipients in the State varies by a significant number from the caseload, as determined by the Secretary.

(F) *EXEMPTION ADJUSTMENTS.*—During fiscal year 1999 and each subsequent fiscal year, the Secretary shall increase or decrease the number of individuals who may be granted an exemption by a State agency to the extent that the average monthly number of exemptions in effect in the State for the preceding fiscal year is greater or less than the average monthly number of exemptions estimated for the State agency during such preceding fiscal year.

(G) *REPORTING REQUIREMENT.*—A State agency shall submit such reports to the Secretary as the Secretary determines are necessary to ensure compliance with this paragraph.

[(5)] (6) *SUBSEQUENT ELIGIBILITY.*—

(A) *REGAINING ELIGIBILITY.*—An individual denied eligibility under paragraph (2) shall regain eligibility to participate in the food stamp program if, during a 30-day period, the individual—

(i) works 80 or more hours;

(ii) participates in and complies with the requirements of a work program for 80 or more hours, as determined by a State agency; or

(iii) participates in and complies with the requirements of a program under section 20 or a comparable program established by a State or political subdivision of a State.

(B) MAINTAINING ELIGIBILITY.—An individual who regains eligibility under subparagraph (A) shall remain eligible as long as the individual meets the requirements of subparagraph (A), (B), or (C) of paragraph (2).

(C) LOSS OF EMPLOYMENT.—

(i) IN GENERAL.—An individual who regained eligibility under subparagraph (A) and who no longer meets the requirements of subparagraph (A), (B), or (C) of paragraph (2) shall remain eligible for a consecutive 3-month period, beginning on the date the individual first notifies the State agency that the individual no longer meets the requirements of subparagraph (A), (B), or (C) of paragraph (2).

(ii) LIMITATION.—An individual shall not receive any benefits pursuant to clause (i) for more than a single 3-month period in any 36-month period.

[(6)] (7) OTHER PROGRAM RULES.—Nothing in this subsection shall make an individual eligible for benefits under this Act if the individual is not otherwise eligible for benefits under the other provisions of this Act.

* * * * *

ADMINISTRATIVE COST-SHARING AND QUALITY CONTROL

SEC. 16. (a) * * *

* * * * *

(h) FUNDING OF EMPLOYMENT AND TRAINING PROGRAMS.—

[(1)] IN GENERAL.—

[(A)] AMOUNTS.—To carry out employment and training programs, the Secretary shall reserve for allocation to State agencies from funds made available for each fiscal year under section 18(a)(1) the amount of—

- [(i)] for fiscal year 1996, \$75,000,000;
- [(ii)] for fiscal year 1997, \$79,000,000;
- [(iii)] for fiscal year 1998, \$81,000,000;
- [(iv)] for fiscal year 1999, \$84,000,000;
- [(v)] for fiscal year 2000, \$86,000,000;
- [(vi)] for fiscal year 2001, \$88,000,000; and
- [(vii)] for fiscal year 2002, \$90,000,000.

[(B)] ALLOCATION.—The Secretary shall allocate the amounts reserved under subparagraph (A) among the State agencies using a reasonable formula (as determined by the Secretary) that gives consideration to the population in each State affected by section 6(o).

[(C)] REALLOCATION.—

[(i)] NOTIFICATION.—A State agency shall promptly notify the Secretary if the State agency determines

that the State agency will not expend all of the funds allocated to the State agency under subparagraph (B).

[(ii) REALLOCATION.—On notification under clause (i), the Secretary shall reallocate the funds that the State agency will not expend as the Secretary considers appropriate and equitable.]

[(D) MINIMUM ALLOCATION.—Notwithstanding subparagraphs (A) through (C), the Secretary shall ensure that each State agency operating an employment and training program shall receive not less than \$50,000 for each fiscal year.]

(1) *IN GENERAL.*—

(A) *AMOUNTS.*—*To carry out employment and training programs, the Secretary shall reserve for allocation to State agencies, to remain available until expended, from funds made available for each fiscal year under section 18(a)(1) the amount of—*

- (i) for fiscal year 1996, \$75,000,000;
- (ii) for fiscal year 1997, \$79,000,000;
- (iii) for fiscal year 1998, \$221,000,000;
- (iv) for fiscal year 1999, \$224,000,000;
- (v) for fiscal year 2000, \$226,000,000;
- (vi) for fiscal year 2001, \$228,000,000; and
- (vii) for fiscal year 2002, \$210,000,000.

(B) *LIMITATIONS.*—*The Secretary shall ensure that—*

- (i) the funds provided in this subparagraph shall not be used for food stamp recipients who receive benefits under a State program funded under part A of title IV of the Social Security Act (42 U.S.C. 601 et seq.); and
- (ii) not less than 75 percent of the funds provided in this subparagraph shall be used by a State agency for the employment and training of food stamp recipients not excepted by section 6(o)(3).

(C) *ALLOCATION.*—

(i) *ALLOCATION FORMULA.*—*The Secretary shall allocate the amounts reserved under subparagraph (A) among the State agencies using a reasonable formula, as determined and adjusted by the Secretary each fiscal year, to reflect changes in each State's caseload (as defined in section 6(o)(5)(A)) that reflects the proportion of food stamp recipients who reside in each State—*

(I) *who are not eligible for an exception under section 6(o)(3); and*

(II) *who do not reside in an area subject to the waiver granted by the Secretary under section 6(o)(4), if the State agency does not provide employment and training services in the area to food stamp recipients not excepted by section 6(o)(3).*

(ii) *REPORTING REQUIREMENT.*—*A State agency shall submit such reports to the Secretary as the Secretary determines are necessary to ensure compliance with this paragraph.*

(D) *REALLOCATION.*—

(i) *NOTIFICATION.*—A State agency shall promptly notify the Secretary if the State agency determines that it will not expend all of the funds allocated to it under subparagraph (B).

(ii) *REALLOCATION.*—On notification under clause (i), the Secretary shall reallocate the funds that the State agency will not expend as the Secretary considers appropriate and equitable.

(E) *MINIMUM ALLOCATION.*—Notwithstanding subparagraphs (A) through (C), the Secretary shall ensure that each State agency operating an employment and training program shall receive not less than \$50,000 for each fiscal year.

(F) *MAINTENANCE OF EFFORT.*—To receive the additional funding under subparagraph (A), as provided by the amendment made by section 1002 of the Balanced Budget Act of 1997, a State agency shall maintain the expenditures of the State agency for employment and training programs and workfare programs for any fiscal year under paragraph (2), and administrative expenses under section 20(g)(1), at a level that is not less than the level of the expenditures by the State agency to carry out the programs for fiscal year 1996.

(2) *REPORT TO CONGRESS ON ADDITIONAL FUNDING.*—Beginning one year after the date of the enactment of this paragraph, the Secretary shall submit an annual report to the Committee on Agriculture of the House of Representatives and the Committee on Agriculture, Nutrition, and Forestry of the Senate regarding whether the additional funding provided under paragraph (1)(A) has been utilized by State agencies to increase the number of work slots in their employment and training programs and workfare for recipients subject to section 6(o) in the most efficient and effective manner.

[(2)] (3) If, in carrying out such program during such fiscal year, a State agency incurs costs that exceed the amount allocated to the State agency under paragraph (1), the Secretary shall pay such State agency an amount equal to 50 per centum of such additional costs, subject to the first limitation in [paragraph (3)] paragraph (4), including the costs for case management and casework to facilitate the transition from economic dependency to self-sufficiency through work.

[(3)] (4) The Secretary shall also reimburse each State agency in an amount equal to 50 per centum of the total amount of payments made or costs incurred by the State agency in connection with transportation costs and other expenses reasonably necessary and directly related to participation in an employment and training program under section 6(d)(4), except that such total amount shall not exceed an amount representing \$25 per participant per month for costs of transportation and other actual costs (other than dependent care costs) and an amount equal to the payment made under section 6(d)(4)(I)(i)(II) but not more than the applicable local market rate, and such reimbursement shall not be made out of funds allocated under paragraph (1).

[(4)] (5) Funds provided to a State agency under this subsection may be used only for operating an employment and training program under section 6(d)(4), and may not be used for carrying out other provisions of this Act.

[(5)] (6) The Secretary shall monitor the employment and training programs carried out by State agencies under section 6(d)(4) to measure their effectiveness in terms of the increase in the numbers of household members who obtain employment and the numbers of such members who retain such employment as a result of their participation in such employment and training programs.

* * * * *

RESEARCH, DEMONSTRATION, AND EVALUATIONS

SEC. 17. (a)(1) * * *

(b)(1)(A) The Secretary may conduct on a trial basis, in one or more areas of the United States, pilot or experimental projects designed to test program changes that might increase the efficiency of the food stamp program and improve the delivery of food stamp benefits to eligible households, and may waive any requirement of this Act to the extent necessary for the project to be conducted.

(B) PROJECT REQUIREMENTS.—

(i) * * *

* * * * *

(iv) IMPERMISSIBLE PROJECTS.—The Secretary may not conduct a project under subparagraph (A) that—

(I) * * *

* * * * *

(III) is inconsistent with—

(aa) * * *

* * * * *

(hh) subsection (a), (c), (g), [(h)(2), or (h)(3) of section 16] (h)(3), or (h)(4) of section 16;

* * * * *

FOOD STAMP PORTION OF MINNESOTA FAMILY INVESTMENT PLAN

SEC. 22. (a) * * *

* * * * *

(d) FUNDING.—

(1) If an application submitted under subsection (a) complies with the requirements specified in subsection (b), then the Secretary shall—

(A) approve such application; and

(B) subject to subsection (b)(12) from the funds appropriated under this Act provide grant awards and pay the State each calendar quarter for—

(i) the cost of food assistance provided under the Project equal to the amount that would have otherwise been issued in the form of coupons under the food stamp program had the Project not been implemented,

as estimated under a methodology satisfactory to the Secretary after negotiations with the State; and

(ii) the administrative costs incurred by the State to provide food assistance under the Project that are authorized under subsections (a), (g), [(h)(2), and (h)(3) of section 16] (h)(3), and (h)(4) of section 16 equal to the amount that otherwise would have been paid under such subsections had the Project not been implemented, as estimated under a methodology satisfactory to the Secretary after negotiations with the State: *Provided*, That payments made under subsection (g) of section 16 shall equal payments that would have been made if the Project had not been implemented.

* * * * *

HOUSE OF REPRESENTATIVES,
COMMITTEE ON BANKING AND FINANCIAL SERVICES,
Washington, DC, June 13, 1997.

Hon. JOHN KASICH,
Chairman, House Budget Committee,
Washington, DC.

DEAR MR. CHAIRMAN: The Banking Committee reported out on June 11, 1997 three authorizing provisions that achieve specific spending and revenue amounts outlined in the Concurrent Budget Resolution for FY1998. Specifically, the Committee is charged with recommending legislation under its jurisdiction to effect \$136 million in budget savings in FY1998 and \$1.59 billion in savings over the five-year period from FY 1998 through FY2002.

Enclosed is the legislative language for Title II, report language, and other information you requested in your May 30, 1997 letter. CBO cost estimates are attached.

Sincerely,

JAMES A. LEACH, *Chairman.*

PURPOSES AND SUMMARY OF MAJOR POLICY DECISIONS IN
LEGISLATION

The Committee under the Concurrent Budget Resolution for FY1998 is required to effect \$0.136 billion in budget savings in FY1998 and \$1.59 billion in savings over the five-year period from FY1998 to FY2002. The three provisions reported-out of Committee reflect reforms to existing FHA and Section 8 (U.S. Housing Act of 1937) project-based multifamily housing programs that will ensure savings for the federal government and ultimately the U.S. taxpayer.

The FHA Single Family Assignment Program was originally terminated and replaced by Section 407 of The Balanced Budget Downpayment Act, I for mortgages executed on and after April 26, 1996 through September 30, 1996. The Appropriations Committee subsequently made mortgages executed in FY 1996 and later added mortgages executed in FY 1997 eligible for the replacement program, to achieve offsets for discretionary spending. Permanent changes made by the Banking Committee will achieve real savings for the taxpayers and is a valid policy goal.

A review of the former FHA single family assignment program, by the General Accounting Office, indicated only limited success. In most cases, defaulted borrowers ultimately faced foreclosure and thus additional costs to FHA and the taxpayer. Some indicators estimated approximately up to 70% in defaulted loans from the assignment program. Rather than eliminate the assignment program, the Committee recommended in 1995 a replacement program that provided FHA with flexible tools, similar to the private-sector mortgage markets, to address defaulted borrowers who had a realistic

opportunity to retain their homes after a short-term calamity. Therefore, this replacement program provides HUD with discretionary authority, rather than a mandatory requirement, to accept applicants to the assignment program.

The Section 8 Rental Assistance Program provides project-based rental/multi-family assistance for families under 80% of area medium income. As a counter-part to public housing, this form of housing is operated by the private sector and is subsidized by the federal government in return for housing low- and very-low income families. The Annual Adjustment Factors (AAF) increases the per-unit subsidy annually in order to keep pace with any increases in area rents. Rather than automatically increase rents for every project-based rent, the annual increases are limited for Section 8 New Construction, Moderate Rehabilitation and Substantial Rehabilitation projects where unit rents exceed the HUD established Fair Market Rents for the relevant housing area. This reform will continue the process of realigning subsidized units with the rents of similar unassisted units in the area. Additionally, Section 8 annual rent increases would be limited for those Section 8 units in which there has been no tenant turnover since the preceding annual rent adjustment, by reducing the AAF by one percentage point. For example, if the published AAF is 1.03, which would provide a 3% rent increase, the AAF would be reduced to 1.02, and provide a 2% rent increase instead.

HEARINGS

There were no hearings during the 105th Congress on Section 8 or FHA assignment reforms.

CONSTITUTIONAL AUTHORITY

In compliance with clause 2(1)(4) of rule XI of the Rules of the House of Representatives, the constitutional authority for Congress to enact this legislation is derived from the general welfare clause (Article I, Sec. 8).

COMMITTEE VOTES

There were no roll call votes. The Committee passed by voice vote to adopt and favorably report the authorization provisions, pursuant to Subsection (c)(2) of Section 105 of the Concurrent Budget Resolution for FY 1998.

CONGRESSIONAL BUDGET OFFICE COST ESTIMATES

The Cost estimate pursuant to Clause 2(1)(3)(C) of rule XI, of the Rules of the House of Representatives and Section 403 of the Congressional Budget Act of 1974, is attached.

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, June 13, 1997.

Hon. JAMES A. LEACH,
*Chairman, Committee on Banking and Financial Services,
House of Representatives, Washington, DC.*

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the enclosed cost estimate for the reconciliation recommendations of the House Committee on Banking and Financial Services.

The estimate shows the budgetary effects of the committee's proposals over the 1998–2002 period, and an attached table shows the effects through 2007. CBO understands that the Committee on the Budget will be responsible for interpreting how these proposals compare with the reconciliation instructions in the budget resolution. This estimate assumes the reconciliation bill will be enacted by August 15, 1997; the estimate could change if the bill is enacted later.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contacts are Susanne S. Mehlman (for the FHA provision), and Carla Pedone (for rental assistance provisions).

Sincerely,

PAUL VAN DE WATER
(For June E. O'Neill, Director).

Enclosure.

Reconciliation recommendations of the House Committee on Banking and Financial Services (Title II)

Summary: This bill would permanently prohibit the Federal Housing Administration (FHA) from providing foreclosure avoidance relief to mortgagors who have defaulted in making payments on FHA-insured single-family mortgages. This bill also would make two changes affecting rent adjustments for section 8 housing. First, it would generally prohibit rent increases for projects assisted under the section 8 new construction and substantial or moderate rehabilitation programs, if their assisted rents exceeded the fair market rent (FMR) established by the Department of Housing and Urban Development (HUD) for that housing area. Another provision in the bill would limit rent increases for units without tenant turnover.

Estimated cost to the Federal Government: CBO estimates that the committee's proposals would reduce direct spending by about \$1.8 billion over the 1998–2002 period. This title also would provide for potential discretionary savings of \$824 million in outlays over the next five years, subject to appropriations action. The estimated budgetary effects of these proposals over the 1998–2002 period are shown in the following table.

ESTIMATED BUDGETARY IMPACT OF THE RECONCILIATION RECOMMENDATIONS OF THE HOUSE
COMMITTEE ON BANKING AND FINANCIAL SERVICES

	By fiscal years in millions of dollars—					
	1997	1998	1999	2000	2001	2002
FHA SINGLE-FAMILY MORTGAGE INSURANCE						
Spending Under Current Law:						
Estimated Budget Authority	-772	-977	-1,226	-1,221	-1,109	-1,095
Estimated Outlays	-772	-977	-1,226	-1,221	-1,109	-1,095
Proposed Changes:						
Estimated Budget Authority	0	-136	-161	-183	-183	-183
Estimated Outlays	0	-136	-161	-183	-183	-183
Spending Under Title II:						
Estimated Budget Authority	-772	-1,113	-1,387	-1,404	-1,292	-1,278
Estimated Outlays	-772	-1,113	-1,387	-1,404	-1,292	-1,278
SECTION 8 RENTAL ASSISTANCE						
Spending Under Current Law: ¹						
Estimated Budget Authority	3,550	10,286	12,295	14,424	16,085	17,641
Estimated Outlays	15,941	16,360	17,025	17,717	18,402	19,121
Proposed Changes:						
Direct Spending:						
Estimated Budget Authority	0	0	0	0	0	0
Estimated Outlays	0	0	-88	-219	-294	-323
Spending Subject to Appropriations:						
Estimated Authorization Level	0	0	-103	-199	-323	-457
Estimated Outlays	0	0	-40	-139	-257	-388
Spending Under Title II:						
Estimated Authorization Level	3,550	10,286	12,192	14,225	15,762	17,184
Estimated Outlays	15,941	16,360	16,897	17,359	17,851	18,410
TOTAL PROPOSED CHANGES IN DIRECT SPENDING						
Estimated Budget Authority	0	-136	-161	-183	-183	-183
Estimated Outlays	0	-136	-249	-402	-477	-506

¹ CBO's baseline with annual adjustments for anticipated inflation.

The effects of this legislation fall within budget functions 600 (income security) and 370 (commerce and housing credit)

Basis of estimate

Elimination of FHA's single-family assignment program

Under current law, FHA's assignment program has been suspended through fiscal year 1997. Section 2002 would permanently eliminate the assignment program, enabling FHA to foreclose quickly on properties that would otherwise enter the assignment program. CBO estimates that more rapid foreclosure would reduce FHA's costs by decreasing the amount of taxes and other expenses that FHA would pay while holding these properties. Early foreclosures also would expedite the receipt of sales revenues that FHA would collect on the affected properties. CBO estimates that 16 percent of all claims from new loan guarantees will eventually enter the assignment program if it continues in place. Based on information provided by FHA. We estimate that eliminating the program would increase FHA's recoveries on such defaults by an average of 30 to 40 percent.

CBO estimates that the decrease in FHA's costs from defaults would reduce direct spending by \$846 million over the next five years. These estimated savings represent the net decrease in subsidy costs of new loan guarantees expected to be made by FHA over the 1998–2002 period. Under current law, FHA guarantees of new

single-family mortgage result in offsetting receipts on the budget because the credit subsidies are estimated to be negative. (That is, guarantee fees for new mortgages more than offset the costs of expected defaults.) Eliminating the assignment program would make such subsidies more negative and the estimated change in those subsidy receipts would be recorded in the years in which new loans are guaranteed. For example, estimated savings for 1998 represent the present value (subsidy) savings of a avoided costs in all future years associated with the new guarantees made in 1998.

Rent adjustment for section 8 housing

Section 8 of the United States Housing Act of 1937 provides for annual adjustments in the maximum rents that owners receive on behalf of assisted tenants. The bill would make permanent, starting in fiscal year 1999, two provisions enacted in the appropriations act for 1997 that eliminate or reduce those adjustment factors for certain units. Because the federal government pays part of the rental costs, CBO estimates that those two provisions combined would save the government \$924 million over the 1998–2002 period on subsidies for existing rental contracts.

Section 2003 would bar rent increases in projects assisted under the section 8 new construction and substantial or moderate rehabilitation programs, if their assisted rents exceed the higher of the local market rents for similar unassisted units or the FMR, which is set by HUD at the 40th percentile of local rents. CBO estimates that this provision would reduce spending for existing contracts by \$773 million over the five-year period. We estimate that this provision would initially affect about three-quarters of all units assisted under these programs. Over time, however, that proportion would decrease by about 4 percent per year, as some of the assisted rents would begin to fall below the market rents or the FMR. In addition, the number of units affected would decline sharply each year as contracts expire. In all, CBO estimates the average number of affected units to decline from about 787,000 in 1999 to 418,000 in 2002.

Section 2004 would reduce by 1 percentage point rent increases for units occupied by the same families at the time of the last annual rent adjustment. (Such families are often referred to as stayers.) This provision would reduce outlays for existing contracts by an estimated \$151 million over the five-year period. CBO estimates that, in a given year, this provision would affect between 80 and 85 percent of assisted units that receive an annual rent adjustment. (The provision would generate no savings from units that would be affected by section 2003.) Because of expiring contracts, the number of affected units is estimated to decline from about 430,000 in 1999 to about 230,000 in 2002.

Savings that would result from the application of these two provisions to future contract renewals would depend on annual appropriation levels and thus would not be considered direct spending. Assuming that all expiring contracts would be renewed, CBO estimates that these two provisions combined would produce savings from future appropriations of \$824 million over the 1998–2002 period.

Intergovernmental and private-sector impact

This bill contains no intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act of 1995, and would not impose any costs on state, local, or tribal governments.

Estimate prepared by: FHA Single Family Mortgage Insurance—Susanne S. Mehlman (226–2860), Rental Assistance Program—Carla Pedone (226–2820)

Estimate approved by: Robert A. Sunshine, Deputy Assistant Director for Budget Analysis.

ESTIMATED BUDGETARY EFFECTS OF TITLE II—RECONCILIATION RECOMMENDATIONS OF THE HOUSE COMMITTEE ON BANKING AND FINANCIAL SERVICES

[In millions of dollars, by fiscal year]

	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	1998-2007 Total
CHANGES IN DIRECT SPENDING											
FHA Single Family Assignment Reform:											
Estimated Budget Authority	-136	-161	-183	-183	-183	-183	-183	-183	-183	-183	-1,761
Estimated Outlays	-136	-161	-183	-183	-183	-183	-183	-183	-183	-183	-1,761
Freeze Rents for High Cost Areas:											
Estimated Budget Authority	0	0	0	0	0	0	0	0	0	0	0
Estimated Outlays	0	-71	-182	-248	-272	-268	-245	-239	-237	-235	-1,996
Reduce Rent Increases for Stayers by J Percentage Point:											
Estimated Budget Authority	0	0	0	0	0	0	0	0	0	0	0
Estimated Outlays	0	-17	-37	-46	-51	-53	-55	-62	-69	-78	-466
Total:											
Estimated Budget Authority	-136	-161	-183	-183	-183	-183	-183	-183	-183	-183	-1,761
Estimated Outlays	-136	-249	-402	-477	-506	-504	-483	-484	-489	-494	-4,224
CHANGES IN SPENDING SUBJECT TO APPROPRIATION											
Freeze Rents for High Cost Areas:											
Estimated Authorization Level	0	-15	-48	-101	-171	-250	-329	-402	-471	-543	-2,330
Estimated Outlays	0	-4	-26	-69	-133	-209	-292	-367	-437	-506	-2,043
Reduce Rent Increases for Stayers by J Percentage Point:											
Estimated Authorization Level	0	-88	-151	-222	-286	-344	-394	-439	-480	-521	-2,925
Estimated Outlays	0	-36	-113	-188	-255	-317	-371	-418	-460	-500	-2,658
Total:											
Estimated Authorization Level	0	-103	-199	-323	-457	-594	-723	-841	-951	-1,064	-5,255
Estimated Outlays	0	-40	-139	-257	-388	-526	-663	-785	-897	-1,006	-4,701

COMMITTEE OVERSIGHT FINDINGS

In compliance with clause 2(1)(3)(A) of rule XI of the Rules of the House of Representatives, the Committee reports that the findings and recommendations of the Committee, based on oversight activities under clause 2(b)(1) of rule X of the Rules of the House of the House of Representatives, are incorporated in the descriptive portions of this report.

COMMITTEE ON GOVERNMENT REFORM AND OVERSIGHT FINDINGS

No findings and recommendations of the Committee on Government Reform and Oversight were received as referred to in clause 2(1)(3)(D) of rule XI and clause 4(c)(2) of rule X of the Rules of the House of Representatives.

ADVISORY COMMITTEE STATEMENT

No advisory committees within the meaning of Section 5(b) of the Federal Advisory Committee Act were created by this legislation.

CONGRESSIONAL ACCOUNTABILITY ACT

The reporting requirement under Section 102(b)(3) of the Congressional Accountability Act (P.L. 104–1) is inapplicable because this legislation does not relate to terms and conditions of employment or access to public services or accommodations

CONGRESSIONAL BUDGET OFFICE FEDERAL MANDATE COST ESTIMATE

The cost estimate pursuant to Section 424 of the Unfunded Mandates Reform Act (P.L. 104–4) is attached.

SECTION-BY-SECTION ANALYSIS

TITLE II—COMMITTEE ON BANKING AND FINANCIAL SERVICES

Section 2001. Table of contents

Section 2002. Extension of foreclosure avoidance and borrower assistance provisions for FHA single family housing mortgage insurance program

This section extends permanently the FHA Assignment Reforms from Section 407 of the Balanced Budget Downpayment Act, I. Section 407 amended Sections 204(a) and 230 of the National Housing Act to authorize HUD to pay mortgagees for undertaking loss mitigation measures, to greatly restrict HUD's ability to accept assignments of mortgages, and to make clear that no law compels HUD either to provide an alternative to foreclosure or to take assignment of mortgages. It reformed the assignment process to achieve cost savings comparable to those achieved in the private sector by working out delinquent loans to avoid foreclosure and minimizing losses to the mortgage insurer.

Section 2003. Adjustment of maximum monthly rents for certain dwelling units in new construction and substantial or moderate rehabilitation projects assisted under section 8 rental assistance program

For FY 1999 and subsequent years, this provision limits the application of the annual adjustment factor (AAF)¹ for Section 8 New Construction, Substantial Rehabilitation, or Moderate Rehabilitation projects where the rents are adjusted using the AAF and the rents are in excess of the fair market rents ("FMRs") for that housing area. For such projects, the Secretary may adjust rents, but only to the extent that the owner demonstrates that the adjusted rent would not exceed the rent for a similar unassisted unit. For FY 1998, it is expected that the HUD appropriations Act will continue this same policy, which has been in effect during FY 1996, FY 1996 prior to April 26, 1996, and FY 1997.

Section 2004. Adjustment of maximum monthly rents for non-turn-over dwelling units assisted under section 8 rental assistance program

For FY 1999 and subsequent fiscal years, this provision reduces the AAF by one percentage point for those Section 8 units in which there has been no turnover since the preceding annual rental adjustment, except that the AAF shall not be reduced to less than 1.0 (so rents will not be reduced because of the one percentage point reduction). For FY 1998, it is expected that the HUD appropriations Act will continue this same policy, which has been in effect during FY 1996, FY 1996 prior to April 26, 1996, and FY 1997.

CHANGES IN EXISTING LAW MADE BY TITLE II OF THE BILL, AS REPORTED

In compliance with clause 3 of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

**SECTION 407 OF THE THE BALANCED BUDGET
DOWNPAYMENT ACT, I**

FHA SINGLE-FAMILY ASSIGNMENT PROGRAM REFORM

SEC. 407. (a) * * *

* * * * *

(c) APPLICABILITY OF AMENDMENTS.—Except as provided in subsection (e), the amendments made by subsections (a) and (b) shall apply [only] with respect to mortgages insured under the National Housing Act that are originated before, *on, or after* October 1, 1995.

* * * * *

[(e) EFFECTIVENESS AND APPLICABILITY.—If this Act is enacted after the date of enactment of the Balanced Budget Act of 1995—

¹ AAFs are used to adjust rents for many Section 8 contracts to reflect increases in rents in the market area.

[(1) subsections (a), (b), (c), and (d) of this section shall not take effect; and

[(2) section 2052(c) of the Balanced Budget Act of 1995 is amended by striking "that are originated on or after October 1, 1995" and inserting in lieu thereof "that are originated before, during, and after fiscal year 1996.".]

This Act may be cited as "The Balanced Budget Downpayment Act, I".

SECTION 8 OF THE UNITED STATES HOUSING ACT

LOWER INCOME HOUSING ASSISTANCE

SEC. 8. (a) * * *

* * * * *

(c)(1) * * *

(2)(A) The assistance contract shall provide for adjustment annually or more frequently in the maximum monthly rents for units covered by the contract to reflect changes in the fair market rentals established in the housing area for similar types and sizes of dwelling units or, if the Secretary determines, on the basis of a reasonable formula. However, where the maximum monthly rent, for a unit in a new construction, substantial rehabilitation, or moderate rehabilitation project, to be adjusted using an annual adjustment factor exceeds the fair market rental for an existing dwelling unit in the market area, the Secretary shall adjust the rent only to the extent that the owner demonstrates that the adjusted rent would not exceed the rent for an unassisted unit of similar quality, type, and age in the same market area, as determined by the Secretary. The immediately foregoing sentence shall be effective only during fiscal year 1995, fiscal year 1996 prior to April 26, 1996, and fiscal year 1997, and during fiscal year 1999 and thereafter. Except for assistance under the certificate program, for any unit occupied by the same family at the time of the last annual rental adjustment, where the assistance contract provides for the adjustment of the maximum monthly rent by applying an annual adjustment factor and where the rent for a unit is otherwise eligible for an adjustment based on the full amount of the factor, 0.01 shall be subtracted from the amount of the factor, except that the factor shall not be reduced to less than 1.0. In the case of assistance under the certificate program, 0.01 shall be subtracted from the amount of the annual adjustment factor (except that the factor shall not be reduced to less than 1.0), and the adjusted rent shall not exceed the rent for a comparable unassisted unit of similar quality, type, and age in the market area. The immediately foregoing two sentences shall be effective only during fiscal year 1995, fiscal year 1996 prior to April 26, 1996, and fiscal year 1997, and during fiscal year 1999 and thereafter.

* * * * *

HOUSE OF REPRESENTATIVE,
COMMITTEE ON COMMERCE
Washington, DC, June 17, 1997.

Hon. JOHN R. KASICH,
Chairman, Committee on the Budget, Washington, DC

DEAR MR. CHAIRMAN: I am transmitting herewith the recommendations of the Committee on Commerce for changes in Non-Medicare laws within its jurisdiction, pursuant to the provisions of section 310 of the Congressional Budget Act of 1974 and H. Con. Res. 84, the Concurrent Resolution of the Budget—Fiscal Years 1998–2002.

The enclosed recommendations were embodied in a series of Committee Prints adopted by the Committee on June 11 and 12, 1997. Pursuant to your instructions, the legislative language of these Committee Prints has been incorporated into title III as follows:

Title III—Committee on Commerce—NonMedicare: Subtitle A: Nuclear Regulatory Commission Annual Charges; Subtitle B: Lease of Excess Strategic Petroleum Reserve, Capacity; Subtitle C: Sale of DOE Assets; Subtitle D: Communications; Subtitle E: Medicaid; and Subtitle F. Child Health Assistance Program.

Enclosed is the legislative language for Title III, the accompanying report language, and a Ramsayer submission for Subtitles A through D. I have been informed that the Legislative Counsel's Office has made arrangements with your staff to submit the Ramsayer language for Subtitles E and F directly to the Budget Committee to expedite your Committee's action.

The Committee's recommendations for title IV—Committee on Commerce—Medicare will be transmitted to your office separately.

If you have any questions concerning the Committee's recommendations, if I can be of any further assistance to you as you proceed with your Committee's deliberations, please do not hesitate to contact me.

Sincerely,

TOM BLILEY, *Chairman.*

Enclosures.

TITLE III—COMMITTEE ON COMMERCE—NONMEDICARE

SUBTITLE A—NUCLEAR REGULATORY COMMISSION ANNUAL CHARGES

PURPOSE AND SUMMARY

Subtitle A extends the Nuclear Regulatory Commission's (NRC's) authority to collect up to 100 percent of its budget from user fees through Fiscal Year 2002.

BACKGROUND AND NEED FOR LEGISLATION

Millions of Americans, on a daily basis, benefit from use of radioactive materials, from the electricity produced by nuclear reactors to the widespread use of nuclear materials in medical and industrial applications. The NRC is responsible for ensuring the safety of civilian uses of nuclear materials, and the independence and integrity of this agency is essential to maintaining public confidence in the use of such materials. Thus, a reliable stream of long-term funding is vital to assuring the uninterrupted operation of this important organization.

The NRC budget is paid for entirely through user fees and annual charges on its licensees, except for work on the high-level nuclear waste repository which is paid for through the Nuclear Waste Fund. User fees are an equitable way of paying for the cost of Federal regulation. By collecting user fees, those who use an agency's resources pay the costs of funding that agency. Those who use the greatest amount of the agency's resources are required to pay the greatest annual fees. In the case of the NRC, nuclear licensees pay for the cost of Federal regulation and then pass that cost on to their customers. The result is an equitable one: those who do not buy electricity or products utilizing nuclear materials do not bear the costs associated with regulating them.

Section 6101 of the Omnibus Budget Reconciliation Act of 1990 (P.L. 101-508) requires the Nuclear Regulatory Commission to collect annual charges from its licensees to provide offsetting collections to pay for its programs. Specifically, section 6101 allows the NRC to collect amounts which, when added to other amounts collected by the NRC (such as fees collected under the Independent Offices Appropriation Act of 1952, 31 U.S.C. 9701), equals 100 percent. However, current law only provides authority to collect fees and annual charges equal to 100 percent of the budget through Fiscal Year 1998. After that time, absent an extension, NRC's permanent authority to collect 33 percent of its budget through fees and annual charges, as provided by Section 7601 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272), would take effect.

Currently, the NRC budget is made up of money collected through three different methodologies. First, the NRC receives appropriations from the Nuclear Waste Fund established under section 302(c) of the Nuclear Waste Policy Act of 1982 (42 U.S.C. 10222(c)) for licensing the Department of Energy's nuclear waste management program. Charges for these activities are not recovered through annual charges because nuclear utilities pay for the cost of these activities through their payments to the Nuclear Waste Fund. Thus, recovery of Nuclear Waste Fund appropriations through the annual charge would constitute double payment by utilities. Second, the NRC recovers a portion of its budget through fees assessed on licensees under the Independent Offices Appropriation Act of 1952 (31 U.S.C. 9701). This Act provides that anyone receiving a service or a thing of value from the NRC shall pay the NRC's cost of providing that service or thing of value. The purpose of this provision is to recover the costs of providing individually identifiable services to applicants and holders of NRC licenses from the recipients of those services. The third collection methodology involves the recovery of annual charges for generic NRC activities that benefit all licensees.

Subtitle A extends NRC's authority to collect up to 100 percent of its budget through user fees and annual charges through Fiscal Year 2002. This extension will generate revenues in amounts sufficient to offset expenditures by the NRC. The NRC is charged by the Omnibus Budget Reconciliation Act of 1990 to assess these charges under the principle that licensees who require the greatest expenditures of the NRC's resources should pay the greatest annual charge. Section 3001 of Subtitle A does not alter, in any way, the fee structure as currently administered by the NRC.

HEARINGS

The Committee's Subcommittee on Energy and Power has not held hearings on Subtitle A. In the 104th Congress, the Subcommittee on Energy and Power did hold a general oversight hearing on the Nuclear Regulatory Commission on September 5, 1996.

COMMITTEE CONSIDERATION

On June 5, 1997, the Subcommittee on Energy and Power met in open session and approved for Full Committee consideration a Committee Print entitled "Title III, Subtitle A—Nuclear Regulatory Commission Annual Charges," without amendment, by a voice vote. On June 11, 1997, the Committee met in open session and ordered a Committee Print entitled "Title III, Subtitle A—Nuclear Regulatory Commission Annual Charges" transmitted to the House Committee on the Budget, without amendment, for inclusion in the 1997 Omnibus Budget Reconciliation Act by a voice vote, a quorum being present.

ROLL CALL VOTES

Clause 2(1)(2)(B) of rule XI of the Rules of the House of Representatives requires the Committee to list the recorded votes on the motion to report legislation and amendments thereto. There were no recorded votes taken in connection with ordering Subtitle

A transmitted to the House Committee on the Budget. A motion by Mr. Bliley to order Subtitle A transmitted to the House Committee on the Budget, without amendment, for inclusion in the 1997 Omnibus Budget Reconciliation Act was agreed to by a voice vote, a quorum being present.

COMMITTEE OVERSIGHT FINDINGS

Pursuant to clause 2(l)(3)(A) of rule XI of the Rules of the House of Representatives, the Committee has not held oversight or legislative hearings on this Subtitle.

COMMITTEE ON GOVERNMENT REFORM AND OVERSIGHT

Pursuant to clause 2(l)(3)(D) of rule XI of the Rules of the House of Representatives, no oversight findings have been submitted to the Committee by the Committee on Government Reform and Oversight.

COMMITTEE COST ESTIMATE

In compliance with clause 7(a) of rule XIII of the Rules of the House of Representatives, the Committee believes that enactment of Subtitle A would result in no additional costs to the Federal government.

CONGRESSIONAL BUDGET OFFICE ESTIMATE

Pursuant to clause 2(l)(3)(C) of rule XI of the Rules of the House of Representatives, a letter from the Congressional Budget Office providing a cost estimate for all six subtitles of Title III is found at the conclusion of the report on this Title of the bill.

FEDERAL MANDATES STATEMENT

The Committee adopts as its own the estimate of Federal mandates prepared by the Director of the Congressional Budget Office pursuant to section 423 of the Unfunded Mandates Reform Act.

ADVISORY COMMITTEE STATEMENT

No advisory committees within the meaning of section 5(b) of the Federal Advisory Committee Act were created by this Subtitle.

CONSTITUTIONAL AUTHORITY STATEMENT

Pursuant to clause 2(l)(4) of rule XI of the Rules of the House of Representatives, the Committee finds that the Constitutional authority for this legislation is provided in Article I, section 8, clause 3, which grants Congress the power to regulate commerce with foreign nations, among the several States, and with the Indian tribes.

SECTION-BY-SECTION ANALYSIS OF THE LEGISLATION

Section 3001 of Subtitle A amends section 6101(a)(3) of the Omnibus Budget Reconciliation Act of 1990 to extend the current authority to collect annual charges and user fees which pay for the budget of the NRC from September 30, 1998, to September 30, 2002.

CHANGES IN EXISTING LAW MADE BY SUBTITLE A

The changes in existing law made by Subtitle A are included at the conclusion of the report on this Title of the bill.

SUBTITLE B—LEASE OF EXCESS STRATEGIC PETROLEUM RESERVE
CAPACITY

PURPOSE AND SUMMARY

Subtitle B gives the Department of Energy the authority to lease to foreign countries space in the Strategic Petroleum Reserve that is not currently being used by the United States.

BACKGROUND AND NEED FOR LEGISLATION

The Energy Policy and Conservation Act (EPCA), as amended, authorized the Department of Energy (DOE) to build and maintain a one billion barrel Strategic Petroleum Reserve (SPR or Reserve) to protect the U.S. in an energy emergency and to comply with U.S. obligations under the International Energy Agreement (IEA). Today, the SPR is capable of storing up to 680 million barrels of oil at four sites in Louisiana and Texas. (The closure of the Weeks Island, Louisiana site reduced Reserve capacity by approximately 70 million barrels; from a maximum capacity of 750 million barrels to today's 680 million barrels.) In addition, after three oil sales of a total of 28 million barrels in FY 96 and FY 97 to raise revenues, approximately only 563 million barrels of oil are stored in the Reserve today.

In light of current budgetary constraints, it is unlikely that any new oil will be purchased for storage in the Reserve for the foreseeable future. Thus, Subtitle B would allow DOE to lease the excess storage capacity of the Reserve (approximately 110 million barrels) to foreign governments or their agents. U.S. allies, like South Korea and Japan, have expressed an interest in leasing such space in order to meet their obligations under the IEA. (The IEA requires its member nations to maintain oil reserves equal to a 90 days supply of that country's net imports.) This leasing option may prove very attractive to some of these countries because the United States has some of the lowest costs of building and maintaining strategic oil reserves. For example, it costs Japan approximately \$50 per barrel to create oil storage space and five dollars a barrel annually to store oil in that space. In contrast, it is estimated that creating new SPR capacity in the U.S. would cost about \$9 per barrel. In addition, it costs the U.S. about 30 cents per barrel to operate and maintain the oil currently stored in the Reserve. It has been estimated that the U.S. could receive as much as \$1.20 per barrel annually if such leasing is authorized.

Importantly, Subtitle B requires that the fee for allowing such leasing must fully compensate the U.S. for the costs of storage and removal of such oil and the cost of any replacement facilities necessitated by the removal of such oil. Subtitle B also requires that such storage not affect the ability of the U.S. to withdraw its own oil in an energy emergency or to meet its IEA obligations. Finally, Subtitle B provides that funds collected pursuant to this section

after September 30, 2002, shall be used to purchase oil for, or operate and maintain the Reserve.

HEARINGS

The Committee's Subcommittee on Energy and Power did not hold hearings on Subtitle B.

COMMITTEE CONSIDERATION

On June 5, 1997, the Subcommittee on Energy and Power met in open session and approved for Full Committee consideration a Committee Print entitled "Title III, Subtitle B—Lease of Excess Strategic Petroleum Reserve Capacity," without amendment, by a voice vote. On June 11, 1997, the Committee met in open session and ordered a Committee Print entitled "Title III, Subtitle B—Lease of Excess Strategic Petroleum Reserve Capacity" transmitted to the House Committee on the Budget, without amendment, for inclusion in the 1997 Omnibus Budget Reconciliation Act, by a voice vote, a quorum being present.

ROLL CALL VOTES

Clause 2(1)(2)(B) of rule XI of the Rules of the House of Representatives requires the Committee to list the recorded votes on the motion to report legislation and amendments thereto. There were no recorded votes taken in connection with ordering Subtitle B transmitted to the House Committee on the Budget. A motion by Mr. Bliley to order Subtitle B transmitted to the House Committee on the Budget, without amendment, for inclusion in the 1997 Omnibus Budget Reconciliation Act was agreed to by a voice vote, a quorum being present.

COMMITTEE OVERSIGHT FINDINGS

Pursuant to clause 2(1)(3)(A) of rule XI of the Rules of the House of Representatives, the Committee has not held oversight or legislative hearings on this Subtitle.

COMMITTEE ON GOVERNMENT REFORM AND OVERSIGHT

Pursuant to clause 2(1)(3)(D) of rule XI of the Rules of the House of Representatives, no oversight findings have been submitted to the Committee by the Committee on Government Reform and Oversight.

COMMITTEE COST ESTIMATE

In compliance with clause 7(a) of rule XIII of the Rules of the House of Representatives, the Committee believes that enactment of Subtitle B would result in no additional costs to the Federal government.

CONGRESSIONAL BUDGET OFFICE ESTIMATE

Pursuant to clause 2(1)(3)(C) of rule XI of the Rules of the House of Representatives, a letter from the Congressional Budget Office

providing a cost estimate for all six subtitles of Title III is found at the conclusion of the report on this Title of the bill.

FEDERAL MANDATES STATEMENT

The Committee adopts as its own the estimate of Federal mandates prepared by the Director of the Congressional Budget Office pursuant to section 423 of the Unfunded Mandates Reform Act.

ADVISORY COMMITTEE STATEMENT

No advisory committees within the meaning of section 5(b) of the Federal Advisory Committee Act were created by this legislation.

CONSTITUTIONAL AUTHORITY STATEMENT

Pursuant to clause 2(1)(4) of rule XI of the Rules of the House of Representatives, the Committee finds that the Constitutional authority for this legislation is provided in Article I, section 8, clause 3, which grants Congress the power to regulate commerce with foreign nations, among the several States, and with the Indian tribes.

SECTION-BY-SECTION ANALYSIS OF THE LEGISLATION

Subtitle B adds a new section 168 to Part B of Title I of the Energy Policy and Conservation Act.

Subsection (a) of Subtitle B makes the following amendments to Part B of Title I of EPCA:

Section 168(a) provides DOE with the authority to lease underutilized SPR facilities to foreign governments or their representatives. This section also provides that petroleum products stored under this part are not part of the SPR and may be exported from the U.S. without a license.

Section 168(b) requires that the price received for the leasing of these underutilized facilities must fully compensate the U.S. for petroleum removal and storage costs, as well as the cost of building replacement facilities necessitated as a result of withdrawals of any such oil.

Section 168(c) provides that any agreements entered into pursuant to this provision may not impair the ability of the U.S. to withdraw, distribute, or sell its own petroleum from the SPR in response to an energy emergency or to comply with obligations of the U.S. under the IEA.

Section 168(d) provides that after September 30, 2002, any funds collected from the leasing of underutilized SPR facilities shall be used by the Secretary of Energy for the purchase of oil for, and operation and maintenance costs, of the Strategic Petroleum Reserve.

Subsection (b) of Subtitle B provides for conforming changes to be made to the table of contents of EPCA.

CHANGES IN EXISTING LAW MADE BY SUBTITLE B

The changes in existing law made by Subtitle B are included at the conclusion of the report on this Title of the bill.

SUBTITLE C—SALE OF DOE ASSETS

PURPOSE AND SUMMARY

Subtitle C directs the Department of Energy (DOE) to sell 3.2 million pounds of surplus natural and low-enriched uranium per year during the period Fiscal Year 1999 through Fiscal Year 2002 at not less than fair market value, subject to a determination that such sale or sales would not have an adverse material impact on the domestic uranium mining, conversion, or enrichment industry.

BACKGROUND AND NEED FOR LEGISLATION

The Department of Energy owns substantial amounts of natural and low-enriched uranium that have substantial commercial value. The Department has declared about 21.5 million pounds of natural uranium equivalent to be surplus. This surplus uranium is stored at the Department's gaseous diffusion plants in Paducah, Kentucky, and Portsmouth, Ohio.

Selling this material in an orderly manner would allow the beneficial use of an asset that is no longer needed by the Federal government. In addition, sale of these surplus assets would relieve the Department of the storage costs and other liabilities associated with long-term storage of this material. Further, revenue from the sale of surplus uranium assets would benefit the taxpayers by producing savings that help balance the Federal budget.

Congress authorized the Department to sell surplus uranium from its inventory in the USEC Privatization Act of 1996 (Public Law 104-134) as long as certain conditions are met. Section 3112(d) of the Act provides that "no sale or transfer of natural or low-enriched uranium shall be made unless—(A) the President determines that the material is not necessary for national security needs, (B) the Secretary determines that the sale of the material will not have an adverse material impact on the domestic uranium mining, conversion, or enrichment industry, taking into account the sales of uranium under the Russian HEU Agreement and the Suspension Agreement, and (C) the price paid to the Secretary will not be less than the fair market value of the material."

The conditions contained in the USEC Privatization Act are intended to protect various interests; first, the national security interest, since the President must determine that the material is not necessary for national security needs before a sale can take place; second, assuring that sales do not have an adverse material impact on the domestic uranium industry, since a precondition for any sale is a determination by the Secretary that sale of the material would not have an adverse material impact on the domestic mining, conversion, and enrichment industry; and third, the taxpayer interest, by requiring that the price paid to the Secretary will not be less than the fair market value of the material.

Proposals to sell surplus uranium are not new. The USEC Privatization Act of 1996 permitted DOE to sell surplus uranium subject to certain conditions, and the Department has taken steps to sell 3.2 million pounds of uranium in Fiscal Year 1997. In January 1997, the Secretary issued a finding that sales at that level would not have an adverse material impact on the domestic uranium in-

dustry, and DOE is proceeding with that sale. In addition, the Fiscal Year 1997 Energy and Water Development Appropriations Act of 1996 (Public Law 104-206) provided that "revenues received from the Department for uranium programs [including sales of uranium] and estimated to total \$42,200,000 in fiscal year 1997, shall be retained and used for the specific purpose of offsetting costs incurred by the Department for such activities, notwithstanding the provisions of 31 U.S.C. 3302(b) and 42 U.S.C. 2296(b)(2)." Further, the President has proposed selling larger amounts of surplus uranium through 2002.

Subtitle C directs the Department of Energy (DOE) to sell 3.2 million pounds of surplus natural and low-enriched uranium per year during the period Fiscal Year 1999 through Fiscal Year 2002 at not less than fair market value, subject to a determination that such sale or sales would not have an adverse material impact on the domestic uranium mining, conversion, or enrichment industry.

Subtitle C is consistent with the USEC Privatization Act. First, only those materials already determined by the President to be surplus can be sold by the Department under Subtitle C. This determination was made through a process involving the President's Nuclear Weapons Council and the Department of Energy, resulting in a finding that the Department has 21.5 million pounds of surplus natural and low-enriched uranium. Second, the Secretary must make the same determination as required by section 3112(d)(2)(B) of the USEC Privatization Act before any sales can take place. Third, Subtitle C requires that sales be "made at a price not less than the fair market value of the uranium and in a manner that maximizes proceeds to the Treasury." Uranium is a commodity whose market price is well-established.

Subtitle C directs the Secretary to make a single determination under section 3112(d)(2)(B) of the USEC Privatization Act of 1996 for the period Fiscal Year 1999 through Fiscal Year 2002. This permits the Department to engage in spot sales, short-term sales, long-term sales, or any combination of the above, as long as sales are "made at a price not less than the fair market value of the uranium and in a manner that maximizes proceeds to the Treasury." A determination that covers the period Fiscal Year 1999 through Fiscal Year 2002 permits the Department to engage in advance sales for delivery in future years. It is believed that advance sales will provide greater stability for uranium prices, while spot sales may exacerbate the volatility of spot market prices.

The Committee expects the Department will exercise this discretion in a manner that maximizes proceeds to the Treasury. For example, if the Department can maximize proceeds by engaging in long-term sales compared to other alternatives, the Committee expects the agency will favor long-term sales over spot market and short-term sales. Moreover, sales of surplus uranium under Subtitle C are not required until Fiscal Year 1999, which enables the Department to time future sales to obtain the best price over the period Fiscal Year 1999 through Fiscal Year 2002.

Importantly, sales of surplus uranium under Subtitle C are much less than the levels proposed by the Administration. The President proposed selling up to \$100 million in surplus uranium per year during Fiscal Years 1998 through 2001, and \$200 million in Fiscal

Year 2002. By contrast, sales under Subtitle C are expected to generate about \$45 million per year in revenue. Sales at the level proposed by the President and considered by the Department may not only have an adverse material impact on the uranium mining, conversion, and enrichment industry, but also significantly lower uranium prices and fail to maximize proceeds to the Treasury from sales.

In addition, Subtitle C provides for sale of only a portion of DOE's surplus uranium. The President has declared 21.5 million pounds of natural uranium equivalent to be surplus, but Subtitle C provides for sales of roughly half of this existing surplus. The Department retains its authority to sell additional amounts of surplus uranium under the USEC Privatization Act, as long as such sales are consistent with section 3112(d) of that Act.

Analysis by the Department of Energy indicated sales of 3.2 million pounds in 1997 will have an immaterial impact on domestic uranium prices, reducing projected prices by less than one percent. In addition, the Department estimated a 3.2 million pound sale would reduce production by about 1.2 percent. Significantly, both these fluctuations are well within the yearly fluctuations in price and production experienced by the domestic uranium mining industry and are not expected to adversely affect domestic uranium products. Sales at higher levels—such as proposed by the President and under consideration by the Department—may have a significant adverse impact on uranium prices. The Department has indicated it will mitigate the impact of sales on the uranium conversion industry through selling the uranium conversion component separate from the natural uranium component. The Department projects there will be no adverse material impact on the domestic uranium enrichment industry from sales of surplus natural uranium.

Sales under Subtitle C are limited to 12.8 million pounds of the 21.5 million pounds determined by the President to be no longer needed for national security needs. Subtitle C does not direct the Department to sell any material derived from Russian highly-enriched uranium under the Russian HEU Agreement, the Suspension Agreement, and the terms of the USEC Privatization Act of 1996. Disposition of highly-enriched uranium received from Russia will continue to be governed by the Russian HEU Agreement, the Suspension Agreement, and the USEC Privatization Act.

The Committee observes that the sale of surplus uranium assets is a very different situation than that presented by the sale of Conrail or the Naval Petroleum Reserves. These instances involved sales of enterprises operated by the Federal government, not the sale of surplus assets no longer needed to discharge the missions of the Department. The Department has only two options with respect to surplus uranium: (1) continue to store and maintain surplus uranium at the expense of taxpayers; or (2) sell these surplus assets at a fair market price and in a manner that maximizes the proceeds to the Treasury. Subtitle C directs the Department to pursue the latter course of action.

The valuation of surplus uranium is not a difficult matter, since it is a commodity with well-established prices. By contrast, there were great difficulties determining the value of Conrail and the

Naval Petroleum Reserves. For that reason, the taxpayer protections are different. Subtitle C bars sales of surplus uranium at less than fair market value. This protects the taxpayer interest, because the fair market value of uranium can be easily determined. The taxpayer protections for the sale of the Naval Petroleum Reserves were different because the value of the Naval Petroleum Reserves was much more difficult to determine.

HEARINGS

The Committee's Subcommittee on Energy and Power did not hold hearings on Subtitle C. The Subcommittee held hearings on Privatization of the United States Enrichment Corporation on February 24, 1995.

COMMITTEE CONSIDERATION

On June 5, 1997, the Subcommittee on Energy and Power met in open session and approved for Full Committee consideration a Committee Print entitled "Title III, Subtitle C—Sale of DOE Assets," without amendment, by a voice vote. On June 11, 1997, the Committee met in open session and ordered Subtitle C transmitted to the House Committee on the Budget, as amended, for inclusion in the 1997 Omnibus Budget Reconciliation Act, by a voice vote, a quorum being present.

ROLL CALL VOTES

Clause 2(1)(2)(B) of rule XI of the Rules of the House of Representatives requires the Committee to list the recorded votes on the motion to report legislation and amendments thereto. There were no recorded votes taken in connection with ordering Subtitle C transmitted to the House Committee on the Budget. A motion by Mr. Bliley to order Subtitle C transmitted to the House Committee on the Budget, as amended, for inclusion in the 1997 Omnibus Budget Reconciliation Act was agreed to by a voice vote, a quorum being present. The roll call vote and voice votes on amendments for Subtitle C, including the names of those Members voting for and against, are as follows:

**COMMITTEE ON COMMERCE -- 105TH CONGRESS
ROLL CALL VOTE #5**

BILL: Committee Print entitled "Title III, Subtitle C - Sale of DOE Assets"

AMENDMENT: Amendment to the Schaefer Amendment in the Nature of a Substitute by Mr. Dingell re: add additional restrictions on the sale of surplus uranium.

DISPOSITION: NOT AGREED TO, by a roll call vote of 21 yeas to 25 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Bliley		X		Mr. Dingell	X		
Mr. Tauzin		X		Mr. Waxman	X		
Mr. Oxley		X		Mr. Markey	X		
Mr. Bilirakis		X		Mr. Hall	X		
Mr. Schaefer		X		Mr. Boucher	X		
Mr. Barton		X		Mr. Manton	X		
Mr. Hastert				Mr. Towns			
Mr. Upton		X		Mr. Pallone	X		
Mr. Stearns		X		Mr. Brown	X		
Mr. Paxon				Mr. Gordon	X		
Mr. Gillmor		X		Ms. Furse	X		
Mr. Klug		X		Mr. Deutsch	X		
Mr. Greenwood		X		Mr. Rush	X		
Mr. Crapo		X		Ms. Eshoo	X		
Mr. Cox		X		Mr. Klink	X		
Mr. Deal		X		Mr. Stupak	X		
Mr. Largent		X		Mr. Engel			
Mr. Burr		X		Mr. Sawyer	X		
Mr. Bilbray		X		Mr. Wynn	X		
Mr. Whitfield		X		Mr. Green	X		
Mr. Ganske		X		Ms. McCarthy	X		
Mr. Norwood		X		Mr. Strickland	X		
Mr. White				Ms. DeGette	X		
Mr. Coburn		X					
Mr. Lazio		X					
Mrs. Cubin		X					
Mr. Rogan		X					
Mr. Shimkus		X					

6/11/97

COMMITTEE ON COMMERCE—105TH CONGRESS VOICE
VOTES, 6/11/97

Bill: Committee Print entitled “Title III, Subtitle C—Sale of DOE Assets”

Amendment: Amendment in the Nature of a Substitute by Mr. Schaefer re: narrow the sale requirement to sales of natural and low-enriched uranium deemed surplus by the Department of Energy.

Disposition: Agreed to, by a voice vote.

Motion: Motion by Mr. Bliley to order the Committee Print entitled “Title III, Subtitle C—Sale of DOE Assets”, amended, transmitted to the Committee on the Budget for inclusion in the 1997 Omnibus Budget Reconciliation Act.

Disposition: Agreed to, by a voice vote.

COMMITTEE OVERSIGHT FINDINGS

Pursuant to clause 2(1)(3)(A) of rule XI of the Rules of the House of Representatives, the Committee has not held oversight or legislative hearings on this Subtitle.

COMMITTEE ON GOVERNMENT REFORM AND OVERSIGHT

Pursuant to clause 2(1)(3)(D) of rule XI of the Rules of the House of Representatives, no oversight findings have been submitted to the Committee by the Committee on Government Reform and Oversight.

COMMITTEE COST ESTIMATE

In compliance with clause 7(a) of rule XIII of the Rules of the House of Representatives, the Committee believes that enactment of Subtitle C would result in no additional costs to the Federal government.

CONGRESSIONAL BUDGET OFFICE ESTIMATE

Pursuant to clause 2(1)(3)(C) of rule XI of the Rules of the House of Representatives, a letter from the Congressional Budget Office providing a cost estimate for all six subtitles of Title III is attached.

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, June 16, 1997.

Hon. TOM BLILEY,
*Chairman, Committee on Commerce,
House of Representatives, Washington, DC.*

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the enclosed cost estimate for the non-Medicare reconciliation recommendations of the House Committee on Commerce (Title III). The estimate for the committee’s recommendations for Medicare (Title IV) is being provided under separate cover.

The estimate includes a summary table that shows the budgetary effects of the committee’s proposals over the 1998–2002 period, and additional, more detailed tables of estimated effects

through 2007. CBO understands that the Committee on the Budget will be responsible for interpreting how these proposals compare with the reconciliation instructions in the budget resolution. This estimate assumes the reconciliation bill will be enacted by August 15, 1997; the estimate could change if the bill is enacted later.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contacts are listed at the end of the estimate.

Sincerely,

JUNE E. O'NEILL, *Director.*

Enclosure.

Non-Medicare Reconciliation Recommendations of the House Committee on Commerce (Title III)

Summary: Title III contains five subtitles aimed at providing budgetary savings from federal energy programs, auctions of licenses for use of portions of the electromagnetic spectrum, and Medicaid. A sixth subtitle would provide for increased direct spending by funding a child health care initiative. CBO estimates that enacting the provisions of Title III would produce net budgetary savings totaling \$6.9 billion over the 1998–2002 period.

By extending the Nuclear Regulatory Commission's (NRC's) authority to collect fees from utilities. Subtitle A would impose an intergovernmental and private-sector mandate as defined by the unfunded Mandates Reform Act of 1995 (UMRA). This provision would not impose costs above the threshold established in that law for intergovernmental mandates (\$50 million in 1996, adjusted for inflation). CBO cannot determine whether the direct costs of this provision would exceed the annual threshold for private-sector mandates (\$100 million in 1996, adjusted for inflation), because UMRA is unclear as to how to define the direct cost associated with extending an existing mandate that has not yet expired. Depending on how they are measured, the direct costs to the private sector could exceed the threshold. Other subtitles of Title III contain provisions that, while not mandates as defined in UMRA, would have significant impacts on the budgets of state, local, and tribal governments.

Description of major provisions: Subtitle A would extend through 2002 the NRC's authority to charge fees to offset 100 percent of its general fund appropriation.

Subtitle B would revise the terms under which the Department of Energy (DOE) could lease excess capacity of the Strategic Petroleum Reserve (SPR) to foreign governments and would direct the department to spend any income derived from leasing after fiscal year 2002 on SPR-related activities without further appropriation. The fees charged for storage would have to fully compensate the United States for all of the costs associated with storing and removing the oil, including the cost of replacement facilities, if necessitated by the leasing activity.

Subtitle C would direct DOE to sell specified amounts of natural and low enriched uranium that have been declared surplus to national security needs. DOE would be required to sell 3.2 million pounds during each of the fiscal years 1999 through 2002, subject to certain conditions. In particular, before selling the uranium,

DOE would have to determine that selling the specified amounts over the 1999–2002 period would satisfy existing statutory criteria regarding the sale of such materials from DOE's stockpiles, and proceeds from the sales would have to be collected and deposited in the general fund of the Treasury between 1999 and 2002.

Subtitle D contains several provisions relating to assignment of licenses for using the electromagnetic spectrum. It would instruct the Federal Communications Commission (FCC) to use competitive bidding to assign licenses for most mutually exclusive applications of the electromagnetic spectrum and it would extend the FCC's authority to conduct such auctions through fiscal year 2002. Under current law, that authority expires at the end of fiscal year 1998. The subtitle also would amend current law by broadening the commission's authority to use competitive bidding to assign licenses. Current law restricts the use of competitive bidding to those mutually exclusive applications in which the licensee would receive compensation from subscribers to a communications service.

In addition, Subtitle D would require the FCC and the Department of Commerce, through the National Telecommunications and Information Administration (NTIA), to make available blocks of spectrum for allocation for commercial use and to assign the rights to use those blocks by competitive bidding, if the FCC determines that various specified conditions are met for each of the blocks of spectrum identified in the subtitle. The additional licenses that could be assigned by competitive bidding would grant the right to use 100 megahertz (MHz) of spectrum located below 3 gigahertz (GHz) currently under the FCC's jurisdiction and an additional 20 MHz also below 3 GHz to be identified by the NTIA and transferred to the FCC's jurisdiction.

Under current law, a part of the spectrum currently reserved for television broadcasting will become available for reallocation as broadcasters comply (over the next several years) with the FCC's direction to adopt digital television broadcasting technology to replace the current analog technology. This subtitle would make available for licensing and assignment by competitive bidding certain frequencies that are currently allocated for analog television broadcasting, including a part of the spectrum between 746 MHz and 806 MHz (frequencies currently allocated for primary use by ultra high frequency television broadcasting on channels 60 through 69).

The requirement that the commission use competitive bidding to assign the rights to use the frequencies noted in Subtitle D would be conditional. In all cases, the FCC would be directed to refrain from using competitive bidding unless it determines that license sales granting the use of various frequencies will meet specified dollar targets for aggregate winning bids. In addition, the commission would be authorized to void the results of any auctions that take place but fail to meet targets for aggregate winning bids. Moreover, the commission could choose to delay assignment of licenses by competitive bidding if it determines that conducting auctions at a later date "will better attain the objectives of recovering for the public a fair portion of the value of the public spectrum resource and avoiding unjust enrichment." Finally, for the frequencies between 746 MHz and 806 MHz, the FCC would not be

permitted to make allocations and assign licenses by auction unless each qualifying low-power television station (as defined in the title) is assigned a frequency below 746 MHz to continue its operation.

Subtitle E would reduce federal payments for disproportionate share hospitals (DSH). Except for states whose DSH spending in 1995 was under 1 percent of medical assistance spending, state allotments would depend on whether a state was designated as a high- or low-DSH state in 1997. For high-DSH states, allotments would equal each state's 1995 DSH spending reduced by 2 percent in 1998, with larger reductions in later years, reaching 40 percent in 2002. For low-DSH states, the state allotment would equal the state's 1995 spending reduced by half of the percentage reduction applied to high-DSH states.

This subtitle also includes provisions giving states greater flexibility in how they administer their Medicaid programs. The Boren amendment, which requires states to reimburse hospitals and nursing homes at "reasonable and adequate" rates, would be repealed. States would also have greater leeway to implement managed care programs, expand eligibility, change benefits, and meet federal requirements for administrative activities.

Subtitle F establishes a Child Health Assistance Program that would provide matching grants to states for the provision of child health care assistance to uninsured, low-income children. The money would be allocated on the basis of participating states' shares of the total number of uninsured children, adjusted for the average cost of health care. The state matching requirement would be 20 percent. States would have substantial discretion in how to spend these funds, and could use them to purchase health insurance coverage from group plans, arrange for health care services directly through providers, expand their Medicaid programs, or use other approved methods.

Estimated cost to the Federal Government: CBO estimates that the provisions of Title III would reduce direct spending by \$6.7 billion over the next five years. That estimated impact would come from enacting Subtitles B, D, E, and F. In addition, we estimate that enacting Subtitle C would yield \$184 million in asset sale proceeds over the same period. Gross budgetary savings would total \$24.5 billion over the 1998–2002 period, but that amount would be partially offset by new direct spending, primarily under Subtitle F, totaling \$17.6 billion over the same period. Enacting Subtitle A would, by itself, have no budgetary impact relative to the budget resolution baseline.

Table 1 summarizes the estimated budgetary impact of Title III over the 1998–2002 period. More detailed tables showing estimated budgetary effects through 2007 appear at the end of this estimate. Table 2 summarizes the 10-year budgetary effects by subtitle. Table 3 displays detailed estimates for Subtitle D (Communications), while Table 4 presents detailed estimates for Subtitle E (Medicaid).

The budgetary effects of this legislation fall within budget functions 270 (energy), 370 (commerce and housing credit), 550 (health), and 950 (undistributed offsetting receipts).

Basis of estimate:

NUCLEAR REGULATORY COMMISSION ANNUAL CHARGES (SUBTITLE A)

This provision would extend through 2002 the NRC's authority to charge fees to offset 100 percent of its general fund appropriation. Under current law, after 1998 the NRC would be authorized to set fees on the industries it regulates sufficient to cover only 33 percent of its budget. Because the amount of fees collected under this provision would be determined by the size of the NRC's general fund appropriation, this provision would not affect direct spending.

Assuming future appropriations for the NRC continue at the 1997 level adjusted for inflation, enactment of this provision would increase offsetting collections by an average of about \$340 million annually over the 1999–2002 period. Under rules for projecting discretionary spending established in the Budget Enforcement Act of 1990, however, the baseline projection of NRC spending for the 1998–2002 period is based on the agency's net spending level in 1997. Because the 1997 level reflects fee collections sufficient to offset 100 percent of the NRC's general fund appropriations, the provision to extend full-cost recovery does not produce any discretionary savings relative to the budget resolution baseline.

TABLE 1.—ESTIMATED BUDGETARY IMPACT OF THE NON-MEDICARE RECONCILIATION RECOMMENDATIONS OF THE HOUSE COMMITTEE ON COMMERCE

[By fiscal year, in millions of dollars]

	1998	1999	2000	2001	2002
CHANGES IN DIRECT SPENDING					
Subtitle B: Lease of Excess SPR Capacity:					
Estimated budget authority	0	-1	-2	-4	-6
Estimated outlays	0	-1	-2	-4	-6
Subtitle D: Receipts from Spectrum Auctions:					
Estimated budget authority	0	-800	-2,100	-3,000	-3,800
Estimated outlays	0	-800	-2,100	-3,000	-3,800
Subtitle E: Medicaid:					
Estimated budget authority	260	-700	-2,360	-3,620	-4,960
Estimated outlays	260	-700	-2,360	-3,620	-4,960
Subtitle F: State Child Health Coverage:					
Estimated budget authority	2,880	2,880	2,880	2,880	2,880
Estimated outlays	2,880	2,880	2,880	2,880	2,880
Total Proposed Changes in Direct Spending:					
Estimated budget authority	3,140	1,379	-1,582	-3,744	-5,886
Estimated outlays	3,140	1,379	-1,582	-3,744	-5,886
RECEIPTS FROM ASSET SALES					
Subtitle C: Sale of DOE Assets:					
Estimated budget authority	0	-10	-52	-52	-70
Estimated outlays	0	-10	-52	-52	-70
ADDITIONAL SPENDING SUBJECT TO APPROPRIATION					
Subtitle D: Spectrum Auction Expenses:					
Estimated budget authority	12	12	12	12	12
Estimated outlays	11	12	12	12	12

LEASE OF EXCESS SPR CAPACITY (SUBTITLE B)

This subtitle would remove some of the statutory impediments to leasing the excess capacity of the SPR to foreign governments. For example, products stored on behalf of foreign governments would not be considered part of the U.S. reserve and could be exported.

Estimates of how much of the excess capacity (currently about 110 million barrels) would be leased are speculative, because the decision to lease resides with foreign governments, not DOE. At this time, most nations needing capacity either have plans for domestic storage or face regulatory barriers to using U.S. facilities. CBO expects, however, that one or more nations would choose to store small quantities of oil in the SPR to accommodate growth in their storage requirements or to satisfy other strategic objectives. We estimate that such leasing activity would generate receipts totaling about \$13 million over the 1999–2002 period, assuming a storage fee of about \$1.20 per barrel (in 1997 dollars). Beginning in 2003, this provision would no longer generate net receipts because DOE would be authorized to spend the proceeds from leasing to purchase oil for the reserve without further appropriation.

SALE OF DOE ASSETS (SUBTITLE C)

CBO estimates that enacting Subtitle C would generate asset sale proceeds totaling \$184 million over the 1992–2002 period. Under current law, DOE is required to sell uranium from its stockpile to raise a total of \$77 million to offset appropriations provided for fiscal years 1996 and 1997. CBO projects that DOE will sell about three million pounds of uranium in 1998 and about 1.5 million pounds in 1999 to meet the \$77 million target in current law. Based on recent departmental findings supporting that effort, CBO expects that, under the conditions specified in this subtitle, the Secretary could justify selling a total of 3.2 million pounds per year through 2002. Because we expect DOE to be marketing about 1.5 million pounds in 1999 under current law, we assume that DOE would sell slightly less than 2 million pounds under this new authority that year. Hence, the estimate of \$184 million in proceeds attributable to Subtitle C is based on an assumed sales total of about 11 million pounds of uranium over the 1999–2002 period. Based on information provided by the department and committee staff, we assume that the uranium being sold as a result of this provision would be in addition to the Russian-derived uranium that must be sold over the same period. Finally, the spending required to conduct the sale would have no net effect on outlays, because this bill would require DOE to finance such costs using unobligated balances that otherwise would have been spent on other activities.

RECEIPTS FROM SPECTRUM AUCTIONS (SUBTITLE D)

CBO estimates that the federal government would collect \$9.7 billion in offsetting receipts over the 1998–2002 period from enacting the provisions contained in Subtitle D. This estimate reflects the likelihood that some of the auctions authorized by the subtitle would either not occur in the next five years or would yield relatively low aggregate winning bids. CBO believes that significantly higher aggregate auction receipts could be obtained under auction authority without the restrictions included in Subtitle D. Estimates for the major components of Subtitle D are discussed below and displayed in Table 3.

CBO expects that extending and broadening the FCC's authority to auction licenses through 2002 (under section 3301) would increase receipts by \$5.8 billion over the 1998–2002 period. Most of

the estimated receipts would be generated by the auction of licenses permitting the use of frequencies above 3 GHz that have not been specifically designated for reallocation or auction under existing law. CBO anticipates that, in complying with its mandate to assign licenses for most mutually exclusive applications of the spectrum by competitive bidding, the commission will make available such frequencies under the general authority provided by this section.

In addition, CBO estimates that the provisions of section 3301 that require the FCC to use competitive bidding to assign the rights to use 120 MHz of frequencies below 3 GHz (100 MHz to be reallocated by the FCC and 20 MHz to be identified by the NTIA) would generate receipts of \$3.2 billion over the 1998–2002 period. This estimate reflects the significant probability that some auctions would not be held in the next five years and that some would be voided under the conditions set forth in the legislation. CBO's estimate of receipts for future FCC auctions is based on the expectation that prices for FCC licenses will fall from the levels of recent years as more spectrum is brought to the market. CBO has further reduced its estimate for the 102 MHz of spectrum identified for auction in this subtitle because the legislation does not specify the location on the electromagnetic spectrum for 55 MHz of the 100 MHz that it would require the commission to reallocate and auction. There is some doubt as to whether sufficient spectrum can be identified and auctioned to meet the 120 MHz target. Moreover, the subtitle directs the commission to refrain from holding auctions under certain circumstances, and authorizes it to void the results of auctions if the targeted level of two-thirds of \$7.5 billion in aggregate winning bids is not achieved. These provisions create the prospect that the commission will decide not to conduct some auctions and will void the results of others. Our estimate reflects these uncertainties.

CBO estimates that enacting section 3302, which pertains to the recovery and auction of frequencies now allocated for analog television broadcasting, would yield \$700 million in auction receipts. This section requires the FCC to delay the recovery of the frequencies used by analog TV broadcasters in a market beyond December 31, 2006, if more than 5 percent of households in that market continue to rely exclusively on over-the-air terrestrial analog television signals. It would therefore have significant uncertainty as to when bidders would be able to use the frequencies and could reduce auction receipts by 50 percent or more. Accordingly, the \$700 million figure reflects (1) the possibility that the FCC might refrain from conducting the auction, (2) a lower estimate of the likely receipts if the commission holds the auction, and (3) the possibility that the commission would void the auction results because receipts would fall below the target of two-thirds of \$4 billion.

CBO estimates that no receipts would result from enacting section 3303, which pertains to the current television frequencies between 746 MHz and 806 MHz. Subsection (f) would require the FCC to assign each qualifying low-power television station a frequency below 746 MHz to permit continued operation before it allocates and assigns by auction any new licenses in the 746 MHz to 806 MHz range. Based on information from the FCC, CBO believes

that there is not enough free spectrum below 746 MHz to allow the commission to carry out that requirements.

MEDICAID (SUBTITLE E)

Subtitle E includes provisions to give states greater leeway in how they administer their Medicaid programs, maintain quality assurance, and reduce federal payments for disproportionate share hospitals (DSH). Some of these provisions would not significantly affect spending and others would increase spending. On balance, however, the subtitle would reduce federal outlays by \$11.4 billion over the 1998–2002 period (see Table 4). The assumptions underlying the estimates of costs or savings for provisions that would affect federal spending are described below.

CHAPTER 1—STATE FLEXIBILITY REFORMS

The provisions in this chapter would give states increased flexibility to implement managed care programs, set payment rates, expand eligibility, implement programs of all-inclusive care for the elderly (PACE), change benefit requirements; and meet federal requirements for administrative activities.

Determination of Hospital Stay.—CBO estimates that requiring Medicaid health plans to allow physicians or other attending health care providers and patients to determine the appropriate length of inpatient hospital stays would increase costs by \$0.8 billion over five years. This provision would lead to an increase in the number of inpatient days, with the result that states would have to pay health plans higher capitation rates to cover enrollees.

Payment for Federally Qualified Health Care Services (FQHCs).—This provision would phase out over five years the requirement that states reimburse rural health clinics (RHCs) and most federally qualified health centers on a cost basis. The provision would eliminate cost-based reimbursement for organizations designated by the Health Resources and Services Administration as look-alike FQHCs. Without the requirement that payments reflect costs, CBO assumes that states would lower reimbursement rates to FQHCs and RHCs to be more consistent with overall Medicaid payment rates at the end of the phase-out period. CBO estimates that this provision would reduce Medicaid costs by \$0.3 billion over the next five years.

Repeal the Boren Amendment.—The Boren Amendment requires states to reimburse hospitals and nursing homes at rates that are “reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable state and federal laws, regulations, and quality and safety standards.” Many states have argued that suits or threats of suits under the Boren Amendment have been an important cause of rapid increases in provider reimbursement rates.

CBO estimates that the repeal of the Boren Amendment would reduce spending by about \$1.2 billion over the 1998–2002 period. This estimate assumes that reimbursement rates for institutional providers would increase more slowly than if providers could continue to use the threat of Boren suits as leverage against the states. About 40 percent of the savings would come from payments

to hospitals and 60 percent would come from payments to nursing homes.

Although payments to these providers are generally increasing overall, CBO's projections of Medicaid spending under current law assume that some states reduce provider reimbursement rates in any given year. Accordingly, the floor would increase costs slightly in 1998 because it would prevent these states from reducing rates.

12-Month Continuous Coverage.—This provision would allow states to enroll children for the entire year without regard to changes in the incomes of their families. Under current law, CBO estimates that children stay enrolled in the Medicaid program for an average of 9 months in any year. If all states opted to extend coverage for an entire year, Medicaid costs would increase by almost \$14 billion. However, because this option would be so costly—and because few states take advantage of the option to provide 6-month continuous coverage under Section 1115 or Section 1915(b) waivers—CBO estimates that states accounting for only 5 percent of total costs would choose the option. Thus, this provision would cost \$0.7 billion over the 1998–2002 period.

This provision would increase the average number of children enrolled on the Medicaid program in any month by 130,000. But because some of these children would otherwise have been insured, the number of children would decline by about 80,000.

Payment of Home Health Related Medicare Part B Premium.—This provision would expand the Specified Low-Income Medicare Beneficiary (SLMB) program, which pays the Medicare Part B premium for Medicaid enrollees with family incomes between 100 percent and 120 percent of the poverty level. Under the provision, the federal government would reimburse states for 100 percent of costs for the portion of the Medicare Part B premium attributable to home health spending for enrollees with family incomes between 120 and 175 percent of the federal poverty level. CBO estimates that federal outlays would increase by \$0.5 billion over the 1998–2002 period.

Physician Assistants.—Expanding Medicaid benefits for services of physician assistants would increase costs by \$0.1 billion during the 1998–2002 period. Although most state Medicaid programs already pay for these services, there are several states for which this policy would represent a change from current law. CBO's estimate accounts for costs due to increased demand for physician assistant services that would accompany this policy change in these states and, to a lesser degree, for induced demand in the other states that would occur with the inclusion of this provision. Half of the costs attributable to new demand for services would be offset by lower spending for physician services that are covered under current law.

CHAPTER 2—QUALITY ASSURANCE

CBO estimates that the application of the prudent layperson standard for emergency medical conditions to contracts with Medicaid HMOs would increase costs by \$0.1 billion over five years. This provision would increase managed care plans' liability for emergency room use and, therefore, increase premiums for Medicaid managed care plans and thus federal spending.

CHAPTER 3—FEDERAL PAYMENTS

This chapter specifies allotments that would limit the amount of federal reimbursement available for state disproportionate share hospital (DSH) programs over the 1998–2002 period. The bill classifies states into three categories according to how their DSH spending compared with total medical assistance payments. The allotment for a state whose DSH spending in 1995 was under 1 percent of medical assistance spending that year would equal the state's 1995 amount. The allotment for a state designated as a high-DSH state in 1997—one whose DSH payments were greater than 12 percent of medical assistance payments—would equal the state's 1995 spending reduced by 2 percent in 1998, 5 percent in 1999, 20 percent in 2000, 30 percent in 2001 and 40 percent in 2002 and subsequent years. The allotment for any other state would equal the state's 1995 spending reduced by half of the percentage reduction applied to high-DSH states. The bill also specifies that DSH payments would be made directly to hospitals and not included in the capitation payments for managed care plans. This chapter also includes provisions that would guarantee that DSH payments to certain children's and teaching hospitals be no less than DSH payments made to such hospitals in 1995 for fiscal year 1999. This amount would be increased by overall Medicaid growth for subsequent years.

CBO estimates that these provisions would reduce federal outlays by \$13.1 billion over the 1998–2002 period. This estimate takes into account state responses to the reduced availability of DSH money and interactions with the Child Health Assistance Program (CHAP) in Subtitle F of the bill. It is based on the preliminary designations of high- and low-DSH states published in the *Federal Register* on January 31, 1997.

By itself, a policy to limit DSH spending would not be fully effective because states could restore some of the lost federal revenues by increasing their use of intergovernmental transfers or Medicaid maximization techniques. (Intergovernmental transfers are a process by which public hospitals or other public facilities transfer money to the state, which then uses these funds to make DSH payments—mainly to those same facilities—and receives federal matching dollars for those payments. Medicaid maximization refers to states shifting to the Medicaid program activities that were previously financed without federal assistance.) CBO estimates that these strategies would reduce the savings from limits on DSH spending by 25 percent. In this case, however, states would not feel the full effects of the limits because some of their CHAP funds could be used for existing state activities, such as health insurance programs or direct provision of health care services to uninsured children. Because of this flexibility, the reduction in payments to states to which CBO applies the 25 percent factor is smaller, and net federal savings from limiting DSH spending are larger than would be the case for a stand-alone policy.

Finally, this subtitle would provide \$20 million a year to be allocated among the 12 states with the highest number of undocumented aliens for emergency health services provided to them.

CHILD HEALTH ASSISTANCE PROGRAM (CHAP)—(SUBTITLE F)

The Child Health Assistance Program would provide funds enabling states to initiate and expand the provision of child health care assistance to uninsured, low-income children. The bill would provide \$2.9 billion per year (\$14.4 billion over the 1998–2002 period) to finance these activities. Of this amount, 0.5 percent would be allocated to the territories. The remaining money would be distributed according to each state's share of the total number of uninsured children in all states, adjusted for the average cost of health care. The state matching requirement would be 20 percent.

The bill would provide states with a great deal of flexibility in how to spend these funds. State could purchase health insurance coverage from group plans, arrange for health care services directly through providers, expand their Medicaid programs, or use other methods approved by the Secretary. CBO makes no specific assumption about which approach states would choose. However, CBO assumes it unlikely that states would opt to use their state allocations to expand the Medicaid program.

Given the range of options from which a state could choose, the number of children who would be covered under the programs cannot be estimated with precision. Whereas some states would choose to purchase insurance coverage, others might choose to provide health care services directly. Access to health care for uninsured children would increase under both approaches, but only the former approach would be counted as an increase in health insurance coverage. Further, not all of this spending would represent a net increase in health care services. CBO assumes that states would use some of the money to substitute for funds that are currently being spent on these services, including payments to disproportionate share hospitals, state health programs, and administrative activities.

After accounting for spending on the provision of direct services and other activities, CBO assumes that states could cover about 500,000 children through new health insurance programs. In addition, CBO estimates that in the process of enrolling children in these programs, states would identify some children who were eligible for Medicaid and would enroll them in that program. As a result, federal Medicaid outlays would increase by \$0.7 billion over the 1998–2002 period; on a full-year equivalent basis, Medicaid enrollment would increase by about 125,000 children annually. Not all of the children newly enrolled in State programs or Medicaid would otherwise have been uninsured, however, so that the net effect of this provision would be to reduce the number of uninsured children by about 380,000.

Subtitle F would also allow states the option to provide Medicaid coverage to children during a period of presumptive eligibility. CBO estimates that this provision would increase federal costs of \$0.5 billion over five years. Of this amount, \$0.1 billion would be deducted from states' CHAP allotments for spending during a period of presumptive eligibility. The remaining \$0.4 billion would be attributable to an overall increase in Medicaid enrollment. (These costs are shown under Subtitle E in Table 4.) CBO assumes that

states would limit the entities authorized to determine eligibility to those who currently so do for pregnant women.

Estimated impact on State, local, and tribal governments: By extending the NRC's authority to collect fees from publicly owned utilities, Subtitle A would impose an intergovernmental mandate as defined by UMRA, but this mandate would not impose costs above the threshold established in that law (\$50 million in 1996, adjusted for inflation). Other subtitles of Title III contain provisions that would have significant impacts on the budgets of state, local, and tribal governments.

MANDATES

Subtitle A would extend, through fiscal year 2002, the NRC's authority to charge fees to offset 100 percent of its general fund appropriation. The existing authority to charge these fees expires after fiscal year 1998. After that year, NRC would be authorized to set fees equal to only 33 percent of its budget. CBO cannot determine whether this mandate would impose any direct costs because UMRA is unclear as to how to define costs associated with extending an existing mandate that has not yet expired.

In any case, this mandate would impose costs on state, local and tribal governments significantly below the threshold established by UMRA. The amount of fees collected under this provision would depend on the level of future appropriations. Assuming appropriations remain at the 1997 level, adjusted for inflation, CBO estimates that this provision would result in additional collections of about \$340 million annually over the 1999–2002 period. CBO estimates that a small percentage of these fees—less than five percent—would be paid by publicly owned utilities, so this provision would result in additional costs to state, local, and tribal governments totaling no more than \$20 million per year.

OTHER SIGNIFICANT IMPACTS

Communications (Subtitle D).—This subtitle would instruct the FCC to allocate a portion of the spectrum to state and local governments for public safety services. It would also allow state and local governments to use unassigned radio frequencies for public safety purposes under certain circumstances.

Medicaid (Subtitle E).—By expanding benefits and eligibility, CBO estimates that this subtitle would increase net state Medicaid spending excluding DSH. The subtitle would also decrease the federal government's share of DSH payments by \$13.1 billion over the next five years but contains a provision that would require states to maintain their DSH payments to certain teaching and children's hospitals at 1995 levels (increased annually by the rate of growth of their Medicaid programs). This reduction in DSH payments would not constitute a mandate under UMRA because reductions in federal funding to states for large entitlement programs are not mandates if states have the flexibility to reduce their own programmatic or financial responsibilities under the program. States have significant programmatic flexibility under Medicaid. Finally, this title would provide states with \$100 million over the next five years to provide emergency health services to undocumented aliens.

Child Health Coverage (Subtitle F).—This subtitle would create a new program—Child Health Assistance Program (CHAP)—that would provide states with \$14.4 billion over the next five years to provide assistance to low income children who are uninsured in obtaining health coverage. States would provide 20 percent of this program’s funding.

Estimated impact on the private sector: CBO has identified one private-sector mandate in Title III. Subtitle A would impose a mandate on the private sector by extending the Nuclear Regulatory Commission’s authority to collect annual charges from nuclear utilities, resulting in additional collections averaging \$340 million a year from 1999 through 2002. CBO estimates that most of the fees would be paid by investor-owned nuclear utilities.

CBO cannot determine whether the direct costs of this mandate would exceed the annual threshold defined in UMRA, because UMRA is unclear as to how to define the direct costs associated with extending an existing mandate that has not yet expired. Measured against the private-sector costs that would be incurred if current law remains in place and the annual fee declines, the total direct cost of extending this mandate would be about \$300 million annually, beginning in fiscal year 1999. In this case the cost of the mandate would exceed the annual threshold for the private sector as defined in UMRA. By contrast, measured against current private-sector costs, the direct cost of the mandate would be zero.

Estimate prepared by—Federal Costs: NRC Fees—Kim Cawley (226–2860); SPR Leasing and DOE Asset Sales—Kathleen Gramp (226–2860); Spectrum—Rachel Forward (226–2860); David Moore and Perry Beider (226–2940); Medicaid—Robin Rudowitz and Jeanne De Sa (226–9010); Child Health Care Initiative—Robin Rudowitz and Jeanne De Sa (226–9010).

Impact on State, Local, and Tribal Governments: NRC Fees—Marjorie Miller (225–3220); Medicaid and Child Health Care Initiative—John Patterson (225–3220); Other provisions—Pepper Santalucia (225–3220).

Impact on the Private Sector: Medicaid and Child Health Care Initiative—Linda Bilheimer (226–2673); Other provisions—Jean Wooster and Patrice Gordon (226–2940).

Estimate approved by: Paul N. Van de Water, Assistant Director for Budget Analysis.

TABLE 2.—ESTIMATED 10-YEAR BUDGETARY EFFECTS OF TITLE III: RECONCILIATION RECOMMENDATIONS OF THE HOUSE COMMITTEE ON COMMERCE
 [In millions of dollars, by fiscal years]

	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	1998-2007 Total
Summary of Changes in Direct Spending and Asset Sale Proceeds											
Subtitle A. NRC Fees:											
Estimated Budget Authority	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)
Estimated Outlays	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)
Subtitle B. Lease of Excess SPR Capacity:											
Estimated Budget Authority	0	-1	-2	-4	-6	0	0	0	0	0	-13
Estimated Outlays	0	-1	-2	-4	-6	-6	0	0	0	0	-19
Subtitle C. Sale of DOE Assets:											
Estimated Budget Authority	0	-10	-52	-52	-70	0	0	0	0	0	-184
Estimated Outlays	0	-10	-52	-52	-70	0	0	0	0	0	-184
Subtitle D. Receipts from Spectrum Auctions:											
Estimated Budget Authority	0	-800	-2,100	-3,000	-3,800	0	0	0	0	0	-9,700
Estimated Outlays	0	-800	-2,100	-3,000	-3,800	0	0	0	0	0	-9,700
Subtitle E. Medicaid: ¹											
Estimated Budget Authority	260	-700	-2,360	-3,620	-4,960	-5,880	-6,790	-7,850	-9,010	-10,300	-51,190
Estimated Outlays	260	-700	-2,360	-3,620	-4,960	-5,880	-6,790	-7,850	-9,010	-10,300	-51,190
Subtitle F. State Child Health Coverage:											
Estimated Budget Authority	2,880	2,880	2,880	2,880	2,880	2,880	2,880	2,880	2,880	2,880	28,800
Estimated Outlays	2,880	2,880	2,880	2,880	2,880	2,880	2,880	2,880	2,880	2,880	28,800
Total Changes in Direct Spending and Asset Sale Proceeds:											
Estimated Budget Authority	3,140	1,369	-1,634	-3,796	-5,956	-2,980	-3,910	-4,970	-6,130	-7,420	-32,287
Estimated Outlays	3,140	1,369	-1,634	-3,796	-5,956	-2,986	-3,910	-4,970	-6,130	-7,420	-32,293

¹ Not Applicable: extension of NRC fees at their current full-cost recovery rate has no effect on direct spending because such fees are recorded in the budget as offsetting collections credited to appropriations. The amount of fees that would be collected under Subtitle A would be determined by the annual general fund appropriation for NRC operations.

² These estimates assume continuation of 2002 DSH policy for 2003 through 2007.

TABLE 3.—ESTIMATED 10-YEAR BUDGETARY EFFECTS OF SUBTITLE D OF TITLE III: RECONCILIATION RECOMMENDATIONS OF THE HOUSE COMMITTEE ON COMMERCE
 [In millions of dollars, by fiscal years]

	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	1997-2007 Total
Estimated Budgetary Effects of Subtitle D—Communications												
DIRECT SPENDING (OFFSETTING RECEIPTS)												
Auction Receipts Under Current Law:												
Estimated Budget Authority	-9,600	-7,100	-1,600	-550	-150	0	0	0	0	0	0	-19,000
Estimated Outlays	-9,600	-7,100	-1,800	-550	-150	0	0	0	0	0	0	-19,000
Proposed Changes:												
Broaden and Extend:												
Estimated Budget Authority	0	0	-800	-1,500	-1,700	-1,800	0	0	0	0	0	-5,800
Estimated Outlays	0	0	-800	-1,500	-1,700	-1,800	0	0	0	0	0	-5,800
Reallocation of 120 Mhz:												
Estimated Budget Authority	0	0	0	-600	-1,300	-1,300	0	0	0	0	0	-3,200
Estimated Outlays	0	0	0	-600	-1,300	-1,300	0	0	0	0	0	-3,200
Analog Return and Channels 60-69:												
Estimated Budget Authority	0	0	0	0	0	-700	0	0	0	0	0	-700
Estimated Outlays	0	0	0	0	0	-700	0	0	0	0	0	-700
Total Changes:												
Estimated Budget Authority	0	0	-800	-2,100	-3,000	-3,800	0	0	0	0	0	-9,700
Estimated Outlays	0	0	-800	-2,100	-3,000	-3,800	0	0	0	0	0	-9,700
Auction Receipts Under Subtitle D:												
Estimated Budget Authority	-9,600	-7,100	-2,400	-2,650	-3,150	-3,800	0	0	0	0	0	-28,700
Estimated Outlays	-9,600	-7,100	-2,400	-2,650	-3,150	-3,800	0	0	0	0	0	-28,700
SPENDING SUBJECT TO APPROPRIATION												
FCC Spending Under Current Law:												
Estimated Authorization Level ¹	37	38	40	41	43	44	46	47	49	51	53	452
Estimated Outlays	35	38	40	41	43	44	46	47	49	51	53	452
Proposed Changes—Auction Expenses:												
Estimated Authorization Level ¹	0	12	12	12	12	12	0	0	0	0	0	60
Estimated Outlays	0	11	12	12	12	12	1	0	0	0	0	60
FCC Spending Under Subtitle D:												
Estimated Authorization Level ¹	37	50	52	53	55	56	46	47	49	51	53	512
Estimated Outlays	35	49	52	53	55	56	47	47	49	51	53	512

¹The 1997 level is the amount appropriated for that year. Amounts shown for subsequent years are CBO baseline projections.

TABLE 4.—MEDICAID AND CHILD HEALTH ASSISTANCE PROPOSALS, AS APPROVED BY THE COMMITTEE ON COMMERCE ON JUNE 12, 1997

[By fiscal years, in billions of dollars]

	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	1998-2007 Total	1998-2007 Total
Subtitle E—Medicaid:												
Spending Under Current Law	105.3	113.6	122.9	132.8	143.8	155.9	168.7	183.1	198.9	216.2	618.4	1,541.2
Chapter 1—State Flexibility Reforms:												
Use of Managed Care:												
Determination of hospital stay	0.1	0.1	0.1	0.2	0.2	0.2	0.2	0.3	0.3	0.3	0.8	2.1
Payment Methodology:												
FQHC payment reform	-0.0	-0.0	-0.0	-0.1	-0.1	-0.2	-0.2	-0.2	-0.2	-0.3	-0.3	-1.4
Repeat of Boren Requirements	0.0	-0.1	-0.2	-0.4	-0.5	-0.7	-0.9	-1.1	-1.4	-1.6	-1.2	-6.9
Extension of moratorium for certain IMDs ¹	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Eligibility:												
Option for 12 month continuous eligibility	0.1	0.1	0.1	0.1	0.2	0.2	0.2	0.2	0.2	0.2	0.7	1.6
Payment of home-health Medicare B premium	0.0	0.1	0.1	0.1	0.2	0.2	0.3	0.3	0.3	0.3	0.5	1.9
PACE:												
PACE as Medicaid option ²	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Benefits:												
Benefits for services of Physician Assistants	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.3
Chapter 2—Quality Assurance:												
Application of standards for emergency conditions	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.2
Chapter 3—Federal Payments:												
Disproportionate Share ³	-0.2	-1.1	-2.7	-3.9	-5.1	-5.9	-6.7	-7.6	-8.6	-9.6	-13.1	-51.6
Emergency health services for aliens	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.2
Medicaid interaction with CHAP	0.1	0.1	0.1	0.1	0.1	0.2	0.2	0.2	0.2	0.2	0.7	1.5
Presumptive eligibility for low-income children ⁴	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.4	0.9
Total Change in Spending	0.3	-0.7	-2.4	-3.6	-5.0	-5.9	-6.8	-7.8	-9.0	-10.3	-11.4	-51.2
Spending Under Proposal	105.6	112.9	120.5	129.2	138.8	150.0	161.9	176.3	189.9	205.9	607.0	1,490.0
Subtitle F—Child Health Assistance Program (CHAP):												
Total Federal Allotments	2.9	2.9	2.9	2.9	2.9	2.9	2.9	2.9	2.9	2.9	14.4	28.8

¹ Would increase federal costs by about \$500,000 per year.

² Would increase Medicare outlays by \$8 million over 5 years.

³ Estimate includes interaction with CHAP.

⁴ This provision is included in Subtitle F.

FEDERAL MANDATES STATEMENT

The Committee adopts as its own the estimate of Federal mandates prepared by the Director of the Congressional Budget Office pursuant to section 423 of the Unfunded Mandates Reform Act.

ADVISORY COMMITTEE STATEMENT

No advisory committees within the meaning of section 5(b) of the Federal Advisory Committee Act were created by this legislation.

CONSTITUTIONAL AUTHORITY STATEMENT

Pursuant to clause 2(1)(4) of rule XI of the Rules of the House of Representatives, the Committee finds that the Constitutional authority for this legislation is provided in Article I, section 8, clause 3, which grants Congress the power to regulate commerce with foreign nations, among the several States, and with the Indian tribes.

SECTION-BY-SECTION ANALYSIS OF THE LEGISLATION

Section 3201. Sale of DOE surplus uranium assets

Subsection (a) directs the Secretary of Energy to sell 3.2 million pounds per year of natural and low-enriched uranium that the President has determined is not necessary for national security needs during the period Fiscal Year 1999 through Fiscal Year 2002.

Paragraph (1) provides that such sales shall be for delivery after January 1, 1999.

Paragraph (2) conditions any sale of surplus uranium on a determination, for the period Fiscal Year 1999 through Fiscal Year 2002, by the Secretary under section 3112(d)(2)(B) of the USEC Privatization Act of 1996 (42 U.S.C.2297h-10(d)(2)(B)).

Paragraph (3) requires that any sale or sales be made at a price not less than fair market value of the uranium and in a manner that maximizes proceeds to the Treasury.

The Secretary is directed to receive the proceeds from such sale in the period Fiscal Year 1999 through Fiscal Year 2002 and deposit such proceeds in the General Fund of the Treasury.

Subsection (b) provides that the cost of making the sales required by subsection (a) shall be covered by unobligated balances of appropriations of the Department of Energy.

CHANGES IN EXISTING LAW MADE BY SUBTITLE C

Subtitle C makes no changes in existing law.

MINORITY, ADDITIONAL OR DISSENTING VIEWS

Minority Views on Subtitle C are provided at the conclusion of the report on this Title of the bill.

SUBTITLE D—COMMUNICATIONS

PURPOSE AND SUMMARY

The purposes of Subtitle D are: (1) to broaden and to extend the Federal Communications Commission's (FCC's) authority to assign

licenses for radio-based services by means of competitive bidding, or specifically “auctions;” (2) to direct the FCC and the National Telecommunications and Information Administration (NTIA) to make certain spectrum reallocations; and (3) to instruct the FCC to assign most of the licenses for the use of the reallocated spectrum by means of auctions.

Subtitle D consists of four sections. Section 3301 extends the FCC’s auction authority through the end of Fiscal Year 2002. It also broadens the FCC’s auction authority by requiring all radio-based licenses for which mutually exclusive applications are filed with the FCC to be assigned by means of competitive bidding, unless the license is intended for a service which is exempted from the FCC’s auction authority. Section 3301 also directs the FCC and the NTIA collectively to reallocate 120 megahertz (MHz) of spectrum located below 3 gigahertz (GHz) for commercial use, and to assign through competitive bidding the licenses to use the newly allocated spectrum. The FCC is further charged with ensuring that the public recovers a minimum level of receipts.

Section 3302 establishes a statutory framework for both auctioning and recapturing the 78 MHz of spectrum that current television broadcast licensees use to transmit in analog format. It precludes the FCC from renewing any analog license beyond December 31, 2006, unless a certain number of households in a given market continue to rely exclusively on over-the-air analog signals. The licenses to use the recaptured 78 MHz of spectrum will be assigned through competitive bidding beginning in 2001. The FCC must ensure that the public recovers a minimum level of receipts.

Section 3303 allocates and assigns the 60 MHz of spectrum located between television broadcast channels 60 through 69 to public safety services and for general commercial use. The FCC is directed to set aside up to 24 MHz of the 60 MHz total for public safety, and the remaining 36 MHz for general commercial use to be assigned by means of competitive bidding. With regard to the 36 MHz slated for auction, the FCC must ensure that the public recovers a minimum level of receipts.

Finally, section 3304 directs the FCC to initiate its statutorily mandated evaluation of its competitive bidding systems no later than July 1, 1997.

BACKGROUND AND NEED FOR LEGISLATION

Spectrum management

The radio “spectrum” is not a physical object, but instead is a conceptual tool used to organize and map a set of physical phenomena. Electric and magnetic fields produce waves that move through space at different speeds, or “frequencies.” The set of all possible frequencies is called the electromagnetic spectrum. The most widely used portion of the electromagnetic spectrum for radio communications is the portion of the spectrum ranging from 10 kilohertz (KHz) to 300 GHz. Spectrum may be shared by two or more users, but in many cases, the use of a frequency at a given location typically excludes the use of that frequency, and maybe even adjacent frequencies, from being used by others. Spectrum, in other words, is a finite (though non-depletable) resource.

The right to use the electromagnetic spectrum is essential to the provision of such services as mobile telephone service and television broadcasting. It also is essential for such public goods as local law enforcement and national defense communications. The FCC allocates use of the radio spectrum for private parties and for State and local governments. NTIA, an agency within the Department of Commerce, is responsible for the same management activities for Federal government use of the radio spectrum. NTIA utilizes the Interdepartmental Radio Advisory Committee (IRAC) to establish priorities and encourage efficient spectrum use by Federal government users.

Spectrum auctions

Prior to 1993, licenses for use of the radio spectrum were assigned in one of three possible ways: (1) on a first-come, first-served basis; (2) through comparative hearings; or (3) by lottery. Each of these methods had shortcomings and proved to be an inefficient way to assign licenses. Therefore, as part of the Omnibus Budget Reconciliation Act of 1993 (OBRA 93), Congress gave the FCC authority to use competitive bidding to assign licenses when more than one applicant seeks an exclusive license to provide telecommunications service on a subscription or fee-for-service basis. For example, the FCC traditionally could not use auctions for non-subscription services (such as the traditional broadcast services of radio and television), even though mutual exclusivity typically exists. Likewise, the FCC *may not* use auctions where two parties are capable of sharing spectrum, notwithstanding the fact that both parties intend to use the spectrum for subscription-based services. The FCC's auction authority is scheduled to expire on September 30, 1998.

Auctions, for the most part, have proven to be consistent with the Committee's long-term goals for telecommunications policy. The FCC has used auctions to assign licenses for competing applicants far more expeditiously than under comparative hearings or lotteries. A wide array of innovative radio-based services, including personal communications services (PCS), narrowband and broadband paging services, and direct broadcast satellite services (DBS), have expeditiously reached consumers as a result of auctions. Auctions also ensure that licenses are assigned to the entity that most values the frequencies. Consequently, consumers now enjoy the benefits of new and improved services that are offered in a more price-competitive marketplace.

Auctions are also administratively efficient. They expedite licensing, and thus ensure that new or additional services are rapidly deployed. In addition, since the advent of auctions in 1993, the FCC has recorded winning bids of approximately \$23 billion and has collected receipts of more than \$10 billion. Auctions thus have made a contribution to reducing the Federal deficit, something comparative hearings and lotteries never did.

Still, the Committee is concerned that some policymakers have come to view auctions exclusively as a tool for balancing the Federal budget, and that this view poses a threat to long-term telecommunications policy. The Committee believes that auctions must be designed to serve spectrum management goals, and not short-

term budgetary needs. Otherwise, auctions will be held for the sake of raising money, rather than on the basis of technological availability and clearly identified consumer demand. Indeed, the inevitable (not to mention absurd) result of an auction policy driven solely by budgetary considerations would be a dictate to the FCC that it reallocate every single megahertz for competitive bidding—without regard for incumbent licensees—and that the FCC hold those auctions as soon as possible.

The Committee also notes that policymakers must be careful in advocating auctions on the basis of expected revenues. The process of predicting the outcome of spectrum auctions is an imprecise one. Thus, American taxpayers should not be misled to believe that a critical resource of theirs will be sold at a premium, only to find out that in the end, the scarce resource was given away at “fire sale” prices. For example, Congress, in response to budgetary pressures, passed legislation in 1996 directing the FCC to auction licenses for flexible-use wireless communications services (WCS) located in the 2.3 GHz band. The Congressional Budget Office initially predicted the WCS auction would raise \$2.9 billion. In the end, the WCS auction raised only \$13.6 million, less than 0.5 percent of the expected outcome.

Thus, while the Committee concludes that the FCC’s auction authority should be broadened and extended, it also seeks to ensure that the FCC designs its future auctions to reflect more than just budgetary considerations. Auctions were originally intended to speed the deployment of new services, as well as to guarantee that the American public is fairly compensated for the use of one of its most precious resources. The Committee is confident that Subtitle D serves these overarching goals. The Committee, however, intends to remain vigilant in overseeing the FCC’s administration of its auction authority. Indeed, the Committee will not hesitate to let the FCC’s auction authority expire on September 30, 2002, if, and when, auctions no longer serve the Committee’s stated objectives.

HEARINGS

On Wednesday, February 12, 1997, the Committee’s Subcommittee on Telecommunications, Trade, and Consumer Protection held an oversight hearing on Spectrum Management Policy. Mr. Robert Wright, President and Chief Executive Officer (CEO) of NBC, began the hearing with a brief demonstration on digital television. The demonstration was followed by testimony from: The Honorable Larry Irving, Administrator for the National Telecommunications and Information Administration (NTIA); The Honorable Reed Hundt, Chairman of the FCC; Mr. Michael Amarosa, Deputy Commissioner for the New York City Police Department; Mr. James Keelor, President of Cosmos Broadcasting; and Mr. Benjamin Scott, President and CEO of PrimeCo PCS.

COMMITTEE CONSIDERATION

On June 5, and June 10, 1997, the Subcommittee on Telecommunications, Trade, and Consumer Protection met in open session and considered a Committee Print entitled “Title III, Subtitle D—Communications.” On June 10, 1997, the Subcommittee ap-

proved for Full Committee consideration the Committee Print entitled "Title III, Subtitle D—Communications," amended, by a roll call vote of 13 yeas to 12 nays, with 1 voting "Pass". On June 11, 1997, the Committee met in open session and ordered a Committee Print entitled "Title III, Subtitle D—Communications" transmitted to the House Committee on the Budget, amended, for inclusion in the 1997 Omnibus Budget Reconciliation Act by a roll call vote of 27 yeas to 22 nays.

ROLL CALL VOTES

Pursuant to Clause 2(1)(2)(B) of rule XI of the Rules of the House of Representatives, following are listed the recorded votes on the motion to order Subtitle D transmitted to the House Committee on the Budget, and on amendments thereto, including the names of those Members voting for and against.

**COMMITTEE ON COMMERCE -- 105TH CONGRESS
ROLL CALL VOTE #6**

BILL: Committee Print entitled "Title III, Subtitle D - Communications"

AMENDMENT: Substitute amendment to the Dingell Amendment by Mr. Tauzin re: establish minimum aggregate bids for auctions.

DISPOSITION: AGREED TO, by a roll call vote of 26 yeas to 20 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Bliley	X			Mr. Dingell		X	
Mr. Tauzin	X			Mr. Waxman		X	
Mr. Oxley	X			Mr. Markey		X	
Mr. Bilirakis	X			Mr. Hall			
Mr. Schaefer	X			Mr. Boucher		X	
Mr. Barton	X			Mr. Manton		X	
Mr. Hastert	X			Mr. Towns			
Mr. Upton	X			Mr. Pallone		X	
Mr. Stearns	X			Mr. Brown		X	
Mr. Paxon	X			Mr. Gordon		X	
Mr. Gillmor	X			Ms. Furse		X	
Mr. Klug	X			Mr. Deutsch		X	
Mr. Greenwood				Mr. Rush		X	
Mr. Crapo	X			Ms. Eshoo		X	
Mr. Cox	X			Mr. Klink		X	
Mr. Deal	X			Mr. Stupak		X	
Mr. Largent	X			Mr. Engel			
Mr. Burr	X			Mr. Sawyer		X	
Mr. Bilbray	X			Mr. Wynn		X	
Mr. Whitfield	X			Mr. Green		X	
Mr. Ganske	X			Ms. McCarthy		X	
Mr. Norwood				Mr. Strickland		X	
Mr. White	X			Ms. DeGette		X	
Mr. Coburn	X						
Mr. Lazio	X						
Mrs. Cubin	X						
Mr. Rogan	X						
Mr. Shimkus	X						

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**COMMITTEE ON COMMERCE -- 105TH CONGRESS
ROLL CALL VOTE #7**

BILL: Committee Print entitled "Title III, Subtitle D - Communications"

AMENDMENT: Amendment by Mr. Markey re: availability of returned spectrum.

DISPOSITION: NOT AGREED TO, by a roll call vote of 11 yeas to 31 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Billey		X		Mr. Dingell	X		
Mr. Tauzin		X		Mr. Waxman			
Mr. Oxley		X		Mr. Markey	X		
Mr. Bilirakis		X		Mr. Hall		X	
Mr. Schaefer		X		Mr. Boucher			
Mr. Barton				Mr. Manton		X	
Mr. Hastert				Mr. Towns			
Mr. Upton		X		Mr. Pallone	X		
Mr. Stearns		X		Mr. Brown	X		
Mr. Paxon		X		Mr. Gordon		X	
Mr. Gillmor		X		Ms. Furse	X		
Mr. Klug		X		Mr. Deutsch	X		
Mr. Greenwood		X		Mr. Rush		X	
Mr. Crapo		X		Ms. Eshoo		X	
Mr. Cox				Mr. Klink	X		
Mr. Deal		X		Mr. Stupak	X		
Mr. Largent		X		Mr. Engel			
Mr. Burr		X		Mr. Sawyer			
Mr. Bilbray		X		Mr. Wynn	X		
Mr. Whitfield		X		Mr. Green	X		
Mr. Ganske		X		Ms. McCarthy	X		
Mr. Norwood		X		Mr. Strickland			
Mr. White		X		Ms. DeGette		X	
Mr. Coburn		X					
Mr. Lazio		X					
Mrs. Cubin		X					
Mr. Rogan		X					
Mr. Shimkus		X					

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**COMMITTEE ON COMMERCE -- 105TH CONGRESS
ROLL CALL VOTE #9**

BILL: Committee Print entitled "Title III, Subtitle D - Communications"

AMENDMENT: Amendment by Mr. Oxley re: limited waiver of the duopoly rule.

DISPOSITION: AGREED TO, as amended, by a roll call vote of 26 yeas to 23 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Bliley	X			Mr. Dingell		X	
Mr. Tauzin	X			Mr. Waxman		X	
Mr. Oxley	X			Mr. Markey		X	
Mr. Bilirakis	X			Mr. Hall	X		
Mr. Schaefer	X			Mr. Boucher		X	
Mr. Barton	X			Mr. Manton		X	
Mr. Hastert	X			Mr. Towns		X	
Mr. Upton				Mr. Pallone		X	
Mr. Stearns	X			Mr. Brown		X	
Mr. Paxon	X			Mr. Gordon		X	
Mr. Gillmor		X		Ms. Furse		X	
Mr. Klug	X			Mr. Deutsch		X	
Mr. Greenwood	X			Mr. Rush		X	
Mr. Crapo	X			Ms. Eshoo		X	
Mr. Cox	X			Mr. Klink		X	
Mr. Deal	X			Mr. Stupak		X	
Mr. Largent	X			Mr. Engel		X	
Mr. Burr	X			Mr. Sawyer		X	
Mr. Bilbray	X			Mr. Wynn		X	
Mr. Whitfield	X			Mr. Green		X	
Mr. Ganske	X			Ms. McCarthy		X	
Mr. Norwood	X			Mr. Strickland		X	
Mr. White	X			Ms. DeGette		X	
Mr. Coburn	X						
Mr. Lazio							
Mrs. Cubin	X						
Mr. Rogan	X						
Mr. Shimkus	X						

6/11/97

**COMMITTEE ON COMMERCE -- 105TH CONGRESS
ROLL CALL VOTE #10**

BILL: Committee Print entitled "Title III, Subtitle D - Communications"

AMENDMENT: Amendment by Ms. Furse re: require televisio., manufacturers to label new analog sets.

DISPOSITION: NOT AGREED TO, by a roll call vote of 16 yeas to 30 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Biiley		X		Mr. Dingell			
Mr. Tauzin		X		Mr. Waxman			
Mr. Oxley		X		Mr. Markey	X		
Mr. Bilirakis		X		Mr. Hall		X	
Mr. Schaefer		X		Mr. Boucher	X		
Mr. Barton		X		Mr. Manton	X		
Mr. Hastert		X		Mr. Towns			
Mr. Upton		X		Mr. Pallone	X		
Mr. Stearns		X		Mr. Brown			
Mr. Paxon		X		Mr. Gordon		X	
Mr. Gillmor		X		Ms. Furse	X		
Mr. Klug		X		Mr. Deutsch	X		
Mr. Greenwood		X		Mr. Rush	X		
Mr. Crapo		X		Ms. Eshoo	X		
Mr. Cox		X		Mr. Klink	X		
Mr. Deal		X		Mr. Stupak	X		
Mr. Largent		X		Mr. Engel	X		
Mr. Burr		X		Mr. Sawyer	X		
Mr. Bilbray		X		Mr. Wynn	X		
Mr. Whitfield		X		Mr. Green	X		
Mr. Ganske		X		Ms. McCarthy	X		
Mr. Norwood		X		Mr. Strickland	X		
Mr. White		X		Ms. DeGette			
Mr. Coburn		X					
Mr. Lazio		X					
Mrs. Cubin		X					
Mr. Rogan		X					
Mr. Shimkus		X					

6/11/97

**COMMITTEE ON COMMERCE -- 105TH CONGRESS
ROLL CALL VOTE #11**

BILL: Committee Print entitled "Title III, Subtitle D - Communications"

MOTION: Motion by Mr. Bilely to order the Committee Print entitled "Title III, Subtitle D - Communications", amended, transmitted to the Committee on the Budget for inclusion in the 1997 Omnibus Budget Reconciliation Act.

DISPOSITION: AGREED TO, by a roll call vote of 27 yeas to 22 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Bilely	X			Mr. Dingell			
Mr. Tauzin	X			Mr. Waxman		X	
Mr. Oxley	X			Mr. Markey		X	
Mr. Bilirakis	X			Mr. Hall	X		
Mr. Schaefer	X			Mr. Boucher		X	
Mr. Barton		X		Mr. Manton		X	
Mr. Hastert	X			Mr. Towns			
Mr. Upton	X			Mr. Pallone		X	
Mr. Stearns	X			Mr. Brown		X	
Mr. Paxon	X			Mr. Gordon		X	
Mr. Gillmor	X			Ms. Furse		X	
Mr. Klug	X			Mr. Deutsch		X	
Mr. Greenwood	X			Mr. Rush		X	
Mr. Crapo	X			Ms. Eshoo		X	
Mr. Cox	X			Mr. Klink		X	
Mr. Deal	X			Mr. Stupak		X	
Mr. Largent	X			Mr. Engel		X	
Mr. Burr	X			Mr. Sawyer		X	
Mr. Bilbray	X			Mr. Wynn		X	
Mr. Whitfield	X			Mr. Green		X	
Mr. Ganske	X			Ms. McCarthy		X	
Mr. Norwood		X		Mr. Strickland		X	
Mr. White	X			Ms. DeGette		X	
Mr. Coburn	X						
Mr. Lazio	X						
Mrs. Cubin	X						
Mr. Rogan	X						
Mr. Shimkus	X						

6/11/97

COMMITTEE ON COMMERCE—105TH CONGRESS, VOICE
VOTES, 6/11/97

Bill: Committee Print entitled "Title III, Subtitle D—Communications".

Amendment: Amendment by Mr. Oxley re: test of combinatorial bidding systems.

Disposition: Agreed to, by a voice vote.

Amendment: Amendment by Mr. Dingell re: eliminate the effective dates for spectrum auctions.

Disposition: Agreed to, as amended, by a voice vote.

Amendment: Amendment by Mr. Oxley re: repeal of FCC fee retention authority.

Disposition: Agreed to, by a voice vote.

Amendment: Amendment by Mr. Gillmor re: clarify the definition of public safety services.

Disposition: Agreed to, by a voice vote.

Amendment: Amendment by Mr. Rush re: require the FCC to complete the inquiry into spectrum auctions.

Disposition: Agreed to, by a voice vote.

Amendment: Amendment by Mr. Rogan re: use of public safety spectrum in congested areas.

Disposition: Agreed to, by a voice vote.

Amendment: Amendment to the Oxley Amendment by Mr. Klug re: eliminate the limitation on cross ownership of a newspaper and a broadcast station in the same market.

Disposition: Agreed to, by a voice vote. Previously a roll call vote (Roll Call Vote #8) was begun on the amendment and then suspended by unanimous consent.

Amendment: Amendment by Mr. Gordon re: exemption from auctions for unlicensed spectrum users (Part 15).

Disposition: Agreed to, by a voice vote.

Amendment: Amendment by Mr. Oxley re: require the FCC to provide sufficient time between the auction notice and the commencement of auction.

Disposition: Agreed to, by a voice vote.

Amendment: Amendment to the Furse Amendment by Mr. Gordon re: modify labeling requirement to permit industry involvement on a portion of the requirement.

Disposition: Not agreed to, by a voice vote.

COMMITTEE OVERSIGHT FINDINGS

Pursuant to clause 2(l)(3)(A) of rule XI of the Rules of the House of Representatives, the Subcommittee on Telecommunications, Trade, and Consumer Protection held an oversight hearing and made findings that are reflected in this report.

COMMITTEE ON GOVERNMENT REFORM AND OVERSIGHT

Pursuant to clause 2(l)(3)(D) of rule XI of the Rules of the House of Representatives, no oversight findings have been submitted to the Committee by the Committee on Government Reform and Oversight.

COMMITTEE COST ESTIMATE

In compliance with clause 7(a) of rule XIII of the Rules of the House of Representatives, the Committee believes that cumulative effect of enacting of Subtitle D would result in no additional costs to the Federal government.

CONGRESSIONAL BUDGET OFFICE ESTIMATE

Pursuant to clause 2(l)(3)(C) of rule XI of the Rules of the House of Representatives, a letter from the Congressional Budget Office providing a cost estimate for all six subtitles of Title III is found at the conclusion of the report on this Title of the bill.

SECTION-BY-SECTION ANALYSIS OF THE LEGISLATION

*Section 3301. Spectrum auctions**(a) Extension and expansion of auction authority*

Subsection 3301(a) amends section 309(j) of the Communications Act, which grants to the FCC authority to use auctions as a means of granting licenses for radio-based services. The subsection requires the FCC to employ a system of competitive bidding if presented with mutually exclusive applications for the use of spectrum. The Committee makes clear, however, that the FCC must continue to seek solutions to avoid a finding of mutual exclusivity. Notwithstanding the FCC's broadened auction authority, this subsection explicitly exempts certain services from such authority. The exemption, for example, applies to licenses for public safety radio services, including private, internal radio services offered by both State and local government entities, as well as non-government entities. The exemption also applies to initial licenses for digital television service that the FCC chooses to assign to existing analog television licensees.

Subsection 3301(a) also directs the FCC, in designing future auctions, to conduct a pilot test of a system known as "contingent combinatorial bidding" by operating an FCC auction using such a system. Contingent combinatorial bidding (also known as contingent package bidding) is an auction system that allows prospective bidders to bid on various combinations, or packages, of licenses in a single bid, and allows bidders to enter multiple alternative bids within a single auction round. The Committee believes that using a contingent combinatorial bidding system may allow the FCC to conduct auctions more efficiently and effectively. Potential licensees may be able to better tailor their bidding to obtain the best possible license configuration for their needs, creating the most efficient use of the spectrum. This system may also potentially enhance auction revenues for the U.S. Treasury. The FCC is encouraged to test this system as soon as practicable, and may perform the test on its own or by contract.

Subsection 3301(a) further requires the FCC to ensure that interested bidders have sufficient time: (1) before the issuance of bidding rules, to comment on any proposed rules; and (2) after the issuance of bidding rules, to develop business plans, assess market conditions, and evaluate the availability of service equipment. By adopting this language, the Committee intends for the FCC to pro-

tect against future auctions that attract only a few participants because of insufficient time to gather the information that is necessary for a robust auction.

Subsection 3301(a) also extends the FCC's auction authority to September 30, 2002, and repeals the FCC's authority to select licensees randomly from among competing applications. It also repeals the FCC's authority to retain auction receipts for the purpose of offsetting the cost of conducting auctions. In repealing the FCC's fee retention authority, subsection 3301(a) ensures that Congress will have a proper accounting of all of the FCC's expenditures.

The FCC's broadened auction authority under subsection 3301(a) does not cover any licenses for which the FCC has accepted mutually exclusive applications prior to the date of enactment of the Balanced Budget Act of 1997. The Committee is aware that numerous applications for new stations on vacant NTSC channels were filed on or before the September 20, 1996, deadline established by the FCC for the filing of applications. And according to established procedures, the FCC will announce that competing applications to these applications may be filed when cut-off notices are issued. The Committee expects the FCC to process these applications promptly, and to also establish cut-off dates for competing applications. This process will ensure that all such applications are filed and accepted by the FCC prior to the enactment of this legislation.

(b) Commission obligation to make additional spectrum available by auction

Subsection 3301(b) directs the FCC to reallocate, in the aggregate, 100 MHz of spectrum. This spectrum must be located below 3 GHz, and be comprised of individual bands spanning not less than 25 MHz (unless smaller bands can be expected to produce greater receipts). The spectrum must also not have been previously identified by the FCC or NTIA for reallocation, or been allocated by the FCC for unlicensed use pursuant to FCC rules. The FCC shall include the 45 MHz located between 1710 MHz through 1755 MHz as part of the total 100 MHz it must reallocate pursuant to section 3301(b), notwithstanding the fact that the 45 MHz is currently allocated for Federal government exclusive use.

The FCC must assign the radio frequencies at issue here by means of competitive bidding by September 30, 2002, and in so doing, must take into account the cost of relocating incumbent licensees, give consideration to internationally-established spectrum allocations, and ensure that future licensees do not interfere with space research and earth-exploration services. In the event the FCC cannot effectively relocate incumbent users on bands of frequencies available to the FCC, then the FCC must notify the NTIA about the need for additional bands.

(c) Identification and reallocation of frequencies

In the event the FCC makes a notification to the NTIA that it cannot relocate incumbent users, pursuant to subsection 3301(b), then subsection 3301(c) directs the NTIA to issue a report to Congress and the President recommending bands of frequencies that could be reallocated to the FCC to accommodate those users that have been displaced by the FCC. The FCC would have one year

from the receipt of NTIA's report to implement a plan that reallocates and assigns these bands to displaced incumbent users.

(d) Identification and reallocation of auctionable frequencies

Subsection 3301(d) requires the NTIA to submit a reallocation report to Congress, identifying and recommending for reallocation a single frequency band of at least 20 MHz, and which is located below 3 GHz. The Committee has determined that the best way to promote efficiency by Federal government users and to free up this vital resource for use by the general public is to mandate that the Secretary of Commerce find spectrum that can be relinquished. The Committee is confident that 20 MHz can be located below 3 GHz that can be reallocated to use by non-Government users without impairing the mission of any government agency. The FCC would have a year to implement a plan to allocate and assign the full 20 MHz in accordance with the Communications Act's competitive bidding provisions.

(e) Minimum recovery for public required

In recognition of the scarcity (and hence, the value) of spectrum below 3 GHz, subsection 3301(e) directs the FCC to establish auction procedures to ensure that the American taxpayer recovers at least two-thirds of the \$7.5 billion in currently projected receipts. The Committee recognizes that the FCC will hold a series of auctions to assign licenses using the 120 MHz at issue in section 3301. The Committee does not, however, expect the FCC to wait until the last auction is completed to determine whether the total winning bids for all auctions exceeds two-thirds of \$7.5 billion. Rather, subsection 3301(e) permits the FCC to partition the total minimum recovery among separate auctions, or even among separate bands, regions, or markets. Moreover, to the extent an auction fails to obtain its total (or subtotal) minimum recovery, the FCC is authorized under subsection 3301(e)(2) to void the auction. The FCC may also use minimum bid requirements to obtain the total (or subtotal) minimum recovery.

Subsection 3301(e) thus gives the FCC fairly wide latitude in fashioning a methodology to secure a total minimum recovery of two-thirds of \$7.5 billion. Accordingly, the FCC is precluded under subsection 3301(e)(3) from conducting any auctions unless the FCC determines that its methodology will secure two-thirds of \$7.5 billion. If the FCC refrains from conducting any competitive bidding proceedings pursuant to the requirement under subsection 3301(e)(3), or pursuant to its permissive authority under subsection 3301(e)(2), then subsection 3301(e)(4) gives the FCC the discretion to hold those auctions at a future date.

Section 3302. Auction of recaptured broadcast television spectrum

Section 3302 adds a new subsection 309(j)(14) to the Communications Act to require the FCC to reclaim the 6 MHz broadcasters now use for analog transmission by no later than December 31, 2006. The FCC, however, must grant extensions to broadcasters in those markets where more than five percent of the households continue to rely exclusively on an over-the-air, analog broadcast signal.

The Committee adopted the five percent threshold to ensure that a substantial number of American households are able to make a smooth transition to digital television. While the Committee seeks to clear the 78 MHz of broadcast spectrum as soon as practicable, the Committee is concerned that an inflexible date will cause serious disruption to consumers. The Committee believes that the provision of free, over-the-air television is an important governmental interest, and that analog television service should not be terminated if a significant number of Americans rely on such over-the-air service. The Committee expects that the FCC will administer the five percent threshold by a generally-applicable rule, and not require every broadcaster in a market to file a waiver petition.

Section 3302 also directs the FCC to assign the full 78 MHz that is reclaimed from incumbent broadcast licensees by means of competitive bidding. The FCC is required to commence bidding by July 1, 2001. To the extent that the FCC allocates the reclaimed spectrum for digital television broadcast service, section 3302 precludes the FCC from enforcing either the duopoly rule or the newspaper cross-ownership rule against qualified licensees intending to use the spectrum for digital television service. The Committee finds that this limited prohibition on enforcement of these FCC rules will serve the public interest in two ways.

First, it limits the enforcement of otherwise obsolete rules. The Committee finds that given the multiplicity of information outlets in today's society, including broadcast television, cable television, satellite-based services, newspapers, on-line news services, and the Internet, these ownership rules have outlived their usefulness. The Committee fully expects that the FCC will provide for even greater and more immediate relaxation of these rules in the course of its mandatory biennial review of ownership rules.

Second, section 3302's limited prohibition on enforcement of the duopoly and cross-ownership rules will likely increase the pool of bidders for the 78 MHz of spectrum. The Committee believes that relaxation of these rules in this context will entice both broadcast station owners and newspaper owners to participate in the 2001 auction for these frequencies. As a result, the winning bids are likely to be higher than without the owners' participation.

In recognition of the scarcity (and hence, the value) of spectrum below 3 GHz, section 3302 directs the FCC to establish auction procedures to ensure that the American taxpayer recovers at least two-thirds of the \$4.0 billion in currently projected receipts. The Committee recognizes that the FCC may hold a series of auctions to assign licenses using the 78 MHz at issue here. The Committee does not, however, expect the FCC to wait until the last auction is completed to determine whether the total winning bids for all auctions exceeds two-thirds of \$4.0 billion. Rather, section 3302 permits the FCC to partition the total minimum recovery among separate auctions, or even among separate bands, regions, or markets. Moreover, to the extent an auction fails to obtain its total (or subtotal) minimum recovery, the FCC is authorized under new subsection 309(j)(14)(C)(ii) to void the auction. The FCC may also use minimum bid requirements to obtain the total (or subtotal) minimum recovery.

Section 3302 thus gives the FCC fairly wide latitude in fashioning a methodology to secure a total minimum recovery of two-thirds of \$4.0 billion. Accordingly, the FCC is precluded under section 3302 from conducting any auctions unless the FCC determines that its methodology will secure two-thirds of \$4.0 billion. If the FCC refrains from conducting any competitive bidding proceedings pursuant to this requirement under new subsection 309(j)(14)(C)(iii), or pursuant to its permissive authority under new subsection 309(j)(14)(C)(ii), then new subsection 309(j)(14)(C)(iv) gives the FCC the discretion to hold those auctions at a future date.

Section 3302 defines both “digital television service” and “analog television service.”

Section 3303. Allocation and assignment of new public safety and commercial licenses

(a) In general

Subsection 3303(a) directs the FCC to reallocate on a national, regional, or market basis 24 MHz in television broadcast channels 60 through 69 to public safety, unless the FCC finds that the needs of public safety can be met in particular areas with allocations of less than 24 MHz. The Committee has learned from public safety representatives that they do not necessarily need 24 MHz in every market, especially in rural markets. This explains why the Committee refrained from making a nationwide block allocation of 24 MHz. The Committee thus encourages the FCC to closely evaluate the public safety needs for each market.

The FCC must allocate the remainder of the spectrum located in channels 60 through 69 for commercial use, and to assign these commercial licenses by means of competitive bidding.

(b) Assignment

In light of the critical public safety needs in some markets, subsection 3303(b) requires the FCC to assign public safety licenses by no later than March 31, 1998. The Committee emphasizes that the definition of “public safety services” in subsection 3303(g) is quite narrow, particularly in relation to the service exemption found in subsection 3301(a) for “public safety radio services.” The FCC is required to commence bidding for the commercial licenses no later than July 1, 2001.

(c) Licensing of unused frequencies for public safety radio services

The Committee recognizes that in some heavily congested markets, such as Los Angeles, California, 24 MHz of spectrum is simply not available in channels 60 through 69 for immediate reallocation. Subsection 3303(c) thus directs the FCC to waive its eligibility and other rules to permit public safety to use any unassigned radio frequencies. The Committee regards such waivers as extraordinary, and thus to qualify for such a waiver, a State or local governmental agency must demonstrate to the FCC that no other frequencies allocated to public safety are immediately available, that the proposed use of unassigned frequencies will cause no harmful interference to incumbent users in the proposed band, and that public

safety usage is consistent with other existing public safety channel allocations in the same geographic area. The Committee, once again, notes that this provision will be applicable in only a limited number of circumstances.

(d) Conditions on licenses

This subsection imposes technical restrictions on public safety and commercial licensees operating in channels 60 through 69 in order to prevent interference with television broadcasters' analog and digital service. The Committee recognizes the inherent difficulty of inter-service sharing of spectrum between different spectrum users, and thus the FCC must adopt rules to ensure that current users of the spectrum suffer no new interference from the new spectrum uses that will be introduced in this band. It is the intent of the Committee that the protection for full-service analog television service provided for by this subsection shall include protection for the service proposed to be provided by any application for a new station on a vacant NTSC channel that was or is filed on or before the deadline established by the FCC for such a filing, including any cut-off date for competing applications. Public safety and commercial licensees are permitted to aggregate or disaggregate their licenses to create smaller or larger spectrum blocks.

(e) Minimum recovery for public required

In recognition of the scarcity (and hence, the value) of spectrum below 3 GHz, section 3303 directs the FCC to establish auction procedures to ensure that the American taxpayer recovers at least two-thirds of the \$1.9 billion in currently projected receipts. The Committee recognizes that the FCC may hold a series of auctions to assign licenses using the 36 MHz at issue in section 3303. The Committee does not, however, expect the FCC to wait until the last auction is completed to determine whether the total winning bids for all auctions exceeds two-thirds of \$1.9 billion. Rather, subsection 3303(e) permits the FCC to partition the total minimum recovery among separate auctions, or even among separate bands, regions, or markets. Moreover, to the extent an auction fails to obtain its total (or subtotal) minimum recovery, the FCC is authorized under subsection 3303(e)(2) to void the auction. The FCC may also use minimum bid requirements to obtain the total (or subtotal) minimum recovery.

Subsection 3303(e) thus gives the FCC fairly wide latitude in fashioning a methodology to secure a total minimum recovery of two-thirds of \$1.9 billion. Accordingly, the FCC is precluded under subsection 3303(e) from conducting any auctions unless the FCC determines that its methodology will secure two-thirds of \$1.9 billion. If the FCC refrains from conducting any competitive bidding proceedings pursuant to this requirement under subsection 3303(e)(3), or pursuant to its permissive authority under subsection 3303(e)(2), then subsection 3303(e)(4) gives the FCC the discretion to hold those auctions at a future date.

(f) Protection of qualifying low-power stations

Subsection 3303(f) directs the FCC to assure that each qualifying low power television station is assigned a frequency below 746 megahertz prior to making any allocation or assignment under this section. The Committee emphasizes that subsection 3303(g) narrowly defines “qualifying low-power television stations” to mean only those stations that broadcast at least 18 hours a day, with at least 3 hours a week of locally-originated programming. The FCC must make any assignments called for by subsection 3303(f) consistent with the primary status of incumbent licensees below 746 megahertz and the secondary status of low-power television stations. The FCC shall ensure that primary spectrum users will suffer no new or additional interference.

(g) Definitions

This subsection defines certain terms used in this Subtitle.

Section 3304. Inquiry required

Section 309(j)(12) of the Communications Act requires the FCC to conduct a public inquiry and report to Congress, no later than September 30, 1997, on a range of topics relating to its use of competitive bidding systems. Section 3304 of Subtitle D orders the FCC to initiate this inquiry no later than July 1, 1997.

CHANGES IN EXISTING LAW MADE BY SUBTITLE D

The changes in existing law made by Subtitle D are included at the conclusion of the report on this Title of the bill.

MINORITY, ADDITIONAL OR DISSENTING VIEWS

Minority and Dissenting Views on Subtitle D are provided at the conclusion of the report on this Title of the bill.

SUBTITLE E—MEDICAID

PURPOSE AND SUMMARY

The purpose of Subtitle E of Title III is to modify Title XIX of the Social Security Act in a manner providing for greater operational and administrative flexibility for the States, enhanced protections and quality assurance for recipients, and program savings for the purpose of achieving a balanced Federal budget in Fiscal Year 2002.

BACKGROUND AND NEED FOR LEGISLATION

Established in 1965, Medicaid is a joint Federal-State entitlement program that pays for medical services and institutional care on behalf of certain low-income persons. Each State designs and administers its own Medicaid program within Federal guidelines. States are required to cover certain population groups, including recipients of cash assistance programs, income-eligible families with pregnant women and children, and aged, blind, and disabled persons.

In 1967, Federal and State spending under Medicaid was \$2.4 billion. For Fiscal Year 1997, Medicaid is expected to serve 47 million persons at a combined cost to the Federal and State governments of \$170 billion. The Federal share of this cost is expected to be \$98 billion, or about 57 percent of total Medicaid spending. The \$98 billion in Federal funds is the single largest source of Federal funds to the States. By 2007, the Congressional Budget Office (CBO) projects that Federal and State Medicaid expenditures will reach \$372 billion.

During Fiscal Years 1990 through 1994, Medicaid spending grew at an annual average rate of 18.9 percent. This rapid growth was due to increased enrollment, medical care inflation, and State initiatives to maximize collection of Federal funds. Spending growth subsided in recent years, however, with the annual growth rate decelerating to just 3.3 percent in 1996. This decline in the growth of Medicaid spending was attributed to Federally imposed limits on disproportionate share hospital (DSH) payments and greater flexibility accorded to the States, which allowed for cost-saving innovations in program administration, delivery, and management. Nevertheless, CBO predicts that Medicaid spending will once again increase by 7.7 percent in 1997, and continue to grow over the next decade at an average annual rate of 8.1 percent.

Despite recent decreases in Medicaid spending growth, Medicaid remains the single largest program in virtually every State budget. As a share of State spending, Medicaid grew from just over 10 percent in 1987 to 19 percent in 1995. As a result, the Medicaid program has had the unintended effect of curtailing State investment in a variety of other programs, including education, child welfare services, law enforcement, and transportation. Absent reform, the continued growth of the Medicaid program raises the prospect of severe financial crisis in the States in the years to come.

Although States are given the option of extending coverage to other individuals, they have little operational or administrative flexibility. As a result, Governors and other elected officials have long complained that the Medicaid program is too rigid to enable them to develop more innovative health care delivery strategies.

One of the problems frequently raised by the States concerns the role of the Health Care Financing Administration (HCFA). Medicaid is administered at the Federal level by HCFA, a division of the Department of Health and Human Services. Through a network of regional offices, HCFA is supposed to work with State Medicaid departments to ensure appropriate management of the Medicaid program. Many States complain, however, that HCFA's role is less a matter of coordinated cooperation than an example of excess Federal micro management.

A number of States have sought waivers, the only form of relief currently available under Federal statute. Section 1915(b) program waivers allow States to restrict the providers from whom recipients may receive care, or to mandate participation in a managed care program for a specific population or geographical area. There are currently 96 Section 1915 program waivers operating in 42 States. Section 1115(a) research and demonstration waivers allow States to experiment with new, more flexible benefit packages and eligibility criteria than permitted by the Medicaid statute. Although many

States have sought Section 1115 waivers, the application process is lengthy, complex, and expensive. To date, HCFA has approved only 16 State waivers, 6 of which have not yet been implemented. At least 9 other State applications have been pending at HCFA for as long as over two years without any definitive action taken.

On February 4, 1997, the National Governors' Association (NGA) unanimously adopted The Governors' Agenda for the 105th Congress, which expressed their recommendations for reforming the Medicaid program. As part of their agenda, the NGA opposes a per capita cap on Federal Medicaid spending, and any other measure that would shift greater financial responsibility for the program onto the States. In addition, the NGA urges a repeal of the Boren Amendment, and seeks greater State flexibility in establishing managed care networks and controlling Medicaid eligibility standards and benefits by repealing Medicaid waiver requirements.

Following on its efforts with the Medicaid Transformation Act of 1995 and the Medicaid Restructuring Act of 1996, the Committee's proposal to reform the Medicaid program within the Balanced Budget Act of 1997 would remove the program's most restrictive barriers to innovation and quality. By replacing many existing waiver requirements with simple plan amendments, the measure would restore States' control over their Medicaid programs. In addition, the measure facilitates the use of innovative and cost-effective health service delivery mechanisms, such as managed care and primary care case management, while strengthening quality assurance protections. Although these changes do not constitute complete Medicaid reform, if enacted, they would represent the single most important improvement to the administration, operations, and service delivery of the Medicaid program.

HEARINGS

The Committee's Subcommittee on Health and Environment has not held hearings specifically on Subtitle E. The Health and Environment Subcommittee, however, held an oversight hearing on the Medicaid program and a variety of reform issues on Tuesday, March 11, 1997. Testifying before the Subcommittee on March 11, 1997, were: The Honorable Michael O. Leavitt, Governor, State of Utah; The Honorable Bob Miller, Governor, State of Nevada; Mr. William Scanlon, Director of Health Financing Systems, U.S. General Accounting Office; Gail Wilensky, Ph.D., Chair, Board of Directors, Physician Payment Review Commission; and Diane Rowland, Senior Vice President, Henry J. Kaiser Family Foundation.

COMMITTEE CONSIDERATION

On June 10, 1997, the Subcommittee on Health and Environment met in open session and approved for Full Committee consideration a Committee Print entitled "Title III, Subtitle E—Medicaid," amended, by a roll call vote of 16 yeas to 12 nays. On June 12, 1997, the Committee met in open session and ordered the Committee Print entitled "Title III, Subtitle E—Medicaid" transmitted to the House Committee on the Budget, amended, for inclusion in the 1997 Omnibus Budget Reconciliation Act, by a roll call vote of 28 yeas to 18 nays.

ROLL CALL VOTES

Pursuant to Clause 2(1)(2)(B) of rule XI of the Rules of the House of Representatives, following are listed the recorded votes on the motion to order Subtitle E transmitted to the House Committee on the Budget, and on amendments thereto, including the names of those Members voting for and against.

**COMMITTEE ON COMMERCE -- 105TH CONGRESS
ROLL CALL VOTE #20**

BILL: Committee Print entitled "Title III, Subtitle E - Medicaid"

AMENDMENT: Amendment by Mr. Waxman re: extension of SLMB protection.

DISPOSITION: NOT AGREED TO, by a roll call vote of 19 yeas to 25 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Bliley		X		Mr. Dingell	X		
Mr. Tauzin		X		Mr. Waxman	X		
Mr. Oxley		X		Mr. Markey	X		
Mr. Bilirakis		X		Mr. Hall	X		
Mr. Schaefer		X		Mr. Boucher			
Mr. Barton				Mr. Manton	X		
Mr. Hastert		X		Mr. Towns	X		
Mr. Upton		X		Mr. Pallone	X		
Mr. Stearns				Mr. Brown			
Mr. Paxon		X		Mr. Gordon	X		
Mr. Gillmor				Ms. Furse	X		
Mr. Klug		X		Mr. Deutsch	X		
Mr. Greenwood		X		Mr. Rush			
Mr. Crapo		X		Ms. Eshoo	X		
Mr. Cox		X		Mr. Klink	X		
Mr. Deal		X		Mr. Stupak	X		
Mr. Largent		X		Mr. Engel	X		
Mr. Burr		X		Mr. Sawyer	X		
Mr. Bilbray		X		Mr. Wynn			
Mr. Whitfield		X		Mr. Green	X		
Mr. Ganske		X		Ms. McCarthy	X		
Mr. Norwood		X		Mr. Strickland	X		
Mr. White		X		Ms. DeGette	X		
Mr. Coburn		X					
Mr. Lazio		X					
Mrs. Cubin		X					
Mr. Rogan		X					
Mr. Shimkus		X					

6/12/97

**COMMITTEE ON COMMERCE -- 105TH CONGRESS
ROLL CALL VOTE #21**

BILL: Committee Print entitled "Title III, Subtitle E - Medicaid"

AMENDMENT: Amendment by Mr. Strickland re: definition of children with special needs.

DISPOSITION: AGREED TO, by a roll call vote of 27 yeas to 20 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Bliley				Mr. Dingell	X		
Mr. Tauzin		X		Mr. Waxman	X		
Mr. Oxley		X		Mr. Markey			
Mr. Bilirakis		X		Mr. Hall	X		
Mr. Schaefer		X		Mr. Boucher			
Mr. Barton		X		Mr. Manton	X		
Mr. Hastert		X		Mr. Towns	X		
Mr. Upton		X		Mr. Pallone	X		
Mr. Stearns		X		Mr. Brown	X		
Mr. Paxon		X		Mr. Gordon	X		
Mr. Gillmor		X		Ms. Furse	X		
Mr. Klug		X		Mr. Deutsch	X		
Mr. Greenwood	X			Mr. Rush			
Mr. Crapo		X		Ms. Eshoo	X		
Mr. Cox		X		Mr. Klink	X		
Mr. Deal		X		Mr. Stupak	X		
Mr. Largent		X		Mr. Engel	X		
Mr. Burr		X		Mr. Sawyer	X		
Mr. Bilbray		X		Mr. Wynn	X		
Mr. Whitfield	X			Mr. Green	X		
Mr. Ganske	X			Ms. McCarthy	X		
Mr. Norwood	X			Mr. Strickland	X		
Mr. White		X		Ms. DeGette	X		
Mr. Coburn	X						
Mr. Lazio	X						
Mrs. Cubin		X					
Mr. Rogan		X					
Mr. Shimkus	X						

6/12/97

**COMMITTEE ON COMMERCE -- 105TH CONGRESS
ROLL CALL VOTE #22**

BILL: Committee Print entitled "Title III, Subtitle E - Medicaid"

AMENDMENT: Amendment by Mr. Bliley re: strike the Boren Amendment and replace it with a public rate-setting process and an 18-month rate floor.

DISPOSITION: AGREED TO, by a roll call vote of 28 yeas to 19 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Bliley	X			Mr. Dingell			
Mr. Tauzin	X			Mr. Waxman		X	
Mr. Oxley	X			Mr. Markey		X	
Mr. Bilirakis	X			Mr. Hall		X	
Mr. Schaefer	X			Mr. Boucher			
Mr. Barton	X			Mr. Manton		X	
Mr. Hastert	X			Mr. Towns		X	
Mr. Upton	X			Mr. Pallone		X	
Mr. Stearns	X			Mr. Brown		X	
Mr. Paxon	X			Mr. Gordon		X	
Mr. Gillmor	X			Ms. Furse		X	
Mr. Klug	X			Mr. Deutsch		X	
Mr. Greenwood	X			Mr. Rush			
Mr. Crapo	X			Ms. Eshoo		X	
Mr. Cox	X			Mr. Klink		X	
Mr. Deal	X			Mr. Stupak		X	
Mr. Largent	X			Mr. Engel			
Mr. Burr	X			Mr. Sawyer		X	
Mr. Bilbray	X			Mr. Wynn		X	
Mr. Whitfield	X			Mr. Green		X	
Mr. Ganske	X			Ms. McCarthy	X		
Mr. Norwood	X			Mr. Strickland		X	
Mr. White	X			Ms. DeGette		X	
Mr. Coburn	X						
Mr. Lazio	X						
Mrs. Cubin	X						
Mr. Rogan	X						
Mr. Shimkus		X					

6/12/97

**COMMITTEE ON COMMERCE -- 105TH CONGRESS
ROLL CALL VOTE #23**

BILL: Committee Print entitled "Title III, Subtitle E - Medicaid"

AMENDMENT: Amendment by Mr. Green re: revising disproportionate share payments under State Medicaid programs.

DISPOSITION: NOT AGREED TO, by a roll call vote of 8 yeas to 39 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Bliley		X		Mr. Dingell			
Mr. Tauzin	X			Mr. Waxman		X	
Mr. Oxley		X		Mr. Markey		X	
Mr. Bilirakis		X		Mr. Hall	X		
Mr. Schaefer	X			Mr. Boucher			
Mr. Barton	X			Mr. Manton		X	
Mr. Hastert		X		Mr. Towns		X	
Mr. Upton		X		Mr. Pallone	X		
Mr. Stearns				Mr. Brown		X	
Mr. Paxon		X		Mr. Gordon		X	
Mr. Gillmor		X		Ms. Furse		X	
Mr. Klug		X		Mr. Deutsch		X	
Mr. Greenwood		X		Mr. Rush			
Mr. Crapo		X		Ms. Eshoo		X	
Mr. Cox		X		Mr. Klink		X	
Mr. Deal		X		Mr. Stupak		X	
Mr. Largent		X		Mr. Engel		X	
Mr. Burr		X		Mr. Sawyer		X	
Mr. Bilbray		X		Mr. Wynn		X	
Mr. Whitfield		X		Mr. Green	X		
Mr. Ganske		X		Ms. McCarthy	X		
Mr. Norwood		X		Mr. Strickland		X	
Mr. White		X		Ms. DeGette	X		
Mr. Coburn		X					
Mr. Lazio		X					
Mrs. Cubin		X					
Mr. Rogan		X					
Mr. Shimkus		X					

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**COMMITTEE ON COMMERCE -- 105TH CONGRESS
ROLL CALL VOTE #24**

BILL: Committee Print entitled "Title III, Subtitle E - Medicaid"

AMENDMENT: Amendment by Mr. Waxman re: DSH targeting.

DISPOSITION: NOT AGREED TO, as amended, by a roll call vote of 19 yeas to 28 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Bliley		X		Mr. Dingell			
Mr. Tauzin	X			Mr. Waxman	X		
Mr. Oxley		X		Mr. Markey	X		
Mr. Bilirakis	X			Mr. Hall		X	
Mr. Schaefer	X			Mr. Boucher			
Mr. Barton		X		Mr. Manton	X		
Mr. Hastert		X		Mr. Towns	X		
Mr. Upton		X		Mr. Pallone		X	
Mr. Stearns				Mr. Brown	X		
Mr. Paxon		X		Mr. Gordon		X	
Mr. Gillmor		X		Ms. Furse	X		
Mr. Klug		X		Mr. Deutsch	X		
Mr. Greenwood		X		Mr. Rush			
Mr. Crapo		X		Ms. Eshoo	X		
Mr. Cox		X		Mr. Klink		X	
Mr. Deal		X		Mr. Stupak		X	
Mr. Largent		X		Mr. Engel	X		
Mr. Burr		X		Mr. Sawyer	X		
Mr. Bilbray	X			Mr. Wynn	X		
Mr. Whitfield		X		Mr. Green	X		
Mr. Ganske		X		Ms. McCarthy	X		
Mr. Norwood		X		Mr. Strickland		X	
Mr. White		X		Ms. DeGette	X		
Mr. Coburn		X					
Mr. Lazio		X					
Mrs. Cubin		X					
Mr. Rogan	X						
Mr. Shimkus		X					

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**COMMITTEE ON COMMERCE -- 105TH CONGRESS
ROLL CALL VOTE #25**

BILL: Committee Print entitled "Title III, Subtitle E - Medicaid"

AMENDMENT: Amendment to the Hall Amendment by Mr. Green re: use of nongovernmental personnel under Medicaid.

DISPOSITION: NOT AGREED TO, by a roll call vote of 19 yeas to 27 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Bliley		X		Mr. Dingell	X		
Mr. Tauzin		X		Mr. Waxman	X		
Mr. Oxley		X		Mr. Markey			
Mr. Bilirakis		X		Mr. Hall		X	
Mr. Schaefer		X		Mr. Boucher			
Mr. Barton		X		Mr. Manton	X		
Mr. Hastert		X		Mr. Towns	X		
Mr. Upton		X		Mr. Pallone	X		
Mr. Stearns				Mr. Brown	X		
Mr. Paxon		X		Mr. Gordon	X		
Mr. Gillmor		X		Ms. Furse	X		
Mr. Klug		X		Mr. Deutsch	X		
Mr. Greenwood		X		Mr. Rush			
Mr. Crapo		X		Ms. Eshoo	X		
Mr. Cox		X		Mr. Klink	X		
Mr. Deal		X		Mr. Stupak	X		
Mr. Largent		X		Mr. Engel	X		
Mr. Burr		X		Mr. Sawyer	X		
Mr. Bilbray		X		Mr. Wynn	X		
Mr. Whitfield		X		Mr. Green	X		
Mr. Ganske		X		Ms. McCarthy	X		
Mr. Norwood		X		Mr. Strickland	X		
Mr. White		X		Ms. DeGette	X		
Mr. Coburn		X					
Mr. Lazio							
Mrs. Cubin		X					
Mr. Rogan		X					
Mr. Shimkus		X					

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**COMMITTEE ON COMMERCE -- 105TH CONGRESS
ROLL CALL VOTE #26**

BILL: Committee Print entitled "Title III, Subtitle E - Medicaid"

AMENDMENT: Amendment by Mr. Hall re: use of nongovernmental personnel under Medicaid.

DISPOSITION: **AGREED TO**, by a roll call vote of 27 yeas to 20 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Biiley	X			Mr. Dingell		X	
Mr. Tauzin	X			Mr. Waxman		X	
Mr. Oxley	X			Mr. Markey		X	
Mr. Bilirakis	X			Mr. Hall	X		
Mr. Schaefer	X			Mr. Boucher			
Mr. Barton	X			Mr. Manton		X	
Mr. Hastert	X			Mr. Towns		X	
Mr. Upton	X			Mr. Pallone		X	
Mr. Stearns				Mr. Brown		X	
Mr. Paxon	X			Mr. Gordon		X	
Mr. Gillmor	X			Ms. Furse		X	
Mr. Klug	X			Mr. Deutsch		X	
Mr. Greenwood	X			Mr. Rush			
Mr. Crapo	X			Ms. Eshoo		X	
Mr. Cox	X			Mr. Klink		X	
Mr. Deal	X			Mr. Stupak		X	
Mr. Largent	X			Mr. Engel		X	
Mr. Burr	X			Mr. Sawyer		X	
Mr. Bilbray	X			Mr. Wynn		X	
Mr. Whitfield	X			Mr. Green		X	
Mr. Ganske	X			Ms. McCarthy		X	
Mr. Norwood	X			Mr. Strickland		X	
Mr. White	X			Ms. DeGette		X	
Mr. Coburn	X						
Mr. Lazio							
Mrs. Cubin	X						
Mr. Rogan	X						
Mr. Shimkus	X						

6/12/97

**COMMITTEE ON COMMERCE -- 105TH CONGRESS
ROLL CALL VOTE #27**

BILL: Committee Print entitled "Title III, Subtitle E - Medicaid"

AMENDMENT: Amendment by Mr. Klink re: increase in the matching rate for nursing home survey and certification.

DISPOSITION: NOT AGREED TO, by a roll call vote of 18 yeas to 25 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Bliley		X		Mr. Dingell	X		
Mr. Tauzin		X		Mr. Waxman	X		
Mr. Oxley		X		Mr. Markey	X		
Mr. Bilirakis		X		Mr. Hall			
Mr. Schaefer		X		Mr. Boucher			
Mr. Barton		X		Mr. Manton	X		
Mr. Hastert		X		Mr. Towns	X		
Mr. Upton		X		Mr. Pallone	X		
Mr. Stearns				Mr. Brown	X		
Mr. Paxon		X		Mr. Gordon			
Mr. Gillmor				Ms. Furse	X		
Mr. Klug				Mr. Deutsch	X		
Mr. Greenwood		X		Mr. Rush			
Mr. Crapo		X		Ms. Eshoo	X		
Mr. Cox				Mr. Klink	X		
Mr. Deal		X		Mr. Stupak	X		
Mr. Largent		X		Mr. Engel	X		
Mr. Burr		X		Mr. Sawyer	X		
Mr. Bilbray		X		Mr. Wynn	X		
Mr. Whitfield		X		Mr. Green	X		
Mr. Ganske		X		Ms. McCarthy		X	
Mr. Norwood		X		Mr. Strickland	X		
Mr. White		X		Ms. DeGette	X		
Mr. Coburn		X					
Mr. Lazio		X					
Mrs. Cubin		X					
Mr. Rogan		X					
Mr. Shimkus		X					

6/12/97

**COMMITTEE ON COMMERCE - 105TH CONGRESS
ROLL CALL VOTE #28**

BILL: Committee Print entitled "Title III, Subtitle E - Medicaid"

AMENDMENT: Amendment by Mr. Deal re: Medicaid disability eligibility.

DISPOSITION: AGREED TO, as amended, by a roll call vote of 27 yeas to 18 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Bliley	X			Mr. Dingell			
Mr. Tauzin	X			Mr. Waxman		X	
Mr. Oxley	X			Mr. Markey			
Mr. Bilirakis	X			Mr. Hall			
Mr. Schaefer	X			Mr. Boucher			
Mr. Barton	X			Mr. Manton		X	
Mr. Hastert	X			Mr. Towns		X	
Mr. Upton	X			Mr. Pallone		X	
Mr. Stearns	X			Mr. Brown		X	
Mr. Paxon	X			Mr. Gordon		X	
Mr. Gillmor	X			Ms. Furse		X	
Mr. Klug	X			Mr. Deutsch		X	
Mr. Greenwood	X			Mr. Rush			
Mr. Crapo				Ms. Eshoo		X	
Mr. Cox	X			Mr. Klink		X	
Mr. Deal	X			Mr. Stupak		X	
Mr. Largent	X			Mr. Engel		X	
Mr. Burr	X			Mr. Sawyer		X	
Mr. Bilbray	X			Mr. Wynn		X	
Mr. Whitfield	X			Mr. Green		X	
Mr. Ganske	X			Ms. McCarthy		X	
Mr. Norwood	X			Mr. Strickland		X	
Mr. White	X			Ms. DeGette		X	
Mr. Coburn	X						
Mr. Lazio	X						
Mrs. Cubin	X						
Mr. Rogan	X						
Mr. Shimkus	X						

6/12/97

**COMMITTEE ON COMMERCE -- 105TH CONGRESS
ROLL CALL VOTE #29**

BILL: Committee Print entitled "Title III, Subtitle E - Medicaid"

MOTION: Motion by Mr. Bilely to order the Committee Print entitled "Title III, Subtitle E - Medicaid", amended, transmitted to the Committee on the Budget for inclusion in the 1997 Omnibus Budget Reconciliation Act.

DISPOSITION: AGREED TO, by a roll call vote of 28 yeas to 18 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Bilely	X			Mr. Dingell		X	
Mr. Tauzin	X			Mr. Waxman		X	
Mr. Oxley	X			Mr. Markey		X	
Mr. Bilirakis	X			Mr. Hall	X		
Mr. Schaefer	X			Mr. Boucher			
Mr. Barton				Mr. Manton		X	
Mr. Hastert	X			Mr. Towns		X	
Mr. Upton	X			Mr. Pallone		X	
Mr. Stearns	X			Mr. Brown		X	
Mr. Paxon	X			Mr. Gordon		X	
Mr. Gillmor	X			Ms. Furse	X		
Mr. Klug	X			Mr. Deutsch		X	
Mr. Greenwood	X			Mr. Rush			
Mr. Crapo	X			Ms. Eshoo		X	
Mr. Cox	X			Mr. Klink		X	
Mr. Deal	X			Mr. Stupak		X	
Mr. Largent	X			Mr. Engel		X	
Mr. Burr	X			Mr. Sawyer		X	
Mr. Bilbray	X			Mr. Wynn		X	
Mr. Whitfield	X			Mr. Green			
Mr. Ganske	X			Ms. McCarthy		X	
Mr. Norwood	X			Mr. Strickland		X	
Mr. White				Ms. DeGette		X	
Mr. Coburn	X						
Mr. Lazio	X						
Mrs. Cubin	X						
Mr. Rogan	X						
Mr. Shimkus	X						

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COMMITTEE ON COMMERCE—105TH CONGRESS, VOICE
VOTES, 6/12/97

Bill: Committee Print entitled "Title III, Subtitle E—Medicaid"
Amendment: Amendment by Mr. Bilirakis re: treatment of taxes on certain hospitals which provide free care.
Disposition: Agreed to, by a voice vote.
Amendment: Amendment by Mr. Upton re: extension of a waiver for an institution for individuals with mental diseases.
Disposition: Agreed to, by a voice vote.
Amendment: Amendment by Mr. Deal re: Medicaid disability eligibility.
Disposition: Withdrawn, by unanimous consent.
Amendment: Amendment by Mr. Brown re: additional fraud and abuse protections in managed care.
Disposition: Agreed to, by a voice vote.
Amendment: Amendment by Mr. Klug re: permit States to apply stricter State managed care standards.
Disposition: Agreed to, by a voice vote.
Amendment: Amendment by Mr. Coburn re: grievance procedures under managed care plans.
Disposition: Agreed to, by a voice vote.
Amendment: Amendment by Mr. Waxman re: patient choice.
Disposition: Agreed to, by a voice vote.
Amendment: Amendment by Mr. Towns re: nurse mid-wives.
Disposition: Agreed to, by a voice vote.
Amendment: Amendment by Mr. Upton re: rural health clinics.
Disposition: Agreed to, by a voice vote.
Amendment: Amendment by Mr. Greenwood re: blood factor settlement payments.
Disposition: Agreed to, by a voice vote.
Amendment: Amendment to the Waxman Amendment by Mr. Bilbray re: protecting DSH payments of certain children's and teaching hospitals.
Disposition: Agreed to, by a voice vote.
Amendment: Amendment by Mr. Norwood re: solvency standards for certain HMOs.
Disposition: Agreed to, by a voice vote.
Amendment: Amendment to the Deal Amendment by Mr. Bilbray re: Medicaid disability eligibility and alien funding.
Disposition: Agreed to, by a voice vote.
Amendment: Amendment by Mr. Furse re: increase the limit on Federal Medicaid payments to the territories.
Disposition: Withdrawn, by unanimous consent.
Amendment: Amendment by Mr. Bliley re: substitution of a conscience clause to the Gag Rule.
Disposition: Agreed to, by a voice vote.
Amendment: Amendment by Mr. Strickland re: provides that hospital length-of-stays can be determined by a health care provider.
Disposition: Agreed to, by a voice vote.
Amendment: Amendment by Mr. Waxman re: provide that a State may permit an individual to choose a managed care entity from those who meet the requirements.

Disposition: Agreed to, by a voice vote.

Amendment: Amendment by Mr. Lazio re: standards relating to access to obstetrical and gynecological services under managed care plans.

Disposition: Agreed to, by a voice vote.

Amendment: Amendment by Mr. Waxman re: provide that the conscience clause should only be available to a religious based HMO.

Disposition: Withdrawn, by unanimous consent.

COMMITTEE OVERSIGHT FINDINGS

Pursuant to clause 2(1)(3)(A) of rule XI of the Rules of the House of Representatives, the Committee held an oversight hearing and made findings that are reflected in the report on this Subtitle.

COMMITTEE ON GOVERNMENT REFORM AND OVERSIGHT

Pursuant to clause 2(1)(3)(D) of rule XI of the Rules of the House of Representatives, no oversight findings have been submitted to the Committee by the Committee on Government Reform and Oversight.

COMMITTEE COST ESTIMATE

In compliance with clause 7(a) of rule XIII of the Rules of the House of Representatives, the Committee believes that enactment of Subtitle E would result in no additional costs to the Federal Government.

CONGRESSIONAL BUDGET OFFICE ESTIMATE

Pursuant to clause 2(1)(3)(C) of rule XI of the Rules of the House of Representatives, a letter from the Congressional Budget Office providing a cost estimate for all six subtitles of Title III is found at the conclusion of the report on this Title of the bill.

FEDERAL MANDATES STATEMENT

The Committee adopts as its own the estimate of Federal mandates prepared by the Director of the Congressional Budget Office pursuant to section 423 of the Unfunded Mandates Reform Act.

ADVISORY COMMITTEE STATEMENT

No advisory committees within the meaning of section 5(b) of the Federal Advisory Committee Act were created by this legislation.

CONSTITUTIONAL AUTHORITY STATEMENT

Pursuant to clause 2(1)(4) of rule XI of the Rules of the House of Representatives, the Committee finds that the Constitutional authority for this legislation is provided in Article I, section 8, clause 3, which grants Congress the power to regulate commerce with foreign nations, among the several States, and with the Indian tribes.

SECTION-BY-SECTION ANALYSIS OF THE LEGISLATION

Chapter 1—State Flexibility

SUBCHAPTER A—USE OF MANAGED CARE

Section 3401. State options to provide benefits through managed care entities

Section 3401 gives States the option of providing benefits through a managed care entity, including primary care case managers (discussed below), without requiring a section 1915(b) waiver. States would be allowed to require that individuals eligible for medical assistance under the State plan enroll in a capitated managed care plan or with a primary care case manager. A State would be permitted to restrict the number of plans or providers it contracts with, consistent with quality of care. Individuals must be permitted to choose their manager or managed care entity from among those that meet Medicaid requirements. Individuals must be given a choice of at least two managed care entities or managers. In the case of rural areas, eligible individuals who are required to enroll with a single entity must be given the option of obtaining covered services through an alternative provider; those individuals offered no alternative to a single entity or manager must be given the choice of at least two providers within the managed care entity or through the primary care case manager. Native Americans/Alaskan Natives could only be required to enroll in a managed care entity if it is a participating Indian Health Service, tribally operated health, or urban Indian Health program. The provision would permit States to lock beneficiaries into plans for up to 6 months. As under current law, beneficiaries would be allowed to disenroll from a plan at any time for cause.

States could not require either special needs children or Qualified Medicare Beneficiaries to enroll in managed care plans. As under current law, access to family planning providers could not be restricted.

Section 3402. Elimination of 75/25 restriction on risk contracts.

Section 3402 eliminates the “75/25” rule. As a proxy for quality, current law requires that plans limit their enrollment of Medicaid and Medicare beneficiaries to less than 75 percent of total enrollment (known as the “75/25” rule). This requirement may be waived for community, migrant, or Appalachian health centers which receive Federal grant funds and meet certain other conditions. It may be waived temporarily for a publicly owned contracting plan, a plan with more than 25,000 enrollees that serves a designated “medically underserved” area and that previously participated in an approved demonstration project, or a plan that has had a Medicaid contract for less than 3 years, if the plan is making continuous and reasonable efforts to comply with the 75 percent limit. For some HMOs, the “75/25” rule has been bypassed through State demonstration waivers or through specific Federal legislation.

Section 3403. Primary care case management services as state option without need for waiver

Section 3403 adds primary care case management as an optional service States may provide without a waiver. Primary care case management services would be those case management and primary care services a physician or physician group practice, or, at State option, nurse practitioner, certified nurse-midwife, or physician assistant contracts with the State to provide. These include covered primary care services provided or arranged for directly by the primary care case manager and other services as specified under the contract. The contract would have to provide that: (1) hours of operation are reasonable and adequate; (2) enrollment is restricted to those living reasonably near a service delivery site; (3) a sufficient number of providers are employed or contracted with to meet the needs of enrollees; (4) individuals are not discriminated against in enrollment based on health status or need for care; (5) enrollees are allowed to disenroll without cause during the first month of enrollment and disenroll at any time for cause. Enrollees could not be locked in to a provider for more than 6 months. Primary care services would include all health care and laboratory services customarily provided by or through a general practitioner, family medicine physician, internal medicine physician, obstetrician/gynecologist, or pediatrician.

Section 3404. Change in threshold amount for contracts requiring Secretary's prior approval

Section 3404 raises from \$100,000 to \$1,000,000 the managed care contract expenditure level requiring prior approval from the Secretary of Health and Human Services, effective 1998. In future years, the amount would be indexed for inflation according to the percentage increase in the consumer price index for all urban consumers over the previous year.

Section 3405. Determination of hospital stay

Section 3405 requires that the length of an inpatient hospital stay be determined by the patient and his attending physician or other attending health care provider, based on medical appropriateness. Nothing in Medicaid law could be construed as requiring the provision of inpatient care if the patient and his or her attending physician determine a shorter period of hospital stay is medically appropriate. The provision would not affect the application of deductibles and co-insurance.

SUBCHAPTER B—PAYMENT METHODOLOGY

Section 3411. Flexibility in payment methods

Under the so-called Boren amendment, States are required to pay hospitals, nursing facilities, and intermediate care facilities for the mentally retarded (ICFs/MR) rates that are "reasonable and adequate" to cover the costs which must be incurred by "efficiently and economically operated facilities." A number of Federal courts have ruled that State systems failed to meet the test of "reasonableness" and some States have had to increase payments to these providers as a result of these judicial interpretations.

Section 3411 repeals the Boren Amendment and establishes a public notice process for setting payment rates for hospitals, nursing facilities, and ICFs/MR. In the case of hospitals, rates would have to take into account the situation of hospitals that serve a disproportionate number of low-income patients with special needs. For hospitals and nursing facilities, each State would have to assure that the average level of payments furnished during the 18-month period beginning October 1, 1997, is not less than the average level of payments that would be made for such services based on rates in effect as of May 1, 1997. It is the Committee's intention that, following enactment of this Act, neither this nor any other provision of Section 1902 will be interpreted as establishing a cause of action for hospitals and nursing facilities relative to the adequacy of the rates they receive.

Section 3412. Payment for center and clinic services

Under current law, State Medicaid programs are required to cover ambulatory services that are furnished by Federally qualified health centers (FQHCs) and rural health clinics (RHCs). Medicaid payments for ambulatory services that are provided by FQHCs or RHCs must be equal to 100 percent of the facilities' reasonable costs for providing the services. If an FQHC enters into a contract with a HMO that contracts with a State Medicaid program, the HMO must pay the FQHC 100 percent of reasonable costs and the State's capitation payment to the HMO must reflect the 100 percent rate that is due to the FQHC.

Section 3412 would require States to continue to pay 100 percent of reasonable costs for services furnished by FQHCs and RHCs during Fiscal Years 1998 and 1999, but permits them to reduce rates in later years. States would be required to pay FQHCs and RHCs at least 95 percent of costs for services furnished during FY 2000, 90 percent for FY 2001, and 85 percent for FY 2002.

To ease the transition from cost-based payment rates, the provision specifies two special payment rules that would be applicable during Fiscal Years 1998-2002. First, States would be required to make supplemental payments to FQHCs and RHCs. Such payments would be equal to the difference between the contracted amount and the cost-based amount. Second, in the case of a contract between an FQHC and an HMO, the HMO would have to pay the FQHC or RHC at least as much as it would pay any other provider for similar services.

Section 3412 also requires the Comptroller General to report, not later than February 1, 2001, on the impact of these amendments on access to health care for Medicaid beneficiaries and the uninsured, and on the ability of FQHCs and RHCs to become integrated in a managed care system.

Section 3413. Treatment of State taxes imposed on certain hospitals that provide free care

Currently, States may not claim for Federal matching payments State spending generated from provider-related donations or health care taxes that are not broad-based. Health care provider-specific taxes are not considered broad-based and, thus, may not be used to claim Federal matching payments for Medicaid spending. Sec-

tion 3413 amends the definition of the term “broad-based health care related tax” to specify that taxes that exclude hospitals which are exempt from taxation under Section 501(c)(3) of the Internal Revenue code and do not accept Medicaid or Medicare reimbursement would qualify for Federal matching payments if used as State Medicaid spending. The provision would also prohibit States from claiming Federal matching payments for State spending generated from health care taxes applied to these facilities.

SUBCHAPTER C—ELIGIBILITY

Section 3421. State option of continuous eligibility for 12 months; clarification of State option to cover all children under 19 years of age

Section 3421 permits a State to provide a full continuous 12 months of eligibility for children up to age 19 or an age specified by the State.

Section 3422. Payment of home-health-related Medicare Part B premium amount for certain low-income individuals

States are currently required to pay Medicare Part B premiums for Medicare beneficiaries who have incomes up to 120 percent of the official poverty line. In response to the Part B premium increase that will result from the transfer of Medicare home health spending from Part A to Part B, Section 3422 provides for premium assistance for low-income beneficiaries who do not currently receive Medicaid premium assistance. This section requires State Medicaid programs to cover that portion of the Medicare Part B premium attributable to the transfer of certain home health post-institutional visits from Part A to Part B for Medicare beneficiaries with incomes ranging from 120 percent to 175 percent of poverty. The Federal government would pay 100 percent of these costs.

Section 3423. Penalty for fraudulent eligibility

Section 3423 clarifies a current law anti-fraud protection by providing that a person who, for a fee, assists an individual to dispose of assets in order to obtain Medicaid eligibility for nursing home care, may be subject to criminal liability if the individual disposes of assets and a period of ineligibility is imposed against such individual. It is the Committee’s expectation that, consistent with the Attorney General’s interpretation in the recent judgment of the United States District Court for the District of Oregon in *Peebler v. Reno*, this provision would apply in cases where the transfer of assets results in the imposition of a period of ineligibility for Medicaid benefits.

Section 3424. Treatment of certain settlement payments

Under a recent settlement, four manufacturers of blood plasma products will pay \$100,000 to each of 6,200 hemophilia patients who are infected with human immunodeficiency virus (HIV). Some of the HIV-infected patients are receiving, or may apply for, Medicaid benefits. The amount of the settlement would exceed the income and resource limits for Medicaid eligibility. Section 3424 specifies that payments made from the blood products settlement

shall not be considered income or resources in determining Medicaid eligibility, or the amount of benefits under Medicaid.

SUBCHAPTER D—PROGRAMS OF ALL-INCLUSIVE CARE FOR THE
ELDERLY (PACE)

OBRA 86 required the Secretary to grant waivers of certain Medicare and Medicaid requirements to not more than 10 public or non-profit private community-based organizations to provide health and long-term care services on a capitated basis to frail elderly persons at risk of institutionalization. These projects, known as the Programs of All Inclusive Care for the Elderly, or PACE projects, were intended to determine whether an earlier demonstration program, ON LOK, serving frail elderly persons, could be replicated across the country. OBRA 90 expanded the number of organizations eligible for waivers to 15.

Sections 3431, 3432, 3433, and 3434 repeal current ON LOK and PACE project demonstration waiver authority and establish PACE as a State option under Medicaid. Persons enrolled in PACE would be eligible for Medicaid and need not be eligible for Medicare. Enrollees would receive Medicaid covered benefits solely through the PACE program. PACE providers would offer comprehensive health care services to eligible individuals in accordance with a PACE program agreement and regulations. In general, PACE providers would be public or private nonprofit entities, except for entities (up to 10) participating in a demonstration to test the operation of a PACE program by private, for-profit entities.

SUBCHAPTER E—BENEFITS

Section 3441. Elimination of requirement to pay for private insurance

Under current law, the ability of States to enroll individuals in private insurance is restricted by requirements that they identify cases in which it would be cost-effective to enroll a Medicaid-eligible individual in a private insurance plan and, as a condition of eligibility, require the individual to enroll in the plan. Section 3441 removes the identification and enrollment requirements and gives States a more flexible option of purchasing private insurance for recipients.

Section 3442. Permitting same copayments in health maintenance organizations as in fee-for-service

Section 3442 eliminates the prohibition on enrollment fees, coinsurance, or other cost-sharing charges for services furnished by health maintenance organizations (HMOs).

Section 3443. Physician qualification requirements

This provision repeals the minimum qualifications for physicians who furnish services to a child under age 21 or to a pregnant woman.

Section 3444. Elimination of requirement of prior institutionalization with respect to habilitation services furnished under a waiver for home or community-based services

Under current law, States may obtain waivers to provide a broad range of home and community-based services, including habilitation services, to persons who otherwise would require institutional care. Habilitation services, however, may be provided only to an individual who has been discharged from a nursing facility or an intermediate care facility for the mentally retarded. Section 3444 repeals the prior institutionalization requirement that applies to habilitation services offered under these home and community-based programs.

Section 3445. Benefits for services of physician assistants

This provision permits States to cover services furnished by a physician assistant which the assistant is legally authorized to perform under State law and with the supervision of a physician.

Section 3446. Study and report on actuarial value of EPSDT benefit

This provision requires the Secretary to provide for a study on the actuarial value of early and periodic screening, diagnostic, and treatment (EPSDT) services. The study would include an examination of the value attributable to the non-screening portions of EPSDT services.

SUBCHAPTER F—ADMINISTRATION

Section 3451. Elimination of duplicative inspection of care requirements for ICFs/MR and mental hospitals

Under current law, States that provide services in mental hospitals and in intermediate care facilities for the mentally retarded (ICFs/MR) must provide for periodic inspections of care for each Medicaid beneficiary who receives services in the institution. Inspections of care have been conducted to assure that persons are receiving the appropriate level of care of adequate quality. The Department of Health and Human Services has established a new survey outcome-oriented process for mental hospitals and ICFs/MR. Section 3451 eliminates inspection of care reviews in mental hospitals and ICFs/MR and retains survey and certification reviews for the facilities.

Section 3452. Alternative sanctions for noncompliant ICFs/MR

Under current law, ICFs/MR must meet certain requirements and standards for safety and for the proper provision of care. If a State finds that a facility is out of compliance with the requirements, the facility's participation in Medicaid can be terminated, or the State can withhold payment for new admissions to the facility until the deficiencies have been corrected. States have limited sanctions available for use for ICFs/MR that are found to have deficiencies that do not jeopardize the health and safety of patients. Section 3452 allows States to establish alternative remedies that are demonstrated to be effective in deterring noncompliance.

Section 3453. Modification of MMIS requirements

This provision deletes current statutory language that relates to 1980s requirements for the Medicaid Managed Information System (MMIS). It would require each State to operate a system that is adequate to provide efficient, economical, and effective administration, and is compatible with the claims processing and information retrieval systems that are used to administer the Medicare program. In addition, for claims filed on or after Jan. 1, 1999, the provision would require each State's system to electronically transmit data to the Secretary in a specific format.

Section 3454. Facilitating imposition of State alternative remedies on non-compliant nursing facilities

This provision eliminates the requirement for States to repay Federal funds for failure of a facility to correct deficiencies according to an approved plan of correction.

Section 3455. Medically accepted indication

Each State is required to provide for a drug use review (DUR) program to assure that covered outpatient drugs are appropriate, medically necessary, and are not likely to result in adverse medical results. Under the DUR program, data on drug use is to be assessed against predetermined standards consistent with compendia specified in the law. Section 3455 adds the DRUGDEX Information System to specified compendia for assessing data on drug use.

Section 3456. Continuation of State-wide Section 1115 Medicaid waivers

This provision amends Section 1115 of the Act to provide for a simplified renewal or extension process. Within a year before the expiration date of a waiver project, the chief executive officer of a State could submit a written request to the Secretary of Health and Human Services (HHS) to extend the project for up to 3 years. If the Secretary did not respond to the request within 6 months, the request would be deemed to have been granted. The deadline for a final report on the project would be extended until 1 year after the waivers would originally have expired, and the Secretary's evaluation of the project would be due up to 1 year after the final report. The project extension would be on the same terms and conditions that applied to the project before the extension. If budget neutrality was an original condition of approval of a waiver project, the Secretary would be required to assure that such condition was met in the extension of the project. In so doing, the Secretary would have to take into account the Secretary's best estimate of rates of change in expenditures at the time of the extension.

It is the Committee's intent that a State operating under a Section 1115 research and demonstration waiver be permitted to use disproportionate share funds allotted to the State for the purpose of coverage expansion at the discretion of the State.

Section 3457. Authorizing administrative streamlining and privatizing modifications under the Medicaid Program

This provision would allow Medicaid eligibility determinations to be made by an entity that is not a State or local government, or

by an individual who is not an employee of a State or local government. The conditions for eligibility and the right to challenge determinations would not be affected by this change; nor would determinations regarding quality control or error rates.

Section 3458. Extension of moratorium

Medicaid payment for services provided by institutions for mental disease (IMD) may be made only for beneficiaries who are under age 21 or over age 65. For two specified facilities, previous legislation has imposed a moratorium on determination of the facilities as IMDs. This provision extends the classification of the two facilities as IMDs for purposes of Medicaid reimbursement.

To facilitate its intended review and reform of the designation and payment of IMDs, the Committee calls on the States to collect data, on per-recipient and per-inpatient bases, relating to the utilization and cost of care provided to Medicaid recipients served by IMDs. This data will assist the Committee and other interested Federal agencies in the creation of a reliable baseline for IMD recipient expenditures, upon which cost estimates of statutory reform may be made.

Chapter 2—Quality Assurance

Section 3461. Requirements to ensure quality and access to care under managed care plans

States entering into contracts with managed care entities are required under this provision to establish a quality assurance program, consistent with standards that the Secretary would establish and monitor, in consultation with States and that do not preempt the application of stricter State standards. State quality assurance programs would be required to include: (1) standards for adequate access to primary care and specialized services, including pediatric services for special needs children; (2) procedures for monitoring and evaluating quality of care that includes submitting quality assurance data using requirements for entities with Medicare contracts or other requirements as approved by the Secretary, and periodic assessment of quality improvement strategies; and (3) provisions for financial reporting.

Managed care entities would be required to submit to the State any information the State may find necessary to monitor care, maintain an internal quality assurance program consistent with the State's quality assurance program described above, and provide effective grievance procedures.

Health maintenance organizations with contracts in effect under Section 1876 of the Social Security Act or MedicarePlus organizations with contracts in effect under Part C of Title XVIII of the Social Security Act could, at State option, be deemed to be in compliance with the requirements of Section 1903(m) pertaining to managed care entities.

The provision would allow States to deem those managed care entities that have been accredited by an accrediting organization to be in compliance with the requirements of Section 1903(m) pertaining to managed care entities. Such an accrediting organization must be: (1) private and nonprofit; (2) in existence for the primary

purpose of accrediting managed organizations or health care providers; and (3) independent of health care providers or an association of health care providers. The Secretary would be required to specify requirements for the standards and process by which a managed care entity may be accredited by such an accrediting organization. The provisions of this section would apply to agreements between State agencies and managed care entities entered into or renewed on or after January 1, 1999.

Section 3462. Solvency standards for certain health maintenance organizations

Effective for contracts entered into or renewed on or after October 1, 1998, this section requires an HMO to either meet the same solvency standards set by the States for private HMOs or be licensed or certified by the State as a risk-bearing entity. Such requirements shall not apply to an organization if: (1) the organization does not provide inpatient and physician services; (2) the organization is a public entity; (3) the organization's solvency is guaranteed by the State; or (4) the organization is a Federally qualified health center. Such requirements shall not apply to fully capitated HMOs under contract as of the date of enactment of this Act until 3 years after the date of enactment of this Act.

Section 3463. Application of a prudent layperson standard for emergency medical condition and prohibition of gag rule restrictions

This provision requires that contracts with managed care plans provide for coverage for emergency services without regard to: (1) whether the emergency care provider has an arrangement with the plan; and (2) prior authorization. Plans would be required to comply with such guidelines as the Secretary may prescribe relating to promoting efficiency and timely coordination of appropriate maintenance and post-stabilization care provided to an enrollee determined to be stable by a medical screening examination required under the Examination and Treatment under Emergency Medical Conditions and Women in Labor requirements of the Social Security Act (Section 1867).

Emergency services would be defined, with respect to an individual enrolled with a participating HMO, as covered inpatient and outpatient services that are furnished by a qualified provider and needed to evaluate or stabilize an emergency medical condition. An emergency medical condition would be defined as one manifesting itself by acute symptoms of sufficient severity such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (a) placing the health of the individual in serious jeopardy (and in case of a pregnant woman, her health or that of her unborn child); (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part.

The provision also prohibits interference with physician advice to enrollees. A participating health plan could not prohibit or otherwise restrict covered health care professionals from talking to their patients about their health status, health care, or treatment options, regardless of whether benefits for such care or treatment were provided under the plan so long as the professional is acting

within the lawful scope of practice. "Covered health care professional" would include physicians, and other health care professionals (as specified).

HMOs would not be required to provide, reimburse, or provide coverage of a counseling or referral service if they objected to the provision of such service on moral or religious grounds. HMOs would be required to inform prospective and current enrollees of any such services they did not provide before or during enrollment or within 90 days after the date that the HMO adopts a change in policy regarding such a counseling or referral service.

In subsection (B), the Committee has adopted a "conscience protection" provision. Subsection (B) is intended to ensure that MedicarePlus organizations motivated by religious or moral beliefs can comply with subsection (A) while maintaining ethical integrity. Specifically, subsection (A) should not be construed to require MedicarePlus organizations to provide, reimburse for, or provide coverage of a counseling or referral service if the organization offering the plan objects to the provision of such service on moral or religious grounds. The provision is consistent with the intent of subsection (A) because health care professionals under contract with a MedicarePlus organization are free to advise their patients about relevant medical care or treatment. However, subsection (B) makes clear that neither the organization nor its employees must provide a counseling service or a referral service, nor does the organization have to reimburse for, or provide coverage of, such service, if it objects to such service on moral or religious grounds.

Subsection (B)(ii) is a requirement that MedicarePlus organizations make available to prospective and current enrollees information on its policies regarding the counseling and referral services to which it objects on moral or religious grounds. The Committee has permitted the plans to make this information on its policies available through written instrumentalities in the manner which the MedicarePlus organization deems appropriate so as to remove discretion from the Secretary or any other government entity to impose burdensome regulatory, legal, or stylistic requirements with respect to this subsection. However, the Committee intends that the information not be made available in a manner that intentionally obfuscates or seeks to deceive a prospective or current enrollee.

Subsection (B)(ii) requires a MedicarePlus organization to make such information on its policies available to prospective enrollees before or during enrollment. The subsection also makes clear that if a plan changes such a policy or adopts a new policy regarding a counseling or referral service to which it has moral or religious objections during the plan year, that it must make available information to current enrollees within 90 days of such a policy change regarding such a counseling service.

Subsection (B)(iii) is a construction clause making clear that nothing in subsection (B) should be construed to affect disclosure requirements under the State law or under the Employee Retirement Income Security Act of 1974.

The Committee emphasizes that the underlying guarantees of the Federal Medicaid laws remain in force for managed care enrollees and that States cannot abrogate these guarantees through a

limited contract with a managed care organization. If the managed care provider with which a beneficiary is enrolled is unwilling or unable to provide a particular service (such as a full range of non-directive counseling, referral, and services for reproductive health care), the State must treat such a service as having been “carved out” of its contract with the organization and take positive steps to ensure that the service is truly available without burden to beneficiaries through another system or provider and that the beneficiaries know of this availability. The Committee intends that the prospective and updated notices of the organization’s unwillingness or inability to provide some services be made in a clear and complete manner. Services that must be sought outside the organization should be identified in an easily understood way and not as blanket generalizations or in complex or arcane terms.

Section 3464. Additional fraud and abuse protections in managed care

This provision requires that a State, in consultation with a medical care advisory committee, approve all marketing material an HMO wishes to distribute, prior to distribution. HMOs would be prohibited from: (1) distributing any marketing material containing false or misleading information; (2) seeking to influence enrollment in conjunction with the sale of any other insurance; and (3) directly or indirectly conducting door-to-door, telephonic, or other “cold call” marketing of enrollment. HMOs would be required to distribute marketing information to their entire service area. Before an individual is enrolled in a plan, HMOs would be required to comply with conditions the Secretary would prescribe to ensure that they are provided with accurate oral and written information sufficient to make an informed enrollment decision. The State would be prohibited from contracting with an HMO found to have distributed false or misleading marketing information.

An HMO could not knowingly affiliate with a person (or an affiliate of such person) debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal acquisition regulation, or from participating in nonprocurement activities under regulations issued pursuant to Executive Order 12549. Specifically, an HMO could not have such a person as a director, officer, partner, or person with beneficial ownership of more than 5 percent of the organization equity. Further, an HMO could not have an employment, consulting, or other agreement with such a person for items and services related to the organization’s contract with the State.

If a State found an HMO contractor to be out of compliance with the above requirements, it could continue an existing agreement with such organization unless the Secretary, in consultation with the Inspector General of the Department, directs otherwise. The State could not renew or otherwise extend the duration of an existing contract with such organization unless the Secretary, in consultation with the Inspector General of the Department of HHS, provided to the State and to Congress compelling reasons for such renewal or extension.

States would be required to have conflict-of-interest safeguards in effect relating to State officers and employees having respon-

sibilities over contracts with managed care entities. Such safeguards must be at least as effective as the Federal safeguards provided under Section 27 of the Office of Federal Procurement Policy Act.

Federal financial participation (FFP) would be available in expenditures for the use of an enrollment broker in marketing HMOs and other managed care entities to eligible individuals, on the condition that the broker is independent of any plan or provider in the State, and that no person who is an owner, employee, consultant, or has a contract with the broker has any financial relationship with participating managed care entities or providers, or has been excluded from participating in Medicaid or Medicare.

Section 3465. Grievances under managed care plans

This provision requires that contracts with capitated managed care entities provide for compliance with the following grievance and appeals requirements. One, participating managed care entities must provide a meaningful and expedited procedure for resolving grievances between the entity and its enrollees. Such a procedure would include notice and hearing requirements. Two, the managed care entity must inform plan enrollees in a timely manner of any denial, termination, or reduction of services. The plan must clearly state the reason for the denial of service. The plan must provide enrollees with an explanation of the plan's complaint process and of all other appeal rights available to them. And, three, plans must establish a board of appeals to resolve grievances concerning denials of coverage or payment for services. The board shall consist of representatives of the managed care entity, including physician and nonphysicians; consumers who are not plan enrollees; and providers with expertise in the field of medicine which necessitates treatment. The board shall hear and resolve filed complaints within 30 days. This provision would not replace or supersede any other Medicaid appeal mechanisms.

Section 3466. Standards relating to access to obstetrical and gynecological services under managed care plans

Managed care plans requiring or allowing enrollees to designate their primary care provider are required by this provision to permit female enrollees to designate a participating obstetrician-gynecologist as their primary care provider. Enrollees who have designated other providers as their primary care provider must be permitted to obtain obstetric and gynecologic care from a participating obstetrician-gynecologist without prior authorization. The ordering of any other gynecologic care by the participating obstetrician-gynecologist would be considered prior authorization for such care.

CHAPTER 3—FEDERAL PAYMENTS

Section 3471. Reforming disproportionate share payments under state medicaid programs

This provision establishes additional caps on the State DSH allotments for Fiscal Years 1998-2002. The State DSH allotments for States in which 1995 DSH payments were less than 1 percent of total medical assistance spending would be frozen at the level of

payments for DSH adjustments in those States in 1995. For States classified as “high” DSH States for Fiscal Year 1997, DSH allotments would be reduced from the higher of 1995 or 1996 payment levels. The reduction percentage for “high” DSH States would be equal to 2 percent in 1998, 5 percent in 1999, 20 percent in 2000, 30 percent in 2001, and 40 percent in 2002. All other States’ DSH payments would be equal to the higher of 1995 or 1996 DSH payments levels reduced by one half of the reduction percentages for “high” DSH States. The provisions of this section would become effective beginning with Fiscal Year 1998.

The Committee has long been critical of DSH cuts as a source of Medicaid savings. In the 104th Congress, it reported two Medicaid reform measures that preserved all current DSH funds and provided for positive rates of growth in every subsequent year. Following the Administration’s proposed reduction in DSH funding, and the inclusion of this proposal in the budget agreement, the Committee is focusing its concern on the potential impact of DSH reductions on children’s hospitals and on urban and rural facilities serving high volumes of low-income and uninsured patients. Many of these “safety net” hospitals rely on DSH funding to subsidize care for these patients and, in some cases, to serve as teaching facilities and to provide such essential services as burn care, trauma care, neonatal intensive care, and services to high-risk pregnant women. The Committee expects States, in allocating DSH funds among eligible providers, to take into account the needs of these hospitals and the impact of possible DSH reductions on access to care for vulnerable patients and in underserved areas. The Committee further expects the Secretary to monitor the implementation of this section and to report to the Committee on the extent to which these reductions may adversely impact access to care for low-income children and their families.

Section 3472. Additional funding for state emergency health services furnished to undocumented aliens

This provision provides for additional funding for emergency health services furnished to undocumented aliens for Fiscal Years 1998 through 2002. For each of the five fiscal years, \$20 million would be available to distribute among the 12 States (including the District of Columbia) having the highest number of undocumented aliens. In a fiscal year, each State’s portion of total funds available would be based on its share of total undocumented aliens in all of the eligible States. Each State’s allotment would be available for the following fiscal year. The number of undocumented aliens in a State would be based on estimates prepared by the Statistics Division of the Immigration and Naturalization Services as of October 1992.

CHANGES IN EXISTING LAW MADE BY SUBTITLE E

The changes in existing law made by Subtitle E are included at the conclusion of the report on this Title of the bill.

MINORITY, ADDITIONAL OR DISSENTING VIEWS

Minority and Additional Views on Subtitle E are provided at the conclusion of the report on this Title of the bill.

SUBTITLE F—CHILD HEALTH ASSISTANCE PROGRAM

PURPOSE AND SUMMARY

The purpose of Subtitle F of Title III is to establish a mechanism enabling States to expand the provision of coverage and services to low-income uninsured children through such means as enrollment in the Medicaid program and in private health coverage plans, purchase of services provided by children's hospitals and community health centers, and improvement of initiatives dedicated to enhancing children's access to health services, coverage, and education.

BACKGROUND AND NEED FOR LEGISLATION

In June 1996, the U.S. General Accounting Office (GAO) issued its report on "Health Insurance for Children"—and helped to spark a national debate on how to decrease the rate of uninsurance among low-income children in America. In its report, GAO published an alarming finding: "In 1994, an estimated 3.5 million children—fully 35 percent of all uninsured children—were eligible for Medicaid coverage that they did not receive."

In short, despite unprecedented levels of Medicaid spending and Federal control, many Medicaid-eligible children do not receive the services to which they are entitled.

Over the last three decades, the Medicaid program has experienced unprecedented growth in both its cost and the complexity of its Federal mandates and regulations. Although this evolution has been defended by some as making the Medicaid program more responsive to the needs of low-income Americans, GAO's recent finding suggests that a different approach may be necessary to finally ensuring that the nation's low-income children do not lack the health coverage and services they need. In fact, the persistent problem of child uninsurance indicates that, despite its provision of substantial Federal funding and its passage of numerous operations mandates, Congress has yet to give the States the tools they need to ensure that low-income uninsured children receive the assistance they currently lack.

Washington's failure to give States the tools they need to expand the provision of coverage and services to at-risk children has had a serious impact on the nation's health, its health care marketplace, and—most of all—on the children themselves. Uninsured children, including those eligible for Medicaid coverage they do not now receive, are less likely to receive the primary and preventive care needed to improve their lifelong health. Medicaid-eligible children who are not enrolled in the program are less likely to receive the primary and preventive care that can improve their lifelong health. Without such care, these children are more likely to be served by the so-called "sick-care" system, as opposed to the health care system. As a result, many of them may receive care only when they have already become sick, rather than in time to prevent many common ailments. In addition, these children may need more

costly corrective treatment to address ailments that could have been prevented with coverage providing for consistent primary care.

Due to such circumstances, many of these children may also face a lifetime of more significant health needs and higher medical expenses. Care provided to correct an existing ailment is generally more expensive than preventive care. In fact, leading researchers in the field of pediatrics have estimated that uninsured children may face lifelong medical expenses that could be as much as 20 percent higher than the cost of care borne by children who regularly receive the coverage or services they need.

The cost of health care services provided to uninsured children is often borne by taxpayer-funded public institutions, charitable organizations, or insured Americans who indirectly bear those expenses in the form of higher service costs (a practice known as cost-shifting). As a result, the lack of an effective and broad-based strategy for expanding coverage and service delivery for uninsured low-income children—not to mention the Medicaid program's failure to cover all eligible children—has created serious inefficiencies in the health care marketplace.

The need for an effective and broad-based strategy is timely not solely because of the pressing needs of low-income uninsured children but because of the tremendous gains made independently by States in this effort. For example, States have made significant progress in expanding children's coverage under Medicaid despite restrictive Federal regulations. In fact, GAO estimates that over a third of all Medicaid-covered children were made eligible by voluntary State expansions.

In an effort to further address the lack of coverage and services among low-income children, many States have also undertaken a variety of initiatives aimed at reducing uninsurance among children. Principal among these efforts are State partnerships with nonprofit organizations and private corporations to develop innovative health programs that have expanded access to responsive and effective health care for targeted youths. State- and privately-funded programs have been successful in large part because they tend to achieve a number of objectives essential to expanded children's coverage. Most notably, they:

- cover children who would otherwise be uninsured,
- complement existing Medicaid coverage,
- limit costs and utilize income-sensitive cost-sharing,
- emphasize primary and preventive services,
- integrate a wide range of providers and carriers, and
- utilize existing State, nonprofit, and private administrative systems.

As these successes indicate, advances in the coverage of children have occurred when States have the flexibility to achieve maximum coverage through the Medicaid program and related initiatives. The objective of the Child Health Assistance Program (CHAP) proposal, therefore, is to provide States with the tools they need to effectively provide needed services and expand Medicaid and private coverage to low-income uninsured children in a manner that will increase their access to and use of quality primary and preventive care.

HEARINGS

The Committee's Subcommittee on Health and Environment has not held hearings specifically on Subtitle F. The Health and Environment Subcommittee, however, held oversight hearings on the Medicaid program and a variety of reform issues, including State initiatives that incorporate children's health initiatives, on July 26, 1995, and on March 11, 1997.

Testifying before the Subcommittee on July 26, 1995 were: The Honorable Fife Symington, Governor of Arizona, accompanied by Dr. Mabel Chen, Director, Arizona Health Care Cost Containment System; The Honorable Kay C. James, Secretary of Health and Human Resources, Commonwealth of Virginia; The Honorable Charles Condon, Attorney General of South Carolina; Mr. Bruce Vladeck, Administrator, Health Care Financing Administration; Michael D. McKinney, M.D., Commissioner, Department of Health and Human Services, State of Texas; Mr. Robert Corker, Commissioner, Department of Finance and Administration, State of Tennessee; Ms. Jean Thorne, Director, Office of Medical Assistance Programs, Oregon Department of Human Resources, State of Oregon; Ms. Debra Ward, MPH, Director, Governmental Relations, United Health Plan; Mr. Michael W. Murray, Executive Director, Health Plan of San Mateo; Ms. Judith Stavisky, Associate Vice President for Health Services, Mercy Health Plan; Ms. Maura Bluestone, President and CEO, The Bronx Health Plan; and Dr. Jesse Jampol, HIP Health Insurance Plan.

Testifying before the Subcommittee on March 11, 1997, were: The Honorable Michael O. Leavitt, Governor, State of Utah; The Honorable Bob Miller, Governor, State of Nevada; Mr. William Scanlon, Director of Health Financing Systems, U.S. General Accounting Office; Gail Wilensky, Ph.D., Chair, Board of Directors, Physician Payment Review Commission; and Diane Rowland, Senior Vice President, Henry J. Kaiser Family Foundation.

COMMITTEE CONSIDERATION

On June 10, 1997, the Subcommittee on Health and Environment met in open session and approved for Full Committee consideration a Committee Print entitled "Title III, Subtitle F—Child Health Assistance Program," amended, by a voice vote. On June 12, 1997, the Committee met in open session and ordered the Committee Print entitled "Title III, Subtitle F—Child Health Assistance Program" transmitted to the House Committee on the Budget, amended, for inclusion in the 1997 Omnibus Budget Reconciliation Act, by a roll call vote of 39 yeas to 7 nays.

ROLL CALL VOTES

Pursuant to Clause 2(1)(2)(B) of rule XI of the Rules of the House of Representatives, following are listed the recorded votes on the motion to order Subtitle F transmitted to the House Committee on the Budget, and on amendments thereto, including the names of those Members voting for and against.

**COMMITTEE ON COMMERCE - 105TH CONGRESS
ROLL CALL VOTE #30**

BILL: Committee Print entitled "Title III, Subtitle F - Child Health Assistance Program"

AMENDMENT: Amendment in the Nature of a Substitute by Mr. Brown re: Children's Health Insurance Provides Security (CHIPS) Act of 1997.

DISPOSITION: NOT AGREED TO, by a roll call vote of 20 yeas to 27 nays, with 1 voting "Pass".

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Biiley		X		Mr. Dingell	X		
Mr. Tauzin		X		Mr. Waxman	X		
Mr. Oxley		X		Mr. Markey	X		
Mr. Bilirakis		X		Mr. Hall	X		
Mr. Schaefer		X		Mr. Boucher			
Mr. Barton				Mr. Manton	X		
Mr. Hastert		X		Mr. Towns	X		
Mr. Upton		X		Mr. Pallone	X		
Mr. Stearns		X		Mr. Brown	X		
Mr. Paxon		X		Mr. Gordon	X		
Mr. Gillmor		X		Ms. Furse	X		
Mr. Klug		X		Mr. Deutsch	X		
Mr. Greenwood		X		Mr. Rush			
Mr. Crapo		X		Ms. Eshoo	X		
Mr. Cox			PASS	Mr. Klink		X	
Mr. Deal		X		Mr. Stupak	X		
Mr. Largent		X		Mr. Engel	X		
Mr. Burr		X		Mr. Sawyer	X		
Mr. Bilbray		X		Mr. Wynn	X		
Mr. Whitfield		X		Mr. Green	X		
Mr. Ganske		X		Ms. McCarthy	X		
Mr. Norwood		X		Mr. Strickland	X		
Mr. White		X		Ms. DeGette	X		
Mr. Coburn		X					
Mr. Lazio		X					
Mrs. Cubin		X					
Mr. Rogan		X					
Mr. Shimkus		X					

6/12/97

**COMMITTEE ON COMMERCE -- 105TH CONGRESS
ROLL CALL VOTE #31**

BILL: Committee Print entitled "Title III, Subtitle F - Child Health Assistance Program"

AMENDMENT: Amendment in the Nature of a Substitute by Mr. Pallone re: Child Health Insurance Initiative Act of 1997.

DISPOSITION: NOT AGREED TO, by a roll call vote of 20 yeas to 26 nays, with 1 voting "Pass".

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Bliley		X		Mr. Dingell	X		
Mr. Tauzin		X		Mr. Waxman	X		
Mr. Oxley		X		Mr. Markey	X		
Mr. Bilirakis		X		Mr. Hall	X		
Mr. Schaefer		X		Mr. Boucher			
Mr. Barton				Mr. Manton	X		
Mr. Hastert		X		Mr. Towns	X		
Mr. Upton		X		Mr. Pallone	X		
Mr. Stearns		X		Mr. Brown	X		
Mr. Paxon		X		Mr. Gordon	X		
Mr. Gillmor		X		Ms. Furse	X		
Mr. Klug		X		Mr. Deutsch	X		
Mr. Greenwood		X		Mr. Rush			
Mr. Crapo		X		Ms. Eshoo	X		
Mr. Cox		X		Mr. Klink		PASS	
Mr. Deal		X		Mr. Stupak	X		
Mr. Largent		X		Mr. Engel	X		
Mr. Burr		X		Mr. Sawyer	X		
Mr. Bilbray		X		Mr. Wynn	X		
Mr. Whitfield				Mr. Green	X		
Mr. Ganske		X		Ms. McCarthy	X		
Mr. Norwood		X		Mr. Strickland	X		
Mr. White		X		Ms. DeGette	X		
Mr. Coburn		X					
Mr. Lazio		X					
Mrs. Cubin		X					
Mr. Rogan		X					
Mr. Shimkus		X					

6/12/97

**COMMITTEE ON COMMERCE -- 105TH CONGRESS
ROLL CALL VOTE #32**

BILL: Committee Print entitled "Title III, Subtitle F - Child Health Assistance Program"

AMENDMENT: Amendment by Ms. DeGette re: strike the limitation on payments for abortion.

DISPOSITION: NOT AGREED TO, by a roll call vote of 17 yeas to 30 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Bliley		X		Mr. Dingell	X		
Mr. Tauzin		X		Mr. Waxman	X		
Mr. Oxley		X		Mr. Markey	X		
Mr. Bilirakis		X		Mr. Hall		X	
Mr. Schaefer		X		Mr. Boucher			
Mr. Barton				Mr. Manton		X	
Mr. Hastert		X		Mr. Towns	X		
Mr. Upton		X		Mr. Pallone	X		
Mr. Stearns		X		Mr. Brown	X		
Mr. Paxon		X		Mr. Gordon		X	
Mr. Gillmor		X		Ms. Furse	X		
Mr. Klug		X		Mr. Deutsch	X		
Mr. Greenwood	X			Mr. Rush			
Mr. Crapo		X		Ms. Eshoo	X		
Mr. Cox		X		Mr. Klink		X	
Mr. Deal		X		Mr. Stupak		X	
Mr. Largent		X		Mr. Engel	X		
Mr. Burr		X		Mr. Sawyer	X		
Mr. Bilbray		X		Mr. Wynn	X		
Mr. Whitfield				Mr. Green	X		
Mr. Ganske		X		Ms. McCarthy	X		
Mr. Norwood		X		Mr. Strickland	X		
Mr. White		X		Ms. DeGette	X		
Mr. Coburn		X					
Mr. Lazio		X					
Mrs. Cubin		X					
Mr. Rogan		X					
Mr. Shimkus		X					

6/12/97

**COMMITTEE ON COMMERCE -- 105TH CONGRESS
ROLL CALL VOTE #33**

BILL: Committee Print entitled "Title III, Subtitle F - Child Health Assistance Program"

AMENDMENT: Amendment by Mr. Waxman re: Medicaid disability eligibility.

DISPOSITION: NOT AGREED TO, by a roll call vote of 20 yeas to 27 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Bliley		X		Mr. Dingell	X		
Mr. Tauzin		X		Mr. Waxman	X		
Mr. Oxley		X		Mr. Markey	X		
Mr. Bilirakis		X		Mr. Hall		X	
Mr. Schaefer		X		Mr. Boucher			
Mr. Barton				Mr. Manton	X		
Mr. Hastert		X		Mr. Towns	X		
Mr. Upton		X		Mr. Pallone	X		
Mr. Stearns		X		Mr. Brown	X		
Mr. Paxon		X		Mr. Gordon	X		
Mr. Gillmor		X		Ms. Furse	X		
Mr. Klug		X		Mr. Deutsch	X		
Mr. Greenwood		X		Mr. Rush			
Mr. Crapo		X		Ms. Eshoo	X		
Mr. Cox		X		Mr. Klink	X		
Mr. Deal		X		Mr. Stupak	X		
Mr. Largent		X		Mr. Engel	X		
Mr. Burr		X		Mr. Sawyer	X		
Mr. Bilbray		X		Mr. Wynn	X		
Mr. Whitfield				Mr. Green	X		
Mr. Ganske		X		Ms. McCarthy	X		
Mr. Norwood		X		Mr. Strickland	X		
Mr. White		X		Ms. DeGette	X		
Mr. Coburn		X					
Mr. Lazio		X					
Mrs. Cubin		X					
Mr. Rogan		X					
Mr. Shimkus		X					

6/12/97

**COMMITTEE ON COMMERCE -- 105TH CONGRESS
ROLL CALL VOTE #34**

BILL: Committee Print entitled "Title III, Subtitle F - Child Health Assistance Program"

MOTION: Motion by Mr. Bliley to order the Committee Print entitled "Title III, Subtitle F - Child Health Assistance Program", amended, transmitted to the Committee on the Budget for inclusion in the 1997 Omnibus Budget Reconciliation Act.

DISPOSITION: AGREED TO, by a roll call vote of 39 yeas to 7 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Bliley	X			Mr. Dingell	X		
Mr. Tauzin	X			Mr. Waxman	X		
Mr. Oxley	X			Mr. Markey	X		
Mr. Bilirakis	X			Mr. Hall	X		
Mr. Schaefer	X			Mr. Boucher			
Mr. Barton				Mr. Manton	X		
Mr. Hastert	X			Mr. Towns	X		
Mr. Upton	X			Mr. Pallone		X	
Mr. Stearns		X		Mr. Brown	X		
Mr. Paxon	X			Mr. Gordon	X		
Mr. Gillmor	X			Ms. Furse	X		
Mr. Klug	X			Mr. Deutsch	X		
Mr. Greenwood	X			Mr. Rush			
Mr. Crapo		X		Ms. Eshoo		X	
Mr. Cox		X		Mr. Klink	X		
Mr. Deal	X			Mr. Stupak	X		
Mr. Largent		X		Mr. Engel		X	
Mr. Burr	X			Mr. Sawyer	X		
Mr. Bilbray	X			Mr. Wynn	X		
Mr. Whitfield				Mr. Green	X		
Mr. Ganske	X			Ms. McCarthy	X		
Mr. Norwood	X			Mr. Strickland	X		
Mr. White	X			Ms. DeGette	X		
Mr. Coburn							
Mr. Lazio	X						
Mrs. Cubin	X						
Mr. Rogan	X						
Mr. Shimkus	X						

6/12/97

COMMITTEE ON COMMERCE—105TH CONGRESS, VOICE
VOTES, 6/12/97

Bill: Committee Print entitled "Title II, Subtitle F—Child Health Assistance Program."

Amendment: Amendment by Mr. Whitfield re: make the authorization for CHAP discretionary starting in 2003.

Disposition: Withdrawn, by unanimous consent.

Amendment: Amendment by Mr. Lazio re: change the formula of distribution of funds for CHAP.

Disposition: Withdrawn, by unanimous consent.

Amendment: Amendment by Ms. DeGette re: Medicaid presumptive eligibility for low-income children.

Disposition: Agreed to, by a voice vote.

Amendment: Amendment by Mr. Waxman re: strike the direct service option.

Disposition: Not agreed to, by a voice vote.

Amendment: Amendment by Mr. Stupak re: add a new section on voluntary purchasing cooperatives.

Disposition: Withdrawn, by unanimous consent.

COMMITTEE OVERSIGHT FINDINGS

Pursuant to clause 2(1)(3)(A) of rule XI of the Rules of the House of Representatives, the Committee held oversight hearings and made findings that are reflected in the report on this Subtitle.

COMMITTEE ON GOVERNMENT REFORM AND OVERSIGHT

Pursuant to clause 2(1)(3)(D) of rule XI of the Rules of the House of Representatives, no oversight findings have been submitted to the Committee by the Committee on Government Reform and Oversight.

COMMITTEE COST ESTIMATE

In compliance with clause 7(a) of rule XIII of the Rules of the House of Representatives, the Committee states that enactment of Subtitle F would create a new initiative that is estimated to cost approximately \$16 billion over five years.

CONGRESSIONAL BUDGET OFFICE ESTIMATE

Pursuant to clause 2(1)(3)(C) of rule XI of the Rules of the House of Representatives, a letter from the Congressional Budget Office providing a cost estimate for all six subtitles of Title III is found at the conclusion of the report on this Title of the bill.

FEDERAL MANDATES STATEMENT

The Committee adopts as its own the estimate of Federal mandates prepared by the Director of the Congressional Budget Office pursuant to section 423 of the Unfunded Mandates Reform Act.

ADVISORY COMMITTEE STATEMENT

No advisory committees within the meaning of section 5(b) of the Federal Advisory Committee Act were created by this legislation.

CONSTITUTIONAL AUTHORITY STATEMENT

Pursuant to clause 2(1)(4) of rule XI of the Rules of the House of Representatives, the Committee finds that the Constitutional authority for this legislation is provided in Article I, section 8, clause 3, which grants Congress the power to regulate commerce with foreign nations, among the several States, and with the Indian tribes.

SECTION-BY-SECTION ANALYSIS OF THE LEGISLATION

Section 3501. Short title of subtitle; table of contents

This section states that the short title of this Subtitle is the “Child Health Assistance Program Act of 1997”, and sets forth the table of contents for the Subtitle.

*Section 3502. Establishment of child health assistance program**New section 2101. Purpose; State child health plans*

Current Law. Medicaid, Title XIX of the Social Security Act, provides almost 21 million children with health coverage. States choosing to participate in the Medicaid program are required to cover children in families who would have qualified to receive Aid to Families with Dependent Children (AFDC) under the program rules in effect on August 22, 1996; children under age 6 in families with income below 133 percent of the Federal poverty level; and children under age 14 in families with income below 100 percent of the Federal poverty level. Coverage for children between the ages of 14 and 18 and in families with income below 100 percent of the Federal poverty level is being phased-in through 2002. States also have the option to cover other categories of low-income children under Medicaid and many have done so. All 50 States currently participate in Medicaid. The Maternal and Child Health (MCH) Block Grant is authorized under Title V of the Social Security Act to improve the health of all mothers and children consistent with the goals established under the Public Health Service Act. The program makes block grants to States to enable them to coordinate programs, develop systems, and provide a broad range of direct health services.

Explanation of Provision. The provision would establish a new Title XXI of the Social Security Act, Child Health Assistance Program. This program would establish entitlement to States for grants to expand access to health insurance for eligible children.

New Section 2101 would establish the purpose of the program: to provide funds to States to enable them to initiate and expand the provision of child care assistance to uninsured, low-income children in an effective and efficient manner that is coordinated with other sources for obtaining creditable coverage. Creditable coverage would mean coverage under: (a) a group health plan; (b) other health insurance plans; (c) Medicare; (d) Medicaid; (e) Department of Defense health programs; (f) Department of Veterans’ Affairs health care; (g) the Federal Employees Health Benefits Program; (h) a medical care program of the Indian health service or tribal organization; (i) a State health benefits risk pool; (j) a public health plan; and (k) other specified coverage.

The assistance could be provided through various approaches that would be specified in a State plan, including coverage under group health plans or group or individual health insurance coverage, the State's Medicaid plan, or direct purchase of services from providers. To be eligible for Federal assistance, a State would have to submit a plan to the Secretary of Health and Human Services (the Secretary) that specified how the State intended to use the Federal funds to provide health assistance to needy children consistent with Federal requirements (as described below). States that meet the requirements would be entitled to Federal assistance from funds appropriated for this purpose, and unless otherwise established by State law or judicial precedent, it is the Committee's intention that the Governor shall be responsible for the distribution of these funds and the development and implementation of the State plan required as a condition of eligibility. No State would be eligible for payments before October 1, 1997.

New section 2102. Contents of State child health plan

A State child health plan would have to include a description of: (a) the current insurance status of children, including targeted low-income children; (b) current State efforts to provide or obtain creditable coverage for uncovered children; and (c) how the plan is designed to be coordinated with current State efforts to increase creditable coverage of children. A State plan also would have to include a description of the standards to be used to determine the eligibility of targeted low-income children for child health insurance under the plan. Eligibility standards could include geography, age, income and resources, residency, disability status, and others as specified. The eligibility standards could not, within any defined class or group of covered targeted low-income children, cover children with higher family incomes without covering children with lower family incomes. They also could not deny eligibility to a child based on a preexisting medical condition (defined as a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before such date).

In addition, a State plan would have to describe the methods of establishing and continuing eligibility and enrollment, including a methodology for computing family income that meets requirements specified in the provision. Procedures established for eligibility would have to ensure: (a) that only targeted low-income children received the assistance; (b) that children found through screening to be eligible for medical assistance under the State's Medicaid program were enrolled in Medicaid; (c) that the new insurance did not substitute for coverage under group health plans; and (d) that there was coordination with other public and private programs providing creditable coverage for low-income children. This provision would not create an entitlement for any individual to child health assistance under a State child health plan.

The child health assistance provided under the plan would be required to include at least the following items and services: inpatient and outpatient hospital care, physician services, laboratory and x-ray, well-baby and well child care including immunizations

unless the care is provided under a group health plan. It is the Committee's intention that primary and preventive dental services be included in the definition of well child care, since the Committee recognizes that oral health is an essential component of overall health and that low-income children suffer disproportionately from dental disease. If the care is provided under a group health plan, then the benefits under the plan could be no less for CHAP beneficiaries than the benefits provided for other individuals covered by that plan. A State plan would have to describe the nature of the assistance to be provided including: cost-sharing, the health care delivery method (e.g., managed care, fee-for-service, direct provision of services, or vouchers), and utilization control systems. A plan could vary premiums, deductibles, coinsurance and other cost-sharing based on family income of the targeted low-income children only in a manner that did not favor children from higher-income families over those from lower incomes. Cost sharing would not be allowed for preventive services or benefits. A plan could not permit the imposition of any preexisting medical condition exclusion for covered benefits. If the plan provided for benefits through a group health plan or group insurance, preexisting condition exclusions could be imposed only to the extent that such exclusions are permitted under the Health Insurance Portability and Accountability Act (P.L. 104-191). States would be required to assure access to specialty care as required by eligible children who have chronic or life-threatening conditions. A State would not be permitted to pay benefits to an individual to the extent that such benefits were available to the individual under another public or private health care insurance program. Payments in the form of a voucher or cash would not be considered income for purposes of eligibility for or benefits provided under any means-tested Federal or Federally-assisted program.

Finally, a State plan would have to describe the procedures to be used to accomplish outreach and enrollment assistance to families of eligible children and to coordinate with other public and private health insurance programs.

New section 2103. Allotments

For each of the Fiscal Years 1998 through 2002, a total allotment of \$2.88 billion would be available for the State Child Health Assistance Program. The funds would be allotted to States based on the number of uncovered children in a base period in a State and the relative cost of health care services in that State with a floor of \$2 million for States and the District of Columbia. The base would be determined by taking the State's average number of uninsured children for the years 1993 through 1995 as reported in the March 1994, March 1995, and March 1996 supplements to the Current Population Surveys of the Bureau of the Census. The Secretary would be required to allot 0.5 percent of the total amount of funds to the territories, in a manner specified by the provision. In the case of a State electing the increased Medicaid match (see below), the amount of the State's allotment would be reduced by the amount of the State's additional Federal Medicaid payment. States would have 3 years to spend their allotments.

New section 2104. Payments to States

The Secretary would be required to make quarterly payments to each State with an approved child health assistance plan in amounts up to 80 percent of program spending during that quarter for child health assistance, other initiatives for improving child health, outreach and administration of the plan, except that no more than 15 percent of the total program spending could be used for other child health initiatives, outreach and administration. The Secretary would establish rules regarding the extent to which funds could be used to purchase family coverage for families that include targeted low-income children. The rules would allow such payment if the State demonstrates that the purchase of such coverage is cost effective when compared with the cost of covering only the targeted low-income children in the families involved.

Child health assistance funds may not be used to: (a) cover children who would be eligible for Medicaid using the income and assets standards or methodologies as in effect on June 1, 1997; (b) pay for the services of a provider who has been excluded from participation under the MCH or Social Services Block Grant programs, Medicare or other Federal programs except for emergency services not provided in hospital emergency rooms; (c) pay for services that a private insurer would be obligated to cover but for a provision of its insurance contract that limits its obligation because the child is eligible for child health assistance; (d) pay for services for which payment can reasonably be expected to be made under any other Federally operated or financed health insurance program or the Indian Health Service; or (e) pay for abortions, except in the case of a pregnancy resulting from rape or incest, or unless the mother is in danger of death unless an abortion is performed.

Federal funds or program spending that is largely subsidized by Federal funds may not be claimed as the required non-Federal share of costs.

The Secretary may make payments to States on the basis of advance estimates of spending made by the State and other investigations that the Secretary may find necessary, and may adjust payments as necessary to account for an overpayment or underpayment in prior quarters.

New section 2105. Process for submission, approval, and amendment of State child health plans

As a condition of receiving funding under this title, a State would be required to submit a State child health plan for approval by the Secretary. A State plan would become effective beginning in a specified calendar quarter that is at least 60 days after the plan is submitted. A State may amend its State child health plan at any time with a plan amendment. Plan amendments must be approved for the purposes of this title and would take effect on dates as specified in the amendment. Amendments restricting or limiting eligibility or benefits could not take effect until there had been public notice of the change. The Secretary would be required to promptly review State plans and amendments to determine compliance with the requirements of this title. Unless the State were notified in writing within 90 days that a plan or amendment was disapproved and the reasons for disapproval or that additional information was needed,

the plan or amendment would be deemed approved. In the case of a disapproval, the Secretary would provide a State with a reasonable opportunity for correction.

Child health assistance programs would have to be conducted in accordance with the State plan and any approved amendments. The Secretary would establish a process for enforcing requirements under this title. Approved plans would continue in effect unless amended or unless the Secretary found the plan out of compliance with this title.

New section 2106. Strategic objectives and performance goals

A State child health plan would be required to identify: (a) specific strategic objectives aimed at increasing health coverage among low-income children; (b) performance goals for each strategic objective identified; and (c) performance measures that are objective and verifiable, so that when compared with the performance goals, indicate the State's performance under this title. Plans must include assurances that the State will collect data, maintain records, and furnish reports as required by the Secretary as well as provide the required annual assessments and evaluations. The Secretary would be required to have access to any records or information for reviews or audits as deemed necessary.

Plans would be required to include a description of the process for obtaining ongoing public involvement in the design and implementation of the plan, and the plan's budget to be updated periodically including details on the sources of the non-Federal share of plan spending.

The following sections of Title XI would apply to States' Child Health Assistance Insurance programs as they do under Title XIX: Section 1101(a)(1) relating to the definition of a State; Section 1116 relating to administrative and judicial review; Section 1124 relating to disclosure of ownership and related information; Section 1126 relating to disclosure of information about certain convicted individuals; Section 1128B(d) relating to criminal penalties; and Section 1132 relating to periods within which claims must be filed.

New section 2107. Annual reports and evaluations

A State would be required to provide an annual report to the Secretary by January 1 following the end of each fiscal year assessing the operation of the plan and the progress made in reducing the number of uncovered low-income children during the prior fiscal year. States would also be required to provide a State evaluation by March 31, 2000, assessing (a) the effectiveness of the State plan in increasing the number of children with health coverage; (b) the effectiveness of specific elements of the plan, such as characteristics of families and children assisted and quality of coverage provided; (c) the effectiveness of other public and private programs in the State in increasing health coverage for children; (d) State activities to coordinate the plan with other public and private programs providing health care coverage; (e) trends in the State affecting the provision of health care to children; (f) plans for improving the availability of health insurance and health care for children; and (g) recommendations for improving the program, among other matters the State and Secretary consider appropriate. The Sec-

retary would be required to compile a report based on the State evaluation to submit to Congress and make available to the public by December 31, 2000.

New section 2108. Definitions

This section defines the following terms: child health assistance, targeted low-income child, Medicaid applicable income level, child, creditable health coverage, group health plan and health insurance coverage, low income, poverty line, preexisting condition exclusion, State child health plan, and uncovered child.

Section 3503. Optional use of State child health assistance funds for enhanced Medicaid match for expanded Medicaid eligibility

Current Law. States participating in the Medicaid program are required to cover children under age 6 in families with income under 133 percent of the Federal poverty level and older children under age 14 in families with income under 100 percent of the Federal poverty level. Children between 14 and 18 will have coverage phased-in by the year 2002. States may extend optional eligibility to other categories of low-income children.

The costs of providing Medicaid coverage are shared by the States and the Federal government. The Federal share is determined by a formula that takes into account the average per capita income in the State relative to the national average. States with lower per capita incomes have higher Federal matching rates. These Federal matching rates range from a floor of 50 percent to almost 80 percent.

Explanation of Provision. States may choose to use a portion of their Title XXI funds to increase the Federal matching share of the costs of extending Medicaid coverage to targeted low-income children. Targeted low-income children are those who do not qualify for Medicaid as in effect on June 1, 1997, and whose family income is below the higher of 75 percentage points over the Medicaid applicable income level, or 133 percent of the poverty line. In order to qualify for the enhanced Federal matching funds States must use income and resource standards and methodologies to determine eligibility for Medicaid that are no more restrictive than those in place in the State on June 1, 1997. Qualifying States must also report such information as the Secretary deems necessary to calculate the remaining child health insurance assistance funds available after the enhanced Federal match and to assure that no more than 15 percent of those funds are used for activities other than providing health care coverage. The enhanced Federal matching funds could not exceed the total amount of the child health insurance funds allotted to the State under Section 2104.

The enhanced medical assistance percentage would be equal to the Federal medical assistance percentage increased by the number of percentage points equal to 30 percent multiplied by the number of percentage points by which the Federal medical assistance percentage is less than 100 percent. States would be allowed to impose limits on the number of optional targeted low-income children whose health care costs are eligible for enhanced Federal matching payments under this provision. All provisions in this section become effective on October 1, 1997.

Section 3504. Medicaid presumptive eligibility for low-income children

Current Law. States have the option to allow presumptive eligibility for pregnant women. Under presumptive eligibility, health care providers are able to grant pregnant women with immediate, short-term Medicaid eligibility at the provider site while formal determination is being made. Presumptive eligibility is intended to provide immediate access to prenatal care services. As of 1996, 30 States have opted to provide presumptive eligibility.

Explanation of Provision. The provision would allow States to provide for a presumptive eligibility period for children under the age of 19. The presumptive eligibility period would begin when a qualified entity determines, based on preliminary information, that the family income of the child is below the applicable income eligibility threshold for the State Medicaid program, and ends when a formal determination is made. For children on whose behalf an application is not filed, the presumptive eligibility period would end on the last day of the month following the month when the period began.

CHANGES IN EXISTING LAW MADE BY SUBTITLE F

The changes in existing law made by Subtitle F are included at the conclusion of the report on this Title of the bill.

MINORITY, ADDITIONAL OR DISSENTING VIEWS

Minority Views on Subtitle F are provided at the conclusion of the report on this Title of the bill.

CONGRESSIONAL BUDGET OFFICE ESTIMATE

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, June 16, 1997.

Hon. TOM BLILEY,
*Chairman, Committee on Commerce, U.S. House of Representatives,
Washington, DC.*

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the enclosed cost estimate for the non-Medicare reconciliation recommendations of the House Committee on Commerce (Title III). The estimate for the committee's recommendations for Medicare (Title IV) is being provided under separate cover.

The estimate includes a summary table that shows the budgetary effects of the committee's proposals over the 1998–2002 period, and additional, more detailed tables of estimated effect through 2007. CBO understands that the Committee on the Budget will be responsible for interpreting how these proposals compare with the reconciliation instructions in the budget resolution. This estimate assumes the reconciliation bill will be enacted by August 15, 1997; the estimate could change if the bill is enacted later.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contacts are listed at the end of the estimate.

Sincerely,

JUNE E. O'NEILL, *Director.*

Enclosure.

Non-Medicare Reconciliation Recommendations of the House Committee on Commerce (Title III)

Summary: Title III contains five subtitles aimed at providing budgetary savings from federal energy programs, auctions of licenses for use of portions of the electromagnetic spectrum, and Medicaid. A sixth subtitle would provide for increased direct spending by funding a child health care initiative. CBO estimates that enacting the provisions of Title III would produce net budgetary savings totaling \$6.9 billion over the 1998–2002 period.

By extending the Nuclear Regulatory Commission's (NRC's) authority to collect fees from utilities, Subtitle A would impose an intergovernmental and private-sector mandate as defined by the Unfunded Mandates Reform Act of 1995 (UMRA). This provision would not impose costs above the threshold established in that law for intergovernmental mandates (\$50 million in 1996, adjusted for inflation). CBO cannot determine whether the direct costs of this provision would exceed the annual threshold for private-sector mandates (\$100 million in 1996, adjusted for inflation), because UMRA is unclear as to how to define the direct costs associated with extending an existing mandate that has not yet expired. Depending on how they are measured, the direct costs to the private sector could exceed the threshold. Other subtitles of Title III contain provisions that, while not mandates as defined in UMRA, would have significant impacts on the budgets of state, local, and tribal governments.

Description of Major Provisions: Subtitle A would extend through 2002 the NRC's authority to charge fees to offset 100 percent of its general fund appropriation.

Subtitle B would revise the terms under which the Department of Energy (DOE) could lease excess capacity of the Strategic Petroleum Reserve (SPR) to foreign governments and would direct the department to spend any income derived from leasing after fiscal year 2002 on SPR-related activities without further appropriation. The fees charged for storage would have to fully compensate the United States for all the costs associated with storing and removing the oil, including the cost of replacement facilities, if necessitated by the leasing activity.

Subtitle C would direct DOE to sell specified amounts of natural and low enriched uranium that have been declared surplus to national security needs. DOE would be required to sell 3.2 million pounds during each of the fiscal years 1999 through 2002, subject to certain conditions. In particular, before selling the uranium, DOE would have to determine that selling the specified amounts over the 1999–2002 period would satisfy existing statutory criteria regarding the sale of such materials from DOE's stockpiles, and proceeds from the sales would have to be collected and deposited in the general fund of the Treasury between 1999 and 2002.

Subtitle D contains several provisions relating to assignment of licenses for using the electromagnetic spectrum. It would instruct the Federal Communications Commission (FCC) to use competitive bidding to assign licenses for most mutually exclusive applications of the electromagnetic spectrum and it would extend the FCC's authority to conduct such auctions through fiscal year 2002. Under current law, that authority expires at the end of fiscal year 1998. The subtitle also would amend current law by broadening the commission's authority to use competitive bidding to assign licenses. Current law restricts the use of competitive bidding to those mutually exclusive applications in which the licensee would receive compensation from subscribers to a communications service.

In addition, Subtitle D would require the FCC and the Department of Commerce, through the National Telecommunications and Information Administration (NTIA), to make available blocks of spectrum for allocation for commercial use and to assign the rights to use those blocks by competitive bidding, if the FCC determines that various specified conditions are met for each of the blocks of spectrum identified in the subtitle. The additional licenses that could be assigned by competitive bidding would grant the right to use 100 megahertz (MHz) of spectrum located below 3 gigahertz (GHz) currently under the FCC's jurisdiction and an additional 20 MHz also below 3 GHz to be identified by the NTIA and transferred to the FCC's jurisdiction.

Under current law, a part of the spectrum currently reserved for television broadcasting will become available for reallocation as broadcasters comply (over the next several years) with the FCC's direction to adopt digital television broadcasting technology to replace the current analog technology. This subtitle would make available for licensing and assignment by competitive bidding certain frequencies that are currently allocated for analog television broadcasting, including a part of the spectrum between 746 MHz and 806 MHz (frequencies currently allocated for primary use by ultra high frequency television broadcasting on channels 60 through 69).

The requirement that the commission use competitive bidding to assign the rights to use the frequencies noted in Subtitle D would be conditional. In all cases, the FCC would be directed to refrain from using competitive bidding unless it determines that license sales granting the use of various frequencies will meet specified dollar targets for aggregate winning bids. In addition, the commission would be authorized to void the results of any actions that take place but fail to meet targets for aggregate winning bids. Moreover, the commission could choose to delay assignment of licenses by competitive bidding if it determines that conducting auctions at a later date "will better attain the objectives of recovering for the public a fair portion of the value of the public spectrum resource and avoiding unjust enrichment." Finally, for the frequencies between 746 MHz and 806 MHz, the FCC would not be permitted to make allocations and assign licenses by auction unless each qualifying low-power television station (as defined in the title) is assigned a frequency below 746 MHz to continue its operation.

Subtitle E would reduce federal payments for disproportionate share hospitals (DSH). Except for states whose DSH spending in

1995 was under 1 percent of medical assistance spending state allotments would depend on whether a state was designated as a high- or low-DSH state in 1997. For high-DSH states, allotments would equal each state's 1995 DSH spending reduced by 2 percent in 1998, with larger reductions in later years, reaching 40 percent in 2002. For low-DSH states, the state allotment would equal the state's 1995 spending reduced by half of the percentage reduction applied to high-DSH states.

This subtitle also includes provisions giving states greater flexibility in how they administer their Medicaid programs. The Boren amendment, which requires states to reimburse hospitals and nursing homes at "reasonable and adequate" rates, would be repealed. States would also have greater leeway to implement managed care programs, expand eligibility, change benefits, and meet federal requirements for administrative activities.

Subtitle F establishes a Child Health Assistance Program that would provide matching grants to states for the provisions of child health care assistance to uninsured, low-income children. The money would be allocated on the basis of participating states' shares of the total number of uninsured children, adjusted for the average cost of health care. The state matching requirement would be 20 percent. States would have substantial discretion in how to spend these funds, and could use them to purchase health insurance coverage from group plans, arrange for health care services directly through providers, expand their Medicaid programs, or use other approved methods.

Estimated Cost to the Federal Government: CBO estimates that the provisions of Title III would reduce direct spending by \$6.7 billion over the next five years. That estimated impact would come from enacting Subtitles B, D, E, and F. In addition, we estimate that enacting Subtitle C would yield \$184 million in asset sale proceeds over the same period. Gross budgetary savings would total \$24.5 billion over the 1998–2002 period, but that amount would be partially offset by new direct spending, primarily under Subtitle F, totaling \$17.6 billion over the same period. Enacting Subtitle A would, by itself, have no budgetary impact relative to the budget resolution baseline.

Table 1 summarizes the estimated budgetary impact of Title III over the 1998–2002 period. More detailed table showing estimated budgetary effects through 2007 appear at the end of this estimate. Table 2 summarizes the 10-year budgetary effects by subtitle. Table 3 displays detailed estimates for Subtitle D (Communications), while Table 4 presents detailed estimates for Subtitle E (Medicaid).

The budgetary effects of this legislation fall within budget functions 270 (energy), 370 (commerce and housing credit), 550 (health), and 950 (undistributed offsetting receipts).

Basis of estimate

Nuclear Regulatory Commission Annual Charges (Subtitle A)

This provision would extend through 2002 the NRC's authority to charge fees to offset 100 percent of its general fund appropriation. Under current law, after 1998 the NRC would be authorized

to set fees on the industries it regulates sufficient to cover only 33 percent of its budget. Because the amount of fees collected under this provision would be determined by the size of the NRC's general fund appropriation, this provision would not affect direct spending.

Assuming future appropriations for the NRC continue at the 1997 level adjusted for inflation, enactment of this provision would increase offsetting collections by an average of about \$340 million annually over the 1999–2002 period. Under rules for projecting discretionary spending established in the Budget Enforcement Act of 1990, however, the baseline projection of NRC spending for the 1998–2002 period is based on the agency's net spending level in 1997. Because the 1997 level reflects fee collections sufficient to offset 100 percent of the NRC's general fund appropriations, the provision to extend full-cost recovery does not produce any discretionary savings relative to the budget resolution baseline.

TABLE 1. ESTIMATED BUDGETARY IMPACT OF THE NON-MEDICARE RECONCILIATION RECOMMENDATIONS OF THE HOUSE COMMITTEE ON COMMERCE

[By fiscal year, in millions of dollars]

	1998	1999	2000	2001	2002
CHANGES IN DIRECT SPENDING					
Subtitle B: Lease of Excess SPR Capacity:					
Estimated budget authority	0	-1	-2	-4	-6
Estimated outlays	0	-1	-2	-4	-6
Subtitle D: Receipts from Spectrum Auctions:					
Estimated budget authority	0	-800	-2,100	-3,000	-3,800
Estimated outlays	0	-800	-2,100	-3,000	-3,800
Subtitle E: Medicaid:					
Estimated budget authority	260	-700	-2,360	-3,620	-4,960
Estimated outlays	260	-700	-2,360	-3,620	-4,960
Subtitle F: State Child Health Coverage:					
Estimated budget authority	2,880	2,880	2,880	2,880	2,880
Estimated outlays	2,880	2,880	2,880	2,880	2,880
Total Proposed Changes in Direct Spending:					
Estimated budget authority	3,140	1,379	-1,582	-3,744	-5,886
Estimated outlays	3,140	1,379	-1,582	-3,744	-5,886
RECEIPTS FROM ASSET SALES					
Subtitle C: Sale of DOE Assets:					
Estimated budget authority	0	-10	-52	-52	-70
Estimated outlays	0	-10	-52	-52	-70
ADDITIONAL SPENDING SUBJECT TO APPROPRIATION					
Subtitle D: Spectrum Auction Expenses:					
Estimated authorization level	12	12	12	12	12
Estimated outlays	11	12	12	12	12

Lease of excess SPR capacity (Subtitle B)

This subtitle would remove some of the statutory impediments to leasing the excess capacity of the SPR to foreign governments. For example, products stored on behalf of foreign governments would not be considered part of the U.S. reserve and could be exported. Estimates of how much of the excess capacity (currently about 110 million barrels) would be leased are speculative, because the decision to lease resides with foreign governments, not DOE. At this time, most nations needing capacity either have plans for domestic storage or face regulatory barriers to using U.S. facilities. CBO ex-

pects, however, that one or more nations would chose to store small quantities of oil in the SPR to accommodate growth in their storage requirements or to satisfy other strategic objectives. We estimate that such leasing activity would generate receipts totaling about \$13 million over the 1999–2002 period, assuming a storage fee of about \$1.20 per barrel (in 1997 dollars). Beginning in 2003, this provision would no longer generate net receipts because DOE would be authorized to spend the proceeds from leasing to purchase oil for the reserve without further appropriation.

Sale of DOE assets (Subtitle C)

CBO estimates that enacting Subtitle C would generate asset sale proceeds totaling \$184 million over the 1999–2002 period. Under current law, DOE is required to sell uranium from its stockpile to raise a total of \$77 million to offset appropriations provided for fiscal years 1996 and 1997. CBO projects that DOE will sell about three million pounds of uranium in 1998 and about 1.5 million pounds in 1999 to meet the \$77 million target in current law. Based on recent departmental findings supporting that effort, CBO expects that, under the conditions specified in this subtitle, the Secretary could justify selling a total of 3.2 million pounds per year through 2002. Because we expect DOE to be marketing about 1.5 million pounds in 1999 under current law, we assume that DOE would sell slightly less than 2 million pounds under this new authority that year. Hence, the estimate of \$184 million in proceeds attributable to Subtitle C is based on an assumed sales total of about 11 million pounds of uranium over the 1999–2002 period. Based on information provided by the department and committee staff, we assume that the uranium being sold as a result of this provision would be in addition to the Russian-derived uranium that must be sold over the same period. Finally, the spending required to conduct the sale would have no net effect on outlays, because this bill would require DOE to finance such costs using unobligated balances that otherwise would have been spent on other activities.

Receipts from spectrum auctions (Subtitle D)

CBO estimates that the federal government would collect \$9.7 billion in offsetting receipts over the 1998–2002 period from enacting the provisions contained in Subtitle D. This estimate reflects the likelihood that some of the auctions authorized by the subtitle would either not occur in the next five years or would yield relatively low aggregate winning bids. CBO believes that significantly higher aggregate auction receipts could be obtained under auction authority without the restrictions included in Subtitle D. Estimates for the major components of Subtitle D are discussed below and displayed in Table 3.

CBO expects that extending and broadening the FCC's authority to auction licenses through 2002 (under section 3301) would increase receipts by \$5.8 billion over the 1998–2002 period. Most of the estimated receipts would be generated by the auction of licenses permitting the use of frequencies above 3 GHz that have not been specifically designated for reallocation or auction under existing law. CBO anticipates that, in complying with its mandate to assign licenses for most mutually exclusive applications of the spec-

trum by competitive bidding, the commission will make available such frequencies under the general authority provided by this section.

In addition, CBO estimates that the provisions of section 3301 that require the FCC to use competitive bidding to assign the rights to use 120 MHz of frequencies below 3 GHz (100 MHz to be reallocated by the FCC and 20 MHz to be identified by the NTIA) would generate receipts of \$3.2 billion over the 1998–2002 period. This estimate reflects the significant probability that some auctions would not be held in the next five years and that some would be voided under the conditions set forth in the legislation. CBO's estimate of receipts for future FCC auctions is based on the expectation that prices for FCC licenses will fall from the levels of recent years as more spectrum is brought to the market. CBO has further reduced its estimate for the 120 MHz of spectrum identified for auction in this subtitle because the legislation does not specify the location on the electromagnetic spectrum for 55 MHz of the 100 MHz that it would require the commission to reallocate and auction. There is some doubt as to whether sufficient spectrum can be identified and auctioned to meet the 120 MHz target. Moreover, the subtitle directs the commission to refrain from holding auctions under certain circumstances, and authorizes it to void the results of auctions if the targeted level of two-thirds of \$7.5 billion in aggregate winning bids is not achieved. These provisions create the prospect that the commission will decide not to conduct some auctions and will void the results of others. Our estimate reflects these uncertainties.

CBO estimates that enacting section 3302, which pertains to the recovery and auction of frequencies now allocated for analog television broadcasting, would yield \$700 million in auction receipts. This section requires the FCC to delay the recovery of the frequencies used by analog TV broadcasters in a market beyond December 31, 2006, if more than 5 percent of households in that market continue to rely exclusively on over-the-air terrestrial analog television signals. It would therefore introduce significant uncertainty as to when bidders would be able to use the frequencies and could reduce auction receipts by 50 percent or more. Accordingly, the \$700 million figure reflects (1) the possibility that the FCC might refrain from conducting the auction, (2) a lower estimate of the likely receipts if the commission holds the auction, and (3) the possibility that the commission would void the auction results because receipts would fall below the target of two-thirds of \$4 billion.

CBO estimates that no receipts would result from enacting section 3303, which pertains to the current television frequencies between 746 MHz and 806 MHz. Subsection (f) would require the FCC to assign each qualifying low-power television station a frequency below 746 MHz to permit continued operation before it allocates and assigns by auction any new licenses in the 746 MHz to 806 MHz range. Based on information from the FCC, CBO believes that there is not enough free spectrum below 746 MHz to allow the commission to carry out that requirement.

Medicaid (Subtitle E)

Subtitle E includes provisions to give states greater leeway in how they administer their Medicaid programs, maintain quality assurance, and reduce federal payments for disproportionate share hospitals (DSH). Some of these provisions would not significantly affect spending and others would increase spending. On balance, however, the subtitle would reduce federal outlays by \$11.4 billion over the 1998–2002 period (see Table 4). The assumptions underlying the estimates of costs or savings for provisions that would affect federal spending are described below.

Chapter 1—State flexibility reforms

The provisions in this chapter would give states increased flexibility to implement managed care programs, set payment rates, expand eligibility, implement programs of all-inclusive care for the elderly (PACE), change benefit requirements; and meet federal requirements for administrative activities.

Determination of Hospital Stay. CBO estimates that requiring Medicaid health plans to allow physicians or other attending health care providers and patients to determine the appropriate length of inpatient hospital stays would increase costs by \$0.8 billion over five years. This provision would lead to an increase in the number of inpatient days, with the result that states would have to pay health plans higher capitation rates to cover enrollees.

Payment for Federally Qualified Health Center Services (FQHCs). This provision would phase out over five years the requirement that states reimburse rural health clinics (RHCs) and most federally qualified health centers on a cost basis. The provision would eliminate cost-based reimbursement for organizations designated by the Health Resources and Services Administration as look-alike FQHCs. Without the requirement that payments reflect costs, CBO assumes that states would lower reimbursement rates to FQHCs and RHCs to be more consistent with overall Medicaid payment rates at the end of the phase-out period. CBO estimates that this provision would reduce Medicaid costs by \$0.3 billion over the next five years.

Repeal the Boren Amendment. The Boren Amendment requires states to reimburse hospitals and nursing homes at rates that are “reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable state and federal laws, regulations, and quality and safety standards.” Many states have argued that suits or threats of suits under the Boren Amendment have been an important cause of rapid increases in provider reimbursement rates.

CBO estimates that the repeal of the Boren Amendment would reduce spending by about \$1.2 billion over the 1998–2002 period. This estimate assumes that reimbursement rates for institutional providers would increase more slowly than if providers could continue to use the threat of Boren suits as leverage against the states. About 40 percent of the savings would come from payments to hospitals and 60 percent would come from payments to nursing homes.

Although payments to these providers are generally increasing overall, CBO's projections of Medicaid spending under current law assume that some states reduce provider reimbursement rates in any given year. Accordingly, the floor would increase costs slightly in 1998 because it would prevent these states from reducing rates.

12-Month Continuous Coverage. This provision would allow states to enroll children for the entire year without regard to changes in the incomes of their families. Under current law, CBO estimates that children stay enrolled in the Medicaid program for an average of 9 months in any year. If all states opted to extend coverage for an entire year, Medicaid costs would increase by almost \$14 billion. However, because this option would be so costly—and because few states take advantage of the option to provide 6-month continuous coverage under Section 1115 or Section 1915(b) waivers—CBO estimates that states accounting for only 5 percent of total costs would choose the option. Thus, this provision would cost \$0.7 billion over the 1998–2002 period.

This provision would increase the average number of children enrolled on the Medicaid program in any month by 130,000. But because some of these children would otherwise have been insured, the number of uninsured children would decline by about 80,000.

Payment of Home Health Related Medicare Part B Premium. This provision would expand the Specified Low-Income Medicare Beneficiary (SLMB) program, which pays the Medicare Part B premium for Medicaid enrollees with family incomes between 100 percent and 120 percent of the poverty level. Under the provision, the federal government would reimburse states for 100 percent of costs for the portion of the Medicare Part B premium attributable to home health spending for enrollees with family incomes between 120 and 175 percent of the federal poverty level. CBO estimates that federal outlays would increase by \$0.5 billion over the 1998–2002 period.

Physician Assistants. Expanding Medicaid benefits for services of physician assistants would increase costs by \$0.1 billion during the 1998–2002 period. Although most state Medicaid programs already pay for these services, there are several states for which this policy would represent a change from current law. CBO's estimate accounts for costs due to increased demand for physician assistant services that would accompany this policy change in these states and, to a lesser degree, for induced demand in the other states that would occur with the inclusion of this provision. Half of the costs attributable to new demand for services would be offset by lower spending for physician services that are covered under current law.

Chapter 2—Quality assurance

CBO estimates that the application of the prudent layperson standard for emergency medical conditions to contracts with Medicaid HMOs would increase costs of \$0.1 billion over five years. This provision would increase managed care plans' liability for emergency room use and, therefore, increase premiums for Medicaid managed care plans and thus federal spending.

Chapter 3—Federal payments

This chapter specifies allotments that would limit the amount of federal reimbursement available for state disproportionate share

hospital (DSH) programs over the 1998–2002 period. The bill classifies states into three categories according to how their DSH spending compared with total medical assistance payments. The allotment for a state whose DSH spending in 1995 was under 1 percent of medical assistance spending that year would equal the state's 1995 amount. The allotment for a state designated as a high-DSH state in 1997—one whose DSH payments were greater than 12 percent of medical assistance payments—would equal the state's 1995 spending reduced by 2 percent in 1998, 5 percent in 1999, 20 percent in 2000, 30 percent in 2001 and 40 percent in 2002 and subsequent years. The allotment for any state would equal the state's 1995 spending reduced by half of the percentage reduction applied to high-DSH states. The bill also specifies that DSH payments would be made directly to hospitals and not included in the capitation payments for managed care plans. This chapter also includes provisions that would guarantee that DSH payments to certain children's and teaching hospitals be no less than DSH payments made to such hospitals in 1995 for fiscal year 1999. This amount would be increased by overall Medicaid growth for subsequent years.

CBO estimates that these provisions would reduce federal outlays by \$13.1 billion over the 1998–2002 period. This estimate takes into account state responses to the reduced availability of DSH money and interactions with the Child Health Assistance Program (CHAP) in Subtitle F of the bill. It is based on the preliminary designations of high- and low-DSH states published in the Federal Register on January 31, 1997.

By itself, a policy to limit DSH spending would not be fully effective because states could restore some of the lost federal revenues by increasing their use of intergovernmental transfers or Medicaid maximization techniques. (Intergovernmental transfers are a process by which public hospitals or other public facilities transfer money to the state, which then uses these funds to make DSH payments—mainly to those same facilities—and receives federal matching dollars for those payments. Medicaid maximization refers to states shifting to the Medicaid program activities that were previously financed without federal assistance.) CBO estimates that these strategies would reduce the savings from limits on DSH spending by 25 percent. In this case, however, states would not feel the full effects of the limits because some of their CHAP funds could be used for existing state activities, such as health insurance programs or direct provision of health care services to uninsured children. Because of this flexibility, the reduction in payments to states to which CBO applies the 25 percent factor is smaller, and net federal savings from limiting DSH spending are larger than would be the case for a stand-alone policy.

Finally, this subtitle would provide \$20 million a year to be allocated among the 12 states with the highest number of undocumented aliens for emergency health services provided to them.

Child Health Assistant Program (CHAP)—(Subtitle F)

The Child Health Assistant Program would provide funds enabling states to initiate and expand the provision of child health care assistance to uninsured, low-income children. The bill would

provide \$2.9 billion per year (\$14.4 billion over the 1998–2002 period) to finance these activities. Of this amount, 0.5 percent would be allocated to the territories. The remaining money would be distributed according to each state's share of the total number of uninsured children in all states, adjusted for the average cost of health care. The state matching requirement would be 20 percent.

The bill would provide states with a great deal of flexibility in how to spend these funds. States could purchase health insurance coverage from group plans, arrange for health care services directly through providers, expand their Medicaid programs, or use other methods approved by the Secretary. CBO makes no specific assumption about which approach states would choose. However, CBO assumes it unlikely that states would opt to use their state allocations to expand the Medicaid program.

Given the range of options from which a state could choose, the number of children who would be covered under the programs cannot be estimated with precision. Whereas some states would choose to purchase insurance coverage, others might choose to provide health care services directly. Access to health care for uninsured children would increase under both approaches, but only the former approach would be counted as an increase in health insurance coverage. Further, not all of this spending would represent a net increase in health care services. CBO assumes that states would use some of the money to substitute for funds that are currently being spent on these services, including payments to disproportionate share hospitals, state health programs, and administrative activities.

After accounting for spending on the provision of direct services and other activities, CBO assumes the states could cover about 500,000 children through new health insurance programs. In addition, CBO estimates that in the process of enrolling children in these programs, states would identify some children who were eligible for Medicaid and would enroll them in that program. As a result, federal Medicaid outlays would increase by \$0.7 billion over the 1998–2002 period; on a full-year equivalent basis, Medicaid enrollment would increase by about 125,000 children annually. Not all of the children newly enrolled in state programs or Medicaid would otherwise have been uninsured, however, so that the net effect of this provision would be to reduce the number of uninsured children by about 380,000.

Subtitle F would allow states the option to provide Medicaid coverage to children during a period of presumptive eligibility. CBO estimates that this provision would increase federal costs by \$0.5 billion over five years. Of this amount, \$0.1 billion would be deducted from states' CHAP allotments for spending during a period of presumptive eligibility. The remaining \$0.4 billion would be attributable to an overall increase in Medicaid enrollment. (These costs are shown under Subtitle E in Table 4.) CBO assumes that the states would limit the entities authorized to determine eligibility to those who currently do so for pregnant women.

Estimated impact on State, local, and tribal governments: By extending the NRC's authority to collect fees from publicly owned utilities, Subtitle A would impose an intergovernmental mandate as defined by UMRA, but this mandate would not impose costs

above the threshold established in that law (\$50 million in 1996, adjusted for inflation). Other subtitles of Title III contain provisions that would have significant impacts on the budgets of state, local, and tribal governments.

Mandates

Subtitle A would extend, through fiscal year 2002, the NRC's authority to charge fees to offset 100 percent of its general fund appropriation. The existing authority to charge these fees expires after fiscal year 1998. After that year, NRC would be authorized to set fees equal to only 33 percent of its budget. CBO cannot determine whether this mandate would impose any direct costs because UMRA is unclear as to how to define costs associated with extending an existing mandate that has not yet expired.

In any case, this mandate would impose costs on state, local and tribal governments significantly below the threshold established by UMRA. The amount of fees collected under this provision would depend on the level of future appropriations. Assuming appropriations remain at the 1997 level, adjusted for inflation, CBO estimates that this provision would result in additional collections of about \$340 million annually over the 1999–2002 period. CBO estimates that a small percentage of these fees—less than five percent—would be paid by publicly owned utilities, so this provision would result in additional costs to state, local, and tribal governments totaling no more than \$20 million per year.

Other significant impacts

Communications (Subtitle D).—This subtitle would instruct the FCC to allocate a portion of the spectrum to state and local governments for public safety services. It would also allow state and local governments to use unassigned radio frequencies for public safety purposes under certain circumstances.

Medicaid (Subtitle E).—By expanding benefits and eligibility, CBO estimates that this subtitle would increase net state Medicaid spending excluding DSH. The subtitle would also decrease the federal government's share of DSH payments by \$13.1 billion over the next five years but contains a provision that would require states to maintain their DSH payments to certain teaching and children's hospitals at 1995 levels (increased annually by the rate of growth of their Medicaid programs). This reduction in DSH payments would not constitute a mandate under UMRA because reductions in federal funding to states for large entitlement programs are not mandates if states have the flexibility to reduce their own programmatic or financial responsibilities under the program. States have significant programmatic flexibility under Medicaid. Finally, this title would provide states with \$100 million over the next five years to provide emergency health services to undocumented aliens.

Child Health Coverage (Subtitle F).—This subtitle would create a new program—Child Health Assistance Program (CHAP)—that would provide states with \$14.4 billion over the next five years to provide assistance to low income children who are uninsured in obtaining health coverage. States would provide 20 percent of this program's funding.

Estimated impact on the private sector: CBO has identified one private-sector mandate in Title III. Subtitle A would impose a mandate on the private sector by extending the Nuclear Regulatory Commission's authority to collect annual charges from nuclear utilities, resulting in additional collections averaging \$340 million a year from 1999 through 2002. CBO estimates that most of the fees would be paid by investor-owned nuclear utilities.

CBO cannot determine whether the direct costs of this mandate would exceed the annual threshold in UMRA, because UMRA is unclear as to how to define the direct costs associated with extending an existing mandate that has not yet expired. Measured against the private-sector costs that would be incurred if current law remains in place and the annual fee declines, the total direct cost of extending this mandate would be about \$300 million annually, beginning in fiscal year 1999. In this case the cost of the mandate would exceed the annual threshold for the private sector as defined in UMRA. By contrast, measured against current private-sector costs, the direct cost of the mandate would be zero.

Estimate prepared by: Federal Costs: NRC Fees—Kim Cawley (226-2860); SPR Leasing and DOE Asset Sales—Kathleen Gramp (226-2860); Spectrum—Rachel Forward (226-2860); David Moore and Perry Beider (226-2940); Medicaid—Robin Rudowitz and Jeanne De Sa (226-9010); Child Health Care Initiative—Robin Rudowitz and Jeanne De Sa (226-9010).

Impact on State, Local and Tribal Governments: NRC Fees—Marjorie Miller (225-3220); Medicaid and Child Health Care Initiative—John Patterson (225-3220); Other provisions—Pepper Santalucia (225-3220).

Impact on the Private Sector: Medicaid and Child Health Care Initiative—Linda Bilheimer (226-2673); Other provisions—Jean Wooster and Patrice Gordon (226-2940).

Estimate approved by: Paul N. Van De Water, Assistant Director for Budget Analysis.

TABLE 2. ESTIMATED 10-YEAR BUDGETARY EFFECTS OF TITLE III: RECONCILIATION RECOMMENDATIONS OF THE HOUSE COMMITTEE ON COMMERCE

(In million of dollars, by fiscal year)

	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	1998-2007 total
Summary of Changes in Direct Spending and Asset Sale Proceeds											
Subtitle A: NRC Fees:											
Estimated budget authority	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)
Estimated outlays	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)
Subtitle B: Lease of Excess SPR Capacity:											
Estimated budget authority	0	-1	-2	-4	-6	0	0	0	0	0	-13
Estimated outlays	0	-1	-2	-4	-6	-6	0	0	0	0	-19
Subtitle C: Sale of DOE Assets:											
Estimated budget authority	0	-10	-52	-52	-70	0	0	0	0	0	-184
Estimated outlays	0	-10	-52	-52	-70	0	0	0	0	0	-184
Subtitle D: Receipts from Spectrum Auctions:											
Estimated budget authority	0	-800	-2,100	-3,000	-3,800	0	0	0	0	0	-9,700
Estimated outlays	0	-800	-2,100	-3,000	-3,800	0	0	0	0	0	-9,700
Subtitle E: Medicaid: ²											
Estimated budget authority	260	-700	-2,360	-3,620	-4,960	-5,860	-6,790	-7,850	-9,010	-10,300	-51,190
Estimated outlays	260	-700	-2,360	-3,620	-4,960	-5,860	-6,790	-7,850	-9,010	-10,300	-51,190
Subtitle F: State Child Health Coverage:											
Estimated budget authority	2,880	2,880	2,880	2,880	2,880	2,880	2,880	2,880	2,880	2,880	28,800
Estimated outlays	2,880	2,880	2,880	2,880	2,880	2,880	2,880	2,880	2,880	2,880	28,800
Total changes in direct spending and asset sale proceeds:											
Estimated budget authority	3,140	1,369	-1,634	-3,796	-5,956	-2,980	-3,910	-4,970	-6,130	-7,420	-32,287
Estimated outlays	3,140	1,369	-1,634	-3,796	-5,956	-2,986	-3,910	-4,970	-6,130	-7,420	-32,293

¹Not applicable: extension of NRC fees at their current full-cost recovery rate has no effect on direct spending because such fees are recorded in the budget as offsetting collections credited to appropriations. The amount of fees that would be collected under Subtitle A would be determined by the annual general fund appropriation for NRC operations.

²These estimates assume continuation of 2002 DSH policy for 2003 through 2007.

TABLE 3. ESTIMATED 10-YEAR BUDGETARY EFFECTS OF SUBTITLE D OF TITLE III: RECONCILIATION RECOMMENDATIONS OF THE HOUSE COMMITTEE ON COMMERCE
(In million of dollars, by fiscal year)

	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	1997-2007 total
Estimated Budgetary Effects of Subtitle D—Communications												
Direct Spending (Offsetting Receipts)												
Auction Receipts Under Current Law:												
Estimated Budget Authority	-9,600	-7,100	-1,600	-550	-150	0	0	0	0	0	0	-19,000
Estimated Outlays	-9,600	-7,100	-1,600	-550	-150	0	0	0	0	0	0	-19,000
Proposed Changes:												
Broaden and Extend:												
Estimated Budget Authority	0	0	-800	-1,500	-1,700	-1,800	0	0	0	0	0	-5,800
Estimated Outlays	0	0	-800	-1,500	-1,700	-1,800	0	0	0	0	0	-5,800
Relocation of 120 Mhz:												
Estimated Budget Authority	0	0	0	-600	-1,300	-1,300	0	0	0	0	0	-3,200
Estimated Outlays	0	0	0	-600	-1,300	-1,300	0	0	0	0	0	-3,200
Analog Return and Channels 60-69:												
Estimated Budget Authority	0	0	0	0	0	-700	0	0	0	0	0	-700
Estimated Outlays	0	0	0	0	0	-700	0	0	0	0	0	-700
Total Changes:												
Estimated Budget Authority	0	0	-800	-2,100	-3,000	-3,000	0	0	0	0	0	-9,700
Estimated Outlays	0	0	-800	-2,100	-3,000	-3,000	0	0	0	0	0	-9,700
Auction Receipts Under Subtitle D:												
Estimated Budget Authority	-9,600	-7,100	-2,400	-2,650	-3,150	-3,800	0	0	0	0	0	-28,700
Estimated Outlays	-9,600	-7,100	-2,400	-2,650	-3,150	-3,800	0	0	0	0	0	-28,700
SPENDING SUBJECT TO APPROPRIATION												
FCC Spending Under Current Law:												
Estimated Authorization Level ¹	37	38	40	41	43	44	46	47	49	51	53	452
Estimated Outlays	35	38	40	41	43	44	46	47	49	51	53	452
Proposed Changes—Auction Expenses:												
Estimated Authorization Level	0	12	12	12	12	12	0	0	0	0	0	60
Estimated Outlays	0	11	12	12	12	12	1	0	0	0	0	60
FCC Spending Under Subtitle D:												
Estimated Authorization Level ¹	37	50	52	53	55	56	46	47	49	51	53	512
Estimated Outlays	35	49	52	53	55	56	47	47	49	51	53	512

¹The 1997 level is the amount appropriated for that year. Amounts shown for subsequent years are CBO baseline projections.

TABLE 4. MEDICAID AND CHILD HEALTH ASSISTANCE PROPOSALS AS APPROVED BY THE COMMITTEE ON COMMERCE ON JUNE 12, 1997
 [By fiscal year, in billions of dollars]

	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	1998- 2007 total	1998- 2007 total
Subtitle E—Medicaid:												
Spending Under Current Law	105.3	113.6	122.9	132.8	143.8	155.9	168.7	183.1	198.9	216.2	618.4	1,541.2
Chapter 1—State Flexibility Reforms:												
Use of Managed Care:												
Determination of hospital stay	0.1	0.1	0.1	0.2	0.2	0.2	0.2	0.3	0.3	0.3	0.8	2.1
Payment Methodology:												
FQHC payment reform	-0.0	-0.0	-0.0	-0.1	-0.1	-0.2	-0.2	-0.2	-0.2	-0.3	-0.3	-1.4
Repeal of Boren Requirements	0.0	-0.1	-0.2	-0.4	-0.5	-0.7	-0.9	-1.1	-1.4	-1.6	-1.2	-6.9
Extension of moratorium for certain IMDs ¹	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Eligibility:												
Option for 12 month continuous eligibility	0.1	0.1	0.1	0.1	0.2	0.2	0.2	0.2	0.2	0.2	0.7	1.6
Payment of home-health Medicare B premium	0.0	0.1	0.1	0.1	0.2	0.2	0.3	0.3	0.3	0.3	0.5	1.9
PACE:												
PACE as Medicaid option ²	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Benefits:												
Benefits for services of Physician Assistants	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.3
Chapter 2—Quality Assurance:												
Application of standards for emergency conditions	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.2
Chapter 3—Federal Payments:												
Disproportionate Share ³	-0.2	-1.1	-2.7	-3.9	-5.1	-5.9	-6.7	-7.6	-8.6	-9.6	-13.1	-51.6
Emergency health services for aliens	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.2
Medicaid interaction with CHAP	0.1	0.1	0.1	0.1	0.1	0.2	0.2	0.2	0.2	0.2	0.7	1.5
Presumptive eligibility for low-income children ⁴	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.4	0.9
Total Change in Spending	0.3	-0.7	-2.4	-3.6	-5.0	-5.9	-6.8	-7.8	-9.0	-10.3	-11.4	-51.2
Spending Under Proposal	105.6	112.9	120.5	129.2	138.8	150.0	161.9	175.3	189.9	205.9	607.0	1,490.0
Subtitle F—Child Health Assistance Program (CHAP):												
Total Federal Allotments	2.9	2.9	2.9	2.9	2.9	2.9	2.9	2.9	2.9	2.9	14.4	28.8

¹ Would increase federal costs by about \$500,000 per year.
² Would increase Medicare outlays by \$8 million over 5 years.
³ Estimate includes interaction with CHAP.
⁴ This provision is included in Subtitle F.

CHANGES IN EXISTING LAW MADE BY TITLE III OF THE BILL, AS REPORTED

In compliance with clause 3 of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

* * * * *

SECTION 6101 OF THE OMNIBUS BUDGET RECONCILIATION ACT OF 1990

SEC. 6101. NRC USER FEES AND ANNUAL CHARGES.

(a) ANNUAL ASSESSMENT.—

(1) * * *

* * * * *

(3) LAST ASSESSMENT OF ANNUAL CHARGES.—The last assessment of annual charges under subsection (c) shall be made not later than September 30, **[1998]** 2002.

* * * * *

ENERGY POLICY AND CONSERVATION ACT

* * * * *

TITLE I—MATTERS RELATED TO DOMESTIC SUPPLY AVAILABILITY

* * * * *

PART B—STRATEGIC PETROLEUM RESERVE

Sec. 151. Declaration of policy.

* * * * *

Sec. 168. *Use of underutilized facilities.*

* * * * *

TITLE I—MATTERS RELATED TO DOMESTIC SUPPLY AVAILABILITY

PART B—STRATEGIC PETROLEUM RESERVE

* * * * *

USE OF UNDERUTILIZED FACILITIES

SEC. 168. (a) AUTHORITY.—Notwithstanding any other provision of this title, the Secretary, by lease or otherwise, for any term and under such other conditions as the Secretary considers necessary or appropriate, may store in underutilized Strategic Petroleum Reserve facilities petroleum product owned by a foreign government or its representative. Petroleum products stored under this section are not

part of the Strategic Petroleum Reserve and may be exported without license from the United States.

(b) *PROTECTION OF FACILITIES.*—All agreements entered into pursuant to subsection (a) shall contain provisions providing for fees to fully compensate the United States for all costs of storage and removals of petroleum products, including the cost of replacement facilities necessitated as a result of any withdrawals.

(c) *ACCESS TO STORED OIL.*—The Secretary shall ensure that agreements to store petroleum products for foreign governments or their representatives do not affect the ability of the United States to withdraw, distribute, or sell petroleum from the Strategic Petroleum Reserve in response to an energy emergency or to the obligations of the United States under the Agreement on an International Energy Program.

(d) *AVAILABILITY OF FUNDS.*—Funds collected through the leasing of Strategic Petroleum Reserve facilities authorized by subsection (a) after September 30, 2002, shall be used by the Secretary of Energy without further appropriation for the purchase of oil for, and operation and maintenance costs of, the Strategic Petroleum Reserve.

* * * * *

COMMUNICATIONS ACT OF 1934

* * * * *

TITLE III—PROVISIONS RELATING TO RADIO

PART I—GENERAL PROVISIONS

* * * * *

SEC. 309. ACTION UPON APPLICATIONS; FORM OF AND CONDITIONS ATTACHED TO LICENSES.

(a) * * *

* * * * *

[(i) **RANDOM SELECTION.**—

[(1) **GENERAL AUTHORITY.**—If—

[(A) there is more than one application for any initial license or construction permit which will involve a use of the electromagnetic spectrum; and

[(B) the Commission has determined that the use is not described in subsection (j)(2)(A);

then the Commission shall have the authority to grant such license or permit to a qualified applicant through the use of a system of random selection.

[(2) No license or construction permit shall be granted to an applicant selected pursuant to paragraph (1) unless the Commission determines the qualifications of such applicant pursuant to subsection (a) and section 308(b). When substantial and material questions of fact exist concerning such qualifications, the Commission shall conduct a hearing in order to make such determinations.

For the purposes of making such determinations, the Commission may, by rule, and notwithstanding any other provision of law—

[(A) adopt procedures for the submission of all or part of the evidence in written form;

[(B) delegate the function of presiding at the taking of written evidence to Commission employees other than administrative law judges; and

[(C) omit the determination required by subsection (a) with respect to any application other than the one selected pursuant to paragraph (1).

[(3)(A) The Commission shall establish rules and procedures to ensure that, in the administration of any system of random selection under this subsection used for granting licenses or construction permits for any media of mass communications, significant preferences will be granted to applicants or groups of applicants, the grant to which of the license or permit would increase the diversification of ownership of the media of mass communications. To further diversify the ownership of the media of mass communications, an additional significant preference shall be granted to any applicant controlled by a member or members of minority group.

[(B) The Commission shall have authority to require each qualified applicant seeking a significant preference under subparagraph (A) to submit to the Commission such information as may be necessary to enable the Commission to make a determination regarding whether such applicant shall be granted such preference. Such information shall be submitted in such form, at such times, and in accordance with such procedures, as the Commission may require.

[(C) For purposes of this paragraph:

[(i) The term “media of mass communication” includes television, radio, cable television, multipoint distribution service, direct broadcast satellite service, and other services, the licensed facilities of which may be substantially devoted toward providing programming or other information services within the editorial control of the licensee.

[(ii) The term “minority group” includes Blacks, Hispanics, American Indians, Alaska Natives, Asians, and Pacific Islanders.

[(4)(A) The Commission shall, after notice and opportunity for hearing, prescribe rules establishing a system of random selection for use by the Commission under this subsection in any instance in which the Commission, in its discretion, determines that such use is appropriate for the granting of any license or permit in accordance with paragraph (1).

[(B) The Commission shall have authority to amend such rules from time to time to the extent necessary to carry out the provisions of this subsection. Any such amendment shall be made after notice and opportunity for hearing.

[(C) Not later than 180 days after the date of enactment of this subparagraph, the Commission shall prescribe such transfer disclosures and antitrafficking restrictions and payment schedules as are necessary to prevent the unjust enrichment of recipients of licenses or permits as a result of the methods employed to issue licenses under this subsection.]

(j) USE OF COMPETITIVE BIDDING.—

【(1) GENERAL AUTHORITY.—If mutually exclusive applications are accepted for filing for any initial license or construction permit which will involve a use of the electromagnetic spectrum described in paragraph (2), then the Commission shall have the authority, subject to paragraph (10), to grant such license or permit to a qualified applicant through the use of a system of competitive bidding that meets the requirements of this subsection.

【(2) USES TO WHICH BIDDING MAY APPLY.—A use of the electromagnetic spectrum is described in this paragraph if the Commission determines that—

【(A) the principal use of such spectrum will involve, or is reasonably likely to involve, the licensee receiving compensation from subscribers in return for which the licensee—

【(i) enables those subscribers to receive communications signals that are transmitted utilizing frequencies on which the licensee is licensed to operate; or

【(ii) enables those subscribers to transmit directly communications signals utilizing frequencies on which the licensee is licensed to operate; and

【(B) a system of competitive bidding will promote the objectives described in paragraph (3).】

(1) GENERAL AUTHORITY.—*If, consistent with the obligations described in paragraph (6)(E), mutually exclusive applications are accepted for any initial license or construction permit which will involve an exclusive use of the electromagnetic spectrum, then the Commission shall grant such license or permit to a qualified applicant through a system of competitive bidding that meets the requirements of this subsection.*

(2) EXEMPTIONS.—*The competitive bidding authority granted by this subsection shall not apply to licenses or construction permits issued by the Commission—*

(A) *that, as the result of the Commission carrying out the obligations described in paragraph (6)(E), are not mutually exclusive;*

(B) *for public safety radio services, including private internal radio services used by non-Government entities, that—*

(i) protect the safety of life, health, or property; and

(ii) are not made commercially available to the public;

(C) *for initial licenses or construction permits assigned by the Commission to existing terrestrial broadcast licensees for new terrestrial digital television services; or*

(D) *for public telecommunications services, as defined in section 397(14) of the Communications Act of 1934 (47 U.S.C. 397(14)), when the license application is for channels reserved for noncommercial use.*

(3) DESIGN OF SYSTEMS OF COMPETITIVE BIDDING.—For each class of licenses or permits that the Commission grants through the use of a competitive bidding system, the Commission shall, by regulation, establish a competitive bidding methodology. The Commission shall seek to design and test multiple

alternative methodologies under appropriate circumstances. *The Commission shall, directly or by contract, provide for the design and conduct (for purposes of testing) of competitive bidding using a contingent combinatorial bidding system that permits prospective bidders to bid on combinations or groups of licenses in a single bid and to enter multiple alternative bids within a single bidding round.* In identifying classes of licenses and permits to be issued by competitive bidding, in specifying eligibility and other characteristics of such licenses and permits, and in designing the methodologies for use under this subsection, the Commission shall include safeguards to protect the public interest in the use of the spectrum and shall seek to promote the purposes specified in section 1 of this Act and the following objectives:

(A) * * *

* * * * *

(C) recovery for the public of a portion of the value of the public spectrum resource made available for commercial use and avoidance of unjust enrichment through the methods employed to award uses of that resource; **[and]**

(D) efficient and intensive use of the electromagnetic spectrum**[.]; and**

(E) *ensuring that, in the scheduling of any competitive bidding under this subsection, an adequate period is allowed—*

(i) before issuance of bidding rules, to permit notice and comment on proposed auction procedures; and

(ii) after issuance of bidding rules, to ensure that interested parties have a sufficient time to develop business plans, assess market conditions, and evaluate the availability of equipment for the relevant services.

* * * * *

(8) TREATMENT OF REVENUES.—

(A) * * *

[(B) RETENTION OF REVENUES.—Notwithstanding subparagraph (A), the salaries and expenses account of the Commission shall retain as an offsetting collection such sums as may be necessary from such proceeds for the costs of developing and implementing the program required by this subsection. Such offsetting collections shall be available for obligation subject to the terms and conditions of the receiving appropriations account, and shall be deposited in such accounts on a quarterly basis. Any funds appropriated to the Commission for fiscal years 1994 through 1998 for the purpose of assigning licenses using random selection under subsection (i) shall be used by the Commission to implement this subsection. Such offsetting collections are authorized to remain available until expended.]

[(C) (B) DEPOSIT AND USE OF AUCTION ESCROW ACCOUNTS.—Any deposits the Commission may require for the qualification of any person to bid in a system of competitive bidding pursuant to this subsection shall be deposited in an interest bearing account at a financial institu-

tion designated for purposes of this subsection by the Commission (after consultation with the Secretary of the Treasury). Within 45 days following the conclusion of the competitive bidding—

(i) the deposits of successful bidders shall be paid to the Treasury;

(ii) the deposits of unsuccessful bidders shall be returned to such bidders; and

(iii) the interest accrued to the account shall be transferred to the Telecommunications Development Fund established pursuant to section 714 of this Act.

* * * * *

(11) TERMINATION.—The authority of the Commission to grant a license or permit under this subsection shall expire September 30, ~~1998~~ 2002.

* * * * *

(13) RECOVERY OF VALUE OF PUBLIC SPECTRUM IN CONNECTION WITH PIONEER PREFERENCES.—

(A) * * *

* * * * *

(F) EXPIRATION.—The authority of the Commission to provide preferential treatment in licensing procedures (by precluding the filing of mutually exclusive applications) to persons who make significant contributions to the development of a new service or to the development of new technologies that substantially enhance an existing service shall expire on ~~September 30, 1998~~ the date of enactment of the *Balanced Budget Act of 1997*.

* * * * *

(14) AUCTION OF RECAPTURED BROADCAST TELEVISION SPECTRUM.—

(A) LIMITATIONS ON TERMS OF TERRESTRIAL TELEVISION BROADCAST LICENSES.—*A television license that authorizes analog television services may not be renewed to authorize such service for a period that extends beyond December 31, 2006. The Commission shall grant by regulation an extension of such date to licensees in a market if the Commission determines that more than 5 percent of households in such market continue to rely exclusively on over-the-air terrestrial analog television signals.*

(B) SPECTRUM REVERSION AND RESALE.—

(i) *The Commission shall ensure that, when the authority to broadcast analog television services under a license expires pursuant to subparagraph (A), each licensee shall return spectrum according to the Commission's direction and the Commission shall reclaim such spectrum.*

(ii) *Licensees for new services occupying spectrum reclaimed pursuant to clause (i) shall be selected in accordance with this subsection. The Commission shall start such selection process by July 1, 2001, with pay-*

ment pursuant to rules established by the Commission under this subsection.

(C) *MINIMUM RECOVERY FOR PUBLIC REQUIRED.*—

(i) *METHODOLOGY TO SECURE MINIMUM AMOUNTS REQUIRED.*—In establishing, pursuant to section 309(j)(3) of the Communications Act of 1934 (47 U.S.C. 309(j)(3)), a competitive bidding methodology with respect to the frequencies required to be assigned by competitive bidding under subparagraph (B) of this paragraph, the Commission shall establish procedures that are designed to secure winning bids totaling not less than two-thirds of \$4,000,000,000.

(ii) *AUTHORITY.*—In establishing such methodology, the Commission is authorized—

(I) to partition the total required to be obtained under clause (i) among separate competitive bidding proceedings, or among separate bands, regions, or markets;

(II) to void any such separated competitive bidding proceeding that fails to obtain the partitioned subtotal that pertains to that proceeding; and

(III) to prescribe minimum bids or other bidding requirements to obtain such aggregate total.

(iii) *LICENSES WITHHELD.*—Notwithstanding any other requirement of this paragraph, the Commission shall refrain from conducting any competitive bidding pursuant to the methodology established pursuant to this subparagraph unless the Commission determines that such methodology will secure winning bids totaling not less than two-thirds of \$4,000,000,000.

(iv) *AUTHORITY TO REBID AT A LATER TIME TO SECURE STATUTORY OBJECTIVES.*—Nothing in clause (ii) or (iii) shall preclude or limit the Commission from assigning the frequencies described in clause (i) by competitive bidding at such later date (than the date required by this paragraph) as the Commission determines, in its discretion, will better attain the objectives of recovering for the public a fair portion of the value of the public spectrum resource and avoiding unjust enrichment.

(D) *CERTAIN LIMITATIONS ON QUALIFIED BIDDERS PROHIBITED.*—In prescribing any regulations relating to the qualification of bidders for spectrum reclaimed pursuant to subparagraph (B)(i), the Commission shall not—

(i) preclude any party from being a qualified bidder for spectrum that is allocated for any use that includes digital television service on the basis of—

(I) the Commission's duopoly rule (47 C.F.R. 73.3555(b)); or

(II) the Commission's newspaper cross-ownership rule (47 C.F.R. 73.3555(d)); or

(ii) apply either such rule to preclude such a party that is a successful bidder in a competitive bidding for

such spectrum from using such spectrum for digital television service.

(E) *DEFINITIONS.—As used in this paragraph:*

(i) The term “digital television service” means television service provided using digital technology to enhance audio quality and video resolution, as further defined in the Memorandum Opinion, Report, and Order of the Commission entitled “Advanced Television Systems and Their Impact Upon the Existing Television Service”, MM Docket No. 87–268 and any subsequent Commission proceedings dealing with digital television.

(ii) The term “analog television service” means service provided pursuant to the transmission standards prescribed by the Commission in section 73.682(a) of its regulation (47 CFR 73.682(a)).

* * * * *

**NATIONAL TELECOMMUNICATIONS AND INFORMATION
ADMINISTRATION ORGANIZATION ACT**

* * * * *

**TITLE I—NATIONAL TELECOMMUNI-
CATIONS AND INFORMATION ADMIN-
ISTRATION**

* * * * *

**PART B—TRANSFER OF AUCTIONABLE
FREQUENCIES**

* * * * *

SEC. 113. IDENTIFICATION OF REALLOCABLE FREQUENCIES.

(a) * * *

* * * * *

(b) **MINIMUM AMOUNT OF SPECTRUM RECOMMENDED.—**

(1) **[IN GENERAL] INITIAL REALLOCATION REPORT.**—In accordance with the provisions of this section, the Secretary shall recommend for reallocation *in the first report required by subsection (a)*, for use other than by Federal Government stations under section 305 of the 1934 Act (47 U.S.C. 305), bands of frequencies that in the aggregate span not less than 200 megahertz, that are located below 5 gigahertz, and that meet the criteria specified in paragraphs (1) through (5) of subsection (a). Such bands of frequencies shall include bands of frequencies, located below 3 gigahertz, that span in the aggregate not less than 100 megahertz.

(2) **MIXED USES PERMITTED TO BE COUNTED.**—Bands of frequencies which a report of the Secretary under subsection (a) or (d)(1) recommends be partially retained for use by Federal

Government stations, but which are also recommended to be reallocated to be made available under the 1934 Act for use by non-Federal stations, may be counted toward the minimum spectrum required by paragraph (1) or (3) of this subsection, except that—

(A) the bands of frequencies counted under this paragraph may not count toward more than one-half of the minimums required by paragraph (1) or (3) of this subsection;

* * * * *

(3) *SECOND REALLOCATION REPORT.*—*In accordance with the provisions of this section, the Secretary shall recommend for reallocation in the second report required by subsection (a), for use other than by Federal Government stations under section 305 of the 1934 Act (47 U.S.C. 305), a band or bands of frequencies that—*

- (A) *in the aggregate span not less than 20 megahertz;*
- (B) *individually span not less than 20 megahertz, unless a combination of smaller bands can reasonably be expected to produce greater receipts;*
- (C) *are located below 3 gigahertz; and*
- (D) *meet the criteria specified in paragraphs (1) through (5) of subsection (a).*

* * * * *

(f) *ADDITIONAL REALLOCATION REPORT.*—*If the Secretary receives a notice from the Commission pursuant to section 3301(b)(3) of the Balanced Budget Act of 1997, the Secretary shall prepare and submit to the President, the Commission, and the Congress a report recommending for reallocation for use other than by Federal Government stations under section 305 of the 1934 Act (47 U.S.C. 305), bands of frequencies that are suitable for the uses identified in the Commission's notice. The Commission shall, not later than one year after receipt of such report, prepare, submit to the President and the Congress, and implement, a plan for the immediate allocation and assignment of such frequencies under the 1934 Act to incumbent licences described in section 3301(b)(3) of the Balanced Budget Act of 1997.*

SEC. 114. WITHDRAWAL OR LIMITATION OF ASSIGNMENT TO FEDERAL GOVERNMENT STATIONS.

- (a) **IN GENERAL.**—The President shall—
 - (1) within 6 months after receipt of a report by the Secretary under subsection [(a) or (d)(1)] (a), (d)(1), or (f) of section 113, withdraw the assignment to a Federal Government station of any frequency which the report recommends for immediate reallocation;
 - (2) within either such 6-month period, limit the assignment to a Federal Government station of any frequency which the report recommends be made immediately available for mixed use under section 113(b)(2);

* * * * *

SEC. 115. DISTRIBUTION OF FREQUENCIES BY THE COMMISSION.

- (a) * * *

(b) ALLOCATION AND ASSIGNMENT OF REMAINING AVAILABLE FREQUENCIES.—With respect to the frequencies made available for reallocation pursuant to section 113(e)(3), the Commission shall, not later than 1 year after receipt of [the report required by section 113(a)] *the initial reallocation report required by section 113(a)*, prepare, submit to the President and the Congress, and implement, a plan for the allocation and assignment under the 1934 Act of such frequencies. Such plan shall—

(1) * * *

* * * * *

(c) ALLOCATION AND ASSIGNMENT OF FREQUENCIES IDENTIFIED IN THE SECOND REALLOCATION REPORT.—*With respect to the frequencies made available for reallocation pursuant to section 113(b)(3), the Commission shall, not later than one year after receipt of the second reallocation report required by such section, prepare, submit to the President and the Congress, and implement, a plan for the immediate allocation and assignment under the 1934 Act of all such frequencies in accordance with section 309(j) of such Act.*

* * * * *

HOUSE OF REPRESENTATIVES,
COMMITTEE ON COMMERCE,
Washington, DC, June 17, 1997.

Hon. JOHN R. KASICH,
Chairman, Committee on the Budget,
Washington, DC.

DEAR MR. CHAIRMAN: I am transmitting herewith the recommendations of the Committee on Commerce for changes in Medicare laws within the jurisdiction, pursuant to the provisions of section 310 of the Congressional Budget Act of 1974 and H. Con. Res. 84, the Concurrent Resolution on the Budget—Fiscal Years 1998–2002.

The enclosed recommendations were embodied in a Committee Print adopted by the Committee on June 12, 1997. Pursuant to your instructions, the legislative language of this Committee Print has been incorporated into Title IV—Committee on Commerce—Medicare.

Enclosed is the legislative language for Title IV, the accompanying report language, and the Minority Views. I have been informed that the Legislative Counsel's Office has made arrangements with your staff to submit the Ramsayer language for Title IV directly to the Budget Committee to expedite your Committee's action.

If you have any questions concerning the Committee's recommendations, or if I can be of any further assistance to you as you proceed with the Committee's deliberations, please do not hesitate to contact me.

Sincerely,

TOM BLILEY, *Chairman.*

TITLE IV—COMMITTEE ON COMMERCE—MEDICARE

PURPOSE AND SUMMARY

Recently, the Board of Trustees of the Federal Hospital Insurance Trust Fund and the Supplementary Medical Insurance Trust Fund issued their annual reports which pointed to significant short- and long-term financing crises in both Part A and Part B of Medicare. With respect to the Hospital Insurance (HI) Trust Fund, the Trustees noted:

As we reported for the last several years, one of the Medicare Trust Funds, the Hospital Insurance Fund, would be exhausted in four years without legislation that addresses its financial imbalance.

The Trustees also expressed very strong concerns regarding the Supplementary Medical Insurance (SMI) Trust Fund. Although the SMI Program is currently actuarially sound because it receives most of its funds from general revenues, the Trustees noted:

SMI benefits have been growing rapidly. Outlays have increased 45 percent over the past 5 years (33 percent on a per-beneficiary basis). During this period the program grew about 14 percent faster than the economy as a whole, despite efforts to control SMI costs.

SMI expenditures are expected to continue to grow faster than the economy as a whole. SMI outlays were almost 1 percent of the Gross Domestic Product (GDP) in 1996 and are projected to grow about 2.5 percent in 2020.

We note with great concern the past and projected rapid growth in the cost of the program. Therefore, we urge the Congress to take appropriate steps to more effectively control SMI costs. Prompt, effective, and decisive action is necessary.

To address the twin financial crises facing Medicare, the Committee on Commerce has adopted legislation which will place Part B of Medicare, the part of the program which is under the Committee's primary jurisdiction, on a long-term sustainable growth path.

In addition to providing responsible and sustainable financing for Medicare, the Committee's bill will provide Medicare beneficiaries with the same choices in health delivery that younger Americans receive from their employers. While Medicare enrollees will be guaranteed the right to remain in traditional fee-for-service Medicare, they will now have the right to choose new and innovative health plans such as the following: (1) Provider Sponsored Organizations; (2) Health Care Maintenance Organizations with and without Point of Service options; (3) Medical Savings Accounts under a new demonstration authority; and (4) Preferred Provider Networks.

This legislation was developed after several months of public hearings by the Subcommittee on Health and the Environment. Testimony was received from dozens of witnesses including health care providers, health care economists, actuaries, and other health care experts.

BACKGROUND AND NEED FOR LEGISLATION

Medicare is a Federal health insurance program for the aged and certain disabled individuals. It consists of two parts: Part A is the hospital insurance (HI) program; and Part B is the supplementary medical insurance (SMI) program. Most Americans age 65 or older are automatically entitled to health coverage under Part A, whereas participation in Part B is voluntary. Also eligible, after a two-year waiting period, are people under age 65 who are receiving Social Security disability benefits.

The cost and scope of the Medicare program have placed its future financial viability in jeopardy. According to the 1997 report of the Board of Trustees, both Part A and Part B of the Medicare program require immediate attention if they are to remain a solvent and integral component in the health care coverage of America's seniors. In light of the importance of the Medicare program to the lives of millions of Americans, the Medicare legislation was developed to preserve, protect, and strengthen the program for the current and future generations of beneficiaries.

According to the Medicare Trustees, the Hospital Insurance (HI) Trust Fund is projected to run out of reserves in just four years. The Trustees also called for action to restructure the Supplementary Medical Insurance (SMI) program because the rate of growth in this program is unsustainable. SMI growth directly affects Medicare beneficiary Part B Premiums as well as the overall Federal budget from which the largest share of SMI costs are financed.

Among the factors that initiated Congressional action on this critical issue is the fact that recent Medicare cost increases compare very unfavorably to those in the private health care market. According to data from the Congressional Budget Office, Medicare spending growth is more than two times greater than the increase in private health care costs.

For all of the above reasons, this legislation was developed to preserve, protect and strengthen the Medicare program. To achieve these objectives, the following criteria guided the Committee's reform efforts:

- (1) Policy improvements to make Medicare solvent for at least 10 years, and ensure that Medicare continues to increase spending each year. However, Medicare spending will be brought in line with the need to ensure Part B affordability, rather than permitting the program's uncontrolled spending growth rates as in the past;

- (2) Policy improvements designed to create opportunities for beneficiaries to choose more modern private coverage options, as well as for health care providers to reduce waste, eliminate abuse, and increase efficiency;

- (3) Policy improvements that expand coverage for mammography screening (annual mammograms for all women ages 40 and over; waiving of screening deductible); pap smear/pelvic screening (pelvic screening every 3 years; yearly for high-risk women); prostate cancer screening (annually for men over 50; covers digital rectal exam or PSA); colorectal screening (men over 50; fecal-occult blood test, flexible sigmoidoscopy for high-risk individuals, and barium enema if recommended by the Secretary of Health and Human Services (the Secretary)), diabetes screening (self-management training, glucose monitors and testing strips); and vaccines (extension of influenza and pneumonia campaign through 2002); and

- (4) The establishment of a Bipartisan Commission on the Effect of the Baby Boom Generation on the Medicare Program to make recommendations to the Congress on the reforms necessary to ensure the preservation of the program, in light of anticipated demographic pressures on the program's financing.

HEARINGS—

The Committee's Subcommittee on Health and Environment has not held hearings specifically on Title IV. However, the Subcommittee on Health and Environment has held a number of hearings in the 105th Congress on the Medicare program and a variety of reform issues.

Testifying before the Subcommittee on February 12, 1997, on the Department of Health and Human Services's Proposed Budget for

FY 1998, were: Dr. Bruce Vladeck, Administrator, Health Care Financing Administration; and Mr. Paul N. Van de Water, Assistant Director for Budget Analysis, Congressional Budget Office.

Testifying before the Subcommittee on February 27, 1997, on Medicare Managed Care: Payment and Related Issues, were: Mr. Bruce M. Fried, Director, Office of Managed Care, Health Care Financing Administration; Jonathan Ratner, Ph.D., Associate Director, Health Financing Systems, Health, Education, and Human Services, U.S. General Accounting Office; Donald A. Young, M.D., Executive Director, Prospective Payment Assessment Commission; and Roger S. Taylor, M.D., M.P.A., Commissioner, Physician Payment Review Commission.

Testifying before the Subcommittee on March 5, 1997, on Medicare Home Health Care, were: Dr. Bruce Vladeck, Administrator, Health Care Financing Administration; Mr. Michael F. Mangano, Principal Deputy Inspector General, Department of Health and Human Services; Mr. William Scanlon, Director, Health Financing Systems, Health, Education, and Human Services, U.S. General Accounting Office; Donald A. Young, M.D., Executive Director, Prospective Payment Assessment Commission; Ms. Margaret J. Cushman, President, VNA Health Care Inc., representing the National Association for Home Care; and James C. Pyles, Esq., Powers, Pyles, Sutter, and Verville, representing the Home Health Prospective Payment Work Group.

Testifying before the Subcommittee on March 19, 1997, on Medicare Provider Service Networks, were: The Honorable James C. Greenwood, Member of Congress; The Honorable Charles W. Stenholm, Member of Congress; Ms. Josephine Musser, President, National Association of Insurance Commissioners; William F. Bluhm, FSA, MAA, Vice President, Health, The American Academy of Actuaries; The Honorable Bill Gradison, President, Health Insurance Association of America; Ms. Mary Nell Lehnhard, Senior Vice President Office of Policy and Representation, Blue Cross and Blue Shield Association; Mr. Thomas R. Sobocinski, President and CEO, Physicians Plus Insurance Corporation representing the American Association of Health Plans; Richard F. Corlin, M.D., Speaker of the House of Delegates, American Medical Association; Mr. John C. McMeekin, President and CEO Crozer-Keystone Health System, representing the American Hospital Association; and Robert Margolis, M.D., Chairman, American Medical Group Association.

Testifying before the Subcommittee on April 11, 1997, on Medicare Preventive Benefits and Quality Standards, were: The Honorable Newt Gingrich, Speaker of the House, U.S. House of Representatives; The Honorable George R. Nethercutt, Jr., Member of Congress; Ms. Bernice Steinhardt, Director Health Services Quality and Public Health Issues, U.S. General Accounting Office; Mr. Alan Altschuler, Chairman of the Board, American Diabetes Association; Resa Levetan, M.D., Director of Diabetes, Medlantic Research Institute, Washington Hospital Center; Marvin M. Schuster, M.D., President, American College of Gastroenterology; James B. Regan, M.D., Assistant Professor of Surgery, Division of Urology, Georgetown University Medical Center representing the American Urological Association, Inc.; Peter G. Taber, M.D., Chief of Gastroenterology Division, University of Pennsylvania; and Robert Har-

mon, M.D., MPH Member, Board of Directors, Partnership for Prevention, representing the American Gastroenterological Association.

COMMITTEE CONSIDERATION

On June 10, 1997, the Subcommittee on Health and Environment met in open session and approved for Full Committee consideration a Committee Print entitled "Title IV—Committee on Commerce—Medicare," amended, by a roll call vote of 15 yeas to 11 nays. On June 12, 1997, the Committee met in open session and ordered the Committee Print entitled "Title IV—Committee on Commerce—Medicare" transmitted to the House Committee on the Budget, amended, for inclusion in the 1997 Omnibus Budget Reconciliation Act, by a roll call vote of 30 yeas to 17 nays.

ROLL CALL VOTES

Pursuant to Clause 2(1)(2)(B) of rule XI of the Rules of the House of Representatives, following are listed the recorded votes on the motion to order Title IV transmitted to the House Committee on the Budget, and on amendments thereto, including the names of those Members voting for and against.

**COMMITTEE ON COMMERCE -- 105TH CONGRESS
ROLL CALL VOTE #12**

BILL: Committee Print entitled "Title IV - Committee on Commerce - Medicare"

AMENDMENT: Amendment by Mr. Waxman re: strike the provisions dealing with MSA plans.

DISPOSITION: NOT AGREED TO, by a roll call vote of 19 yeas to 28 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Bliley		X		Mr. Dingell	X		
Mr. Tauzin		X		Mr. Waxman	X		
Mr. Oxley		X		Mr. Markey	X		
Mr. Bilirakis		X		Mr. Hall		X	
Mr. Schaefer		X		Mr. Boucher	X		
Mr. Barton		X		Mr. Manton	X		
Mr. Hastert		X		Mr. Towns			
Mr. Upton		X		Mr. Pallone	X		
Mr. Stearns		X		Mr. Brown	X		
Mr. Paxon		X		Mr. Gordon	X		
Mr. Gillmor		X		Ms. Furse	X		
Mr. Klug		X		Mr. Deutsch	X		
Mr. Greenwood				Mr. Rush			
Mr. Crapo		X		Ms. Eshoo	X		
Mr. Cox		X		Mr. Klink	X		
Mr. Deal		X		Mr. Stupak	X		
Mr. Largent		X		Mr. Engel			
Mr. Burr		X		Mr. Sawyer	X		
Mr. Bilbray		X		Mr. Wynn	X		
Mr. Whitfield		X		Mr. Green	X		
Mr. Ganske		X		Ms. McCarthy	X		
Mr. Norwood		X		Mr. Strickland	X		
Mr. White		X		Ms. DeGette	X		
Mr. Coburn		X					
Mr. Lazio		X					
Mrs. Cubin		X					
Mr. Rogan		X					
Mr. Shimkus		X					

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**COMMITTEE ON COMMERCE -- 105TH CONGRESS
ROLL CALL VOTE #13**

BILL: Committee Print entitled "Title IV - Committee on Commerce - Medicare"

AMENDMENT: Amendment by Mr. Brown re: MSA balance billing.

DISPOSITION: NOT AGREED TO, by a roll call vote of 23 yeas to 25 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Bliley		X		Mr. Dingell	X		
Mr. Tauzin		X		Mr. Waxman	X		
Mr. Oxley		X		Mr. Markey	X		
Mr. Billirakis		X		Mr. Hall	X		
Mr. Schaefer		X		Mr. Boucher	X		
Mr. Barton		X		Mr. Manton	X		
Mr. Hastert		X		Mr. Towns	X		
Mr. Upton		X		Mr. Pallone	X		
Mr. Stearns		X		Mr. Brown	X		
Mr. Paxon		X		Mr. Gordon	X		
Mr. Gillmor		X		Ms. Furse	X		
Mr. Klug		X		Mr. Deutsch	X		
Mr. Greenwood		X		Mr. Rush			
Mr. Crapo		X		Ms. Eshoo	X		
Mr. Cox		X		Mr. Klink	X		
Mr. Deal		X		Mr. Stupak	X		
Mr. Largent		X		Mr. Engel			
Mr. Burr		X		Mr. Sawyer	X		
Mr. Bilbray		X		Mr. Wynn	X		
Mr. Whitfield		X		Mr. Green	X		
Mr. Ganske		X		Ms. McCarthy	X		
Mr. Norwood		X		Mr. Strickland	X		
Mr. White		X		Ms. DeGette	X		
Mr. Coburn	X						
Mr. Lazio	X						
Mrs. Cubin		X					
Mr. Rogan		X					
Mr. Shimkus							

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**COMMITTEE ON COMMERCE – 105TH CONGRESS
ROLL CALL VOTE #14**

BILL: Committee Print entitled "Title IV - Committee on Commerce - Medicare"

AMENDMENT: Amendment by Mr. Stupak re: change provisions dealing with Medicare fraud and abuse.

DISPOSITION: NOT AGREED TO, by a roll call vote of 19 yeas to 25 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Bilely		X		Mr. Dingell	X		
Mr. Tauzin		X		Mr. Waxman	X		
Mr. Oxley		X		Mr. Markey	X		
Mr. Bilirakis		X		Mr. Hall	X		
Mr. Schaefer		X		Mr. Boucher			
Mr. Barton				Mr. Manton	X		
Mr. Hastert		X		Mr. Towns			
Mr. Upton		X		Mr. Pallone	X		
Mr. Stearns		X		Mr. Brown	X		
Mr. Paxon		X		Mr. Gordon	X		
Mr. Gillmor		X		Ms. Furse	X		
Mr. Klug				Mr. Deutsch	X		
Mr. Greenwood				Mr. Rush			
Mr. Crapo		X		Ms. Eshoo	X		
Mr. Cox		X		Mr. Klink	X		
Mr. Deal		X		Mr. Stupak	X		
Mr. Largent		X		Mr. Engel	X		
Mr. Burr		X		Mr. Sawyer	X		
Mr. Bilbray		X		Mr. Wynn	X		
Mr. Whitfield		X		Mr. Green			
Mr. Ganske		X		Ms. McCarthy	X		
Mr. Norwood		X		Mr. Strickland	X		
Mr. White		X		Ms. DeGette	X		
Mr. Coburn		X					
Mr. Lazio		X					
Mrs. Cubin		X					
Mr. Rogan		X					
Mr. Shimkus		X					

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**COMMITTEE ON COMMERCE -- 105TH CONGRESS
ROLL CALL VOTE #15**

BILL: Committee Print entitled "Title IV - Committee on Commerce - Medicare"

AMENDMENT: Amendment by Mr. Bliley re: addition of a conscience clause to the Gag Rule.

DISPOSITION: AGREED TO, by a roll call vote of 33 yeas to 12 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Bliley	X			Mr. Dingell	X		
Mr. Tauzin	X			Mr. Waxman		X	
Mr. Oxley	X			Mr. Markey		X	
Mr. Bilirakis	X			Mr. Hall	X		
Mr. Schaefer	X			Mr. Boucher			
Mr. Barton	X			Mr. Manton	X		
Mr. Hastert	X			Mr. Towns			
Mr. Upton	X			Mr. Pallone		X	
Mr. Stearns	X			Mr. Brown		X	
Mr. Paxon	X			Mr. Gordon		X	
Mr. Gillmor	X			Ms. Furse		X	
Mr. Klug	X			Mr. Deutsch		X	
Mr. Greenwood				Mr. Rush			
Mr. Crapo	X			Ms. Eshoo	X		
Mr. Cox	X			Mr. Klink	X		
Mr. Deal	X			Mr. Stupak	X		
Mr. Largent	X			Mr. Engel		X	
Mr. Burr	X			Mr. Sawyer		X	
Mr. Bilbray				Mr. Wynn		X	
Mr. Whitfield	X			Mr. Green	X		
Mr. Ganske	X			Ms. McCarthy			
Mr. Norwood	X			Mr. Strickland		X	
Mr. White	X			Ms. DeGette		X	
Mr. Coburn	X						
Mr. Lazio	X						
Mrs. Cubin	X						
Mr. Rogan	X						
Mr. Shimkus	X						

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**COMMITTEE ON COMMERCE -- 105TH CONGRESS
ROLL CALL VOTE #16**

BILL: Committee Print entitled "Title IV - Committee on Commerce - Medicare"

AMENDMENT: Amendment by Mr. Pallone re: Medicare counseling program.

DISPOSITION: **AGREED TO**, by a roll call vote of 17 yeas to 15 nays, with 1 voting "Pass".

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Bliley	X			Mr. Dingell			
Mr. Tauzin		X		Mr. Waxman	X		
Mr. Oxley				Mr. Markey	X		
Mr. Bilirakis				Mr. Hall			
Mr. Schaefer		X		Mr. Boucher			
Mr. Barton				Mr. Manton	X		
Mr. Hastert		X		Mr. Towns			
Mr. Upton	X			Mr. Pallone	X		
Mr. Stearns	X			Mr. Brown	X		
Mr. Paxon				Mr. Gordon	X		
Mr. Gillmor			PASS	Ms. Furse			
Mr. Klug		X		Mr. Deutsch	X		
Mr. Greenwood		X		Mr. Rush			
Mr. Crapo		X		Ms. Eshoo	X		
Mr. Cox		X		Mr. Klink	X		
Mr. Deal				Mr. Stupak	X		
Mr. Largent		X		Mr. Engel	X		
Mr. Burr		X		Mr. Sawyer			
Mr. Bilbray		X		Mr. Wynn			
Mr. Whitfield				Mr. Green			
Mr. Ganske		X		Ms. McCarthy	X		
Mr. Norwood				Mr. Strickland	X		
Mr. White				Ms. DeGette	X		
Mr. Coburn		X					
Mr. Lazio		X					
Mrs. Cubin		X					
Mr. Rogan							
Mr. Shimkus		X					

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**COMMITTEE ON COMMERCE - 105TH CONGRESS
ROLL CALL VOTE #17**

BILL: Committee Print entitled "Title IV - Committee on Commerce - Medicare"

AMENDMENT: Amendment by Mr. Klink re: MSA balance billing.

DISPOSITION: NOT AGREED TO, by a roll call vote of 16 yeas to 32 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Bilely		X		Mr. Dingell		X	
Mr. Tauzin		X		Mr. Waxman		X	
Mr. Oxley		X		Mr. Markey	X		
Mr. Bilirakis		X		Mr. Hall		X	
Mr. Schaefer		X		Mr. Boucher			
Mr. Barton		X		Mr. Manton	X		
Mr. Hastert		X		Mr. Towns	X		
Mr. Upton		X		Mr. Pallone	X		
Mr. Stearns		X		Mr. Brown	X		
Mr. Paxon		X		Mr. Gordon		X	
Mr. Gillmor		X		Ms. Furse	X		
Mr. Klug		X		Mr. Deutsch	X		
Mr. Greenwood		X		Mr. Rush			
Mr. Crapo		X		Ms. Eshoo	X		
Mr. Cox		X		Mr. Klink	X		
Mr. Deal		X		Mr. Stupak	X		
Mr. Largent		X		Mr. Engel	X		
Mr. Burr		X		Mr. Sawyer	X		
Mr. Bilbray		X		Mr. Wynn	X		
Mr. Whitfield				Mr. Green	X		
Mr. Ganske		X		Ms. McCarthy	X		
Mr. Norwood		X		Mr. Strickland		X	
Mr. White		X		Ms. DeGette	X		
Mr. Coburn		X					
Mr. Lazio		X					
Mrs. Cubin		X					
Mr. Rogan		X					
Mr. Shimkus		X					

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**COMMITTEE ON COMMERCE -- 105TH CONGRESS
ROLL CALL VOTE #18**

BILL: Committee Print entitled "Title IV - Committee on Commerce - Medicare"

AMENDMENT: Amendment by Mr. Markey re: medical liability reform.

DISPOSITION: NOT AGREED TO, by a roll call vote of 16 yeas to 31 nays, with 1 abstaining.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Bilely		X		Mr. Dingell	X		
Mr. Tauzin		X		Mr. Waxman	X		
Mr. Oxley		X		Mr. Markey	X		
Mr. Bilirakis		X		Mr. Hall		X	
Mr. Schaefer		X		Mr. Boucher			
Mr. Barton		X		Mr. Manton		X	
Mr. Hastert		X		Mr. Towns		X	
Mr. Upton		X		Mr. Pallone	X		
Mr. Stearns		X		Mr. Brown	X		
Mr. Paxon		X		Mr. Gordon		X	
Mr. Gillmor		X		Ms. Furse	X		
Mr. Klug		X		Mr. Deutsch	X		
Mr. Greenwood		X		Mr. Rush			
Mr. Crapo		X		Ms. Eshoo		X	
Mr. Cox		X		Mr. Klink	X		
Mr. Deal		X		Mr. Stupak	X		
Mr. Largent		X		Mr. Engel	X		
Mr. Burr		X		Mr. Sawyer	X		
Mr. Bilbray		X		Mr. Wynn	X		
Mr. Whitfield				Mr. Green	X		
Mr. Ganske		X		Ms. McCarthy	X		
Mr. Norwood		X		Mr. Strickland	X		
Mr. White		X		Ms. DeGette	X		
Mr. Coburn			ABSTAIN				
Mr. Lazio		X					
Mrs. Cubin		X					
Mr. Rogan		X					
Mr. Shimkus		X					

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**COMMITTEE ON COMMERCE -- 105TH CONGRESS
ROLL CALL VOTE #19**

BILL: Committee Print entitled "Title IV - Committee on Commerce - Medicare"

MOTION: Motion by Mr. Bliley to order the Committee Print entitled "Title IV - Committee on Commerce - Medicare", amended, transmitted to the Committee on the Budget for inclusion in the 1997 Omnibus Budget Reconciliation Act.

DISPOSITION: **AGREED TO**, by a roll call vote of 30 yeas to 17 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Bliley	X			Mr. Dingell	X		
Mr. Tauzin	X			Mr. Waxman		X	
Mr. Oxley	X			Mr. Markey		X	
Mr. Bilirakis	X			Mr. Hall	X		
Mr. Schaefer	X			Mr. Boucher			
Mr. Barton	X			Mr. Manton		X	
Mr. Hastert	X			Mr. Towns		X	
Mr. Upton	X			Mr. Pallone		X	
Mr. Stearns	X			Mr. Brown		X	
Mr. Paxon	X			Mr. Gordon			
Mr. Gillmor	X			Ms. Furse			
Mr. Klug	X			Mr. Deutsch		X	
Mr. Greenwood	X			Mr. Rush			
Mr. Crapo	X			Ms. Eshoo		X	
Mr. Cox	X			Mr. Klink		X	
Mr. Deal	X			Mr. Stupak		X	
Mr. Largent	X			Mr. Engel		X	
Mr. Burr	X			Mr. Sawyer		X	
Mr. Bilbray	X			Mr. Wynn		X	
Mr. Whitfield	X			Mr. Green		X	
Mr. Ganske	X			Ms. McCarthy		X	
Mr. Norwood	X			Mr. Strickland		X	
Mr. White	X			Ms. DeGette		X	
Mr. Coburn	X						
Mr. Lazio	X						
Mrs. Cubin	X						
Mr. Rogan	X						
Mr. Shimkus	X						

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COMMITTEE ON COMMERCE—105TH CONGRESS, VOICE
VOTES, 6/12/97

Bill: Committee Print entitled "Title IV—Committee on Commerce—Medicare."

Amendment: Amendment by Mr. Hastert re: development and implementation of utilization guidelines for the coverage of chiropractic services.

Disposition: Agreed to, by a voice vote.

Amendment: Amendment by Mr. Coburn re: protect the confidentiality of the use of Social Security numbers.

Disposition: Agreed to, by a voice vote.

Amendment: Amendment by Mr. Klink re: limiting the liability of MSAs.

Disposition: Withdrawn, by unanimous consent.

Amendment: Amendment by Mr. Stearns re: establish a National Fund for Health Research.

Disposition: Withdrawn, by unanimous consent.

Amendment: Amendment by Mr. Green re: Medigap enrollment.

Disposition: Agreed to, by a voice vote.

Amendment: Amendment to Mrs. Cubin re: add a new section dealing with requirements for developing new resource-based practice expense relative value units (RVUs).

Disposition: Withdrawn, by unanimous consent.

Amendment: Amendment by Mr. Pallone re: establish a demonstration project on Medicare coverage of pharmacy professional services and disease management services provided to individuals with certain medical conditions.

Disposition: Not agreed to, by a voice vote.

Amendment: Amendment by Mrs. Cubin re: adding "to the maximum extent practicable" to the requirements for developing a new resource-based value unit to be followed by HCFA.

Disposition: Agreed to, by a voice vote.

Amendment: Amendment by Mr. Brown re: nondiscrimination by health plans against a provider based on license.

Disposition: Agreed to, by a voice vote.

Amendment: Amendment by Mr. Pallone re: require the Medicare Payment Commission to review the role of the Medicare program in addressing chronic illnesses.

Disposition: Agreed to, by a voice vote.

Amendment: Amendment by Mr. Colburn re: home health agency referrals.

Disposition: Withdrawn, by unanimous consent.

Amendment: Amendment by Mr. Colburn re: definition of homebound individuals.

Disposition: Not agreed to, by a voice vote.

Amendment: Amendment by Mr. Stearns re: ambulance services cost per trip.

Disposition: Agreed to, by a voice vote.

Amendment: Amendment by Mr. Engel re: report on rescreening pap smears.

Disposition: Agreed to, by a voice vote.

Amendment: Amendment by Mr. Engel re: study of new home health requirements.

Disposition: Agreed to, by a voice vote.

Amendment: Amendment by Mr. Colburn re: strike penalties for services by excluded providers.

Disposition: Withdrawn, by unanimous consent.

Amendment: Amendment by Mr. Strickland re: add a provision that any attending health care provider can determine length-of-stay.

Disposition: Agreed to, by a voice vote.

Amendment: Amendment by Mr. Coburn re: unrestricted FFS plans.

Disposition: Agreed to, by a voice vote.

Amendment: Amendment by Mr. Coburn re: strike penalties for services by excluded providers.

Disposition: Agreed to, by a voice vote.

COMMITTEE OVERSIGHT FINDINGS

Pursuant to clause 2(1)(3)(A) of rule XI of the Rules of the House of Representatives, the Committee has held oversight hearings and made findings that are reflected in the report on this Title.

COMMITTEE ON GOVERNMENT REFORM AND OVERSIGHT

Pursuant to clause 2(1)(3)(D) of rule XI of the Rules of the House of Representatives, no oversight findings have been submitted to the Committee by the Committee on Government Reform and Oversight.

COMMITTEE COST ESTIMATE

In compliance with clause 7(a) of rule XIII of the Rules of the House of Representatives, the Committee adopts as its own the cost estimate prepared by the Director of the Congressional Budget Office pursuant to section 403 of the Congressional Budget Act of 1974.

CONGRESSIONAL BUDGET OFFICE ESTIMATE

Pursuant to clause 2(1)(3)(C) of rule XI of the Rules of the House of Representatives, the following is a letter from the Congressional Budget Office providing a cost estimate for Title IV.

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, June 16, 1997.

Hon. TOM BLILEY,
*Chairman, Committee on Commerce,
House of Representatives, Washington, DC.*

DEAR MR. CHAIRMAN: The Congressional Budget Office has reviewed Title IV, the Medicare reconciliation recommendations of the Committee on Commerce, as approved by the committee on June 12, 1997.

The enclosed tables show the federal budgetary effects of the committee's proposals over the 1998–2007 period. CBO understands that the Committee on the Budget will be responsible for interpreting how these proposals compare with the reconciliation in-

structions in the budget resolution. The estimate assumes that the reconciliation bill will be enacted by August 15, with timely implementation of the policies that would take effect at the beginning of fiscal year 1998. The estimate could change if the bill is enacted later.

Title IV is broadly similar to the Medicare recommendations of the Committee on Ways and Means, as included in Title X. It would provide for the establishment of MedicarePlus plans, expand preventive benefits, reduce payment rates to certain health care providers, increase premiums required of beneficiaries, and make other changes to reduce the growth of Medicare spending. Because of jurisdictional differences, Title IV does not contain provisions relating only to Part A of Medicare (Subtitle F of Title X).

The proposal would give Medicare beneficiaries the option to remain in the existing fee-for-service Medicare program or to enroll in MedicarePlus plans, which would replace Medicare's current risk plans. MedicarePlus plans would include health maintenance organizations, point-of-service plans, preferred provider organizations, as well as insurance plans operated in conjunction with a medical savings account. New or expanded benefits would be added for mammography, pap smears and pelvic exams, screening for prostate and colorectal cancer, diabetes self-management and supplies, and the diagnosis of osteoporosis.

The proposal would also establish new payment methods for outpatient hospital services and home health services. It would reduce projected payment rates for physicians' services, clinical laboratory services, and durable medical equipment. The premium for Part B of Medicare (Supplementary Medical Insurance) would be set to cover 25 percent of program costs in future years, as it is now, instead of being allowed to decline as a share of spending, as would be the case under current law. Finally, the proposal contains several provisions to expand and improve accounting of claims where Medicare is secondary payer.

Title IV would impose several intergovernmental mandates as defined in the Unfunded Mandates Reform Act (UMRA). The title would prohibit states from imposing premium taxes on MedicarePlus plans. It would also extend and expand the existing mandate that employment-based health insurance plans, including those sponsored by state and local governments, be the primary payer for the working disabled and for individuals with endstage renal disease. CBO is uncertain whether the threshold for intergovernmental mandates (\$50 million in 1996, adjusted annually for inflation) would be exceeded in any of the next five years, because UMRA is unclear about including the costs of extending an existing mandate. If the costs of extending the primary payer requirement are included, then the total costs of the intergovernmental mandates in this title would be at or near the threshold in 1999. If such costs are not included, then the threshold would not be exceeded in any year. Other mandates included in the title would impose no significant costs on state, local, or tribal governments.

Title IV also contains several private-sector mandates as defined in UMRA. The expansion of the primary payer requirement for employment-based health insurance plans would impose direct costs on the private sector of \$110 million in 1998 and \$140 million in

2002. If the costs of extending the primary payer requirement are included, the direct costs of this mandate would be about \$1½ billion a year after 1998. The title would also require Medigap plans to guarantee issue and prohibit coverage exclusions for continuously covered Medicare enrollees switching plans; the costs of this mandate would amount to \$10 million in 1998 and \$30 million in 2002. Other mandates included in the title would impose no significant costs on the private sector.

If you wish further details on these estimates, we will be pleased to provide them.

Sincerely,

JUNE E. O'NEILL, *Director*.

Enclosures.

MEDICARE PROVISIONS AS APPROVED BY THE COMMITTEE ON COMMERCE—Continued

(By fiscal year, in billions of dollars)

	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
Durable Medical Equipment, P+0 and PEN	0.0	0.0	-0.1	-0.2	-0.2	-0.3	-0.4	-0.4	-0.5	-0.5	-0.5
Oxygen	0.0	-0.2	-0.3	-0.4	-0.4	-0.4	-0.5	-0.6	-0.6	-0.7	-0.7
Lab Updates	0.0	-0.2	-0.4	-0.5	-0.6	-0.8	-0.9	-0.9	-1.0	-1.1	-1.1
Lab Administrative Simplification	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Ambulatory Surgical Centers	0.0	-0.0	-0.0	-0.1	-0.1	-0.1	-0.2	-0.2	-0.2	-0.2	-0.2
Pharmaceutical Payments ⁵	0.0	-0.1	-0.1	-0.1	-0.0	-0.0	-0.0	-0.0	-0.0	-0.0	-0.1
Coverage of Oral Anti-emetics	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Rural Health Clinic Services	0.0	-0.0	-0.0	-0.0	-0.0	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1
NPs, PAs, and CNSs	0.0	0.0	0.1	0.1	0.1	0.2	0.2	0.3	0.3	0.3	0.3
Dialysis Audits and Quality Standards	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Cochlear Implants	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Part B Premium	0.0	0.3	0.6	2.2	4.0	6.3	9.2	12.5	15.9	19.4	23.0
Total, Subtitle G	0.0	0.2	2.2	4.4	6.7	9.2	11.7	14.8	18.6	22.8	27.1
Subtitle H:											
MSP Extension, 30 month ESRD	0.0	-0.1	-1.7	-1.8	-1.9	-2.0	-2.1	-2.2	-2.3	-2.5	-2.6
Clarification of Time & Filing Limitations, Recovery against TPAs	0.0	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1
Home Health Policies	0.0	-1.0	-1.9	-2.3	-2.8	-3.2	-3.7	-4.2	-4.8	-5.3	-6.0
Direct Graduate Medical Education ⁶	0.0	-0.1	-0.1	-0.2	-0.3	-0.4	-0.5	-0.6	-0.7	-0.8	-0.9
Part B Premium Penalty and Gap for Military Retirees—Benefits	0.0	0.1	0.2	0.3	0.3	0.3	0.3	0.4	0.4	0.4	0.4
Part B Premium Penalty and Gap for Military Retirees—Premium	0.0	-0.0	-0.0	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1
Centers of Excellence	0.0	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1
Total, Subtitle H	0.0	-1.3	-3.8	-4.3	-4.9	-5.6	-6.2	-7.0	-7.7	-8.5	-9.3
Subtitle I—Medical Liability Reform	0.0	-0.0	-0.0	-0.0	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1
Part A premium interaction	0.0	0.1	0.1	0.2	0.2	0.3	0.3	0.4	0.4	0.5	0.6
Total, Medicare Net Outlays	0.0	-2.2	-7.9	-13.2	-11.0	-24.7	-23.2	-27.2	-32.5	-37.5	-42.3

¹ October 1, 2001 Medicare Plus payments would be accelerated to September 2001.

² Includes interaction with Medicaid.

³ Assumes limits on adjustments to MEI are +3% and -7%.

⁴ Assumes payments are limited to services provided in calendar year 1998.

⁵ Payments for prescription drugs would equal AWP-5%, effective January 1, 1998.
⁶ Direct graduate medical education proposals include changes in number of residents counted, phased cap on overhead, incentive payments, consortia, and combined primary care residencies.
 Note.—Assumes enactment on August 15, 1997 with no delay in implementation of FY98 policies. Later enactment would reduce savings.

MEDICARE PROVISIONS AS APPROVED BY THE COMMITTEE ON COMMERCE

(By fiscal year, in billions of dollars)

	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	
MEMORANDUM												
Monthly Part B Premium (By calendar year):												
Estimated Premium under proposal	\$42.50	\$43.80	\$44.80	\$49.30	\$54.10	\$59.70	\$66.30	\$74.10	\$82.70	\$91.00	\$99.40	\$107.70
Estimated Premium under current law	\$42.50	\$43.80	\$45.80	\$47.10	\$48.50	\$50.00	\$51.50	\$53.00	\$54.60	\$56.20	\$57.90	\$59.70
Home Health Transfer:												
Amount of HH Transfer, in billions of dollars		9.8	13.4	13.8	14.9	16.1	17.3	18.6	19.9	21.2	22.7	22.7
HMO Interaction: Spending Transferred to Part B		0.2	0.6	1.2	1.7	2.7	3.9	5.5	7.4	8.2	9.0	9.0
Impact on Medicaid Spending (in billions of dollars):												
Federal from Premiums		-0.0	0.1	0.2	0.3	0.6	0.8	1.1	1.4	1.8	2.1	2.1
State and Local from Premiums		-0.0	0.0	0.1	0.3	0.4	0.6	0.9	1.1	1.3	1.6	1.6
Total, Federal and State and Local from Premiums		-0.0	0.1	0.3	0.6	1.0	1.4	2.0	2.5	3.1	3.6	3.6
Rural Health Clinic Services—Federal Share		-0.0	-0.0	-0.0	-0.0	-0.0	-0.0	-0.0	-0.0	-0.0	-0.0	-0.1
Rural Health Clinic Services—State and Local Share		-0.0	-0.0	-0.0	-0.0	-0.0	-0.0	-0.0	-0.0	-0.0	-0.0	-0.0
Total, Federal and State and Local from Rural Clinics		-0.0	-0.0	-0.0	-0.0	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1
Total, Federal		-0.1	0.0	0.2	0.3	0.5	0.8	1.1	1.4	1.7	2.0	2.0
Total, State and Local		-0.0	0.0	0.1	0.2	0.4	0.6	0.8	1.1	1.3	1.5	1.5
Total, Federal and State and Local		-0.1	0.0	0.3	0.6	0.9	1.4	1.9	2.4	3.0	3.5	3.5

FEDERAL MANDATES STATEMENT

The Committee adopts as its own the estimate of Federal mandates prepared by the Director of the Congressional Budget Office pursuant to section 423 of the Unfunded Mandates Reform Act.

ADVISORY COMMITTEE STATEMENT

No advisory committees within the meaning of section 5(b) of the Federal Advisory Committee Act were created by this legislation.

CONSTITUTIONAL AUTHORITY STATEMENT

Pursuant to clause 2(1)(4) of rule XI of the Rules of the House of Representatives, the Committee finds that the Constitutional authority for this legislation is provided in Article I, section 8, clause 3, which grants Congress the power to regulate commerce with foreign nations, among the several States, and with the Indian tribes.

SECTION-BY-SECTION ANALYSIS OF THE LEGISLATION

SUBTITLE A—MEDICAREPLUS PROGRAM

Chapter 1—MedicarePlus Program

SUBCHAPTER A—MEDICAREPLUS

*Section 4001. Establishment of MedicarePlus Program**New section 1851 of the Social Security Act. Eligibility, election, and enrollment*

Current Law. Persons enrolling in Medicare have two basic coverage options. They may elect to obtain services through the traditional fee-for-service system under which program payments are made for each service rendered. Under Section 1876 of the Social Security Act, they may also elect to enroll with a managed care organization which has entered into a payment agreement with Medicare. Three types of managed care organizations are authorized to contract with Medicare: an entity that has a risk contract with Medicare, an entity that has a cost contract with Medicare, or a health care prepayment plan (HCPP) that has a cost contract to provide Medicare Part B services. Risk-contracts are frequently referred to as TEFRA risk contracts and cost contracts are frequently referred to as TEFRA cost contracts. TEFRA refers to the 1982 legislation, the Tax Equity and Fiscal Responsibility Act of 1982, which established the rules governing these types of contracts.

A beneficiary in an area served by a health maintenance organization (HMO) or competitive medical plan (CMP) with a Medicare risk contract may voluntarily choose to enroll in the organization. (A CMP is a health plan that is not a federally qualified HMO but that meets specific Medicare requirements.) Medicare makes a single monthly capitation payment for each of its enrollees. In return, the entity agrees to provide or arrange for the full range of Medicare services through an organized system of affiliated physicians, hospitals and other providers. The beneficiary must obtain all covered services through the HMO or CMP, except in emergencies. The beneficiary may be charged the usual cost-sharing charges or

pay the equivalent in the form of a monthly premium to the organization. Beneficiaries are expected to share in any of the HMO's/CMP's projected cost savings between Medicare's capitation payment and what it would cost the organization to provide Medicare benefits to its commercial enrollees through the provision of additional benefits. (It could also return the "savings" to Medicare.)

Beneficiaries may also enroll in organizations with TEFRA cost contracts. These entities must meet essentially the same conditions of participation as risk contractors; however they may have as few as 1,500 enrollees (rather than 5,000) to qualify. Under a cost contract, Medicare pays the actual cost the entity incurs in furnishing covered services (less the estimated value of beneficiary cost-sharing). Enrollees obtain supplemental benefits by paying a monthly premium. The entity must offer a basic package (which covers all or a portion of Medicare cost-sharing charges); any additional benefits must be priced separately. (Conversely, a risk-contractor may offer just one package.) Enrollees in TEFRA cost-contract entities may obtain services outside the entity's network; however, the entity has no obligation to cover the beneficiary's cost-sharing in this case.

A third type of managed care arrangement is the HCPP. A HCPP arrangement is similar to a TEFRA cost contract except that it provides only Part B services. Further, there are no specific statutory conditions to qualify for a HCPP contract. Some HCPPs are private market HMOs, while others are union or employer plans. HCPPs have no minimum enrollment requirements, no requirement that the plan have non-Medicare enrollees, or a requirement for an open enrollment period. Unlike TEFRA cost contractors (but like risk contractors), HCPPs may offer a single supplemental package that includes both Part B cost-sharing and other benefits; cost-sharing benefits need not be priced separately.

Any Medicare beneficiary residing in the area served by an HMO/CMP may enroll, with two exceptions. The first exception applies to beneficiaries not enrolled in Part B. The second exception applies to persons qualifying for Medicare on the basis of end-stage renal disease (ESRD); however, persons already enrolled who later develop ESRD may remain enrolled in the entity.

The HMO/CMP must have an annual open enrollment period of at least 30 days duration. During this period, it must accept beneficiaries in the order in which they apply up to the limits of its capacity, unless to do so would lead to violation of the 50 percent Medicare-Medicaid maximum or to an enrolled population unrepresentative of the population in the area served by the HMO.

TEFRA risk contractors are required to hold an additional open enrollment period if any other risk-based entity serving part of the same geographic area does not renew its Medicare contract, has its contract terminated, or has reduced its service area to exclude any portion of the service area previously served by both contractors. In such cases, the Secretary must establish a single coordinated open enrollment period for the remaining contractors. These remaining HMOs/CMPs must then accept its enrollees during an enrollment period of 30 days.

An enrollee may request termination of his or her enrollment at any time. An individual may file disenrollment requests directly

with the HMO or at the local social security office. Disenrollment takes effect on the first day of the month following the month during which the request is filed. The HMO may not disenroll or refuse to re-enroll a beneficiary on the basis of health status or need for health services.

The requirement for an open enrollment period does not apply to HCPPs. These entities may deny enrollment or terminate enrollment on medical or other grounds, if they use the same criteria for Medicare and non-Medicare enrollees. As a result, employer or union plans may restrict enrollment to covered retirees.

The Secretary of HHS is authorized to prescribe procedures and conditions under which eligible organizations contracting with Medicare may inform beneficiaries about the organization. Brochures, applications forms, or other promotional or informational material may be distributed only after review and approval by the Secretary. HMOs may not disenroll or refuse to re-enroll a beneficiary because of health status or need for health care services. HMOs must provide enrollees, at the time of enrollment and annually thereafter, an explanation of rights to benefits, restrictions on services provided through nonaffiliated providers, out-of-area coverage, coverage of emergency and urgently needed services, and appeal rights. A terminating HMO must arrange for supplementary coverage for Medicare enrollees for the duration of any preexisting condition exclusion under their successor coverage for the lesser of 6 months or the duration of the exclusion period.

Explanation of Provision. The Social Security Act would be amended to insert a new Part C, MedicarePlus Program. New Section 1851 of Part C of the Social Security Act would specify requirements related to eligibility, election of coverage, and enrollment.

a. Types of Choices. Under the provision, every individual entitled to Medicare Part A and enrolled under Part B could elect to receive benefits through two options: (i) the existing Medicare fee-for-service program (Medicare FFS) or (ii) through a MedicarePlus plan. The exception to this would be individuals medically determined to have end-stage renal disease (ESRD). They would not be able to elect MedicarePlus. Individuals who develop ESRD while enrolled in a plan could continue in that plan. A MedicarePlus plan could be offered by: (i) a coordinated care plan (including an HMO or preferred provider organization (PPO)), (ii) a provider sponsored organization (PSO); and (iii) a combination of a medical savings account (MSA) and contributions to a MedicarePlus MSA.

b. Special Rules. In general, an individual would be eligible to elect a MedicarePlus plan offered by a MedicarePlus organization only if the organization served the geographic area in which the individual resided. Enrollment could continue if the plan provided benefits for enrollees located in the area to which the individual moved. An individual eligible for an annuity under the Federal Employee Health Benefits Program (FEHBP) would not be eligible for an MSA plan until the Office of Management and Budget adopted policies to ensure that such enrollment did not result in increased expenditures for the federal government to FEHBP plans. The Secretary could apply similar rules in the case of individuals who are eligible for Departments of Defense or Veterans' Affairs health care. An individual who is a qualified Medicare beneficiary (QMB),

a qualified disabled and working individual, a specified low-income Medicare beneficiary (SLMB), or otherwise entitled to Medicare cost-sharing assistance under a State Medicaid program, would not be eligible to enroll in an MSA plan.

In addition, individuals would not be eligible to enroll in an MSA plan on or after January 1, 2003, or as of any date if the number of individuals enrolled in MSA plans reached 500,000. Individuals enrolling in MSA plans prior to either of those two events would be allowed to continue such enrollment. The Secretary would be required to regularly evaluate and report to Congress on the impact of permitting enrollment of MSA plans on selection (including adverse selection), use of preventive care, access to care, and the financial status of the Trust Funds. In addition, the Secretary would be required to submit to Congress periodic reports on the number of individuals enrolled in MSA plans and to submit a report to Congress by no later than March 1, 2002 on whether the 4-year time limitation should be extended or removed, and whether any change should be made to the number of individuals permitted to enroll in Medicare MSAs.

c. Process for Exercising Choice. The Secretary would be required to establish a process for elections (and changing elections) of Medicare fee-for-service (FFS) and MedicarePlus options. Elections would be made (or changed) only during specified coverage election periods. An individual who wished to elect a MedicarePlus plan would do so by filing an election form with the organization. Disenrollment would be accomplished the same way. An individual failing to make an election during the initial election period would be deemed to have chosen the Medicare FFS option. The Secretary would be required to establish procedures under which individuals enrolled with a MedicarePlus organization at the time of the initial election period and who failed to elect to receive coverage other than through the organization would be deemed to have elected the MedicarePlus plan offered by the organization (or, if the organization offered more than one such plan, such plan as the Secretary provided for under such procedures). An individual who made (or was deemed to have made) an election would be considered to have continued such election until the individual changed the election or the plan was discontinued.

d. Providing Information to Promote Informed Choice. The Secretary would provide for activities to disseminate broadly information to current and prospective Medicare beneficiaries on the coverage options available in order to promote an active, informed selection among such options. At least 30 days before each annual, coordinated election period, the Secretary would send to each MedicarePlus eligible person a notice containing the information specified below in order to assist the individual in making an election. This would include general information, a list of plan options and comparative plan option information, the MedicarePlus monthly capitation rate, and other information determined by the Secretary to be helpful in making elections. This information would have to be written in language easily understood by Medicare beneficiaries. The Secretary would be required to coordinate the mailing of this information with annual mailing of other Medicare information required under current law. To the extent practicable, the Sec-

retary would provide such information to new MedicarePlus individuals at least two months prior to their initial enrollment period.

The required general election information would include information on: (i) services covered and not covered by Medicare FFS (including benefits, cost-sharing, and beneficiary liability for balance billing); (ii) the Part B premium amount, (iii) election procedures, (iv) rights including grievance and appeals procedures under Medicare FFS and MedicarePlus and the right to be protected against discrimination based on health status-related factors, (v) information on Medigap and Medicare Select policies, and (vi) the right of the organization to terminate the contract and what this would mean for enrollees.

Comparative plan option information would have to include: (i) a description of benefits including any covered beyond Medicare FFS, any reductions in cost-sharing and any maximum limits on out-of-pocket costs, whether provider networks are used, coverage of emergency care, grievance and appeal information, and in the case of MSA plans, the differences in their cost sharing compared to other MedicarePlus plans; (ii) the monthly premium (and net monthly premium) for the plan; (iii) the service area of the plan; (iv) to the extent available, quality indicators (compared with indicators for Medicare FFS) including disenrollment rates, enrollee satisfaction and health outcomes, and whether the plan is out of compliance with any federal requirements; and (v) information on any supplemental coverage. The required information would be updated at least annually.

The Secretary would be required to maintain a toll-free number and Internet site for inquiries regarding MedicarePlus options and plans. A MedicarePlus organization would be required to provide the Secretary with such information on the organization and its plans as the Secretary needed to prepare the information described above for Medicare beneficiaries. The Secretary could enter into contracts with appropriate non-federal entities to carry out these information activities.

e. Coverage Election Periods. Individuals would first have a choice ("initial election") between Medicare FFS and MedicarePlus plans (if there were one or more MedicarePlus plans to choose from in their area) upon eligibility for Medicare. The Secretary would designate a time for the election such that coverage would become effective when the individual was eligible to begin coverage.

From 1998 through 2000, there would be continuous open enrollment and disenrollment, when eligible individuals could switch MedicarePlus plans or move into or out of the Medicare FFS program option. For the first 6 months during 2001, there would also be continuous open enrollment and disenrollment, but individuals could only change their election once during 2001 (except for during the annual coordinated open enrollment period or a special enrollment period (as described below)). During subsequent years, individuals would be able to enroll in a MedicarePlus option and disenroll from it at any time during the first 3 months of a year (or during the first 3 months after an individual became eligible to enroll in a MedicarePlus plan). Such changes could be made only once a year except during annual coordinated election and special enrollment periods.

Beginning in October 2000, there would be an annual, coordinated election period during which individuals could change elections for the following calendar year. The Secretary would be required to hold MedicarePlus health fairs in October of each year, beginning with 1998. Such fairs would provide for nationally, coordinated educational and publicity campaigns to inform MedicarePlus eligibles about MedicarePlus plans and the election process, including the annual, coordinated election periods.

Starting January 1, 2001, special election periods would be provided in which an individual could discontinue an election of a MedicarePlus plan and make a new election if: (i) the organization's or plan's certification was terminated or the organization terminated or otherwise discontinued providing the plan; (ii) the person who elected a MedicarePlus plan was no longer eligible because of a change in residence or certain other changes in circumstances; (iii) the individual demonstrated that the organization offering the plan violated its contract with Medicare (including the failure to provide the enrollee on a timely basis medically necessary care or to provide such care in accordance with applicable quality standards), or misrepresented the plan in its marketing; or (4) the individual encountered other exceptional conditions specified by the Secretary.

Special rules would apply for MSA plans. Individuals could elect a MSA plan only during: (i) an initial open enrollment period; (ii) an annual, coordinated election period, or (iii) October 1998 and October 1999. Such individuals could not discontinue an election of an MSA plan except during an annual, coordinated election period, October 1998 and October 1999, or if the MSA plan had been decertified or terminated.

f. Effectiveness of Elections. An election made during the initial election period would become effective when the individual became entitled to Medicare benefits, except as the Secretary might provide in order to prevent retroactive coverage. During continuous open enrollment periods, an election or change of elections would take effect with the first calendar month after the election was made. An election or change of coverage made during a coordinated election period would take effect as of the first day of the following year. Elections during other periods would take effect in the manner specified by the Secretary to protect continuity of coverage.

g. Guaranteed Issue and Renewal. MedicarePlus organizations would be required to accept MedicarePlus eligibles without restriction during election periods. If the organization had a capacity limit, it could limit enrollment but only if priority were given to those who had already elected the plan and then to other persons in a manner that did not discriminate on the basis of health-status related factors (which include health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence) and disability). This would not apply if it would result in enrollment that is substantially misrepresentative of the Medicare population in the service area.

MedicarePlus organizations could not terminate an enrollee's election except for failure to pay premiums on a timely basis, dis-

ruptive behavior, or because of plan termination of all MedicarePlus individuals. Individuals terminated for cause would be deemed to have elected Medicare FFS. An individual whose plan was terminated would have a special election period to change into another MedicarePlus plan. If the individual failed to make an election, he or she would be deemed to be Medicare FFS. Plans would have to transmit to the Secretary a copy of each enrollee's election form.

h. Approval of Marketing Material. The provision would require MedicarePlus plans to submit marketing material to the Secretary at least 45 days before distribution. The material could then be distributed if not disapproved by the Secretary. Medicare's new standards for plans (established as described below under new section 1856) would have to include guidelines for the review of all marketing material submitted. Under these guidelines, the Secretary would have to disapprove marketing materials if they were materially inaccurate or misleading.

Each MedicarePlus organization would have to conform to fair marketing standards, including a prohibition on a MedicarePlus organization (or its agent) completing any portion of any election form on behalf of any individual.

i. Effect of Election of MedicarePlus Plan Option. Payments under a contract with a MedicarePlus organization with respect to an individual electing a MedicarePlus plan offered by an organization would be instead of the amounts which otherwise would have been payable under Medicare Parts A and B.

New section 1852. Benefits and beneficiary protections

Current Law. Section 1876 provides for requirements relating to benefits, payment to the plans by Medicare, and payments to the plans by beneficiaries. In addition, it specifies standards for patient protection and quality assurance.

A Medicare beneficiary enrolled in an HMO/CMP is entitled to receive all services and supplies covered under Medicare Parts A and B (or Part B only, if only enrolled in Part B). These services must be provided directly by the organization or under arrangements with the organization. Enrollees in risk-based organizations are required to receive all services from the HMO/CMP except in emergencies.

In general, HMOs/CMPs offer benefits in addition to those provided under Medicare's benefit package. In certain cases, the beneficiary has the option of selecting the additional benefits, while in other cases some or all of the supplementary benefits are mandatory.

Some entities may require members to accept additional benefits (and pay extra for them in some cases). These required additional services may be approved by the Secretary if it is determined that the provision of such additional services will not discourage enrollment in the organization by other Medicare beneficiaries.

Medicare HMOs/CMPs must provide enrollees, at the time of enrollment and annually thereafter, an explanation of: rights to benefits, restrictions on services provided through nonaffiliated providers, out-of-area coverage, coverage of emergency and urgently needed services, and appeal rights.

Medicare HMOs/CMPs must make all Medicare-covered services and all other services contracted for available and accessible within its service area, with reasonable promptness and in a manner that assures continuity of care. Urgent care must be available and accessible 24 hours a day and 7 days a week. HMOs must also pay for services provided by nonaffiliated providers when services are medically necessary and immediately required because of an unforeseen illness, injury, or condition and it is not reasonable, given the circumstances, to obtain the services through the HMO.

HMOs/CMPs are required to have arrangements for an ongoing quality assurance program that stresses health outcomes and provides review by physicians and other health care professionals of the process followed in the provision of health services. External review is conducted by a peer review organization (PRO), one of the groups that has contracted with the Secretary for review of the quality and appropriateness of hospital services. PRO reviews of HMOs/CMPs covers both inpatient and outpatient care. The Secretary also has the right to inspect or otherwise evaluate the quality, appropriateness, and timeliness of services provided and the facilities of the organization when there is reasonable evidence of some need for inspection.

In up to 25 States, the Secretary is authorized to designate another external agency, known as a quality review organization (QRO) to perform reviews. QROs must meet many of the same standards as PROs, but have not contracted with HHS for the review of services other than those provided by an HMO/CMP.

HMOs/CMPs must have meaningful grievance procedures for the resolution of individual enrollee complaints, about such problems as failure to receive covered services or unpaid bills. In addition, an enrollee who believes that the HMO has improperly denied a service or imposed an excessive charge has the right to a hearing before the Secretary if the amount involved is greater than \$100. If the amount is greater than \$1,000, either the enrollee or the HMO may seek judicial review. On April 30, 1997, Health Care Financing Administration (HCFA) issued final rules for establishing an expedited review process for Medicare beneficiaries enrolled in HMOs and CMPs.

Hospitals and other providers are required under Medicare as a condition of participation to ask whether an individual has an advance directive and make a notice of such in the patient's record. Such hospitals and other providers also have to provide upon admission and at other specified times written information to adult patients: on applicable advance directive laws of the relevant State and of the advance directive policies of the provider.

Payments to Medicare HMOs/CMPs include amounts that reflect Medicare's fee-for-service payments to hospitals in an area for indirect and direct medical education costs and disproportionate share adjustments.

Penalties apply for violations of limits on the use of "physician incentive plans," i.e., compensation arrangements between HMOs and physicians that might induce physicians to withhold services. An HMO may not make a specific payment to a physician as an inducement to reduce or limit services to a specific enrollee. In addition, if physicians or physician groups are placed at substantial

financial risk for services other than their own, the HMO must provide adequate stop-loss protection to limit the physicians' potential liability and must periodically survey enrollee satisfaction.

There are no provisions in current law for provider protections. In addition, there is no provision in current law for medical savings account plans for Medicare beneficiaries.

Explanation of Provision. The provision establishes a new Section 1852 specifying Federal requirements related to MedicarePlus plan benefits and beneficiary protections.

a. Basic Benefits. Each MedicarePlus plan, except an MSA plan, would be required to provide benefits for at least the items and services for which benefits are available under Parts A and B of Medicare and any additional health services as the Secretary may approve under section 1854 of this provision (see below). A MedicarePlus plan would meet this requirement if, for items and services furnished other than through a provider that has a contract with the organization offering the plan, the plan provides (in addition to any cost sharing provided for under the plan) for at least the dollar amount of payment as would otherwise be authorized under Medicare FFS (including any balance billing permitted under Medicare FFS). These cost-sharing limitations would not apply to an individual enrolled under an MSA plan.

MedicarePlus organizations could offer under their MedicarePlus plans supplemental benefits. Supplemental benefits approved by the Secretary may be offered without affording enrollees an option to decline them. Alternatively, a MedicarePlus organization could provide to enrollees (other than those in an MSA plan) optional supplemental benefits. A MedicarePlus plan could seek payment from other payors, such as insurers or employer plans, in circumstances where secondary payor rules apply.

The provision would establish a policy relating to a national coverage determination made between the annual announcements of MedicarePlus payment rates. The application of the determination would be delayed if the determination would result in a significant change in costs to the MedicarePlus plan, and such change was not incorporated in the MedicarePlus payment rate established for that period. In such cases, the national coverage determination would apply to the first contract year beginning after such period. If the determination provided for coverage of additional benefits or benefits under additional circumstances, it would also apply to the first contract year beginning after such period, unless otherwise required by law.

b. Antidiscrimination. A MedicarePlus organization could not deny, limit, or condition the coverage or provision of benefits under this part based on any health-status related factor (health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence) and disability). This requirement should not be construed to mean that a MedicarePlus organization had to enroll individuals determined to have ESRD.

c. Detailed Description of Plan Provisions. The provision would require each MedicarePlus plan to disclose in clear, accurate, and standardized form to each enrollee at the time of enrollment and

annually thereafter, the following information about the plan: (i) its service area; (ii) its benefits and exclusions from coverage (and, in the case of an MSA plan, a comparison with other MedicarePlus plans); (iii) the number, mix, and distribution of participating providers, and whether there is a point-of-service option and, if so, the premium for it (iv) permitted out-of-area coverage; (v) coverage of and procedures for obtaining emergency services (including the appropriate use of 911 or local equivalent); (vi) any supplemental coverage, including the benefits and premium price and whether they are optional; (vii) any prior authorization or other rules that could result in nonpayment; (viii) any grievance and appeals procedures; and (ix) its quality assurance program.

d. Access to Services. The provision would permit a MedicarePlus organization offering a MedicarePlus plan to restrict the providers from whom benefits could be provided so long as: (i) the organization makes the benefits available and accessible to each individual electing the plan within the service area with reasonable promptness and in a manner which assures continuity in the provision of benefits; (ii) when medically necessary, the organization makes benefits available and accessible 24 hours a day, 7 days a week; (iii) the plan provides reimbursement for covered out-of-network services if the services are medically necessary and immediately required because of unforeseen illness, injury, or condition and it is not reasonable to provide the services through the organization or met other conditions; (iv) the organization provides access to appropriate providers, including credentialed specialists, for medically necessary treatment and services; and (v) coverage is provided for emergency services without regard to either prior authorization requirements or the emergency care entity's contractual relationship with the organization.

A MedicarePlus organization would be required to comply with such guidelines as the Secretary may prescribe relating to promoting efficiency and timely coordination of appropriate maintenance and post-stabilization care provided to an enrollee determined to be stable by a medical screening examination required under the Examination and Treatment under Emergency Medical Conditions and Women in Labor requirements of the Social Security Act (Section 1867).

Emergency services mean covered inpatient and outpatient services that are furnished to an enrollee of a MedicarePlus organization by a provider qualified to provide services under Medicare, and are needed to evaluate or stabilize an emergency medical condition.

An emergency medical condition is one manifesting itself by acute symptoms of sufficient severity such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (i) placing the health of the individual in serious jeopardy (and in case of a pregnant woman, her health or that of her unborn child); (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part.

A MedicarePlus organization would be required to ensure that the length of an inpatient hospital stay covered under Medicare be determined by the attending physician (or other attending health care provider to the extent permitted under State law) and the pa-

tient to be medically appropriate. This should not be construed as requiring the provision of inpatient coverage if the attending physician or provider and patient determine that a shorter stay is medically appropriate or as affecting the application of deductibles and coinsurance.

e. Quality Assurance Program. The provision would require a MedicarePlus organization to have arrangements (established in accordance with regulations of the Secretary) for an ongoing quality assurance program for services provided to its MedicarePlus enrollees. The program has to: (i) stress health outcomes and provide for the collection, analysis, and reporting of data that will permit measurement of outcomes and other indices of MedicarePlus plans and organizations; (ii) provide for written protocols for utilization review; (iii) provide review by physicians and other health care professionals of the process followed in the provision of health services; (iv) monitor and evaluate high volume and high risk services and the care of acute and chronic conditions; (v) evaluate the continuity and coordination of care; (vi) have mechanisms in place to detect both underutilization and overutilization; (vii) after identifying areas for improvement, establish or alter practice parameters; (viii) take action to improve quality and assess effectiveness of such actions; (ix) make available information on quality and outcomes measures to facilitate beneficiary comparison and choice; (x) be evaluated on an ongoing basis; (xi) include measures of consumer satisfaction; and (xii) provide the Secretary with such access to information collected as may be appropriate to monitor and ensure quality.

Each organization would be required to have an agreement with an independent quality review and improvement organization, approved by the Secretary, for each plan it operates, to perform functions such as quality review, review for the appropriateness of setting of care, adequacy of access, beneficiary outreach, and review of complaints about poor quality of care. A MedicarePlus organization would be deemed to meet the requirements for quality assurance external review if it is accredited by a private organization under a process that the Secretary has determined assures that the organization applies and enforces standards that are no less stringent than those specified under the plan standards requirements established by this provision (see new Section 1856 as described below).

f. Coverage Determinations. A MedicarePlus organization would be required to make determinations regarding authorization requests for nonemergency care on a timely basis and to provide notice of any denial and the reasons for it. An explanation of the grievance and appeals process would also have to be provided. Reconsideration of denials would generally have to be decided within 30 days of receiving medical information, but not later than 60 days after the coverage determination. Physicians would be the only individuals permitted to make decisions to deny coverage based on medical necessity.

g. Grievances and Appeals. The provision would require each MedicarePlus organization to provide meaningful procedures for hearing and resolving grievances. An enrollee dissatisfied by reason of the enrollee's failure to receive health services would be enti-

tled, if the amount in controversy was \$100 or more, to a hearing before the Secretary. If the amount in controversy was \$1,000 or more, the individual or organization, upon notifying the other party, would be entitled to judicial review. The Secretary would be required to contract with an independent, outside entity to review and resolve appeals of denials of coverage related to urgent or emergency services.

An enrollee in a MedicarePlus plan could request an expedited determination by the organization regarding an appeal. Such requests could also come from physicians. The organization would have to maintain procedures for expediting organization determinations when, upon request of an enrollee, the organization determined that the application of a normal time frame for making a determination or a reconsideration could seriously jeopardize the life or health of an enrollee or the enrollee's ability to regain maximum function. In an urgent case, the organization would have to notify the enrollee (and physician involved) of the determination as expeditiously as the enrollee's condition requires, but not later than 72 hours (or 24 hours in the case of a reconsideration), or such longer period as the Secretary may permit in specified cases. The Secretary would have to annually report publicly on the number and disposition of denials and appeals within each organization, and those resolved by the independent entity.

h. Confidentiality and Accuracy of Enrollee Records. Each MedicarePlus organization would be required to establish procedures to safeguard the privacy of individually identifiable enrollee information, to maintain accurate and timely medical records and other health information, and to assure timely access of enrollees to their medical records.

i. Information on Advance Directives. Each MedicarePlus organization would be required to maintain written policies and procedures respecting advance directives.

j. Rules Regarding Physician Participation. Each MedicarePlus organization would be required to establish reasonable procedures relating to the participation of physicians under a MedicarePlus plan offered by the organization. The procedures would include: (i) providing notice of the rules regarding participation; (ii) providing written notice of adverse participation decisions; and (iii) providing a process for appealing adverse decisions. The organization would be required to consult with physicians who have entered into participation agreements regarding the organization's medical policy, quality, and medical management procedures.

The provision (patient's right to know) would prohibit interference with physician advice to enrollees. A MedicarePlus organization could not prohibit a covered health professional from advising a patient about the patient's health status or about medical care or treatment for the patient's condition or disease, regardless of whether benefits for such care or treatment are provided under the plan if the professional is acting within the lawful scope of practice.

The Committee has adopted a conscience protection provision. This provision is intended to ensure that MedicarePlus organizations motivated by religious or moral beliefs can comply with the general rule while maintaining ethical integrity. Specifically, the

patient's right to know provision should not be construed to require MedicarePlus organizations to provide, reimburse for, or provide coverage of a counseling or referral service if the organization offering the plan objects to the provision of such service on moral or religious grounds. The provision is consistent with the intent of the patient right's to know provision because health care professionals under contract with a MedicarePlus organization are free to advise their patients about relevant medical care or treatment. However, this provision makes clear that neither the organization nor its employees must provide a counseling service or a referral service, nor does the organization have to reimburse for, or provide coverage of, such service, if it objects to such service on moral or religious grounds.

This provision also has a requirement that MedicarePlus organizations make available to prospective and current enrollees information on its policies regarding the counseling and referral services to which it objects on moral or religious grounds. The Committee has permitted the plans to make this information on its policies available through written instrumentalities in the manner which the MedicarePlus organization deems appropriate so as to remove discretion from the Secretary or any other government entity to impose burdensome regulatory, legal or stylistic requirements with respect to this subsection. However, the Committee intends that the information not be made available in a manner that intentionally obfuscates or seeks to deceive a prospective or current enrollee. Rather, the Committee intends for such notice to be provided in a manner that would be meaningful to beneficiaries and reasonably inform them of any policies resulting in plan restrictions.

This provision also requires a MedicarePlus organization to make such information on its policies available to prospective enrollees before or during enrollment. The subsection also makes clear that if a plan changes such a policy or adopts a new policy regarding a counseling or referral service to which it has moral or religious objections during the plan year, that it must make available information to current enrollees within 90 days of such a policy change regarding such a counseling service.

This provision has a construction clause making clear that nothing in subsection (B) should be construed to affect disclosure requirements under the State law or under the Employee Retirement Income Security Act of 1974.

The provision would limit the use of health care provider incentive plans. The provision would define an incentive plan as any compensation arrangement between a MedicarePlus organization and a provider or provider group that has the effect, directly or indirectly, of reducing or limiting services provided. The provision would prohibit MedicarePlus plans from operating such a provider incentive plan unless the following conditions were met. No specific payment could be made, directly or indirectly, to a provider or provider group as an inducement to reduce or limit medically necessary services provided with respect to a specific individual. If the plan placed a provider or provider group at substantial financial risk, the organization would be required to provide adequate and appropriate stop-loss protection and to conduct periodic surveys of

currently and previously enrolled individuals to determine the degree of access to and satisfaction with the quality of services. Further, the organization would be required to provide the Secretary with sufficient descriptive information for the Secretary to determine compliance with these requirements.

A MedicarePlus organization would not be able to provide (directly or indirectly) for a provider (or group of providers) to indemnify the organization against any liability resulting from a civil action brought by or on behalf of an enrollee for any damage caused to the enrollee by the organization's denial of medically necessary care.

A MedicarePlus organization could not (directly or indirectly) seek to enforce contractual provisions which prevent providers whose contractual obligations to the organization for the provision of medical services through the organization have ended from joining or forming any competing MedicarePlus PSO in the same area.

k. Treatment of Services Furnished by Certain Providers. Physician or other entity (other than a provider of services) that does not have a contract establishing payment amounts for services furnished to an individual enrolled with a MedicarePlus organization would be required to accept as payment in full for covered services the amounts that the physician or other entity could collect if the individual were in Medicare FFS. Any penalty or other provision of law that applies to such a payment under Medicare FFS would also apply with respect to an individual covered under a MedicarePlus plan.

l. Disclosure of Use of DSH and Teaching Hospitals. Each MedicarePlus organization would have to provide the Secretary with information on (i) the extent to which it provides inpatient and outpatient hospital benefits under MedicarePlus through the use of hospitals that are eligible for disproportionate share hospital adjustments or through the use of teaching hospitals that receive indirect and direct graduate medical education payments, and (ii) the extent to which differences between payment rates to different hospitals reflect the disproportionate share percentage of low-income patients and the presence of medical residency training programs in those hospitals.

m. Out-of-Network Access. The provision requires that if a MedicarePlus organization offers one plan which provides for coverage primarily through network providers, that it also be allowed to offer individuals (at the time of enrollment) another plan which provides for coverage through non-network providers.

n. Non-Preemption of State Law. A State could establish or enforce requirements with respect to beneficiary protections in this section but only if such requirements were more stringent.

o. Nondiscrimination in Selection of Network Health Professionals. A MedicarePlus plan offering network coverage could not discriminate in selecting the members of its health professional network (or in establishing the terms and conditions for membership in the network) on the basis of the race, national origin, gender, age, or disability (other than a disability that impairs the ability of an individual to provide health care services of that may threaten the health of enrollees) of the health professional. A MedicarePlus organization could not deny any health care profes-

sionals, based solely on the license or certification as applicable under State law, the ability to participate in providing covered health care services or to be reimbursed or indemnified for providing such services.

p. Special Rule for Unrestricted Fee-for-Service MSA Plan. A MedicarePlus MSA plan that is a fee-for-service plan would not be subject to the requirements described above relating to procedures for establishing physician participation in the plan or the limitations on balance billing.

New section 1853. Payments to MedicarePlus organizations.

Current Law. Under a Medicare risk contract, an HMO agrees to provide or arrange for the full scope of covered Medicare services in return for a single monthly capitation payment issued by Medicare for each enrolled beneficiary. One of the numbers used to determine this payment is the adjusted average per capita cost (AAPCC). The other, the adjusted community rate (ACR), is discussed below (see new Section 1854).

The AAPCC is Medicare's estimate of the average per capita amount it would spend for a given beneficiary (classified by certain demographic characteristics and county of residence) who was not enrolled in an HMO and who obtained services on the usual fee-for-service basis. Separate AAPCCs are established for enrollees on the basis of age, sex, whether they are in a nursing home or other institution, whether they are also eligible for Medicaid, whether they are working and being covered under an employer plan, and the county of their residence. These AAPCC values are calculated in three basic steps:

Medicare national average calendar year per capita costs are projected for the future year under consideration. These numbers are known as the U.S. per capita costs (USPCCs) and are estimated average incurred benefit costs per Medicare enrollee and adjusted to include program administration costs. USPCCs are developed separately for Parts A and B of Medicare, and for costs incurred by the aged, disabled, and those with ESRD in those two parts of the program.

Geographic adjustment factors that reflect the historical relationships between the county's and the Nation's per capita costs are used to convert the national average per capita costs to the county level. Expected Medicare per capita costs for the county are calculated only for fee-for-service beneficiaries by removing both reimbursement and enrollment attributable to Medicare beneficiaries in prepaid plans.

Once the county AAPCC is calculated, it is then adjusted for the demographic variables described above, such as age, sex, and Medicaid status.

For each Medicare beneficiary enrolled under a risk contract, Medicare will pay the HMO 95 percent of the rate corresponding to the demographic class to which the beneficiary is assigned.

Medicare payments to risk-contract HMOs include amounts that reflect Medicare's fee-for-service payments to hospitals in an area for disproportionate share adjustment.

Explanation of Provision. The provision would establish a new Section 1853 specifying the methodology for determining payment

to MedicarePlus plans and the procedures for announcing rates and paying plans.

a. In General. Under a MedicarePlus contract, the Secretary would be required to make monthly payments in advance to each MedicarePlus organization for each covered individual in a payment area in an amount equal to 1/12 of the annual MedicarePlus capitation rate with respect to that individual for that area. The payment would be adjusted for such risk factors as age, disability status, gender, institutional status, and other such factors as the Secretary determined to be appropriate, so as to ensure actuarial equivalence. The Secretary could add to, modify, or substitute for such factors, if such changes would improve the determination of actuarial equivalence. The Secretary would be required to establish separate rates of payment with respect to individuals with end stage renal disease (ESRD). Payments to organizations could be retroactively adjusted for (i) actual versus the estimated enrollment used to determine the amount of advance payment; and (ii) individuals' change of enrollment from a MedicarePlus organization sponsored or contributed to by an employer to a MedicarePlus organization.

Risk Adjustment. The Secretary would be required to develop and submit to Congress by no later than October 1, 1999, a report on a method of risk adjustment of payment rates that accounts for variations in per capita costs based on health status. This report would have to include an evaluation of the proposal by an independent actuary of the actuarial soundness of the proposal. The Secretary would have to require MedicarePlus organizations (and risk-contract plans) to submit, for periods beginning on or after January 1, 1998, data regarding inpatient hospital and other services and other information the Secretary deems necessary. The Secretary would have to provide for implementation of a risk adjustment methodology that accounts for variations in per capita costs based on health status by no later than January 1, 2000.

b. Annual Announcement of Payment Rates. Payments to plans would be calculated based on the annual MedicarePlus capitation rate. The Secretary would be required to annually determine, and announce no later than August 1 before the calendar year concerned: (i) the annual MedicarePlus capitation rate for each MedicarePlus payment area for the year, and (ii) the risk and other factors to be used in adjusting such rates for payments for months in that year. An explanation of the assumptions and changes in methodology would have to be included in sufficient detail so that organizations could compute monthly adjusted MedicarePlus capitation rates. The Secretary would be required to provide advance notice (at least 45 days prior to the announcement) of the proposed changes in the methodology and assumptions used to develop the rates, and give organizations an opportunity to comment.

c. Calculation of Annual MedicarePlus Capitation Rates. The annual MedicarePlus capitation rate, for a payment area (for a contract for a calendar year) would be equal to the greatest of the following:

- (A) A blended capitation rate, defined as the sum of:

(1) the area-specific percentage (as defined below) of the annual area-specific MedicarePlus capitation rate for the year for the payment area, and

(2) the national percentage (as defined below) of the input-price adjusted annual national MedicarePlus capitation rate for the year. (This sum is multiplied by the budget neutrality adjustment factors (described below).

(B) A minimum (i.e., “floor”) monthly payment amount set at \$350 for 1998 (but not to exceed, in the case of an area outside the 50 States and the District of Columbia, 150 percent of the 1997 AAPCC). For a subsequent year, this payment amount would be increased by the national per capita MedicarePlus growth percentage for that year.

(C) A minimum percentage increase (i.e., “hold harmless”) amount. In 1998, the payment area would receive a MedicarePlus capitation rate that is 100 percent of its 1997 AAPCC. For 1999 and 2000, it would be 101 percent of the previous year’s rate. For 2001 and subsequent years, it would be 102 percent of the previous year’s rate.

There are five elements in the blended capitation rate referred to in “A” above: First, the area-specific and national percentages are as follows:

1998—the area-specific percentage is 90% and the national percentage is 10%.

1999—the area-specific percentage is 85% and the national percentage is 15%.

2000—the area-specific percentage is 80% and the national percentage is 20%.

2001—the area-specific percentage is 75% and the national percentage is 25%.

After 2001—the area-specific percentage is 70% and the national percentage is 30%.

Second, the annual area-specific MedicarePlus capitation rate for a MedicarePlus payment area would be calculated as follows, after removing certain amounts from historical payment amounts (as described below):

For 1998—the annual per capita rate of payment for 1997 (as determined under the current law calculation to derive the AAPCC), increased by the national average per capita growth percentage for 1998 (as defined below); or

For a subsequent year—the annual area-specific MedicarePlus capitation rate for the previous year, increased by the national per capita MedicarePlus growth percentage for such subsequent year.

Third, in determining the area-specific MedicarePlus capitation rate, amounts attributable to payments for hospitals serving a disproportionate share of low-income patients, payments for the indirect costs of medical education, and payments for direct graduate medical education costs, should be deducted from the 1997 payment amount as follows:

1998—20% of such payments

1999—40% of such payments

2000—60% of such payments

2001—80% of such payments

2002—100% of such payments

Fourth, the input-price-adjusted annual national MedicarePlus capitation rate for a MedicarePlus payment area for a year would be equal to the sum, for all types of Medicare services, of the product of three amounts: (i) the national standardized annual MedicarePlus capitation rate for the year (defined as the weighted average of area-specific MedicarePlus capitation rates), (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 service) the relative input price of such services in the area as compared to the national average input price of such services. (In applying (iii), the Secretary would use those indices that are used in applying (or updating) national payment rates for specific areas and localities.) Special rules specified in the provision would apply for 1998 (and optionally for 1999) in providing for the input price adjustment.

Fifth, in calculating the payment rates, the Secretary would be required to apply a budget neutrality adjustment to the blended rate payments. This adjustment would ensure that the aggregate of payments equals that which would have been made if the payment was based on 100 percent of the area-specific MedicarePlus capitation rates for each payment area. In doing this, the budget neutral amount for each county would be equal to the sum of the area-specific rates used to compute the blended rates multiplied by the product of the update factor and the number of enrollees in that county.

With respect to the blended and the minimum payment rate categories described in “A” and “B” above, the national per capita MedicarePlus growth percentage is the percentage determined by the Secretary, by April 30th before the beginning of the year involved, to reflect the Secretary’s estimate of the projected per capita rate of growth in expenditures under Medicare Parts A and B, reduced by 0.5 percentage points for 1998–2002, and by 0 percentage points for years thereafter. Separate determinations would have to be made for aged enrollees, disabled enrollees, and enrollees with ESRD. The percentage adjustment would have to reflect an adjustment for over or under projecting the percentage growth for previous years.

In the case of a MedicarePlus payment area for which the AAPCC for 1997 varies by more than 20 percent from such rate for 1996, the Secretary, where appropriate, could substitute for the 1997 rate a rate that is more representative of the cost of the enrollees in the area.

d. MedicarePlus Payment Area. The provision defines a MedicarePlus payment area as a county or equivalent area specified by the Secretary. In the case of individuals determined to have ESRD, the MedicarePlus payment area would be each State, or other payment areas as the Secretary specified.

Upon request of a State for a contract year (beginning after 1998) made at least 7 months before the beginning of the year, the Secretary would redefine MedicarePlus payment areas in the State to: (1) a single Statewide MedicarePlus payment area; (2) a metropolitan system (described in the provision); or (3) a single MedicarePlus payment area consolidating noncontiguous counties

(or equivalent areas) within a State. This adjustment would be effective for payments for months beginning with January of the year following the year in which the request was received. The Secretary would be required to make an adjustment to payment areas in the State to ensure budget neutrality.

e. Special Rules for Individuals Electing MSA Plans. If the monthly premium for a MSA plan for a MedicarePlus payment area was less than $\frac{1}{12}$ of the annual MedicarePlus capitation rate for the area and year involved, the Secretary would deposit the difference in a MedicarePlus MSA established by the individual. No payment would be made unless the individual had established the MedicarePlus MSA before the beginning of the month or by such other deadline the Secretary specifies. If the individual had more than one account, he or she would designate one to receive the payment. The payment for the first month for which a MSA plan was effective for a year would also include amounts for successive months in the year. For cases when an MSA election was terminated before the end of the year, the Secretary would establish a procedure to recover deposits attributable to the remaining months.

f. Payments from Trust Funds. Payments to the MedicarePlus organizations and payments to MedicarePlus MSAs, would be made from the HI and SMI trust funds in such proportion as the Secretary determined reflected the relative weights that benefits under Parts A and B represented of Medicare's actuarial value of the total benefits.

g. Special Rule for Certain Inpatient Hospital Stays. In the case of an individual receiving inpatient hospital services from a hospital covered under Medicare's prospective payment system (PPS) as of the effective date of the (1) individual's election of a MedicarePlus plan: (a) payment for such services until the date of the individual's discharge would be made as if the individual did not elect coverage under the MedicarePlus plan; (b) the elected organization would not be financially responsible for payment for such services until the date of the individual's discharge; and (c) the organization would nevertheless be paid the full amount otherwise payable to the organization; or (2) termination of enrollment with a MedicarePlus organization: (a) the organization would be financially responsible for payment for such services after the date of termination and until the date of discharge; (b) payment for such services during the stay would not be made under Medicare's PPS system; and (c) the terminated organization would not receive any payment with respect to the individual during the period in which the individual was not enrolled.

h. Payments to Managed Care Organizations Operating Graduate Medical Education Programs. See Section 4008 below.

New section 1854. Premiums

Current Law. Section 1876 provides for requirements relating to benefits, payment to the plans by Medicare, and payments to the plans by beneficiaries. A Medicare beneficiary enrolled in an HMO/CMP is entitled to receive all services and supplies covered under Medicare Parts A and B (or Part B only, if only enrolled in Part B). These services must be provided directly by the organization or under arrangements with the organization. Enrollees in risk-based

organizations are required to receive all services from the HMO/CMP except in emergencies.

In general, HMOs/CMPs offer benefits in addition to those provided under Medicare's benefit package. In certain cases, the beneficiary has the option of selecting the additional benefits, while in other cases some or all of the supplementary benefits are mandatory.

Some entities may require members to accept additional benefits (and pay extra for them in some cases). These required additional services may be approved by the Secretary if it is determined that the provision of such additional services will not discourage enrollment in the organization by other Medicare beneficiaries.

The amount an HMO/CMP may charge for additional benefits is based on a comparison of the entity's adjusted community rate (ACR), essentially the estimated market price, for the Medicare package and the average of the Medicare per capita payment rate. A risk-based organization is required to offer "additional benefits" at no additional charge if the organization achieves a savings from Medicare. This "savings" occurs if the ACR for the Medicare package is less than the average of the per capita Medicare payment rates. The difference between the two is the amount available to pay additional benefits to enrollees. These may include types of services not covered, such as outpatient prescription drugs, or waivers of coverage limits, such as Medicare's lifetime limit on reserve days for inpatient hospital care. The organization might also waive some or all of the Medicare's cost-sharing requirements.

The entity may elect to have a portion of its "savings" placed in a benefit stabilization fund. The purpose of this fund is to permit the entity to continue to offer the same set of benefits in future years even if the revenues available to finance those benefits diminish. Any amounts not provided as additional benefits or placed in a stabilization fund would be offset by a reduction in Medicare's payment rate.

If the difference between the average Medicare payment rate and the adjusted ACR is insufficient to cover the cost of additional benefits, the HMO/CMP may charge a supplemental premium or impose additional cost-sharing charges. If, on the other hand, the HMO does not offer additional benefits equal in value to the difference between the ACR and the average Medicare payment, the Medicare payments are reduced until the average payment is equal to the sum of the ACR and the value of the additional benefits.

For the basic Medicare covered services, premiums and the projected average amount of any other cost-sharing may not exceed what would have been paid by the average enrollee under Medicare rules if she or he had not joined the HMO. For supplementary services, premiums and projected average cost-sharing may not exceed what the HMO would have charged for the same set of services in the private market.

Explanation of Provision. The provision creates a new Section 1854 specifying requirements for the determination of premiums charged by MedicarePlus organizations to MedicarePlus enrollees.

a. Submission and Charging of Premiums. Each MedicarePlus organization would be required annually to file with the Secretary the amount of the monthly premium for coverage under each of the

plans it would be offering in each payment area, and the enrollment capacity in relation to the plan in each such area. The net monthly premium is the premium for covered services reduced by the monthly MedicarePlus capitation payment.

b. Monthly Premium Charged. The monthly amount of premium charged in a payment area to an enrollee would equal the net monthly premium plus any monthly premium charged (in accordance with (e) below) for supplemental benefits.

c. Uniform Premium. Premiums could not vary among individuals who resided in the same payment area.

d. Terms and Conditions of Imposing Premiums. Each MedicarePlus organization would have to permit monthly payment of premiums. An organization could terminate election of individuals for a MedicarePlus plan for failure to make premium payments but only under specified conditions. A MedicarePlus organization could not provide for cash or other monetary rebates as an inducement for enrollment or otherwise.

e. Limitation on Enrollee Cost-Sharing. In no case could the actuarial value of the net monthly premium rate, deductibles, coinsurance, and copayments applicable on average to individuals enrolled with a MedicarePlus plan with respect to required benefits exceed the actuarial value of the deductibles, coinsurance, and copayments applicable on average to individuals in Medicare FFS. For supplemental benefits, the premium for such benefits and the actuarial value of its deductibles, coinsurance, and copayments could not exceed the adjusted community rate for such benefits. These provisions would not apply to an MSA plan. If the Secretary determined that adequate data were not available to determine the actuarial value of the cost-sharing elements of the plan, the Secretary could determine the amount.

If the actuarial value of the benefits under the MedicarePlus plan (as determined based upon the ACR) for individuals was less than the average of the capitation payments made to the organization for the plan at the beginning of a contract year, the organization would have to provide additional benefits in a value which was at least as much as the amount by which the capitation payment exceeded the ACR. These benefits would have to be uniform for all enrollees in a plan area. (The excess amount could, however, be lower if the organization elected to withhold some of it for a stabilization fund.) A MedicarePlus organization could provide additional benefits (over and above those required to be added as a result of the excess payment), and could impose a premium for such additional benefits.

f. Periodic Auditing. The Secretary would be required to provide annually for the auditing of the financial records (including data relating to utilization and computation of the ACR) of at least one-third of the MedicarePlus organizations offering MedicarePlus plans. The General Accounting Office (GAO) would be required to monitor such auditing activities.

g. Prohibition of State Imposition of Premium Taxes. No State could impose a premium tax or similar tax on the premiums of MedicarePlus plans or the offering of such plans.

New Section 1855. Organizational and financial requirements for MedicarePlus organizations; provider-sponsored organizations

Current Law. Under Section 1876 of the Social Security Act, Medicare specifies requirements to be met by an organization seeking to become a managed care contractor with Medicare. In general, these include the following: (1) the entity must be organized under the laws of the State and be a Federally qualified HMO or a competitive medical plan (CMP) which is an organization that meets specified requirements (it provides physician, inpatient, laboratory, and other services, and provides out-of-area coverage); (2) the organization is paid a predetermined amount without regard to the frequency, extent, or kind of services actually delivered to a member; (3) the entity provides physicians' services primarily through physicians who are either employees or partners of the organization or through contracts with individual physicians or physician groups; (4) the entity assumes full financial risk on a prospective basis for the provision of covered services, except that it may obtain stop-loss coverage and other insurance for catastrophic and other specified costs; and (5) the entity has made adequate provision for protection against the risk of insolvency.

Provider Sponsored Organizations (PSOs) that are not organized under the laws of a State and are neither a Federally qualified HMO or CMP are not eligible to contract with Medicare under the risk contract program. A PSO is a term generally used to describe a cooperative venture of a group of providers who control its health service delivery and financial arrangements.

Explanation of Provision. The provision adds a new Section 1855 to the Social Security Act providing organizational and financial requirements for MedicarePlus organizations, including PSOs.

a. Organized and Licensed Under State Law. A MedicarePlus organization would have to be organized and licensed under State law as a risk-bearing entity eligible to offer health insurance or health benefits coverage in each State in which it offers a MedicarePlus plan. A special exception would apply, however, for PSOs. In general, a PSO seeking to offer a MedicarePlus plan could apply to the Secretary for a waiver of the State licensing requirement. The Secretary would be required to grant or deny a waiver application within 60 days of a completed application.

The Secretary would grant a waiver of the State licensing requirement for an organization that is a PSO if the Secretary determined that: (i) the State had failed to substantially complete action on a licensing application within 90 days of the receipt of an application (not including any period before the date of enactment) (this section is not intended to allow for the submission of incomplete "shell" applications); or (ii) the State denied such a licensing application and (a) the State had imposed documentation or information requirements not related to solvency requirements that were not generally applicable to other entities engaged in substantially similar business, or (b) the State's standards or review process imposed any material requirements, procedures, or standards (other than requirements relating to solvency) on such organizations that were not generally applicable to other entities engaged in substantially similar business; or (iii) the State used its own solvency require-

ments which were not the same as the Federal requirements to deny the licensing application, or the State had imposed as a condition of licensure approval any documentation requirements relating to solvency or other material requirements, procedures, or standards that were different from the requirements, procedures, or standards applied by the Secretary.

In the case of a waiver granted under this paragraph for a PSO: (i) the waiver would be effective for a 36-month period, except it could be renewed based on a subsequent application filed during the last 6 months of such period; (ii) the waiver was conditioned upon the pendency of the licensure application during the period the waiver was in effect; and (iii) any provision of State law related to the licensing of the organization which prohibited the organization from providing coverage pursuant to a MedicarePlus contract would be preempted. Waivers could be renewed more than once.

Nothing in (iii) should be construed as waiving any provision of State law relating to quality of care or consumer protection (and not to solvency standards) and which is imposed uniformly and is generally applicable to other entities engaged in substantially similar business.

The State licensing requirement would not apply to a MedicarePlus organization in a State if the State required the organization, as a condition of licensure, to offer any plan other than a MedicarePlus plan. The fact that an organization was licensed under State law would not substitute for or constitute certification.

b. Prepaid Payment. A MedicarePlus organization would have to be compensated (except for deductibles, coinsurance, and copayments) by a fixed payment paid on a periodic basis and without regard to the frequency, extent, or kind of health care services actually provided to an enrollee.

c. Assumption of Full Financial Risk. The MedicarePlus organization would have to assume full financial risk on a prospective basis for the provision of health services (other than hospice care) except the organization could obtain insurance or make other arrangements for costs in excess of \$5,000, services needing to be provided other than through the organization; and obtain insurance or make other arrangements for not more than 90 percent of the amount by which its fiscal year costs exceed 115 percent of its income for such year. It could also make arrangements with providers or health institutions to assume all or part of the risk on a prospective basis for the provision of basic services.

d. Certification of Provision Against Risk of Insolvency for Unlicensed PSOs. Each MedicarePlus PSO, that is not licensed by a State and for which a waiver of State law has been approved by the Secretary, would be required to meet Federal financial solvency and capital adequacy standards (see new Section 1856 as described below). The Secretary would be required to establish a process for the receipt and approval of applications of entities for certification (and periodic recertification) of a PSO as meeting the Federal solvency standards. The Secretary would be required to act upon the PSO's certification application within 60 days of its receipt.

e. Provider-Sponsored Organization (PSO) Defined. A PSO is a public or private entity that is established or organized by a health care provider or group of affiliated providers that provides a sub-

stantial portion of health care under the contract directly through the provider or affiliated group of providers, and with respect to those affiliated providers that share, directly or indirectly, substantial financial risk, has at least a majority interest in the entity. In defining substantial proportion, the Secretary would be required to consider the need for such an organization to assume responsibility for a substantial portion of services in order to assure financial stability and other factors. "Affiliation," "control," and "health care provider" are specifically defined. The Secretary would be required to issue regulations to carry out this provision.

New Section 1856. Establishment of standards; certification of organizations and plans

Current Law. Under Section 1876 of the Social Security Act, Medicare specifies requirements to be met by an organization seeking to become a managed care contractor with Medicare. There is no provision for Provider Sponsored Organizations (PSOs).

Explanation of Provision. The provision would add a new Section 1856 providing for the establishment of Federal standards for MedicarePlus plans, including solvency standards for PSOs.

a. Establishment of Solvency Standards for PSOs. The provision would require the Secretary of HHS to establish, on an expedited basis and using a negotiated rule-making process, standards related to financial solvency and capital adequacy of organizations seeking to qualify as PSOs. The target date for publication of the resulting rules would be April 1, 1998. The Secretary would be required to consult with interested parties and to take into account: (i) the delivery system assets of such an organization and ability of it to provide services directly to enrollees through affiliated providers, and (ii) alternative means of protection against insolvency, including reinsurance, unrestricted surplus, letters of credit, guarantees, organizational insurance coverage, etc. Such standards would have to include provisions to prevent enrollees from being held liable to any person or entity for the MedicarePlus organization's debts in the event of its insolvency. The negotiated rule-making committee would be appointed by the Secretary. If the committee reported by January 1, 1998 that it had failed to make significant progress towards consensus or was unlikely to reach consensus by a target date, the Secretary could terminate the process and provide for the publication of a rule. If the committee was not terminated, it would have to report with the proposed rule by March 1, 1998. The Secretary would then publish the rule on a final, interim basis, but be subject to change after public notice and comment. In connection with the rule, the Secretary would specify the process for timely review and approval of applications of entities to be certified as PSOs consistent with this subsection. The Secretary would be required to provide for consideration of such comments and republication of the rule within 1 year of its publication.

b. Establishment of Other Standards. The Secretary would be required to establish by regulation other standards (not included in (a)) for MedicarePlus organizations and plans consistent with, and to carry out, this part. By June 1, 1998, the Secretary would be required to issue interim standards based on currently applicable standards for Medicare HMOs/CMPs. In establishing standards,

the Secretary would be required to consider model State and other standards relating to quality of care and consumer protection. Subject to the non-preemption provision of section 1852 (see above) relating to State beneficiary protection requirements that are more stringent, the new standards established under this provision would supersede any State law or regulation with respect to MedicarePlus plans offered by Medicare contractors to the extent that such State law or regulations was inconsistent with such standards. This should not be construed as superseding a State law or regulation that is not related to solvency, that is applied on a uniform basis and is generally applicable to other entities engaged in substantially similar business, and that provides consumer protections in addition to, or more stringent than, those provided under this subsection.

New Section 1857. Contracts with MedicarePlus organizations

Current Law. Contracts with HMOs are for 1 year, and may be made automatically renewable. However, the contract may be terminated by the Secretary at any time (after reasonable notice and opportunity for a hearing) in the event that the organization fails substantially to carry out the contract, carries out the contract in a manner inconsistent with the efficient and effective administration of Medicare HMO law, or no longer meets the requirements specified for Medicare HMOs. The Secretary also has authority to impose lesser sanctions, including suspension of enrollment or payment and imposition of civil monetary penalties. These sanctions may be applied for denial of medically necessary services, overcharging, enrollment violations, misrepresentation, failure to pay promptly for services, or employment of providers barred from Medicare participation.

To be eligible as a risk contractor, HMOs/CMPs generally must have at least 5,000 members. However, if HMOs/CMPs primarily serve members outside urbanized areas, they may have fewer members (regulations specify at least 1,500). Organizations eligible for Medicare cost contracts also may have fewer than 5,000 members (regulations specify at least 1,500).

No more than 50 percent of the organization's enrollees may be Medicare or Medicaid beneficiaries. This rule may be waived, however, for an organization that serves a geographic area where Medicare and Medicaid beneficiaries make up more than 50 percent of the population or (for 3 years) for an HMO that is owned and operated by a governmental entity.

During its annual open enrollment period of at least 30 days duration, HMOs must accept beneficiaries in the order in which they apply, up to the limits of its capacity, unless doing so would lead to violation of the 50 percent Medicare-Medicaid maximum or to an enrolled population unrepresentative of the population in the area served by the HMO. If an HMO chooses to limit enrollment because of its capacity, regulation provides that it must notify HCFA at least 90 days before the beginning of its open enrollment period and, at that time, provide HCFA with its reasons for limiting enrollment.

In areas where Medicare has risk contracts with more than one HMO and an HMO's contract is not renewed or is terminated, the other HMOs serving the area must have an open enrollment period of 30 days for persons enrolled under the terminated contract.

The Secretary is encouraged to use this waiver authority to grant, immediately on enactment, a waiver of the 50-50 requirement to a health plan providing quality health care services to Medicaid beneficiaries, including innovative health promotion and disease prevention programs, particularly if such a plan was unintentionally prevented from participating in the Medicare risk market through provisions of the Social Security and Technical Corrections Act of 1994.

Explanation of Provision. The provision establishes a new Section 1857 specifying requirements for organizations to become MedicarePlus contractors with the Medicare program.

a. In General. The Secretary would not permit the election of a MedicarePlus plan and no payment would be made to an organization unless the Secretary had entered into a contract with the organization with respect to the plan. A contract with an organization could cover more than one MedicarePlus plan. Contracts would provide that organizations agree to comply with applicable requirements and standards.

b. Minimum Enrollment Requirements. The Secretary would be prohibited from entering into a contract with a MedicarePlus organization unless the organization had at least 5,000 individuals (or 1,500 individuals in the case of a PSO) who were receiving health benefits through the organization. An exception would apply if the MedicarePlus standards (as established in new Section 1856 described above) permitted the organization to have a lesser number of beneficiaries (but not less than 500 for a PSO) if the organization primarily served individuals residing outside of urbanized areas. These lower minimum enrollment requirements relating to PSOs are effective January 1, 1998. In addition, the Secretary could waive this requirement during an organization's first 3 contract years. Minimum enrollment requirements would not apply to a contract that related only to an MSA plan.

c. Contract Period and Effectiveness. Contracts would be for at least 1 year, and could be made automatically renewable in the absence of notice by either party of intention to terminate. The Secretary could terminate a contract at any time or impose intermediate sanctions described below if the Secretary determined that the organization: (i) had failed substantially to carry out the contract; (ii) was carrying it out in a manner substantially inconsistent with the efficient and effective administration of MedicarePlus; or (iii) no longer substantially met MedicarePlus conditions. Contracts would specify their effective date, but contracts providing coverage under an MSA plan could not take effect before January 1998. The Secretary would not contract with an organization that had terminated its MedicarePlus contract within the previous 5 years, except in special circumstances as determined by the Secretary. The authority of the Secretary with respect to MedicarePlus plans could be performed without regard to laws or regulations relating to contracts of the United States that the Secretary determined were inconsistent with the purposes of Medicare.

d. Protections Against Fraud and Beneficiary Protections. Contracts would provide that the Secretary or his or her designee would have the right to inspect or otherwise evaluate the quality, appropriateness and timeliness of services, as well as the organization's facilities if there were reasonable evidence of need for such inspection; in addition, they would have the right to audit and inspect any books and records that pertain either to the ability of the organization to bear the risk of potential financial loss or to services performed or determinations of amounts payable under the contract. Contracts would also require the organization to provide and pay for advance written notice to each enrollee of a termination, along with a description of alternatives for obtaining benefits. They would also require that organizations notify the Secretary of loans and other special financial arrangements made with subcontractors, affiliates, and related parties.

MedicarePlus organizations would be required to report financial information to the Secretary, including information demonstrating that the organization was fiscally sound, a copy of the financial report filed with HCFA containing information required under Section 1124 of the Social Security Act, and a description of transactions between the organization and parties in interest. These transactions would include: (i) any sale, exchange, or leasing of property; (ii) any furnishing for consideration of goods, services, and facilities (but generally not including employees' salaries or health services provided to members); and (iii) any lending of money or other extension of credit. Financial information would be available to enrollees upon reasonable request. Consolidated financial statements could be required when the organization controls, is controlled by, or is under common control with another entity.

With respect to financial information, the term "party in interest" means: (i) any director, officer, partner, or employee responsible for management or administration of a MedicarePlus organization; any person who directly or indirectly is a beneficial owner of more than 5 percent of its equity; 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 nonprofit MedicarePlus organization, an incorporator or member of such corporation; (ii) any entity in which a person described in (i) is an officer or director; a partner; has directly or indirectly a beneficial interest in more than 5 percent of the equity; or has a mortgage, deed of trust, note, or other interest valuing more than 5 percent of the assets of the 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 (i).

e. Additional Contract Terms. Contracts would contain other terms and conditions (including requirements for information) as the Secretary found necessary and appropriate. Contracts would require payments to the Secretary for the organization's pro rata share of the estimated costs to be incurred by the Secretary relating to enrollment and dissemination of information, and for certain counseling and assistance programs. These payments would be appropriated to defray such costs and would remain available until

expended. If a contract with a MedicarePlus organization was terminated, the organization would have to notify each enrollee.

f. Prompt Payment by MedicarePlus Organization. Contracts would require a MedicarePlus organization to provide prompt payment of claims submitted for services and supplies furnished to individuals pursuant to the contract, if they are not furnished under a contract between the organization and the provider or supplier. If the Secretary determined (after notice and opportunity for a hearing) that the organization had failed to pay claims promptly, the Secretary could provide for direct payment of the amounts owed providers and suppliers. In these cases, the Secretary would reduce MedicarePlus payments otherwise made to the organization to reflect the amount of the payments and the Secretary's cost in making them.

g. Intermediate Sanctions. The Secretary would be authorized to carry out specific remedies in the event that a MedicarePlus organization: (i) failed substantially to provide medically necessary items and services required to be provided, if the failure adversely affected (or had the substantial likelihood of adversely affecting) the individual; (ii) imposed net monthly premiums on individuals that were in excess of the net monthly premiums permitted; (iii) acted to expel or refused to re-enroll an individual in violation of MedicarePlus requirements; (iv) engaged in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment (except as permitted by MedicarePlus) of eligible individuals whose medical condition or history indicates a need for substantial future medical services; (v) misrepresented or falsified information to the Secretary or others; (vi) failed to comply with rules regarding physician participation; or (vii) employed or contracted with any individual or entity that was excluded from participation in Medicare under Section 1128 or Section 1128A of the Social Security Act (relating to sanctions for program violations) for the provision of health care, utilization review, medical social work, or administrative services, or employed or contracted with any entity for the provision (directly or indirectly) through such an excluded individual or entity.

The remedies would include civil money penalties of not more than \$25,000 for each determination of a failure described above or not more than \$100,000 with respect to misrepresenting information furnished to the Secretary or denying enrollment to persons with a preexisting medical condition. In cases of the latter failure, the Secretary could also levy a \$15,000 fine for each individual not enrolled. In cases of excess premium charges, the Secretary could also recover twice the excess amount and return the excess amount to the affected individual. In addition, the Secretary could suspend enrollment of individuals and payment for them after notifying the organization of an adverse determination, until the Secretary was satisfied that the failure had been corrected and would not likely recur.

Other intermediate sanctions could be imposed if the Secretary determined that a failure had occurred other than those described above. These include: (i) civil money penalties up to \$25,000 if the deficiency directly adversely affected (or had the likelihood of adversely affecting) an individual under the organization's contract;

(ii) civil money penalties of not more than \$10,000 for each week after the Secretary initiated procedures for imposing sanctions; and (iii) suspension of enrollment until the Secretary is satisfied the deficiency had been corrected and would not likely recur.

h. Procedures for Termination. The Secretary could terminate a contract in accordance with formal investigation and compliance procedures under which (i) the Secretary provides the organization with an opportunity to develop and implement a corrective action plan, (ii) the Secretary imposes more severe sanctions on organizations that have a history of deficiencies or have not taken steps to correct those the Secretary brought to their attention, (iii) there are no unreasonable or unnecessary delays between finding a deficiency and imposing sanctions, and (iv) the Secretary provides reasonable notice and opportunity for a hearing, including the right to appeal an initial decision, before imposing any sanction or terminating the contract. The provisions of Section 1128A (other than subsections (a) and (b)) would apply to a civil money penalty in the same manner as they apply to a civil money penalty or proceeding under that section. The Secretary would be authorized not to delay termination of a contract (resulting from the formal investigation and compliance procedures) if such termination would pose an imminent and serious risk to enrollees' health.

New Section 1858. Payments to hospitals for certain costs attributable to managed care enrollees

See Sections 4008 and 4009 below.

New Section 1859. Definitions and miscellaneous provisions

Current Law. No provision.

Explanation of Provision. The provision establishes a new Section 1859 including definitions and other provisions.

Definition of MedicarePlus Organization. A MedicarePlus organization is a public or private entity that is certified under Section 1856 as meeting the MedicarePlus requirements and standards for such an organization (described above).

Definition of MedicarePlus Plan. A MedicarePlus plan is a health benefits coverage offered under a policy, contract, or plan by a MedicarePlus organization pursuant to and in accordance with a contract under Section 1857 (described above).

Definition of MSA Plan. A MSA plan is a MedicarePlus plan that (i) provides reimbursement for at least the items and services for which benefits are available under Medicare Parts A and B to individuals but only after the enrollee incurs countable expenses (as specified in the plan) equal to the amount of the annual deductible; (ii) counts as such expenses at least all amounts that would have been payable under Parts A and B or by the enrollee as deductibles, coinsurance, or copayments if the enrollee had elected to receive benefits through those parts; and (iii) provides, after the deductible is met for a year (and for all subsequent expenses referred to in (i) in the year) for a level of reimbursement that is not less than the lesser of (A) 100 percent of such expenses, or (B) 100 percent of the amount that would have been paid (without regard to any deductibles or coinsurance) under Medicare Parts A and B. For contract year 1999, the annual deductible under a MSA plan

could not be more than \$6,000. For a subsequent contract year, the annual deductible could not be more than the maximum amount for the previous contract year increased by the national per capita MedicarePlus growth percentage and rounded to the nearest multiple of \$50.

Coordinated Acute and Long-Term Care Benefits under a MedicarePlus Plan. A State would not be prevented from coordinating benefits under a Medicaid plan and a MedicarePlus plan 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 Medicare benefits under a MedicarePlus plan.

Restrictions on Enrollment for Certain MedicarePlus Plans. A MedicarePlus religious fraternal benefit society plan could restrict enrollment to individuals who are members of the church, convention, or group with which the society is affiliated. A MedicarePlus religious fraternal benefit society plan would be a MedicarePlus plan that (i) is offered by a religious fraternal benefit society only to members of the church, convention, or affiliated group, and (ii) permits all members to enroll without regard to health status-related factors. This provision could not be construed as waiving plan requirements for financial solvency. In developing solvency standards, the Secretary would take into account open contract and assessment features characteristic of fraternal insurance certificates. Under regulations, the Secretary would provide for adjustments to payment amounts under Section 1854 to assure an appropriate payment level, taking account of the actuarial characteristics and experience of the individuals enrolled in such a plan.

A religious fraternal benefit society is an organization that (i) is exempt from Federal income taxation under Section 501(c)(8) of the Internal Revenue Code; (ii) is affiliated with, carries out the tenets of, and shares a religious bond with, a church or convention or association of churches or an affiliated group of churches; (iii) offers, in addition to a MedicarePlus religious fraternal benefit society plan, at least the same level of health coverage to individuals entitled to Medicare benefits who are members of such church, convention, or group; and (iv) does not impose any limitation on membership in the society based on any health status-related factor.

Reports. (1) The Secretary would provide for a study on the feasibility and impact of removing the restriction on beneficiaries with end-stage renal disease from enrolling in a MedicarePlus MSA plan. No later than October 1, 1998, the Secretary would submit to Congress a report on this study and include recommendations regarding removing or restricting the limitation as may be appropriate. (2) No later than October 1, 1999, the Secretary would submit to Congress a report on the extent to which MedicarePlus organizations are providing payments to disproportionate share hospitals and teaching hospitals. The report would be based on information provided to the Secretary by MedicarePlus organizations as required under the requirements of this provision and such information as the Secretary may obtain.

Section 4002. Transitional rules for current Medicare HMO Program

Current Law. No provision for transition rules. Medicare's requirements for managed care plans are specified in Section 1876 of the Social Security Act. Current law requires that to be a risk contractor, no more than 50 percent of the organization's enrollees may be Medicare or Medicaid beneficiaries. The rule may be waived, however, for an organization that serves a geographic area where Medicare and Medicaid beneficiaries make up more than 50 percent of the population or (for 3 years) for an HMO that is owned and operated by a governmental entity.

Explanation of Provision. Effective for contract periods beginning after December 31, 1996, the Secretary could waive or modify the 50/50 rule to the extent the Secretary finds the waiver is in the public interest.

The provision would allow a PSO with at least 1,500 enrollees in urban areas and 500 enrollees in rural areas to qualify for a risk-sharing contract beginning on or after January 1, 1998.

The Secretary would be prohibited from entering into, renewing, or continuing any risk-sharing contract under Section 1876 for any contract year beginning on or after the date MedicarePlus standards are first established for MedicarePlus organizations that are insurers or HMOs. If the organization had a contract in effect on that date, the prohibition would be effective 1 year later. The Secretary could not enter into, renew, or continue a risk-sharing contract for any contract year beginning on or after January 1, 2000. An individual who is enrolled in Medicare Part B only and also in an organization with a risk-sharing contract on December 31, 1998, could continue enrollment in accordance with regulations issued not later than July 1, 1998.

For individuals enrolled under both Medicare Part A and Part B, payments for risk-sharing contracts for months beginning with January 1998 would be computed by substituting the MedicarePlus payment rates specified in this bill. For individuals enrolled only under Part B, the substitution would be based upon the proportion of those rates that reflects the proportion of payments under title XVIII of the Social Security Act (i.e., Medicare) attributable to Part B. With respect to months in 1998, the Secretary would compute, announce, and apply the MedicarePlus payment rates in as timely manner as possible (notwithstanding deadlines in Section 1853(a) as described above) and could provide for retroactive adjustments in risk-sharing contract payments not in accordance with those rates.

An individual who is enrolled on December 31, 1998, with an organization having a Section 1876 contract would be considered to be enrolled with that organization under MedicarePlus if the organization has a MedicarePlus contract for providing services on January 1, 1999, unless the individual had disenrolled effective that date.

Any reference in law in effect before the date of enactment of this legislation to Part C of Medicare would be deemed a reference to Part D as in effect after such date.

Not later than 90 days after enactment of this legislation, the Secretary would submit to Congress a legislative proposal provid-

ing for technical and conforming amendments as the MedicarePlus provisions require.

Required MedicarePlus organization contributions for costs related to enrollment and dissemination of information would apply to demonstrations if their enrollment were effected or coordinated under Section 1851.

In order to carry out the MedicarePlus provisions in a timely manner, the Secretary could (after notice and opportunity for public comment) promulgate regulations that take effect on an interim basis.

Section 4003. Conforming changes in Medigap Program

Current Law. Current law contains rules regarding the sale of Medicare supplement policies (generally referred to as “Medigap” policies). Included are prohibitions governing the sale of duplicative policies and exceptions to the general prohibitions.

Explanation of Provision. The provision would include conforming language to the duplication provisions for persons electing a MedicarePlus plan. Included in the general prohibitions would be a general prohibition against selling to a person electing a MedicarePlus plan a Medicare supplemental policy with the knowledge that it duplicated benefits to which the individual was otherwise entitled to under Medicare or another supplemental policy. The provision would further specify that a MedicarePlus policy is not included within the definition of a Medicare supplementary policy.

The provision would prohibit the sale of certain policies to a person electing a high deductible plan. Specifically, the prohibition would apply to the sale of policies providing coverage for expenses that are otherwise required to be counted toward meeting the annual deductible amount provided under a medical savings account (MSA) plan.

SUBCHAPTER B—SPECIAL RULES FOR MEDICAREPLUS MEDICAL SAVINGS ACCOUNTS

Section 4006. MedicarePlus MSA.

Current Law. Under present law, the value of Medicare coverage and benefits is not includable in taxable income.

Individuals who itemize deductions may deduct amounts paid during the taxable year (if not reimbursed by insurance or otherwise) for medical expenses of the taxpayer and the taxpayer’s spouse and dependents (including expenses for insurance providing medical care) to the extent that the total of such expenses exceeds 7.5 percent of the taxpayer’s adjusted gross income (“AGI”).

Within limits, contributions to a medical savings account (“MSA”) are deductible in determining AGI if made by an eligible individual and are excludable from gross income and wages for employment tax purposes if made by the employer of an eligible individual.¹ Individuals covered under Medicare are not eligible to have an MSA.

Earnings on amounts in an MSA are not currently includable in income. Distributions from an MSA for medical expenses of the

¹The number of MSAs which can be established is subject to a cap.

MSA account holder and his or her spouse or dependents are not includable in income. For this purpose, medical expenses are defined as under the itemized deduction for medical expenses, except that medical expenses do not include any insurance premiums other than premiums for long-term care insurance, continuation coverage (so-called “COBRA coverage”), or premiums for coverage while an individual is receiving unemployment compensation. Distributions not used for medical expenses are subject to an additional 15 percent tax unless the distribution is made after age 65, death, or disability.

Under present law, there are no provisions for MedicarePlus medical savings accounts (“MedicarePlus MSAs”).

Explanation of provision. Under the bill, individuals who are eligible for Medicare are permitted to choose either the traditional Medicare program or a MedicarePlus MSA plan. To the extent an individual chooses such a plan, the Secretary of Health and Human Services makes a specified contribution directly into a MedicarePlus MSA designated by such individual. Only contributions by the Secretary of Health and Human Services can be made to a MedicarePlus MSA and such contributions are not included in the taxable income of the MedicarePlus MSA holder. Income earned on amounts held in a MedicarePlus MSA are not currently includable in taxable income. Withdrawals from a MedicarePlus MSA are excludable from taxable income if used for the qualified medical expenses of the MedicarePlus MSA holder. Withdrawals from a MedicarePlus MSA that are not used for the qualified medical expenses of the account holder are includable in income and may be subject to an additional tax (described below).

Definition of MedicarePlus MSAs. In general a MedicarePlus MSA is an MSA that is designated as MedicarePlus MSA and to which only the contribution that can be made are those by the Secretary of Health and Human Services.² Thus a MedicarePlus MSA is a tax-exempt trust (or a custodial account) created exclusively for the purpose of paying the qualified medical expenses of the account holder that meets requirements similar to those applicable to individual retirement arrangements (“IRAs”).³ The trustee of a MedicarePlus MSA can be a bank, insurance company, or other person that demonstrates to the satisfaction of the Secretary of the treasury that the manner in which such person will administer the trust will be consistent with applicable requirements.

A MedicarePlus MSA trustee would be required to make such reports as may be required by the Secretary of the Treasury. A \$50 penalty would be imposed for each failure to file without reasonable cause.

Taxation of distributions from a MedicarePlus MSA. Distributions from a MedicarePlus MSA that are used to pay the qualified medical expenses of the account holder would be excludable from

² Medicare Plus MSAs are not taken into account for purposes of the cap on non-MedicarePlus MSAs, nor are they subject to that cap.

³ For example, no MedicarePlus MSA assets could be invested in life insurance contracts, MedicarePlus MSA assets could not be commingled with other property except in a common trust fund or common investment fund, and an account holder's interest in a MedicarePlus MSA would be nonforfeitable. In addition, if an account holder engages in a prohibited transaction with respect to a MedicarePlus MSA or pledges assets in a MedicarePlus MSA, rules similar to those for IRAs would apply, and any amounts treated as distributed to the account holder under such rules would be treated as not used for qualified medical expenses.

taxable income regardless of whether the account holder is enrolled in the MedicarePlus MSA plan at the time of the distribution.⁴ Qualified medical expenses are defined as under the rules relating to the itemized deduction for medical expenses. However, for this purpose, qualified medical expenses would not include any insurance premiums other than premiums for long-term care insurance, continuation insurance (so-called “COBRA coverage”), or premium for coverage while an individual is receiving unemployment compensation. Distributions from a MedicarePlus MSA that are excludable from gross income under the provision can not be taken into account for purposes of the itemized deduction for medical expenses.

Distributions for purposes other than qualified medical expenses are includable in taxable income. An additional tax of 50 percent applies to the extent the total distributions for purposes other than qualified medical expenses in a taxable year exceed the amount by which the value of the MedicarePlus MSA as of December 31, of the preceding taxable year exceeds 60 percent of the deductible of the plan under which the individual is covered. The additional tax does not apply to distributions on account of the disability or death of the account holder. Direct trustee-to-trustee transfers could be made from one MedicarePlus MSA to another MedicarePlus MSA without income inclusion.

The provision includes a corrective mechanism so that if contributions for a year are erroneously made by the Secretary of Health and Human Services, such erroneous contributions can be returned to the Secretary of Health and Human Services (along with any attributable earnings) from the MedicarePlus MSA without tax consequence to the account holder.

Treatment of MedicarePlus MSA at death. If the beneficiary of a MedicarePlus MSA is not the account holder’s spouse, the MedicarePlus MSA is no longer treated as a MedicarePlus MSA and the value of the MedicarePlus MSA on the account holder’s date of death is included in the taxable income of the beneficiary for the taxable year in which the death occurred (under the rules applicable to MSAs generally). If the account holder fails to name a beneficiary, the value of the MedicarePlus MSA on the account holder’s date of death is to be included in the taxable income of the account holder’s final income tax return (under the rules applicable to MSA generally).

In all cases, the value of the MedicarePlus MSA is included in the account holder’s gross estate for estate tax purposes.

Reason for Change. The Committee believes that introduction of significant innovations from the private sector, coupled with the full transfer of responsibility for health care choices to enrollees who choose to participate in private sector health plans, will be effective in tempering the growth of Medicare spending while providing opportunities for beneficiaries to improve upon the traditional government-defined Medicare benefit package. In addition, the Committee believes that senior citizens should be provided with greater power over their own health care choices and expenses.

⁴Under the provision, medical expenses of the account holder’s spouse or dependents would not be treated as qualified medical expenses.

Effective Date. The provision is effective with respect to taxable years beginning after December 31, 1998.

SUBCHAPTER C—GME, IME, DSH PAYMENTS FOR MANAGED CARE ENROLLEES

Section 4008.—Graduate medical education and indirect medical education payments for managed care enrollees

Current Law. Medicare payments to risk-contract HMOs include amounts that reflect Medicare's fee-for-service payments to hospitals in an area for indirect and direct graduate medical education (GME) costs.

Explanation of the Provision. The provision inserts a new subsection (h) into Section 1853 (see above) providing for payments to certain managed care organizations.

(a) *Payments to Medicare managed care organizations.* The proposal would provide a mechanism for the allocation of payments for direct Graduate Medical Education (GME), Indirect Medical Education (IME) and disproportionate share hospitals (DSH) costs carved out from the AAPCCs and MedicarePlus capitation rates to be made to risk contract plans under Section 1876 and MedicarePlus organizations (i.e., Medicare managed care organizations). Beginning January 1, 1998, each contract with a MedicarePlus organization would be required to provide an additional payment for Medicare's share of allowable direct GME costs incurred by the organization for an approved medical residency program. A MedicarePlus organization that incurred all or substantially all of the costs of the medical residency program would receive a payment equal to the national average per resident amount times the number of full-time-equivalent (FTE) residents in the program in non-hospital settings. The Secretary would be required to estimate the national average per resident amount equal to the weighted average amount that would be paid per FTE resident under the direct GME payment in a calendar year. A separate determination would be required to be made for primary care residency programs as defined by Medicare, including obstetrics and gynecology residency programs.

(b) Part C of Medicare, as amended by Section 4001 of this provision, would be amended by inserting a new section 1858, "Payments to Hospitals for Certain Costs Attributable to Managed Care Enrollees."

Payments to Hospitals. The Secretary would be required to make additional payments for the direct GME costs to PPS hospitals and hospitals located in a State with a State hospital reimbursement control system for services furnished to Medicare beneficiaries enrolled in managed care. These payments would be phased in over 5 years in the same proportion as amounts are deducted (carved out) from Medicare managed care plans under the new Section 1853 established by this provision (see above). Total payments under this provision could not exceed amounts deducted (carved out) of the MedicarePlus capitation rates. Subject to certain limits, the direct GME payment amount would be equal to the product of: (1) the aggregate approved amount of direct GME payments for the period, and (2) the fraction of the total number of inpatient-bed-

days determined by the Secretary during the period which was attributable to Medicare managed care enrollees. The Secretary would be required to separately determine the direct GME payment amounts that would be paid to hospitals in a State with a reimbursement control system.

The IME payment amount would be determined, subject to certain limits, as equal to the product of: (1) the amount of the IME adjustment factor applicable to the hospital under PPS, and (2) the product of (i) the number of discharges attributable to Medicare managed care enrollees and (ii) the estimated average per discharge amount that would otherwise have been paid under PPS if the individuals had not been enrolled in a managed care plan. The Secretary would also be required to make payments for the costs attributable to Medicare managed care enrollees, subject to certain limits in the same way as the direct GME payment amount. The Secretary would be required to separately determine the IME payment amounts that would be paid to hospitals in a State with a reimbursement control system.

As rates paid to MedicarePlus organizations are being reduced to allow for the direct payment to hospitals for the direct and indirect costs of graduate medical education and disproportionate share hospital payments, it is the intent of the Committee that rates charged to MedicarePlus organizations by hospitals who receive such direct payments shall be reduced by the amount of such payments. In other words, it is the intent of the Committee that health plan will be able to negotiate new contracts with lower payment rates with academic medical centers and disproportionate share hospitals to offset the reduction in AAPCC payments due to the "carve out" of GME, IME, and DSH.

Section 4009. Disproportionate share hospital payments for managed care enrollees

Current Law. Medicare payments to risk-contract HMOs include amounts that reflect Medicare's fee-for-service payments to hospitals in an area for disproportionate share adjustment.

Explanation of Provision. The provision would require the Secretary to provide additional payments for PPS hospitals and hospitals in a State with a State hospital reimbursement control system for hospitals that furnish services to Medicare risk plan enrollees under Section 1876 and MedicarePlus enrollees (i.e., Medicare managed care enrollees). These payments would be phased in over 5 years in the same proportion as amounts are deducted (carved out) from Medicare managed care plans under the new Section 1853 established by this provision (see above). Subject to certain limits, the DSH payment would be equal to the product of (1) the DSH adjustment factor that would be attributable to the hospital under PPS, and (2) the product of: (i) the aggregate approved amount of direct GME for the hospital during that period, and (ii) the fraction of the total number of inpatient-bed days attributable to Medicare managed care. The Secretary would be required to separately determine the DSH payment amount that would be paid to hospitals in a State with a reimbursement control system.

Chapter 2—Integrated Long-Term Care Programs

SUBCHAPTER A—PROGRAMS OF ALL-INCLUSIVE CARE FOR THE
ELDERLY (PACE)*Section 4011–4014. Coverage of PACE under the Medicare Program*

Current Law. OBRA 86 required the Secretary to grant waivers of certain Medicare and Medicaid requirements to not more than 10 public or non-profit private community-based organizations to provide health and long-term care services on a capitated basis to frail elderly persons at risk of institutionalization. These projects, known as the Programs of All Inclusive Care for the Elderly, or PACE projects, were intended to determine whether an earlier demonstration program, ON LOK, could be replicated across the country. OBRA 90 expanded the number of organizations eligible for waivers to 15.

Explanation of Provision. The provision would repeal current ON LOK and PACE project demonstration waiver authority and establish in Medicare law PACE as a permanent benefit category eligible for coverage and reimbursement under the Medicare program. PACE providers would offer comprehensive health care services to eligible individuals in accordance with a PACE program agreement and regulations. In general, PACE providers would be public or private nonprofit entities, except for entities (up to 10) participating in a demonstration to test the operation of a PACE program by private, for-profit entities.

The Secretary would be required to make prospective monthly capitation payments for each PACE program enrollee in the same manner and from the same sources as payments are made to a MedicarePlus organization. The amount would be adjusted to take into account the comparative frailty of PACE enrollees and such other factors as the Secretary determines to be appropriate. The total payment level for all PACE program enrollees would be required to be less than the projected payment under Medicare for a comparable population not enrolled in PACE.

For purposes of carrying out a PACE program, certain Medicare requirements would be waived, including those pertaining to limits on coverage of institutional services, rules for payment for benefits, limits on coverage of SNF and home health services, the 3-day prior hospitalization requirement for SNF care, and other coverage rules.

The Secretary would be required to promulgate regulations for PACE in a timely manner so that entities may establish and operate PACE programs under Medicare and Medicaid beginning not later than 1 year after enactment.

During the transition from demonstration waiver authority to permanent provider status, applications for waivers (subject to the numerical limitation) would be deemed approved unless the Secretary, within 90 days after the date of submission, either denies the request in writing or informs the applicant in writing that additional information is needed. After the date the Secretary receives the additional information, the application would be deemed approved unless the Secretary, within 90 days, denies the request.

During the 3-year period beginning on the date of enactment, the Secretary would be required to give priority, in processing applications of entities seeking to qualify as PACE programs under Medicare or Medicaid (1) first, to entities that are operating a PACE demonstration waiver program, (2) then, to entities that have applied to operate a program as of May 1, 1997. In awarding additional waivers under the original PACE demonstration authority, the Secretary would be required to give priority to any entities that have applied for a waiver as of May 1, 1997, and to any entity that, as of May 1, 1997, has formally contracted with a State to provide services on a capitation basis with an understanding that the entity was seeking to become a PACE provider. The Secretary would be required to give special consideration, in the processing of applications for PACE provider status and for demonstration waivers, to entities which, as of May 1, 1997, have indicated through formal activities (such as entering into contracts for feasibility studies) a specific intent to become a PACE provider. Repeal of waiver demonstration authority would not apply to waivers granted before the initial effective date of regulations. Repeals would apply to waivers granted before this date only after allowing organizations a transition period (of up to 24 months) in order to permit sufficient time for an orderly transition from demonstration project authority to general authority.

The Secretary (in close consultation with States) would be required to conduct a study of the quality and cost of providing PACE program services under the Medicare and Medicaid programs. This study would be required specifically to compare the costs, quality, and access to services offered by private for-profit entities operating under the new demonstration described above with the costs, quality, and access to services of other PACE providers. The Secretary would be required to report to Congress on findings of the study (including specific finding on private for-profit providers), together with recommendations for changes, not later than 4 years after enactment. The Medicare Payment Evaluation Commission would be required to include in its annual report to Congress recommendations on the methodology and level of payments made to PACE providers and on the treatment of private for-profit PACE providers.

The provision would also establish PACE as a State option under Medicaid. See Medicaid, Title III, Subtitle E for description.

SUBCHAPTER B—SOCIAL HEALTH MAINTENANCE ORGANIZATIONS
(SHMOS)

Section 4015. Social Health Maintenance Organizations (SHMOs).

Current Law. The Deficit Reduction Act of 1984 required the Secretary to grant 3-year waivers for demonstrations of social health maintenance organizations (SHMOs) which provide integrated health and long-term care services on a prepaid capitation basis. The waivers have been extended on several occasions since then and a second generation of projects was authorized by OBRA 90.

Explanation of Provision. The provision would require the Secretary to extend waivers for SHMOs through December 31, 2000, and to submit a final report on the projects by March 31, 2001. The limit on the number of persons served per site would be expanded

from 12,000 to 36,000. The Secretary would also be required to submit to Congress by January 1, 1999, a plan, including an appropriate transition, for the integration of health plans offered by first and second generation SHMOs and similar plans into the MedicarePlus program. The report on the plan would be required to include recommendations on appropriate payment levels for SHMO plans, including an analysis of the extent to which it is appropriate to apply the MedicarePlus risk adjustment factors to SHMO populations.

SUBCHAPTER C—OTHER PROGRAMS

Section 4018. Orderly transition of Municipal Health Service Demonstration Projects

Current Law. Under a general demonstration authority, the Health Care Financing Administration began waiving in the late 1970s certain Medicare requirements to conduct the Municipal Health Services Demonstration. This project has been conducted in four cities—Baltimore, Cincinnati, Milwaukee, and San Jose. As originally conceived, the project was intended to encourage the use of municipal health centers, in place of more costly hospital emergency rooms and outpatient departments, by eliminating coinsurance and deductibles, expanding the range of covered services, and paying the cities the full cost of delivering services at the clinics. Waivers have been extended several times since the inception of the project by budget reconciliation bills.

Explanation of Provision. The provision would extend the demonstration through December 31, 2000, but only with respect to persons enrolled in the projects before January 1, 1998. The Secretary would be required to work with each demonstration project to develop a plan, to be submitted to the House Ways and Means and Senate Finance Committees by March 31, 1998, for the orderly transition of projects and project enrollees to a non-demonstration health plan, such as a Medicaid managed care or MedicarePlus plan. A demonstration project which does not develop and submit a transition plan by March 31, 1998 or within 6 months after enactment of the Act, whichever is later, would be discontinued as of December 31, 1998. The Secretary would be required to provide appropriate technical assistance to assist in the transition so that disruption of medical services to project enrollees would be minimized.

Section 4019. Community Nursing Organization Demonstration Projects

Current Law. OBRA 87 required the Secretary to conduct demonstration projects to test a prepaid capitated, nurse-managed system of care. Covered services include home health care, durable medical equipment, and certain ambulatory care services. Four sites (Mahomet, Illinois; Tucson, Arizona; New York, New York; and St. Paul, Minnesota) were awarded contracts in September 1992, and represent a mix of urban and rural sites and different types of health provider, including a home health agency, a hospital-based system, and a large multi-specialty clinic. The community nursing organization (CNO) sites completed development ac-

tivities and implemented the demonstration in January 1994, with service delivery beginning February 1994.

Explanation of Provision. The provision would extend the CNO demonstration for an additional period of 2 years, and the deadline for the report on the results of the demonstration would be not later than 6 months before the end of the extension.

Chapter 3—Medicare Payment Advisory Commission

Section 4021. Medicare Payment Advisory Commission

Current Law. The Prospective Payment Assessment Commission (ProPac) was established by Congress through the Social Security Act Amendments of 1983 (P.L. 98-21). The Commission is charged with reporting each year its recommendation of an update factor for PPS payment rates and for other changes in reimbursement policy. It is also required each year to submit a report to Congress which provides background information on trends in health care delivery and financing. The Physician Payment Review Commission (PPRC) was established by the Congress through the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272). It was charged with advising and making recommendations to the Congress on methods to reform payment to physicians under the Medicare program. In subsequent laws, Congress mandated additional responsibilities relating to the Medicare and Medicaid programs as well as the health care system more generally.

The law specified that both Commissions were to be appointed by the Director of the Office of Technology Assessment and funded through appropriations from the Medicare trust funds. In 1995, the Office of Technology Assessment was abolished. In May 1997, P.L. 105-13 was enacted; this legislation extended the terms of those Commission members whose terms were slated to expire in 1997 to May 1, 1998.

Explanation of Provision. The provision would establish the Medicare Payment Advisory Commission (hereafter referred to as the Commission) to review and make recommendations to Congress concerning payment policies under Medicare. The Commission would be required to submit a report to Congress by March 1 of each year (beginning in 1998) containing the results of its reviews of payment policies and its recommendations concerning such policies and an examination of issues affecting the Medicare program.

The Commission would be charged with the following specific review responsibilities with respect to the MedicarePlus program: (1) the methodology for making payments to the plans, including the making of differential payments and the distribution of differential updates among different payment areas; (2) the risk adjustment mechanisms and the need to adjust such mechanisms to take into account health status; (3) the implications of risk selection among MedicarePlus organizations and between the MedicarePlus option and the Medicare fee-for-service option; (4) in relation to payment under MedicarePlus, the development and implementation of quality assurance mechanisms for those enrolled with MedicarePlus organizations; (5) the impact of the MedicarePlus program on beneficiary access to care; (6) the appropriate role for Medicare in addressing the needs of individuals with chronic illnesses; and (7)

other major issues in implementation and further development of the MedicarePlus program.

In addition, the Commission would be required to review payments policies under Medicare Parts A and B fee-for-service system, including: (1) factors affecting expenditures in different sectors, including the process for updating hospital, skilled nursing facility, physician, and other fees; (2) payment methodologies; and (3) the relationship of payment policies to access and quality of care. It would also review the effect of Medicare payment policies on the delivery of health care services not provided under Medicare and assess the implications of changes in the health services market on Medicare.

The Commission would be required to evaluate required reports on payment policies submitted by the Secretary to Congress (or a committee of Congress). The Commission would be required to submit a report on the evaluation within 6 months of the Secretary's report. The commission would also be required to consult with the Chairmen and ranking Members of the appropriate committees of Congress (House Ways and Means, House Commerce, and Senate Finance) regarding its agenda. The Commission would be authorized to submit from time to time other reports as requested by such Chairmen and Members and as it deemed appropriate. The reports would be made public.

The Commission would be composed of 11 members appointed by the Comptroller General, with the first appointments being made by September 30, 1997. These members would have to meet specific qualifications (such as national recognition for their expertise). Commission membership would consist of a broad mix of different professionals, a broad geographic representation, and a balance between urban and rural representatives. It would include representatives of consumers and the elderly. Health care providers could not constitute a majority of the membership. Commissioners would serve for 3-year staggered terms. The provision would include a mechanism for filling vacancies, compensating commissioners, appointing a chair and vice chair; convening meetings; and providing for the executive director and other staff, experts, and consultants. The Commission would be authorized to secure directly from any department or agency information to carry out these provisions. It would be required to collect and assess information (which would be available on an unrestricted basis to GAO). The Commission would be subject to periodic audit by GAO.

The provision would require the Commission to submit appropriations requests in the same manner as the Comptroller General does; however, the amounts appropriated for each would be separate. It would authorize such sums as may be necessary to be appropriated from the Medicare trust funds (60 percent from Part A and 40 percent from Part B).

The Commission would require that the Comptroller first provide for appointment of members of the Commission (to be known as MedPAC) by not later than September 30, 1997. As quickly as possible after they were first appointed, the Comptroller General (in consultation with ProPac and PPRC) would provide for termination of these entities. As of that date, ProPac and PPRC would be abolished. To the extent possible, the Comptroller General would be re-

quired to provide for the transfer to the new commission assets and staff of the former commissions without any loss of benefits or seniority by virtue of such transfers. Fund balances available to the former commissions would be transferred to the new commission. MedPAC would be responsible for the preparation and submission of reports required by law to be submitted (and which had not been submitted by the time it was established) by the former commissions.

Chapter 4—Medigap Protections

Section 4031. Medigap protections

Current Law. Medigap is the term used to describe individually-purchased Medicare supplement policies. In 1990, Congress provided for a standardization of Medigap policies; the intention was to enable consumers to better understand policy choices. Implementing regulations generally limit the number of different types of Medigap plans that can be sold in a State to no more than 10 standard benefit plans; these are known as Plans A through J. The Plan A standardized package covers a basic benefits package. Each of the other nine plans includes the basic benefits plus a different combination of additional benefits.

All insurers offering Medigap policies are required to offer a 6-month open enrollment period for persons turning age 65. This is known as guaranteed open enrollment. There is no guaranteed open enrollment provision for the under-65 disabled population.

At the time insurers sell a Medigap policy, whether or not during an open enrollment period, they are permitted to limit or exclude coverage for services related to a preexisting health condition; such exclusions cannot be imposed for more than 6 months. An individual who has met the preexisting condition limitation in one Medigap policy does not have to meet the requirement under a new policy for previously covered benefits. However, an insurer could impose exclusions for newly covered benefits.

Federal requirements for open enrollment and limits on preexisting condition exclusions are designed to insure beneficiaries have access to Medigap protection. However, persons who disenroll (or wish to disenroll) from managed care plans and move back into fee-for-service Medicare may not have the same access to Medigap coverage as those who join during the open enrollment period.

Explanation of Provision. The provision would guarantee issuance of a Medigap “A”, “B”, “C”, or “F” policy without a pre-existing condition exclusion for certain continuously covered individuals. The insurer also would be prohibited from discriminating in the pricing of such policy on the basis of the individual’s health status, claims experience, receipt of health care, or medical condition.

The provision would specify those persons covered under the guaranteed issuance provision. They include:

Individuals enrolled under an employee welfare benefit plan that provides benefits supplementing Medicare and the plan terminates or ceases to provide such benefits.

Persons enrolled with a MedicarePlus organization who discontinue under circumstances permitting disenrollment other than during an annual election period. (These include: (1) the

termination of the entity's certification, (2) the individual moves outside of the entity's service area; or (3) the individual elects termination due to cause.)

Persons enrolled with a risk or cost contract HMO, a similar organization operating under a demonstration project authority, a Medicare SELECT policy, and enrollment ceases for the reasons noted above, and in the case of a SELECT policy, there is no applicable provision in State law for continuation of such coverage.

Individuals enrolled under a Medigap policy and enrollment ceases because of the bankruptcy or insolvency of the issuer, or because of other involuntary termination of coverage and there is no provision under applicable State law for the continuation of such coverage.

The guaranteed issue provision would also apply to an individual who: (1) was enrolled under a Medigap policy; (2) subsequently terminates such enrollment and enrolls with a MedicarePlus organization, a risk or cost contract HMO, a similar organization operating under a demonstration project authority, or a Medicare SELECT policy; and (3) terminates such enrollment within 6 months (or within 3 months beginning in 2003), but only if the individual was never previously enrolled with such an entity. The guarantee would also apply to persons who terminate such first time enrollment (occurring in 2002 or later) during the next coordinated annual coordinated election period. At the time of the event which results in the cessation of enrollment or loss of coverage, the organization, insurer, or plan administrator (whichever is appropriate) would notify the individual of his or her rights and the obligations of issuers of Medigap policies. The individual must seek to enroll under the Medigap "A", "B", "C", or "F" policy not later than 63 days after termination of other enrollment and provide evidence of the date of termination or disenrollment along with the application for such Medicare supplemental policy. Individuals who re-enroll with a Medigap plan after the one time test of MedicarePlus could re-enroll in the same Medigap policy (if still available from the same issuer) as they had before trying MedicarePlus.

The provision would limit the application of a preexisting condition exclusion during the initial 6-month open enrollment period. Specifically, such an exclusion could not be imposed on an individual who, on the date of application, had a continuous period of at least 6 months of health insurance coverage defined as "creditable coverage" under the Health Insurance Portability and Accountability Act (HIPAA). If the individual had less than 6 months coverage, the policy would reduce the period of any pre-existing exclusion by the aggregate of periods of "creditable coverage" applicable to the individual as of the enrollment date. The rules used to determine the reduction would be based on rules used under HIPAA.

The provision would give the National Association of Insurance Commissioners (NAIC) 9 months to modify its regulations to conform to the new requirements. If the NAIC, did not make the changes within this time, the Secretary would make the appropriate modification in the regulations.

The provision would be effective July 1, 1998. In general, a State would not be deemed out of compliance due solely to failure to make changes before 1 year after the date the NAIC or Secretary made changes in its regulations. A longer time may be permitted if a State requires legislation.

Section 4032. Medicare prepaid competitive pricing demonstration project

Current Law. Under Section 402 of the Social Security Amendments of 1967 (P.L. 90-248, 42 U.S.C. 1395b-1), the Secretary is authorized to develop and engage in experiments and demonstration projects for specified purposes, including to determine whether, and if so, which changes in methods of payment or reimbursement for Medicare services, including a change to methods based on negotiated rates, would have the effect of increasing the efficiency and economy of such health services. Under this authority, HCFA is seeking to demonstrate the application of competitive bidding as a method for establishing payments for risk contract HMOs in the Denver area. HCFA's actions have been challenged in the courts.

Explanation of Provision. The provision requires the Secretary of HHS to provide for a demonstration of competitive pricing for private health plans participating in Medicare.

a. Establishment of Project. The Secretary would be required to provide, no later than one year after enactment, for implementation of a project to demonstrate the application of, and the consequences of applying, a market-oriented pricing system for the provision of a full range of Medicare benefits in several geographic areas.

b. Research Design Advisory Committee. Before implementing the project, the Secretary would be required to appoint a national advisory committee, including independent actuaries and individuals with expertise in competitive health plan pricing, to recommend to the Secretary the appropriate research design for implementing the project, including the method for area selection, benefit design among plans offered, structuring choice among health plans offered, methods for setting the price to be paid to plans, collection of plan information, information dissemination, and methods of evaluating the results of the project. Upon implementation of the project, the Committee would continue to advise the Secretary on the application of the design in different areas and changes in the project based on experience with its operations.

c. Area Selection. Taking into account the national advisory committee's recommendations, the Secretary would be required to designate demonstration areas. Upon such designation, the Secretary would be required to appoint an area advisory committee, composed of representatives of health plans, providers, and beneficiaries in each demonstration area. The committee could advise the Secretary on marketing and pricing of plans in the area, and other relevant factors.

d. Monitoring and Report. Taking into considerations the recommendations of the advisory committee (established under (b)), the Secretary would be required to closely monitor the impact of projects in areas on the price and quality of, and access to, Medi-

care covered services, choice of plans, changes in enrollment, and other relevant factors. The Secretary would be required to periodically report to Congress on project progress.

e. Waiver Authority. The provision authorizes the Secretary to waive such requirements of Section 1876 (relating to Medicare risk, cost, and HCPP plans) and of MedicarePlus as may be needed to carry out the demonstration project.

f. Denver Demonstration. Except as specified above, the Secretary would be prohibited from conducting or continuing any ongoing demonstration project (i.e., the Denver demonstration) designed to demonstrate competitive bidding as an alternative to paying plans on the basis of the AAPCCs (as specified under current law) or the Medicare Plus capitation rates (as established under new Section 1853 of the provision).

SUBTITLE B—PREVENTION INITIATIVES

Section 4101. Screening mammography

Current Law. Medicare provides coverage for screening mammograms. Frequency of coverage is dependent on the age and risk factors of the woman. For women ages 35–39, one test is authorized. For women ages 40–49, a test is covered every 24 months, except, an annual test is authorized for women at high risk. Annual tests are covered for women ages 50–64. For women aged 65 and over, the program covers one test every 24 months. Medicare's Part B deductible and coinsurance apply for these services.

Explanation of provision. The proposal would authorize coverage for annual mammograms for all women ages 40 and over. It would also waive the deductible for screening mammograms. These provisions would be effective January 1, 1998.

Section 4102. Screening pap smear and pelvic exams

Medicare covers a screening Pap smear once every 3 years for purposes of early detection of cervical cancer. The Secretary is permitted to specify a shorter time period in the case of women at high risk of developing cervical cancer.

Explanation of provision. The provision would authorize coverage, every 3 years, for a screening pelvic exam which would include a clinical breast examination. It would modify the purpose of Pap smears to include early detection of vaginal cancer.

The provision would specify that for both Pap smears and screening pelvic exams, coverage would be authorized on a yearly basis for women at high risk of developing cervical or vaginal cancer (as determined pursuant to factors identified by the Secretary). Coverage would also be authorized on a yearly basis for a woman of childbearing age who had not had a test in each of the preceding 3 years that did not indicate the presence of cervical or vaginal cancer. The provision would waive the deductible for screening Pap smears and screening pelvic exams. The provisions would be effective January 1, 1998.

The provision would require the Secretary, within 6 months of enactment, to submit a report to Congress on the extent to which the use of supplemental computer-assisted diagnostic tests (consisting of interactive automated computer imaging of an exfoliative cy-

tology test) in conjunction with pap smears improves the early detection of cervical or vaginal cancer. The report must also consider cost implications.

Section 4103. Prostate cancer screening tests

Current law. Medicare does not cover prostate cancer screening tests.

Explanation of provision. The provision would authorize an annual prostate cancer screening test for men over age 50. The test could consist of any (or all) of the following procedures: (1) a digital rectal exam; (2) a prostate-specific antigen blood test; and (3) after 2001, other procedures as the Secretary finds appropriate for the purpose of early detection of prostate cancer, taking into account such factors as changes in technology and standards of medical practice, availability, effectiveness, and costs.

The provision would specify that payment for prostate-specific antigen blood tests would be made under the clinical laboratory fee schedule. The provisions would be effective January 1, 1998.

Section 4104. Coverage of colorectal screening

Current law. Medicare does not cover preventive colorectal screening procedures. Such services are covered only as diagnostic services.

Explanation of provision. The provision would authorize coverage of colorectal cancer screening tests. A test covered under the provision would be any of the following procedures furnished for the purpose of early detection of colorectal cancer: (1) screening fecal-occult blood test; (2) screening flexible sigmoidoscopy; (3) screening colonoscopy for a high-risk individual; (4) screening barium enema, if found by the Secretary to be an appropriate alternative to screening flexible sigmoidoscopy or screening colonoscopy; and (5) after 2002, other procedures as the Secretary finds appropriate for the purpose of early detection of colorectal cancer, taking into account such factors as changes in technology and standards of medical practice, availability, effectiveness, and costs. A high-risk individual (for purposes of coverage for screening colonoscopy) would be defined as one who faces a high risk for colorectal cancer because of family history, prior experience of cancer or precursor neoplastic polyps, a history of chronic digestive disease condition (including inflammatory bowel disease, Crohn's disease or ulcerative colitis), the presence of any appropriate recognized gene markers, or other predisposing factors. The Secretary would be required to make a decision with respect to coverage of screening barium enema tests within 2 years of enactment; the determination would be published.

The provision would establish frequency and payment limits for the tests. For screening fecal-occult blood tests, payment would be made under the lab fee schedule. In 1998, the payment amount could not exceed \$5; in future years the update would be limited to the update applicable under the fee schedule. Medicare could not make payments if the test were performed on an individual under age 50 or within 11 months of a previous screening fecal-occult blood test.

The provision would require the Secretary to establish a payment amount under the physician fee schedule for screening flexible

sigmoidoscopies that is consistent with payment amounts for similar or related services. The payment amount could not exceed the amount the Secretary specifies, based upon the rates recognized for diagnostic flexible sigmoidoscopy services. For services performed in ambulatory surgical centers or hospital outpatient departments, the payment amount could not exceed the lesser of the payment rate that would apply to such services if they were performed at either site. Medicare could not make payments for a screening flexible sigmoidoscopy if the test were performed on an individual under age 50 or within 47 months of a previous screening flexible sigmoidoscopy.

The provision would require the Secretary to establish a payment amount under the physician fee schedule for screening colonoscopy for high risk individuals that is consistent with payment amounts for similar or related services. The payment amount could not exceed the amount the Secretary specifies, based upon the rates recognized for diagnostic colonoscopy services. For services performed in ambulatory surgical centers or hospital outpatient departments, the payment amount could not exceed the lesser of the payment rate that would apply to such services if they were performed at either site. Medicare could not make payments if the test were performed on a high-risk individual within 23 months of a previous screening colonoscopy.

The provision would establish special payment rules, in the case of both a screening flexible sigmoidoscopy or screening colonoscopy, if a lesion or growth is discovered during the procedure which results in a biopsy or removal of the lesion or growth during the procedure. In these cases, payment would be made for the procedure classified as either a flexible sigmoidoscopy with such biopsy or removal or screening colonoscopy with such biopsy or removal.

The provision would require the Secretary to review from time to time the appropriateness of the amount of the payment limit for fecal-occult blood tests. The Secretary could, beginning after 2000, reduce the amount of the limit as it applies nationally or in a given area to the amount the Secretary estimates is required to assure that such tests of an appropriate quality are readily and conveniently available.

The provision would require the Secretary to review periodically the appropriate frequency for performing colorectal cancer screening tests based on age and other factors the Secretary believes to be pertinent. The Secretary may revise from time to time the frequency limitations, but no revisions could occur before January 1, 2001.

Nonparticipating physicians providing screening flexible sigmoidoscopies or screening colonoscopies for high risk individuals would be subject to limiting charge provisions applicable for physicians services. The Secretary could impose sanctions if a physician or supplier knowingly and willfully imposed a charge in violation of this requirement.

The provision would require the Secretary to establish payment limits and frequency limits for screening barium enema tests if the Secretary issues a determination that such tests should be covered. Payment limits would be consistent with those established for diagnostic barium enema procedures.

The provisions would be effective January 1, 1998.

Section 4105. Diabetes screening tests

Current law. In general, Medicare covers only those items and services which are medically reasonable and necessary for the diagnosis or treatment of illness or injury. In addition, Medicare covers home blood glucose monitors and associated testing strips for certain diabetes patients. Home blood glucose monitors enable diabetics to measure their blood glucose levels and then alter their diets or insulin dosages to ensure that they are maintaining an adequate blood glucose level. Home glucose monitors and testing strips are covered under Medicare's durable medical equipment benefit. Coverage of home blood glucose monitors is currently limited to certain diabetics, formerly referred to as Type I diabetics, if: (1) the patient is an insulin-treated diabetic; (2) the patient is capable of being trained to use the monitor in an appropriate manner, or, in some cases, another responsible person is capable of being trained to use the equipment and monitor the patient to assure that the intended effect is achieved; and (3) the device is designed for home rather than clinical use.

Explanation of provision. Effective January 1, 1998, the provision would include among Medicare's covered benefits diabetes outpatient self-management training services. These services would include educational and training services furnished to an individual with diabetes by a certified provider in an outpatient setting meeting certain quality standards. They would be covered only if the physician who is managing the individual's diabetic condition certifies that the services are needed under a comprehensive plan of care 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. Certified providers for these purposes would be defined as physicians or other individuals or entities designated by the Secretary that, in addition to providing diabetes outpatient self-management training services, provide other items or services reimbursed by Medicare. Providers would have to meet quality standards established by the Secretary. They would be deemed to have met the Secretary's standards if they meet standards originally established by the National Diabetes Advisory Board and subsequently revised by organizations who participated in the establishment of standards of the Board, or if they are recognized by an organization representing persons with diabetes as meeting standards for furnishing such services. In establishing payment amounts for diabetes outpatient self-management training provided by physicians and determining the relative value for these services, the Secretary would be required to consult with appropriate organizations, including organizations representing persons or Medicare beneficiaries with diabetes.

In addition, beginning January 1, 1998, the provision would extend Medicare coverage of blood glucose monitors and testing strips to Type II diabetics and without regard to a person's use of insulin (as determined under standards established by the Secretary in consultation with appropriate organization). The provision would

also reduce the national payment limit for testing strips by 10 percent beginning in 1998.

The Secretary, in consultation with appropriate organizations, would be required to establish outcome measures, including glycosylated hemoglobin (past 90-day average blood sugar levels), for purposes of evaluating the improvement of the health status of Medicare beneficiaries with diabetes. The Secretary would also be required to submit recommendations to Congress from time to time on modifications to coverage of services for these beneficiaries.

The Committee notes the important role of registered dietitians and other qualified nutrition professionals in providing dietary counseling and education services related to diabetes self-management training. These health care professionals are trained and authorized by the States to perform these services and regularly do so in private sector health plans. While this section does not authorize direct reimbursement for these professionals to perform diabetes self-management services, nothing in this bill precludes them from providing services under arrangements with individuals or entities authorized to receive payment for services under this Title.

Section 4106. Standardization of Medicare coverage of bone mass measurements

Current law. Medicare does not include specific coverage of bone mass measurement.

Explanation of provision. The provision authorizes coverage of bone mass measurement for the following high risk persons: an estrogen-deficient woman at clinical risk for osteoporosis; an individual with vertebral abnormalities; an individual receiving long-term glucocorticoid steroid therapy, and an individual with primary hyperparathyroidism, or an individual being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy. The Secretary would be required to establish frequency limits. Payments would be made under the physician fee schedule. The provision would be effective July 1, 1998.

Section 4107. Vaccines outreach expansion

Current law. The Health Care Financing Administration, in conjunction with the Centers for Disease Control and the National Coalition for Adult Immunization, conducts an Influenza and Pneumococcal Vaccination Campaign. The Campaign is scheduled to cease operations in 2000.

Explanation of provision. The provision would extend the campaign through the end of FY 2002. The provision would appropriate \$8 million for each Fiscal Year 1998 through 2002 to the Campaign; 60 percent of the appropriation would come from the Federal Hospital Insurance Trust Fund and 40 percent from the Federal Supplementary Medical Insurance Trust Fund.

Section 4108. Study on preventive benefits

Current Law. No provision.

Explanation of provision. The provision would require the Secretary to request the National Academy of Sciences, in conjunction with the United States Preventive Services Task Force, to analyze the expansion or modification of preventive services covered under

Medicare. The study would consider both the short term and long term benefits and costs to Medicare. The study would have to include specific findings with respect to the following: (1) nutrition therapy, including parenteral and enteral nutrition; (2) standardization of coverage for bone mass measurement; (3) medically necessary dental care; (4) routine patient care costs for beneficiaries enrolled in approved clinical trial programs; and (5) elimination of time limitation for coverage of immunosuppressive drugs for transplant patients. The Secretary would be required to provide such funding as may be necessary in FY 1998 and FY 1999.

SUBTITLE C—RURAL INITIATIVES

Section 4206. Informatics, telemedicine, and education demonstration project

Current law. No provision.

Explanation of provision. The provision would require the Secretary to begin, no later than 9 months after enactment, a 4-year demonstration project designed to use eligible health care provider telemedicine networks to apply high-capacity computing and advanced networks for the provision of health care to Medicare beneficiaries who are residents of medically underserved rural and inner-city areas. The project would focus on improvements in primary care and prevention of complications for those residents with diabetes mellitus. The objectives of the project would include: (1) improving patient access to and compliance with appropriate care guidelines for chronic diseases through direct telecommunications links with information networks; (2) developing a curriculum to train, and provide standards for credentialing and licensure of, health professionals (particularly primary care) in the use of medical informatics and telecommunications; (3) demonstrating the application of advanced technologies to assist primary care providers in assisting patients with chronic illnesses in a home setting; (4) applying medical informatics to residents with limited English language skills; (5) developing standards in the application of telemedicine and medical informatics; and (6) developing a model for the cost-effective delivery of primary and related care both in a managed care and fee-for-service environment.

The provision defines an eligible health care provider telemedicine network as a consortium that includes at least one tertiary care hospital, at least one medical school (but no more than two such hospitals), and at least one regional telecommunications provider, no more than four facilities in rural or urban areas, and meets certain additional requirements. The provision would define those services to be covered under Part B for the purposes of this demonstration project. Medicare payment for covered Part B services would be made at a rate of 50 percent of the reasonable costs of providing such services. The Secretary would be required to recognize the following project costs as permissible costs for coverage under Part B: (1) the acquisition of telemedicine equipment for use in patient homes; (2) curriculum development and training of health professionals in medical informatics and telemedicine, (3) payment of certain telecommunications costs, including costs of telecommunications between patients' homes and the eligible net-

work and between the network and other entities under the arrangements described in the bill; and (4) payments to practitioners and providers under Medicare. Costs not covered under Part B would include: (1) purchase or installation of transmission equipment, (2) the establishment or operation of a telecommunications common carrier network, (3) the costs of construction (except for minor renovations related to the installation of reimbursable equipment), or (4) the acquisition or building of real property.

The total amount of Medicare payments permitted under the project would be \$30 million. The project would be prohibited from imposing cost sharing on a Medicare beneficiary for the receipt of services under the project of more than 20 percent of the recognized costs of the project attributable to these services. The Secretary would be required to submit to the House Committee on Ways and Means, House Committee on Commerce and the Senate Committee on Finance interim reports on the project and a final report on the project within 6 months of the conclusion of the project. The final report would be required to include an evaluation of the impact of the use of telemedicine and medical informatics on improving the access of Medicare beneficiaries to health care services, on reducing the costs of such services, and on improving the quality of life of such beneficiaries.

The Committee continues to recognize the need to make quality mental health care services available to Medicare beneficiaries and is particularly concerned about access to such services in rural communities. The Committee encourages the Secretary to assess the availability and geographic distribution of mental health professionals who are Medicare providers and to submit information to the Committee identifying characteristics of the program that may serve to impede beneficiary access to mental health services.

SUBTITLE D—ANTI-FRAUD AND ABUSE PROVISIONS

Section 4301. Permanent exclusion for those convicted of 3 health care related crimes

Current law. Section 1128(a) of the Social Security Act directs the Secretary of Health and Human Services to mandatorily exclude individuals and entities from participation in the Medicare program and State health care programs (Medicaid, Title V Maternal and Child Health Block Grants, and Title XX Social Services Block Grants) upon conviction of certain criminal offenses including Medicare and Medicaid program-related crimes, patient abuse crimes, health care fraud felonies, and felonies relating to controlled substances. Such mandatory exclusions are, in most cases, for a minimum period of 5 years.

Explanation of provision. The provision would provide that if an individual has been mandatorily excluded by the Secretary from participation in Federal health care programs, as defined in Section 1128b(f) of the Social Security Act (see Section 4311 of this title), and State health care programs, because of a conviction relating to Medicare and Medicaid program-related crimes, patient abuse, or felonies related to health care fraud or controlled substances, that the exclusion be either for a period of 10 years if the individual has been convicted on only one previous occasion of one or more of-

fenses for which such an exclusion may be imposed, or that the exclusion be permanent if the individual has been convicted on two or more previous occasions of one or more offenses for which such an exclusion may be imposed. The provision would apply to exclusions based on a conviction occurring on or after the date of enactment of this section where the individual has had prior convictions occurring before, on or after the date of enactment of this section.

Section 4302. Authority to refuse to enter into Medicare agreements with individuals or entities convicted of felonies

Current law. Section 1866 of the Social Security Act sets forth certain conditions under which providers may become qualified to participate in the Medicare program. The Secretary may refuse to enter into an agreement with a provider, or may refuse to renew or may terminate such an agreement, if the Secretary determines that the provider has failed to comply with provisions of the agreement, other applicable Medicare requirements and regulations, or if the provider has been excluded from participation in a health care program under Section 1128 or 1128A of the Social Security Act. Section 1842 of the Social Security Act permits physicians and suppliers to enter into agreements with the Secretary under which they become “participating” physicians or suppliers under the Medicare program.

Explanation of provision. The provision would add a new section giving the Secretary authority to refuse to enter into an agreement, or refuse to renew or terminate an agreement with a provider if the provider has been convicted of a felony under Federal or State law for an offense which the Secretary determines is inconsistent with the best interests of program beneficiaries. This authority would extend to the Secretary’s agreements with physicians or suppliers who become “participating” physicians or suppliers under the Medicare program. Similar provisions would apply to the Medicaid program. This section would take effect as of the date of enactment of this Act, and apply to new and renewed contracts on or after that date.

Section 4303. Inclusion of toll-free number to report Medicare waste, fraud and abuse in explanation of benefits forms

Current law. An explanation of benefits is provided to beneficiaries in conjunction with Medicare claims payments. The explanation provides certain information including a toll-free telephone number for enrollees to obtain information on participating physicians and suppliers.

Explanation of provision. The provision would specify that each explanation of benefits form contain a toll-free telephone number maintained by the Inspector General in the Department of Health and Human Services for persons to report complaints and information about waste, fraud and abuse in Medicare services or billing for services.

Section 4304. Liability of Medicare carriers and fiscal intermediaries for claims submitted by excluded persons

Current law. Carriers and fiscal intermediaries are the entities which process claims for Medicare. Intermediaries process claims

submitted by institutional providers of services and carriers process claims submitted by physicians and suppliers.

Explanation of provision. The provision would provide that agreements with fiscal intermediaries or carriers require that such organizations reimburse the Secretary for any amounts paid for services under Medicare which have been furnished, directed, or prescribed by an individual or entity during any period in which the individual or entity has been excluded from participation under Medicare, if the amounts have been paid after the fiscal intermediary or carrier has received notice of the exclusion. Similar restrictions would be imposed upon States under the Medicaid program. These provisions would apply to contracts and agreements entered into, renewed, or extended after the date of enactment of this Act, but only with respect to claims submitted on or after either January 1, 1998, or the effective date of the contract, whichever is later.

Section 4305. Exclusion of entity controlled by family member of a sanctioned individual

Current law. Section 1128 of the Social Security act authorizes the Secretary of HHS to impose mandatory and permissive exclusions of individuals and entities from participation in the Medicare program, Medicaid program and programs receiving funds under the Title V Maternal and Child Health Services Block Grant, or the Title XX Social Services Block Grant. The Secretary may exclude any entity which the Secretary determines has a person with a direct or indirect ownership or control interest of 5 percent or more in the entity or who is an officer, director, agent, or managing employee of the entity, where that person has been convicted of a specified criminal offense, or against whom a civil monetary penalty has been assessed, or who has been excluded from participation under Medicare or a State health care program.

Explanation of provision. The provision would provide that if a person transfers an ownership or control interest in an entity to an immediate family member or to a member of the household of the person in anticipation of, or following, a conviction, assessment or exclusion against the person, that the entity may be excluded from participation in Federal health care programs (see Section 4311 of this bill) on the basis of that transfer. The terms “immediate family member” and “member of the household” are defined in this section. This provision would take effect 45 days after enactment of this Act.

Section 4306. Imposition of civil money penalties

Current law. Section 1128A of the Social Security Act sets forth a list of fraudulent activities relating to claims submitted for payments for items of services under a Federal health care program. Civil money penalties of up to \$10,000 for each item or service may be assessed. In addition, the Secretary of HHS (or head of the department or agency for the Federal health care program involved) may also exclude the person involved in the fraudulent activity from participation in a Federal health care program, defined as any program providing health benefits, whether directly or otherwise, which is funded directly, in whole or in part, by the United States

Government (other than the Federal Employees Health Benefits Program).

Explanation of provision. The provision would add a new civil money penalty for cases in which a person contracts with an excluded provider for the provision of health care items or services, where the person knows or should know that the provider has been excluded from participation in a Federal health care program.

Section 4307. Disclosure of information and surety bonds

Current law. Section 1834(a) of the Social Security Act establishes requirements for payments under Medicare for covered items defined as durable medical equipment. Home health agencies are required, under Section 1861(o) of the Social Security Act, to meet specified conditions in order to provide health care services under Medicare, including requirements, set by the Secretary, relating to bonding or establishing of escrow accounts, as the Secretary finds necessary for the effective and efficient operation of the Medicare program.

Explanation of provision. The provision would require that suppliers of durable medical equipment provide the Secretary with full and complete information as to persons with an ownership or control interest in the supplier, or in any subcontractor in which the supplier has a direct or indirect 5 percent or more ownership interest, other information concerning such ownership or control, and a surety bond for at least \$50,000. Home health agencies, comprehensive outpatient rehabilitation facilities, and rehabilitation agencies would also be required to provide a surety bond for at least \$50,000. The Secretary may impose the surety bond requirement which applies to durable medical equipment suppliers to suppliers of ambulance services and certain clinics that furnish medical and other health services (other than physicians' services). In each of these cases the Secretary could waive the surety bond requirement if the entity provides a comparable surety bond under State law.

The amendments with respect to suppliers of durable medical equipment would apply to equipment furnished on or after January 1, 1998. The amendments with respect to home health agencies would apply to services furnished on or after such date, and the Secretary of HHS is directed to modify participation agreements with home health agencies to provide for implementation of these amendments on a timely basis. The amendments with respect to ambulance services, certain clinics, comprehensive outpatient rehabilitation facilities and rehabilitation agencies would take effect on the date of enactment of this Act.

Section 4308. Provision of certain identification numbers

Current law. Section 1124 of the Social Security Act requires that entities participating in Medicare, Medicaid and the Maternal and Child Health Block Grant programs (including providers, clinical laboratories, renal disease facilities, health maintenance organizations, carriers and fiscal intermediaries), provide certain information regarding the identity of each person with an ownership or control interest in the entity, or in any subcontractor in which the entity has a direct or indirect 5 percent or more ownership interest.

Section 1124A of the Social Security Act requires that providers under part B of Medicare also provide information regarding persons with ownership or control interest in a provider, or in any subcontractor in which the provider has a direct or indirect 5 percent or more ownership interest.

Explanation of provision. The provision would require that all Medicare providers supply the Secretary with both the employer identification number and social security account number of each disclosing entity, each person with an ownership or control interest, and any subcontractor in which the entity has a direct or indirect 5 percent or more ownership interest. The Secretary of HHS is directed to transmit to the Commissioner of Social Security information concerning each social security account number and to the Secretary of the Treasury information concerning each employer identification number supplied to the Secretary for verification of such information. Social security numbers would not be disclosed to other persons or entities, and use of such numbers would be limited to verification and matching purposes only. The Secretary would reimburse the Commissioner and the Secretary of the Treasury for costs incurred in performing the verification services required by this provision. The Secretary of HHS would report to Congress on the steps taken to assure confidentiality of social security numbers to be provided to the Secretary under this section before it becomes effective. This section's reporting requirements would then become effective 90 days after submission of the Secretary's report to Congress on confidentiality of social security numbers.

Section 4309. Advisory opinions regarding certain physician self-referral provisions

Current law. Section 1877 of the Social Security Act establishes a ban on certain financial arrangements between a referring physician and an entity. Specifically, if a physician (or immediate family member) has an ownership or investment interest in or a compensation arrangement with an entity, the physician is prohibited from making certain referrals to the entity for services for which Medicare would otherwise pay.

Explanation of provision. The provision would require the Secretary of HHS to issue written advisory opinions concerning whether a physician referral relating to designated health services (other than clinical laboratory services) is prohibited under Section 1877 of the Social Security Act. Such opinions would be binding as to the Secretary and the party requesting the opinion. To the extent practicable, the Secretary is to apply the regulations issued under the advisory opinion provisions of Section 1128D of the Social Security Act to the issuance of advisory opinions under this provision.

Section 4310. Notification of availability of providers as part of discharge planning process

Current law. Hospitals are required to have a discharge planning process meeting certain requirements. The discharge planning evaluation must include an evaluation of the patient's need for likely post-hospital services and the availability of those services.

Explanation of provision. The provision would include, as part of this evaluation, the availability of those services through individuals and entities that participate in Medicare, serve the geographic area where the patient resides, and request to be listed by the hospital as available. The provision would prohibit the discharge plan from specifying or otherwise limiting the qualified provider which may provide post-hospital care. The plan would also identify any provider (to whom the individual is referred) in which the hospital has a disclosable financial interest or which has such disclosable interest in the hospital.

The Committee intends that a hospital, for a Medicare beneficiary who is not enrolled in a managed care plan, may not restrict the selection of a qualified home health agency to provided post-hospital services for such agency expressed by the patient.

The provision would require hospitals with a financial interest in a provider of post-hospital services (including an entity which furnishes durable medical equipment) to maintain and disclose to the Secretary information on the nature of the financial interest; the number of individuals who were discharged from the hospital who were identified as requiring the type of services provided by such provider; and, the percentage of such individuals who receive services from such provider or another such provider. The provision would further require the Secretary to make available disclosed information to the public.

Section 4311. Other fraud and abuse related provisions

Current law. Section 1128D provides for safe harbors, advisory opinions, and fraud alerts as guidance regarding application of health care fraud and abuse sanctions. Section 1128E of the Social Security Act directs the Secretary of HHS to establish a national health care fraud and abuse data collection program for the reporting of final adverse actions against health care providers, suppliers, or practitioners.

Explanation of provision. The provision would make certain technical changes in provisions added by the Health Insurance Portability and Accountability Act of 1996. The provision would also provide that mandatory and permissive exclusions under Section 1128 apply to any Federal health care program, defined as any program providing health benefits, whether directly or otherwise, which is funded directly, in whole or in part, by the United States Government (other than the Federal Employees Health Benefits Program). A new provision is added to the health care fraud and abuse data collection program to provide a civil money penalty of up to \$25,000 to be imposed against a health plan that fails to report information on an adverse action required to be reported under this program. The Secretary would also publicize those government agencies which fail to report information on adverse actions as required.

The change in the Federal programs under which a person may be excluded under Section 1128 of the Social Security Act would be effective on the date of enactment of this Act. The sanction provision for failure to report adverse action information as required under Section 1128E of the Social Security Act would apply to failures occurring on or after the date of the enactment of this Act.

The other amendments made by this section would be effective as if included in the enactment of the Health Insurance Portability and Accountability Act of 1996.

SUBTITLE E—PROSPECTIVE PAYMENT SYSTEMS

Chapter 2—Payment Under Part B

SUBCHAPTER A—PAYMENT FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES

Section 4411. Elimination of formula-driven overpayments [FDO] for certain outpatient hospital services

Current law. Medicare payments for hospital outpatient ambulatory surgery, radiology, and other diagnostic services equals the lesser of: (1) the lower of a hospital's reasonable costs or its customary charges, net of deductible and coinsurance amounts, or (2) a blended amount comprised of a cost portion and a fee schedule portion, net of beneficiary cost-sharing. The cost portion of the blend is based on the lower of the hospital's costs or charges, net of beneficiary cost sharing, and the fee schedule portion is based, in part, on ambulatory surgery center payment rates or the rates for radiology and diagnostic services in other settings, net of beneficiary coinsurance (for those settings). The hospital cost portion and the ambulatory surgical center (ASC) cost portion are 42 percent and 58 percent, respectively. For diagnostic services the hospital cost portion is 50 percent and the fee schedule portion is 50 percent.

A hospital may bill a beneficiary for the coinsurance amount owed for the outpatient service provided. The beneficiary coinsurance is based on 20 percent of the hospital's submitted charges for the outpatient service, whereas Medicare usually pays based on the blend of the hospital's costs and the amount paid in other settings for the same service. This results in an anomaly whereby the amount a beneficiary pays in coinsurance does not equal 20 percent of the program's payment and does not result in a dollar-for-dollar decrease in Medicare program payments.

Explanation of provision. The provision would require that beneficiary coinsurance amounts be deducted later in the reimbursement calculation for hospital outpatient services, so that Medicare payments for covered services would be lower than under current law. Medicare's payment for hospital outpatient services would equal the blended amounts less any amount the hospital may charge the beneficiary as coinsurance for services furnished during portions of cost reporting periods occurring on or after October 1, 1997.

Section 4412. Extension of reductions in payments for costs of hospital outpatient services

Current law.

a. Reduction in payments for capital-related costs. Hospitals receive payments for Medicare's share of capital costs associated with outpatient departments. OBRA 93 extended a 10 percent reduction in payments for the capital costs of outpatient departments through FY 1998.

b. Reduction in payments for non-capital-related costs. Certain hospital outpatient services are paid on the basis of reasonable costs. OBRA 93 extended a 5.8 percent reduction for those services paid on a cost-related basis through FY 1998.

Explanation of provision.

a. Reduction in payments for capital-related costs. The provision would extend the 10 percent reduction in payments for outpatient capital through FY 1999 and during FY 2000 before January 1, 2000.

b. Reduction in payments for non-capital-related costs. The 5.8 percent reduction for outpatient services paid on a cost basis would be extended through FY 1999 and during FY 2000 before January 1, 2000.

Section 4413. Prospective payment system for hospital outpatient department services [ODP]

Current law. Medicare payments for hospital outpatient ambulatory surgery, radiology, and other diagnostic services equals the lesser of: (1) the lower of a hospital's reasonable costs or its customary charges, net of deductible and coinsurance amounts, or (2) a blended amount comprised of a cost portion and a fee schedule portion, net of beneficiary cost-sharing. The cost portion of the blend is based on the lower of the hospital's costs or charges, net of beneficiary cost sharing, and the fee schedule portion is based, in part, on ambulatory surgery center payment rates or the rates for radiology and diagnostic services in other settings, net of beneficiary coinsurance (for those settings). For cost reporting periods beginning on or after January 1, 1991, the hospital cost portion and the ASC cost portion are 42 percent and 58 percent, respectively. For diagnostic services the hospital cost portion is 50 percent and the fee schedule portion is 50 percent.

Explanation of provision. The provision would require the Secretary to establish a prospective payment system for covered OPD services furnished beginning in 1999. The Secretary would be required to develop a classification system for covered OPD services, such that services classified within each group would be comparable clinically and with respect to the use of resources. The Secretary would be required to establish relative payment rates for covered OPD services using 1996 hospital claims and cost report data, and determine projections of the frequency of utilization of each such service or group of services in 1999. The Secretary would be required to determine a wage adjustment factor to adjust the portions of payment attributable to labor-related costs for relative geographic differences in labor and labor-related costs that would be applied in a budget neutral manner. The Secretary would be required to establish other adjustments as necessary, including adjustments to account for variations in coinsurance payments for procedures with similar resource costs, to ensure equitable payments under the system. The Secretary would also be required to develop a method for controlling unnecessary increases in the volume of covered OPD services.

Hospitals OPD copayments would be limited to 20 percent of the national median of the charges for the service (or services within the group) furnished in 1996 updated to 1999 using the Secretary's

estimate of charge growth during this period. The Secretary would be required to establish rules for the establishment of a coinsurance payment amount for a covered OPD service not furnished during 1996, based on its classification within a group of such services.

For 1999, the Secretary would be required to establish a conversion factor for determining the Medicare OPD fee payment amounts for each covered OPD service (or group of services) furnished in 1999 so that the sum of the products of the Medicare OPD fee payment amounts and the frequencies for each service or group would be required to equal the total amounts estimated by the Secretary that would be paid for OPD services in 1999. In subsequent years, the Secretary would be required to establish a conversion factor for covered OPD services furnished in an amount equal to the conversion factor established for 1999 and applicable to services furnished in the previous year increased by the OPD payment increase factor. The increase factor would be equal to the hospital market basket (MB) percentage increase plus 3.5 percentage points. When the amount of the beneficiary coinsurance for an individual procedure is equal to 20 percent of the total payment, both the coinsurance and the Medicare program payment would be increased by the market basket.

The Secretary would be required to establish a procedure under which a hospital, before the beginning of a year (starting with 1999), could elect to reduce the coinsurance payment for some or all covered OPD services to an amount that is not less than 25 percent of the total (Medicare program plus beneficiary coinsurance payment) amount for the service involved, adjusted for relative differences in labor costs and other factors. A reduced copayment amount could not be further reduced or increased during the year involved, and hospitals could disseminate information on the reduction of copayment amount.

The Secretary would be authorized periodically to review and revise the groups, relative payment weights, and the wage and other adjustments to take into account changes in medical practice, medical technology, the addition of new services new cost data, and other relevant information. Any adjustments made by the Secretary would be made in a budget neutral manner. If the Secretary determined that the volume of services paid for under this subsection increased beyond amounts established through those methodologies, the Secretary would be authorized to adjust the update to the conversion factor otherwise applicable in a subsequent year.

The provision would provide that the copayment for covered OPD services would be determined by the provisions of this bill instead of the standard 20 percent coinsurance for other Part B services. The provision would prohibit administrative or judicial review of the prospective payment system. The provision would also provide for conforming amendments regarding approved ambulatory surgical center procedures performed in hospital OPDs, for radiology and other diagnostic procedures, and for other hospital outpatient services.

In the interest of achieving better clinical homogeneity and comparability of economic resources of services and products provided on a hospital outpatient basis, the Committee encourages the Secretary to develop appropriate categories of hospital outpatient serv-

ices and items. It is anticipated that this will facilitate identification of those products whose costs do not correlate with the procedure with which they are used. Following such identification, the Secretary may consider instituting a system of separate payment or creating separate classification groups for such products, if such a change would more accurately reflect the clinical and economic components of the total service provided.

The Committee also strongly encourages the Secretary to make any appropriate adjustments to prospective payment rates that would reflect the patient mix and treatments of freestanding cancer centers.

SUBCHAPTER B—REHABILITATION SERVICES

Section 4421. Rehabilitation agencies and services

Current law. Medicare provides for special payment rules for certain types of providers of services covered under Part B and paid out of the SMI Trust Fund.

Explanation of provision. For outpatient physical therapy and occupational therapy services, payments for services provided in 1998 would be the least of: (1) the actual charges for the services; (2) the adjusted reasonable costs for the services, defined as reasonable costs reduced by 5.8 percent of the reasonable costs for operating costs and 10 percent of the reasonable cost for capital; or (3) a blended rate equal to the sum of 50 percent of the adjusted reasonable cost for the services and 50 percent of the applicable physician fee schedule amount for the services. After 1998, payment for these services would be 80 percent of the lesser of the actual charge for the services, or the applicable physician fee schedule amount. The provision would also exclude from Medicare coverage outpatient occupational therapy and physical therapy services furnished as an incident to a physician's professional services that did not meet the standards provided for outpatient physical therapy services furnished by a provider in a clinic, rehabilitation agency, public health agency, or by others under an arrangement with and under the supervision of such providers.

The provision would also apply the per beneficiary cap of \$900 per year for outpatient physical therapy services.

Section 4422. Comprehensive outpatient rehabilitation facilities [CORFs]

Current law. Medicare provides for special payment rules for certain types of providers of services covered under Part B and paid out of the SMI Trust Fund.

Explanation of provision. CORF payments for services provided in 1998, would be the least of: (1) the charges for the services; (2) the adjusted reasonable costs for the services, defined as reasonable costs reduced by 5.8 percent of the reasonable costs for operating costs and 10 percent of the reasonable cost for capital; or (3) a blended rate equal to the sum of 50 percent of the adjusted reasonable cost for the services and 50 percent of the applicable physician fee schedule amount for the services. After 1998, payment for these services would be 80 percent of the lesser of the actual

charge for the services, or the applicable physician fee schedule amount.

SUBCHAPTER C—AMBULANCE SERVICES

Section 4431. Payments for ambulance services

Current law. Payment for ambulance services provided by freestanding suppliers is based on reasonable charge screens developed by individual carriers based on local billings. Hospital or other provider-based ambulance services are paid on a reasonable cost basis; payment cannot exceed what would be paid to a freestanding suppliers.

Explanation of provision. The provision would specify payment limits for ambulance services for FY 1998 through FY 2002. For ambulance services paid on a reasonable cost basis, the annual increase in the costs recognized as reasonable on a per trip basis would be limited to the percentage increase in the consumer price index reduced for fiscal years 1998 and 1999 by 1 percent. Similarly, for ambulance services furnished on a reasonable charge basis, the annual increase in the charges recognized as reasonable would be limited to the percentage increase in the consumer price index reduced for fiscal years 1998 and 1999 by 1 percent.

The provision would require the Secretary to establish a fee schedule for ambulance services through a negotiated rule-making process. In establishing the fee schedule, the Secretary would be required to: (1) establish mechanisms to control Medicare expenditure increases; (2) establish definitions for services; (3) consider appropriate regional and operational differences; (4) consider adjustments to payment rates to account for inflation and other relevant factors; and (5) phase-in the application of the payment rates in an efficient and fair manner. In establishing the fee schedule, the Secretary would be required to consult with various national organizations representing individuals and entities who furnish and regulate ambulance services. The Secretary would be required to assure that payments in FY 2000 under the fee schedule did not exceed the aggregate amount of payments which would have been made in the absence of the fee schedule. The annual increase in the payment amounts in each subsequent year would be limited to the increase in the consumer price index. Medicare payments would equal 80 percent of the lesser of the fee schedule amount or the actual charge.

The provision would authorize payment for advanced life support (ALS) services provided by paramedic intercept service providers in rural areas. The ALS services would be provided under contract with one or more volunteer ambulance services. The volunteer ambulance service involved must be certified as qualified to provide the service, provide only basic life support services at the time of the intercept, and be prohibited by State law from billing for services. The ALS service provider must be certified to provide the services and bill all recipients (not just Medicare beneficiaries) for ALS intercept services.

Section 4432. Demonstration of coverage of ambulance services under Medicare through contracts with units of local government

Current law. No provision.

Explanation of provision. The provision would require the Secretary to establish up to three demonstration projects under which, at the request of a county or parish, the Secretary enters into agreement with such entity to furnish or arrange for the furnishing of ambulance services. The county or parish could not enter into a contract unless the contract covered at least 80 percent of the residents enrolled in Part B. Individuals or entities furnishing services would have to meet the requirements otherwise applicable. The Secretary would make monthly per capita payments to the county or parish. In the first year, the capitated payment would equal 95 percent of the average annual per capita payment for ambulance services made in the most recent 3 years for which data is available. In subsequent years, it would be the amount established for the preceding year increased by the CPI. Payments under the contract would be in lieu of other payments for ambulance services.

The contract could provide for the inclusion of persons residing in additional counties or parishes, permit transportation to non-hospital providers, and implement other innovations proposed by the county or parish.

The Secretary would be required to evaluate the demonstration projects and report by January 1, 2000, on the study including recommendations regarding modifications to the payment methodology and whether to extend or expand such projects.

Chapter 3—Payment Under Parts A and B

Section 4441. Prospective payment for home health services

Current law. Medicare reimburses home health agencies on a retrospective cost-based basis. This means that agencies are paid after services are delivered for the reasonable costs (as defined by the program) they have incurred for the care they provide to program beneficiaries, up to certain limits. In provisions contained in the Orphan Drug Act of 1983, OBRA 87 and OBRA 90, Congress required the Secretary to develop alternative methods for paying for home health care on a prospective basis. In 1994, the Office of Research and Demonstration in the Health Care Financing Administration (HCFA) completed a demonstration project that tested prospective payment on a per visit basis. Preliminary analysis indicates that the per visit prospective payment methodology had no effect on cost per visit or volume of visits. HCFA has begun a second project, referred to as Phase II, to test prospective payment on a per episode basis, and has also undertaken research to develop a home health case-mix adjustor that would translate patients' varying service needs into specific reimbursement rates.

Explanation of provision. The provision would require the Secretary to establish a prospective payment system for home health and implement the system beginning October 1, 1999. All services covered and paid on a reasonable cost basis at the time of enactment of this section, including medical supplies, would be required to be paid on a prospective basis. In implementing the system, the

Secretary could provide for a transition of not longer than 4 years during which a portion of the payment would be based on agency-specific costs, but only if aggregate payments were not greater than they would have been if a transition had not occurred.

In establishing the prospective system, the Secretary would be authorized to consider an appropriate unit of service, as well as the number, type, and duration of visits provided within that unit, potential changes in the mix of services provided within that unit and their cost, and a general system design that provides for continued access to quality services.

Under the new system, the Secretary would compute a standard prospective payment amount (or amounts) that would initially be based on the most current audited cost report data available to the Secretary. For fiscal year 2000, payment amounts under the prospective system would be computed in such a way that total payments would equal amounts that would have been paid had the system not been in effect, but would also reflect a 15 percent reduction in cost limits and per beneficiary limits in effect September 30, 1999. Payment amounts would be standardized in a manner that eliminates the effect of variations in relative case mix and wage levels among different home health agencies in a budget neutral manner. The Secretary could recognize regional differences or differences based on whether or not services are provided in an urbanized area. Beginning with FY 2001, standard prospective payment amounts would be adjusted by the home health market basket.

The payment amount for a unit of home health service would be adjusted by a case mix adjustor factor established by the Secretary to explain a significant amount of the variation in the cost of different units of service. The labor-related portion of the payment amount would be adjusted by an area wage adjustment factor that would reflect the relative level of wages and wage-related costs in a particular geographic area as compared to the national average. The Secretary could provide for additions or adjustments to payment amounts for outliers because of unusual variations in the type or amount of medically necessary care. The total amount of outlier payments could not exceed 5 percent of total payments projected or estimated to be made in a year. The Secretary would be required to reduce the standard prospective payments by amounts that in the aggregate would equal outlier adjustments. If a beneficiary were to transfer to or receive services from another home health agency within the period covered by a prospective payment amount, then the payment would be prorated between the agencies involved.

Claims for home health services furnished on or after October 1, 1998, would be required to contain an appropriate identifier for the physician prescribing home health services or certifying the need for care. Claims would also be required to include, for four home health service categories, information (coded in an appropriate manner) on the length of time of a service, as measured in 15-minute increments. The four categories of services for which time information would have to be included on a claim would be: skilled nursing care; therapies—physical and occupational therapy and

speech language pathology; medical social services; and home health aide services.

Administrative or judicial review would not be permitted for the transition period (if any) for the prospective system; the definition and application of payment units; the computation of initial standard payment amounts; adjustments for outlier, case-mix and area wage adjustments; and the amounts or types of exceptions or adjustments to the prospective payment amounts.

Periodic interim payments for home health services would be eliminated. All home health care agencies would be paid according to the prospective payment system.

In order for home health services to be considered covered care, home health care agencies would be required to submit claims for all services, and all payments would be made to a home health agency without regard to whether or not the item or service was furnished by the agency, by others under arrangement, or under any other contracting or consulting arrangement.

SUBTITLE G—PROVISIONS RELATING TO PART B ONLY

Chapter 1—Physicians' Services

Section 4601. Establishment of single conversion factor for 1998

Current law. Medicare pays for physicians services on the basis of a fee schedule. The fee schedule assigns relative values to services. Relative values reflect three factors: physician work (time, skill, and intensity involved in the service), practice expenses, and malpractice costs. These relative values are adjusted for geographic variations in the costs of practicing medicine. Geographically-adjusted relative values are converted into a dollar payment amount by a dollar figure known as the conversion factor. There are three conversion factors—one for surgical services, one for primary care services, and one for other services. The conversion factors in 1997 are \$40.96 for surgical services, \$35.77 for primary care services, and \$33.85 for other services.

Explanation of provision. The provision would set a single conversion factor for 1998, based on the 1997 primary care conversion factor, updated to 1998 by the Secretary's estimate of the weighted average of the three separate updates that would occur in the absence of the legislation.

Section 4602. Establishing update to conversion factor to match spending under sustainable growth rate

Current law. The conversion factors are updated each year by a formula specified in the law. The update equals inflation plus or minus actual rate of spending growth in a prior period compared to a target known as the Medicare volume performance standard (MVPS). (For example, fiscal year 1995 data were used in calculating the calendar 1997 update.) However, regardless of actual performance during a base period, there is a 5 percentage point limit on the amount of the reduction. There is no limit on the amount of the increase.

Explanation of provision. The provision would specify the update to the conversion factor that would apply beginning in 1999 (unless

otherwise provided for by law). The provision would specify that the update to the single conversion factor for a year would equal the Medicare Economic Index (MEI) subject to an adjustment to match spending under a sustainable growth rate. Specifically, the update for a year would be calculated by multiplying: (1) 1 plus the percentage change in the MEI, times (2) 1 plus the update adjustment factor (expressed as a percentage) for the year. The result would be reduced by 1 and multiplied by 100.

The provision links the update to the sustainable growth rate. The update adjustment factor would be calculated as follows: First, the Secretary would estimate the difference between the cumulative sum of allowed expenditures for July 1, 1997 through June 30 of the year involved and the cumulative sum of actual expenditures for July 1, 1997 through June 30 of the preceding year. This amount would be divided by the actual expenditures for the 12-month period (ending June 30) of the preceding year, increased by the applicable sustainable growth rate. For the 12-month period ending June 30, 1997, allowed expenditures would be defined as actual expenditures for the period, as estimated by the Secretary. For a subsequent 12-month period, allowed expenditures would be defined as allowed expenditures established for the previous period, increased by the sustainable growth rate established for the fiscal year which begins during that 12-month period.

The provision would establish limits on the amount of variation from the MEI; the update could not be more than three percentage points above or seven percentage points below the MEI.

Section 4603. Replacement of volume performance standard with sustainable growth rate

Current law. The Medicare Volume Performance Standard (MVPS), used to calculate the update in the conversion factor, is a goal for the rate of expenditure growth from one fiscal year to the next. The MVPS for a year is based on estimates of several factors (changes in fees, enrollment, volume and intensity, and laws and regulations). The calculation is subject to a reduction known as the performance standard factor.

Explanation of provision. The provision would replace the MVPS with the sustainable growth rate based on real gross domestic product (GDP) growth. Specifically, the rate for FY 1998 and subsequent years would be equal to the product of: (1) 1 plus the weighted average percentage change in fees for all physicians services in the fiscal year; (2) 1 plus the percentage change in the average number of individuals enrolled under Part B (other than private plan enrollees) from the previous fiscal year; (3) 1 plus the Secretary's estimate of the percentage growth in real GDP per capita from the previous fiscal year; and (4) 1 plus the Secretary's estimate of the percentage change in expenditures for all physicians services in the fiscal year which will result from changes in law and regulations (excluding changes in volume and intensity resulting from changes in the conversion factor update). The result would be reduced by one and multiplied by 100. The term "physicians services" would exclude services furnished to a MedicarePlus plan enrollee.

Section 4604. Payment rules for anesthesia services

Current law. Anesthesia services are paid under a separate fee schedule (based on base and time units) with a separate conversion factor. The 1997 conversion factor is \$16.68.

Explanation of provision. The provision would specify that the conversion factor would equal 46 percent of the conversion factor established for other services for the year.

Section 4605. Implementation of resource-based physician practice expense

Current law. P.L. 103-432 required that the Secretary develop and provide for the implementation, beginning in 1998, of a resource-based methodology for payment of practice expenses under the physician fee schedule. Such expenses are currently paid on the basis of historical charges.

Explanation of provision. The provision would delay implementation of the practice expense methodology for 1 year until 1999. It would provide for a phase-in of the new methodology. In 1999, 25 percent of the practice payment would be based on the new methodology. This percentage would increase to 50 percent in 2000 and 75 percent in 2001. Beginning in 2002, the payment would be based solely on the new methodology.

The provision would require the Secretary, to develop new resource-based relative value units. In developing the units, the Secretary would be required to utilize, to the maximum extent practicable, generally accepted accounting principles and standards which recognize all staff, equipment, supplies and expenses, not just those that can be tied to specific procedures. The Secretary would be required to use actual data on equipment utilization and other key assumptions such as the proportion of costs which are direct versus indirect. The Secretary would be required to study whether hospital cost reduction methods and changing practice patterns may have increased physician practice costs and consider adverse effects on patient access. The Secretary would further be required to consult with organizations representing physicians regarding methodology and data to be used.

The Secretary would be required to transmit a report to the House Committee on Ways and Means, House Committee on Commerce and the Senate Committee on Finance by March 1, 1998. The report would include a presentation of the data used and an explanation of the methodology.

The Secretary would be required to publish a notice of proposed rulemaking by May 1, 1998, and allow for a 90-day public comment period.

The proposed rule would include: (1) detailed impact projections which compare proposed payment amounts with data on actual practice expenses; (2) impact projections for specialties, sub-specialties, geographic payment localities, urban versus rural localities, and academic versus non-academic medical staffs; and (3) impact projections on access to care for Medicare patients and physician employment of clinical and administrative staff.

Section 4606. Dissemination of hospital-specific per admission relative values for inpatient hospital services.

Current Law. In general, the law does not include a specific limit on the number or mix of physicians services provided in connection with an inpatient hospital stay. (However, the law does require that certain services provided in connection with a surgery be included in a global surgical package and not billed separately.)

Explanation of Provision. During 1999 and 2001, the Secretary would determine for each hospital the hospital-specific per admission relative value amount for the following year and whether this amount is projected to be excessive (based on the 1998 national median of such values). The Secretary would be required to notify the medical executive committee of each hospital having been identified as having an excessive hospital-specific relative value.

The hospital-specific relative value projected for a non-teaching hospital would be the average per admission relative value for inpatient physicians services furnished by the medical staff for the second preceding calendar year, adjusted for variations in case mix and disproportionate share status. For teaching hospitals, the projected hospital-specific relative value would be: (1) the average per admission relative value for inpatient physicians services furnished by the medical staff for the second preceding calendar year; plus (2) the equivalent per admission relative value for physicians services furnished by interns and residents during the second preceding year, adjusted for case-mix, disproportionate share status, and teaching status among hospitals. The Secretary would be required to determine the equivalent relative value unit per intern and resident based on the best available data and could make such adjustment in the aggregate. The Secretary would be required to adjust the allowable per admission relative value otherwise determined to take into account the needs of teaching hospitals and hospitals receiving additional payments under PPS as disproportionate share hospitals or on the basis of their classification as Medicare-dependent small rural hospitals. The adjustment for teaching or disproportionate share status could not be less than zero.

Section 4607. No x-ray required for chiropractic services.

Current Law. Medicare covers chiropractic services involving manual manipulation of the spine to correct a subluxation demonstrated to exist by X-ray. Medicare regulations prohibit payment for the X-ray either if performed by a chiropractor or ordered by a chiropractor.

Explanation of Provision. The provision would eliminate the X-ray requirement effective January 1, 1998. It would also require the Secretary to develop and implement utilization guidelines relating to coverage of chiropractic services when a subluxation has not been demonstrated to exist by X-ray.

Section 4608. Temporary coverage restoration for portable electrocardiogram transportation.

Current Law. Medicare regulations for the 1997 physician fee schedule eliminated the separate payment for transportation of EKG equipment by any supplier.

Explanation of Provision. The provision would restore separate payment for 1 year, 1998, for transportation of EKG equipment based on the coding in effect in 1996. By July 1, 1998, GAO would submit a report to Congress on the appropriateness of continuing such payment.

Chapter 2—Other Payment Provisions

Section 4611. Payments for durable medical equipment.

Current Law

(a) *Freeze in Durable Medical Equipment (DME) Updates.* DME is reimbursed on the basis of a fee schedule. Items are classified into five groups for purposes of determining the fee schedules and making payments: (1) inexpensive or other routinely purchased equipment (defined as items costing less than \$150 or which is purchased at least 75 percent of the time); (2) items requiring frequent and substantial servicing; (3) customized items; (4) oxygen and oxygen equipment; and (5) other items referred to as capped rental items. In general, the fee schedules establish national payment limits for DME. The limits have floors and ceilings. The floor is equal to 85 percent of the weighted median of local payment amounts and the ceiling is equal to 100 percent of the weighted median of local payment amounts. Fee schedule amounts are updated annually by the consumer price index for all urban consumers (CPI-U).

(b) *Update for Orthotics and Prosthetics.* Prosthetics and orthotics are paid according to a fee schedule with principles similar to the DME fee schedule. The fee schedule establishes regional payment limits for covered items. The payment limits have floors and ceilings. The floor is equal to 90 percent of the weighted average of regional payment amounts and the ceiling is 120 percent. Fee schedule amounts are updated annually by CPI-U.

(c) *Payment Freeze for Parenteral and Enteral Nutrients, Supplies, and Equipment (PEN).* Parenteral and enteral nutrients, supplies, and equipment are paid on the basis of the lowest reasonable charge levels at which items are widely and consistently available in the community.

Explanation of Provision

(a) *Freeze in Durable Medical Equipment (DME) Updates.* The provision would eliminate updates to the DME fee schedules for the period 1998 through 2002.

(b) *Update for Orthotics and Prosthetics.* The update for the prosthetics and orthotics fee schedule would be limited to 1 percent for each of the years 1998 through 2002.

(c) *Payment Freeze for Parenteral and Enteral Nutrients, Supplies, and Equipment (PEN).* Payments for PEN would be frozen at 1995 levels for the period 1998 through 2002.

Section 4612. Oxygen and oxygen equipment

Current Law. Under Medicare oxygen and oxygen equipment are considered durable medical equipment and are paid according to a DME fee schedule. The fee schedule establishes a national payment limit for oxygen and oxygen equipment.

Explanation of Provision. The provision would reduce the national payment limit for oxygen and oxygen equipment by 20 percent for each of the years 1998 through 2002.

Section 4613. Reduction in updates to payment amounts for clinical diagnostic laboratory tests

Current Law. Clinical diagnostic laboratory tests are paid on the basis of an area wide fee schedules. The law sets a cap on payment amounts equal to 76 percent of the median of all fee schedules for the test. The fee schedules amounts are updated by the percentage change in the CPI.

Explanation of Provision. The provision would freeze fee schedule payments for the 1998–2002 period. It would also lower the cap from 76 percent of the median to 72 percent of the median beginning in 1998.

Section 4614. Simplification in administration of laboratory services benefit

Current Law. Significant variations exist among carriers in rules governing requirements labs must meet in filing claims for payments.

Explanation of Provision. The provision would require the Secretary to divide the country into no more than five regions and designate a single carrier for each region to process laboratory claims no later than January 1, 1999. One of the carriers would be selected as a central statistical resource. The allocation of claims to a particular carrier would be based on whether the carrier serves the geographic area where the specimen was collected or other method selected by the Secretary.

The provision would require the Secretary, by July 1, 1998, to adopt uniform coverage, administration, and payment policies for lab tests using a negotiated rule-making process. The policies would be designed to promote uniformity and program integrity and reduce administrative burdens with respect to clinical diagnostic laboratory tests in connection with beneficiary information submitted with a claim, physicians' obligations for documentation and record keeping, claims filing procedures, documentation, and frequency limitations.

The provision would permit the use of interim regional policies where a uniform national policy had not been established and there is a demonstrated need for policy to respond to aberrant utilization or provision of unnecessary services. The Secretary would establish a process under which designated carriers could collectively develop and implement interim national standards for up to 2 years.

The Secretary would be required to conduct a review, at least every 2 years, of uniform national standards. The review would consider whether to incorporate or supersede interim regional or national policies.

With regard to the implementation of new requirements in the period prior to the adoption of uniform policies, and the development of interim regional and interim national standards, carriers must provide advance notice to interested parties and allow a 45 day period for parties to submit comments on proposed modifications.

The provision would require the inclusion of a laboratory representative on carrier advisory committees. The representative would be selected by the committee from nominations submitted by national and local organizations representing independent clinical labs.

Section 4615. Updates for ambulatory surgical services

Current Law. Medicare pays for ambulatory surgical center (ASC) services on the basis of prospectively determined rates. These rates are updated annually by the CPI-U. OBRA 93 eliminated updates for ASCs for FY 1994 and FY 1995.

Explanation of Provision. The provision would set the updates for FY 1996 and FY 1997 at the percentage increase in the CPI-U. For FY 1998 through FY 2002, the update increase would be the increase in the CPI-U minus 2.0 percentage points. For and succeeding fiscal years, the update increase would be the increase in the CPI-U.

Section 4616. Reimbursement for drugs and biologicals

Current Law. Payment for drugs is based on the lower of the estimated acquisition cost or the national average wholesale price. Payment may also be made as part of a reasonable cost or prospective payment.

Explanation of Provision. The provision would specify that in any case where payment is not made on a cost or prospective payment basis, the payment would equal 95 percent of the average wholesale price, as specified by the Secretary.

Section 4617. Coverage of oral anti-nausea drugs under chemotherapeutic regimen

Current Law. Medicare provides coverage for certain oral cancer drugs. The Administration has specified that Medicare will pay for self-administrable oral or rectal versions of self-administered anti-emetic drugs when they are needed for the administration and absorption of primary Medicare covered oral anti-cancer chemotherapeutic agents when a high likelihood of vomiting exists.

Explanation of Provision. The provision would provide coverage, under specified conditions, for an oral drug used as an acute anti-emetic used as part of an anticancer chemotherapeutic regimen. It would have to be administered by or under the supervision of a physician for use immediately before, at the time of or immediately after the administration of the chemotherapeutic agent and used as a full replacement for the anti-emetic therapy which would otherwise be administered intravenously.

The provision would establish a per dose payment limit equal to 90 percent of the average per dose payment basis for the equivalent intravenous anti-emetics administered during the year, as computed based on the payment basis applied in 1996. The Secretary would be required to make adjustments in the coverage of, or payment, for the anti-nausea drugs so that an increase in aggregate payments per capita does not result.

Section 4618. Rural health clinics (RHCs)

Current Law. Medicare establishes payment limits for RHC services provided by independent RHCs. RHCs, among other requirements, must have appropriate procedures for utilization review of clinic services. The Secretary is required to waive the RHC requirement for certain staffing of health professionals if the clinic has been unable to hire a physician assistant, nurse practitioner, or certified nurse-midwife in the previous 9 years. The Secretary is prohibited from granting a waiver to a facility if the request for the waiver is made less than 6 months after the date of the expiration of previous waiver of the facility. RHCs are required to be located in a health professionals shortage area. For RHCs that are in operation and subsequently fail to meet the requirement of being located in a health professions shortage area, the Secretary would be required to continue to consider the facility to meet the health professions shortage area requirement.

Explanation of Provision. The provision would apply per-visit payment limits to all RHCs, other than such clinics in rural hospitals with fewer than 50 beds. The provision would require that RHCs have a quality assessment and performance improvement program, in addition to appropriate procedures for utilization review. The provision would amend the waiver on the staffing requirement, to provide a waiver if the facility has not yet been determined to meet the requirement of having a nurse practitioner, physician assistant, or a certified nurse-midwife available 50 percent of the time the clinic operates. The provision would require that shortage designations for RHCs be reviewed every 3 years. The provision would further amend the shortage area requirement by adding that RHCs must be located in area in which there are insufficient numbers of needed health care practitioners as determined by the Secretary. The provision would require that RHCs that are in operation and subsequently fail to meet the requirement of being located in a health professions shortage area, continue to be considered to meet the health professions shortage requirement, but only when, under criteria established by the Secretary in regulations, to be essential to the delivery of primary care services that would otherwise be unavailable in the geographic area served by the clinic. The Secretary would be required to issue final regulations implementing the grandfathered clinics that would be required to take effect no later than January 1 of the third calendar year beginning at least 1 month after enactment. The provision would take effect on the effective date of the regulations.

Section 4619. Increased Medicare reimbursement for nurse practitioners and clinical nurse specialists

Current Law. Separate payments are made for nurse practitioner (NP) services provided in collaboration with a physician, which are furnished in a nursing facility. Recognized payments equal 85 percent of the physician fee schedule amount. Nurse practitioners and clinical nurse specialists (CNSs) are paid directly for services provided in collaboration with a physician in a rural area. Payment equals 75 percent of the physician fee schedule amount for services

furnished in a hospital and 85 percent of the fee schedule amount for other services.

Explanation of Provision. The provision would remove the restriction on settings. It would also provide that payment for NP and CNS services could only be made if no facility or other provider charges are paid in connection with the service. Payment would equal 80 percent of the lesser of either the actual charge or 85 percent of the fee schedule amount for the same service if provided by a physician. For assistant-at-surgery services, payment would equal 80 percent of the lesser of either the actual charge or 85 percent of the amount that would be recognized for a physician serving as an assistant at surgery. The provision would authorize direct payment for NP and CNS services.

The provision would clarify that a clinical nurse specialist is a registered nurse licensed to practice in the State and who holds a master's degree in a defined clinical area of nursing from an accredited educational institution.

Section 4620. Increased Medicare reimbursement for physician assistants

Current Law. Separate payments are made for physician assistant (PA) services when provided under the supervision of a physician: (1) in a hospital, skilled nursing or nursing facility, (2) as an assistant at surgery, or (3) in a rural area designated as a health professional shortage area.

Explanation of Provision. The provision would remove the restriction on settings. It would also provide that payment for PA services could only be made if no facility or other provider charges are paid in connection with the service. Payment would equal 80 percent of the lesser of either the actual charge or 85 percent of the fee schedule amount for the same service if provided by a physician. For assistant-at-surgery services, payment would equal 80 percent of the lesser of either the actual charge or 85 percent of the amount that would be recognized for a physician serving as an assistant at surgery. The provision would further provide that the PA could be in an independent contractor relationship with the physician. Employer status would be determined in accordance with State law.

Section 4621. Renal dialysis-related services

Current Law. Medicare covers persons who suffer from end-stage renal disease. Facilities providing dialysis services must meet certain requirements.

Explanation of Provision. The provision would require the Secretary to audit a sample of cost reports of renal dialysis providers for 1995 and for each third year thereafter. The Secretary would also be required to develop and implement by January 1, 1999, a method to measure and report on the quality of renal dialysis services provided under Medicare in order to reduce payments for inappropriate or low quality care.

Section 4622. Payment for cochlear implants as customized durable medical equipment

This provision would transfer cochlear implants from its current prosthetic fee schedule to that of a customized device in the durable medical equipment classification.

Chapter 3—Part B Premium

Section 4631. Part B premium

Current Law. When Medicare was established in 1965, the Part B monthly premium was intended to equal 50 percent of program costs. The remainder was to be financed by Federal general revenues, i.e., tax dollars. Legislation enacted in 1972 limited the annual percentage increase in the premium to the same percentage by which social security benefits were adjusted for cost-of-living increases (i.e., cost-of-living or COLA adjustments). As a result, revenues dropped to below 25 percent of program costs in the early 1980s. Since the early 1980s, Congress has regularly voted to set the premium equal to 25 percent of costs. Under current law, the 25 percent provision is extended through 1998; the COLA limitation would again apply in 1999.

Explanation of Provision. The provision would permanently set the Part B premium at 25 percent of program costs.

SUBTITLE H—PROVISIONS RELATING TO PARTS A AND B

Chapter 1—Provisions Relating to Medicare Secondary Payer

Section 4701. Permanent extension of certain secondary payer provisions

Current Law. Generally, Medicare is the primary payer, that is, it pays health claims first, with an individual's private or other public plan filling in some or all of the coverage gaps. In certain cases, the individual's other coverage pays first, while Medicare is the secondary payer. This is known as the Medicare secondary payer (MSP) program. The MSP provisions apply to group health plans for the working aged, large group health plans for the disabled, and employer health plans (regardless of size) for the end-stage renal disease (ESRD) population for 18 months. The MSP provisions for the disabled expire October 1, 1998. The MSP provisions for the ESRD population apply for 12 months, except the period is extended to 18 months for the February 1, 1991-October 1, 1998 period.

The law authorizes a data match program which is intended to identify potential secondary payer situations. Medicare beneficiaries are matched against data contained in the Social Security Administration and Internal Revenue Service files to identify cases where a working beneficiary (or working spouse) may have employer-based health insurance coverage.

Explanation of Provision. The provision would make permanent the provisions relating to the disabled and the data match program.

The provision would extend application of the MSP provisions for the ESRD population for 30 months. This would apply to items and

services furnished on or after enactment with respect to periods beginning on or after the date that is 18 months prior to enactment.

Section 4702. Clarification of time and filing limitations

Current Law. In many cases where MSP recoveries are sought, claims have never been filed with the primary payer. Identification of potential recoveries under the data match process typically takes several years—considerably in excess of the period many health plans allow for claims filing. A 1994 appeals court decision held that HCFA could not recover overpayments without regard to an insurance plan's filing requirements.

Explanation of Provision. The provision would specify that the U.S. could seek to recover payments if the request for payments was submitted to the entity required or responsible to pay within 3 years from the date the item or service was furnished. This provision would apply notwithstanding any other claims filing time limits that may apply under an employer group health plan. The provision would apply to items and services furnished after 1990. The provision should not be construed as permitting any waiver of the 3-year requirement in the case of items and services furnished more than 3 years before enactment.

Section 4703. Permitting recovery against third party administrators

Current Law. A 1994 appeals court decision held that HCFA could not recover from third party administrators of self-insured plans.

Explanation of Provision. The provision would permit recovery from third party administrators of primary plans. However, recovery would not be permitted where the third-party administrator would not be able to recover the amount at issue from the employer or group health plan for whom it provides administrative services due to the insolvency or bankruptcy of the employer or plan.

The provision would clarify that the beneficiary is not liable in MSP recovery cases unless the benefits were paid directly to the beneficiary.

The provision would apply to services furnished on or after enactment.

Chapter 2—Home Health Services

Section 4711. Recapturing savings resulting from temporary freeze on payment increases from home health services

Current Law. Home health care agencies are currently reimbursed on the basis of reasonable costs, up to specified limits. Cost limits are determined separately for each type of covered home health service (skilled nursing care, physical therapy, speech pathology, occupational therapy, medical social services, and home health aide), and according to whether an agency is located in an urban or rural area. Cost limits, however, are applied to aggregate agency expenditures; that is, an aggregate cost limit is set for each agency that equals the limit for each type of service multiplied by the number of visits of each type provided by the agency. Limits for the individual services are set at 112 percent of the mean labor-

related and nonlabor per visit costs for freestanding agencies. Cost limits are updated annually by applying a market basket index to base year data derived from home health agency cost reports. The labor-related portion of a service limit is adjusted by the current hospital wage index.

The Omnibus Budget Reconciliation Act of 1993 (OBRA 93) required that there be no changes in home health cost limits (including no adjustments for changes in the wage index or other updates of data) for cost reporting periods beginning on or after July 1, 1994, and before July 1, 1996. The Secretary was also required, when granting or extending exceptions to cost limits, to limit any exception to the amount that would have been granted if there were no restriction on changes in the cost limits. OBRA 93 also repealed the requirement that additional payments be made to hospital-based home health agencies for costs attributable to excess overhead allocations, effective for cost reporting periods beginning on or after October 1, 1993.

Explanation of Provision. In establishing home health limits for cost reporting periods beginning after September 30, 1997, the Secretary would be required to capture the savings stream resulting from the OBRA 93 freeze of home health limits by not allowing for the market basket updates to the limits that occurred during the cost reporting periods July 1, 1994, through June 30, 1996. In granting exemptions or exceptions to the cost limits, the Secretary would not consider the preceding provision for recapturing savings from the OBRA 93 freeze.

Section 4712. Interim payments for home health services

Current Law. Limits for individual home health services are set at 112 percent of the mean labor-related and nonlabor per visit costs for freestanding agencies (i.e., agencies not affiliated with hospitals), and are applied in the aggregate to all agency visits. The limits are effective for cost reporting periods beginning on or after July 1 of a given year and ending June 30 of the following year.

Explanation of Provision. The provision would reduce per visit cost limits to 105 percent of the national median of labor-related and nonlabor costs for freestanding home health agencies, effective for cost-reporting periods beginning October 1, 1997 (in effect, also delaying the cycle for updating the limits).

For cost reporting periods beginning on or after October 1, 1997, home health agencies would be paid the lesser of: (1) their actual costs (i.e., allowable reasonable costs); (2) the per visit limits, reduced to 105 percent of the national median, applied in the aggregate; or (3) a new agency-specific per beneficiary annual limit calculated from 1994 reasonable costs (including non-routine medical supplies), based on a blend of 75 percent of agency-specific costs and 25 percent regional average costs, updated by the home health market basket, and applied to the agency's unduplicated census count of patients. For new providers and those providers without a 12-month cost reporting period ending in calendar year 1994, the per beneficiary limit would be equal to the median of these limits (or the Secretary's best estimates) applied to home health agencies. Home health agencies that have altered their corporate structure

or name would not be considered new providers for these purposes. For beneficiaries using more than one home health agency, the per beneficiary limit would be prorated among the agencies.

The Secretary would be required to expand research on a prospective payment system for home health that ties prospective payments to a unit of service, including an intensive effort to develop a reliable case mix adjuster that explains a significant amount of variance in cost. The Secretary would be authorized to require all home health agencies to submit additional information that is necessary for the development of a reliable case-mix system, effective for cost reporting periods beginning on or after October 1, 1997.

Section 4713. Clarification of part-time or intermittent nursing care

Current Law. Both Parts A and B of Medicare cover home health visits for persons who need skilled nursing care on an intermittent basis or physical therapy or speech therapy. Once beneficiaries qualify for the benefit, the program covers part-time or intermittent nursing care provided by or under the supervision of a registered nurse and part-time or intermittent home health aide services, among other services. Coverage guidelines issued by HCFA have defined part-time and intermittent.

Explanation of Provision. Effective for services furnished on or after October 1, 1997, the provision would include in Medicare statute definitions for part-time and intermittent skilled nursing and home health aide. For purposes of receiving skilled nursing and home health aide services, "part-time or intermittent" would mean skilled nursing and home health aide services furnished any number of day per week as long as they are furnished (combined) less than 8 hours each day and 28 or fewer hours each week (or, subject to review on a case-by-case basis as to the need for care, less than 8 hours each day and 35 or fewer hours per week). For purposes of qualifying for Medicare's home health benefit because of a need for intermittent skilled nursing care, "intermittent" would mean skilled nursing care that is either provided or needed on fewer than 7 days each week, or less than 8 hours of each day for periods of 21 days or less (with extensions in exceptional circumstances when the need for additional care is finite and predictable).

Section 4714. Study of definition of homebound

Current Law. In order to be eligible for home health care, a Medicare beneficiary must be confined to his or her home. The law specifies that this "homebound" requirement is met when the beneficiary has a condition that restricts the ability of the individual to leave home, except with the assistance of another individual or with the aid of a supportive device (such as crutches, a cane, a wheelchair, or a walker), or if the individual has a condition such that leaving his or her home is medically contraindicated. The law further specifies that while an individual does not have to be bedridden to be considered confined to home, the condition of the individual should be such that there exists a normal inability to leave home, that leaving home requires a considerable and taxing effort by the individual, and that absences from home are infrequent or of relatively short duration, or are attributable to the need to receive medical treatment.

Explanation of Provision. The provision would require the Secretary to conduct a study of the criteria that should be applied, and the method for applying the criteria, in determining whether an individual is considered homebound for purposes of qualifying for Medicare's home health benefit. Criteria would have to include the extent and circumstances under which a person may be absent from the home but nonetheless qualify. The Secretary would be required to submit to Congress a report on the study, together with specific recommendations, by October 1, 1998.

Section 4715. Payment based on location where home health service is furnished

Current Law. Some home health agencies are established with the home office in an urban area and branch offices in rural areas. Payment is based on the where the service is billed, in this case the urban area with its higher wage rate, even if the service had been delivered in a rural area.

Explanation of Provision. Effective for cost reporting periods beginning on or after October 1, 1997, home health agencies would be required to submit claims on the basis of the location where a service is actually furnished.

Section 4716. Normative standards for home health claims denials

Current Law. As long as they remain eligible, home health users are entitled to unlimited number of visits.

Explanation of Provision. The provision would authorize the Secretary to establish normative guidelines for the frequency and duration of home health services. Payments would be denied for visits that exceed the normative standard. The provision would also authorize the Secretary to establish a process for notifying a physician when the number of home health visits furnished according to a prescription or certification of the physician significantly exceeds the threshold normative number of visits that would be covered for specific conditions or situations.

Section 4717. No home health benefits based solely on drawing blood

Current Law. In order to qualify for Medicare's home health benefit, a person must be homebound and be in need a intermittent skilled nursing care or physical or speech therapy.

Explanation of Provision. The provision would clarify that a person could not qualify for Medicare's home health benefit solely on the basis of needing skilled nursing care for venipuncture for the purpose of obtaining a blood sample.

Section 4718. Making Part B primary payor for certain home health services

(a) Making Part B primary payor for certain home health services

Current Law. Both Parts A and B of Medicare cover home health. Neither part of the program applies deductibles or coinsurance to covered visits, and beneficiaries are entitled to an unlimited number of visits as long as they meet eligibility criteria. Section 1833(d)

of Medicare law prohibits payments to be made under Part B for covered services to the extent that individuals are also covered under Part A for the same services. As a result, the comparatively few persons who have no Part A coverage are the only beneficiaries for whom payments are made under Part B.

Explanation of Provision. Effective October 1, 1997, the provision would transfer from Part A to Part B home health visits that are not post-hospital home health services. Post-hospital home health service services would be defined as the first 100 visits furnished to an individual under a plan of treatment established when the individual is an inpatient of a hospital or rural primary care hospital for at least 3 consecutive days, or during a covered SNF stay, so long as services are initiated within 30 days after discharge from the institution.

The Secretary would be required to calculate the increase in the Part B premium attributable to the transfer of visits to Part B. This increase would be phased in between 1998 and 2003. For 1998, the Part B premium would be increased by one-seventh of the extra costs due to the transfer; for 1999, the Part B premium would be increased by two-sevenths of the extra costs; for 2000, three-sevenths; for 2001, four-sevenths; for 2002, five-sevenths; and for 2003, six-sevenths of the extra costs due to the transfer.

(b) Maintaining appeal rights for home health services

Current Law. Medicare beneficiaries have a right to a hearing before an administrative law judge for disputed claims of at least \$500.

Explanation of Provision. The provision would lower the hearing threshold to \$100 for home health services covered under Part B.

(c) Report

Current Law. No provision.

Explanation of Provision. The Secretary would be required to submit to Congress by October 1, 1999, a report on the impact on home health utilization and admissions to hospitals and skilled nursing facilities of covering only the first 100 post-hospital home health visits under Part A of Medicare. In addition, the Secretary would be required to re-examine and submit a report on this impact 1 year after the full implementation of the home health prospective payment system required under this bill.

Chapter 3—Baby Boom Generation Medicare Commission

Section 4721. Bipartisan Commission on the Effect of the Baby Boom Generation on the Medicare Program

Current Law. No provision.

Explanation of Provision. The provision would establish a commission to be known as the Bipartisan Commission on the Effect of the Baby Boom Generation on the Medicare Program, hereafter referred to as “the Commission.” It would be required to: (1) examine the financial impact on the Medicare program of the significant increase in the number of Medicare eligible individuals which will occur beginning approximately in 2010 and lasting for approximately 25 years, and (2) make specific recommendations to Con-

gress with respect to a comprehensive approach to preserve the Medicare program for the period during which such individuals are eligible for Medicare. In making its recommendations, the Commission would be required to consider: (1) the amount and sources of Federal funds to finance Medicare, including innovative financing methods; (2) methods used by other nations to respond to comparable demographics; (3) modifying age-based eligibility to correspond to that under the OASDI program; and (4) trends in employment-related health care for retirees, including the use of medical savings accounts and similar financing devices; and (5) the role Medicare should play in addressing the needs of persons with chronic illness.

The Commission would be composed of 15 voting members, 6 appointed by the Majority Leader of the Senate in consultation with the Minority Leader, of whom no more than 4 are of the same party; 6 by the Speaker of the House, after consultation with the Minority Leader, of whom no more than 4 are in the same party; and 3 ex officio members of the Board of Trustees of the Federal Hospital Insurance Trust Fund and of the Federal Supplementary Medical Insurance Trust Fund who are Cabinet-level officials. The provision spells out the appointment of a chair and vice chair, appointment of staff and consultants, compensation, the procedure for filling vacancies, and requirements relating to meetings and quorums. The Chairman, in consultation with the vice chairman, could appoint an advisory panel. Upon request of the Commission, the Comptroller General would be required to conduct such studies or investigations as the Commission determined were needed to carry out its duties. The Director of the Congressional Budget Office (CBO) would be required to provide the Commission with cost estimates, for which CBO would be compensated. The Commission would be authorized to detail to it employees of Federal agencies, and to obtain technical assistance and information from Federal agencies.

The Commission would be required to submit to Congress a report, no later than May 1, 1999, 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 a period of projected solvency of the Federal Old-Age and Survivors Insurance Trust Fund). The report would be required to include detailed recommendations for legislative initiatives respecting how to accomplish this objective. The Commission would terminate 30 days after the date of submission of the mandated report. An amount of \$1.5 million would be authorized to be appropriated; 60 percent would be payable from the Federal Hospital Insurance Trust Fund and 40 percent from the Federal Supplementary Medical Insurance Trust Fund.

Chapter 4—Provisions Relating to Direct Graduate Medical Education

Section 4731. Limitation on payment based on number of residents and implementation of rolling average FTE count

Current Law. The direct costs of approved graduate medical education (GME) programs (such as the salaries of residents and fac-

ulty, and other costs related to medical education programs) are excluded from PPS and are paid on the basis of a formula that reflects Medicare's share of each hospital's per resident costs. Medicare's payment to each hospital equals the hospital's costs per full-time-equivalent (FTE) resident, times the weighted average number of FTE residents, times the percentage of inpatient days attributable to Medicare Part A beneficiaries. Each hospital's per FTE resident amount is calculated using data from the hospital's cost reporting period that began in FY 1984, increased by 1 percent for hospital cost reporting periods beginning July 1, 1985, and updated in subsequent cost reporting periods by the change in the CPI. OBRA 93 provided that the per resident amount would not be updated by the CPI for costs reporting periods during FY 1994 and FY 1995, except for primary care residents in obstetrics and gynecology. The number of FTE residents is weighted at 100 percent for residents in their initial residency period (i.e., the number of years of formal training necessary to satisfy specialty requirements for board eligibility). Residents in preventive care or geriatrics are allowed a period of up to 2 additional years in the initial residency training period. For residents not in their initial residency period, the weighing factor is 50 percent. On or after July 1, 1986, residents who are foreign medical graduates can only be counted as FTE residents if they have passed designated examinations.

Explanation of Provision. For cost reporting periods beginning on or after October 1, 1997, the provision would limit the total number of full-time equivalent (FTE) residents (excluding dental residents) for which Medicare would make payments to the number of FTE residents in training during the hospital's cost reporting period ending December 31, 1996. For the cost reporting period beginning on or after October 1, 1997, the total number of FTE equivalent residents counted for determining the hospital's direct GME payment would equal the average FTE counts for the cost reporting period and the preceding cost reporting period. For each subsequent cost reporting period, the total number of FTEs residents counted for determining the hospital's direct GME payment, would be equal to the average of the actual FTE counts for the cost reporting period and preceding two cost reporting periods. The provision would allow that, if a hospital's cost reporting period beginning on or after October 1, 1997, was not equal to 12 months, the Secretary would make appropriate modifications to ensure that the average FTE resident counts are based on the equivalent of full 12-month cost reporting periods.

Section 4732. Phased-in limitation on hospital overhead and supervisory physician component of direct medical education costs

Current Law. Medicare's direct medical education costs for a cost reporting period includes an aggregate amount that is the product of the hospital's approved FTE, resident amount and the weighted average number of FTE residents in the hospitals approved medical residency training programs in that period.

Explanation of Provision. The provision would phase-in a limitation on hospital overhead and supervisory physician costs. For hospitals with overhead GME amounts in a base period that exceed the 75 percentile of the weighted overhead GME amount in such

period for all hospitals, the GME amount made for periods beginning on or after October 1, 1997, would be reduced by the lesser of: (1) 20 percent of the amount by which the overhead GME amount exceeds the 75th percentile amount, or (2) 15 percent of the hospital's overhead GME amount otherwise determined without regard to this provision. The overhead GME amount for a period would be the product of the percentage of the hospital's per resident payment amount for the base period that was not attributable to salaries and fringe benefits, and the hospital specific per resident payment amount for the period involved. The base period would be defined as the cost reporting period beginning in FY 1984 or the period used to establish the hospital's per resident payment amount for hospitals that did not have approved residency training programs in FY 1984. The Secretary would be required to establish rules for the application of this provision in the case of a hospital that initiated medical residency training programs during or after the base cost reporting period.

Section 4733. Permitting payment to non-hospital providers

Current Law. No provision.

Explanation of Provision. The provision would require the Secretary to submit to Congress, no later than 18 months after enactment, a proposal for payment to qualified non-hospital providers for their direct costs of medical education, if those costs are incurred in the operation of a Medicare approved medical residency training program. The proposal would be required to specify the amounts, form, and manner in which such payments would be made, and the portion of the payments that would be made from each of the Medicare trust funds. The Secretary would be authorized to implement the proposal for residency years beginning no earlier than 6 months after the date the report is submitted. Qualified non-hospital providers would include Federally qualified health centers, rural health clinics, MedicarePlus organizations, and other providers the Secretary determined to be appropriate.

The provision would also require the Secretary to reduce the aggregate approved amount to the extent payment would be made to non-hospital providers for residents included in the hospital's count of FTE residents, and in the case of residents not included in the FTE count, the Secretary would be required to provide for such a reduction in aggregate approved amounts under this subsection to assure that the application of non-hospital providers does not result in any increase in expenditures than would have occurred if payments were not made to non-hospital providers.

Section 4734. Incentive payments under plans for voluntary reduction in number of residents

Current Law. No provision.

Explanation of Provision. The provision would establish a program to provide incentive payments to hospitals that developed plans for the voluntary reduction in the number of residents in a training program. For voluntary residency reduction plans for which an application was approved, the qualifying entity submitting the plan would be required to be paid an applicable hold harmless percentage equal to the sum of the amount by which (1)

the amount of payment which would have been made under this subsection if there had been a 5 percent reduction in the number of FTE residents in the approved medical education training programs as of June 30, 1997, exceeded the amount of the payment which would be made taking into account the reduction in the number effected FTEs under the plan; and (2) the amount of the reduction in payment under Medicare's indirect medical education adjustment that was attributable to the reduction in the number of residents effected under the plan.

The provision would prohibit the Secretary from approving the application of a qualifying entity unless: (1) the application was submitted in a form and manner specified by not later than March 1, 2000; (2) the application provided for the operation of a plan for the reduction in the number of FTE residents in the approved medical residency training programs of the entity were consistent with those specified in the provision; (3) the entity elected whether such reduction occurs over a period of not longer than 5 residency training years, or 6 residency training years; (4) the Secretary determined that the application and the entity and the plan meet other requirements as the Secretary specifies in regulations.

The provision specifies that qualifying entities would include individual hospitals operating one or more approved medical residency training programs; two or more hospitals operating residency programs that apply as a single qualifying entity; or a qualifying consortium. In the case of an application by a qualifying entity consisting of two hospitals, the Secretary would be prohibited from approving the application unless the application represented that the qualifying entity either (1) would not reduce the number of FTE residents in primary care during the period of the plan, or (2) would not reduce the proportion of its residents in primary care (to the total number of residents) below such proportion as in effect during the period the residency reduction plan was in effect. In the case of an application from a consortia, the Secretary would be prohibited from approving the application unless the application represented that the qualifying entity would not reduce the proportion of residents in primary care (to total residents) below such proportion in effect during the period the residency reduction plan was in effect.

For individual hospital applicants, the number of FTE residents in all the approved medical residency training programs operated by or through the facility would be required to be reduced as follows: (1) if the base number of residents exceeded 750 residents, by a number equal to at least 20 percent of the base number; (2) if the base number of residents exceeded 500, but was less than 750 residents, by 150 residents; (3) if the base number of residents did not exceed 500 residents, by a number equal to at least 25 percent of the base number; (4) in the case of a qualifying entity that was a consortia, by a number equal to at least 20 percent of the base number. The reductions in the number of FTE residents in the approved medical residency programs operated through or by an entity would be below the base number of residents for the entity and would be fully effective no later than the 5th residency training year for entities electing a 5-year plan, or the 6th residency training year for entities making the election of a 6-year reduction plan.

The provision would require that entities provide assurance that in reducing the number of residents, entities maintained their primary care residents. Entities would be required to provide assurance that they would maintain the number of primary care residents if: (1) the base number of residents is less than 750; (2) the number of FTE residents in primary care included in the base year was at least 10 percent of the total number of residents; and (3) the entity represented in its application that there would be no reduction under the plan in the number of FTE residents in primary care. If the entity failed to comply with the requirement that the number of FTE residents in primary care were maintained, the entity would be subject to repayment of all amounts received under this program.

The base number of residents would be defined as the number of FTE residents in residency training program of the entity as of June 30, 1997. The “applicable hold harmless percentage” for entities electing a 5-year reduction plan would be 100 percent for the first and second residency training years in the reduction plan; 75 percent in the third year; 50 percent in the fourth year; and 25 percent in the fifth year. The “applicable hold harmless percentage” for entities electing a 6-year reduction plan would be 100 percent in the first residency training year of the plan; 95 percent in the second year of the plan; 85 percent in the third year; 70 percent in the fourth year; 50 percent in the fifth year; 25 percent in the sixth year. In addition, if payments were made under this program to an entity that increased the number of FTE residents above the number provided in the plan, the entity would then be liable for repayment to the Secretary of the total amount paid under the plan. The Secretary would also be required to establish rules regarding the counting of residents who are assigned to institutions that do not have medical residency training programs participating in a residency reduction plan.

The requirements of the residency reduction plan would not apply to any residency training demonstration project approved by HCFA as of May 27, 1997. The Secretary would be required to take necessary action to assure that in no case the amount of payments under the plan would exceed 95 percent of what payments would have been prior to the plan for direct GME payments under Medicare. As of May 27, 1997, the Secretary would be prohibited from approving any demonstration project that would provide for additional Medicare payments in connection with reductions in the number of residents in a training program for any residency training year beginning before July 1, 2006. The Secretary would be authorized to promulgate regulations, that take effect on an interim basis, after notice and pending opportunity for public comment, by no later than 6 months after the date of enactment.

Section 4735. Demonstration project on use of consortia

Current Law. No provision.

Explanation of Provision. The provision would require the Secretary to establish a demonstration project under which, instead of making direct GME payments to teaching hospitals, the Secretary would make payments to each consortium that met the requirements of the demonstration project. A qualifying consortia would be

required to be in compliance with the following: (1) the consortium would consist of an approved medical residency training program in a teaching hospital and one or more of the following entities: a school of allopathic or osteopathic medicine, another teaching hospital, another approved medical residency training program, a Federally qualified health center, a medical group practice, a managed care entity, an entity providing outpatient services, or an entity determined to be appropriate by the Secretary; (2) the members of the consortium would have agreed to participate in the programs of graduate medical education that are operated by entities in the consortium; (3) with respect to receipt by the consortium of direct GME payments, the members of the consortium would agree on a method for allocating the payments among the members; and (4) the consortium would meet additional requirements established by the Secretary. The total payments to a qualifying consortium for a fiscal year would not be permitted to exceed the amount that would have been paid under the direct GME payment to teaching hospitals in the consortium. The payments would be required to be made in such proportion from each of the Medicare trust funds as the Secretary specifies.

Section 4736. Recommendations on long-term payment policies regarding financing teaching hospitals and graduate medical education

Current Law. No provision.

Explanation of Provision. The provision would require the Medicare Payment Advisory Commission (established by the bill) to examine and develop recommendations on whether and to what extent Medicare payment policies and other Federal policies regarding teaching hospitals and graduate medical education should be reformed. The Commission's recommendations would be required to include each of the following: (1) the financing of graduate medical education, including consideration of alternative broad-based sources of funding for such education and models for the distribution of payments under any all-payer financing mechanism; (2) the financing of teaching hospitals, including consideration of the difficulties encountered by such hospitals as competition among health care entities increases, including consideration of the effects on teaching hospitals of the method of financing used for the MedicarePlus program under Part C of Medicare; (3) possible methodologies for making payments for graduated medical education and the selection of entities to receive such payments, including consideration of matters as (A) issues regarding children's hospitals and approved medical residency training programs in pediatrics, and (B) whether and to what extent payments were being made (or should be made) for training in the various nonphysician health professions; (4) Federal policies regarding international graduates; (5) the dependence of schools of medicine on service-generated income; (6) whether and to what extent the needs of the U.S. regarding the supply of physicians, in the aggregate and in different specialties, would change during the 10-year period beginning on October 1, 1997, and whether and to what extent any such changes would have significant financial effects of teaching hospitals; (7) methods for promoting an appropriate number, mix, and geographi-

cal distribution of health professionals; and (8) the treatment of dual training programs in primary care fields.

The Commission would be required to consult with the Council on Graduate Medical Education and individuals with expertise in the area of graduate medical education, including (1) deans from allopathic and osteopathic schools of medicine; (2) chief executive officers (or their equivalent) from academic health centers, integrated health care systems, approved medical residency training programs, and teaching hospitals that sponsor approved medical residency training programs; (3) chairs of departments or divisions from allopathic and osteopathic schools of medicine, schools of dentistry, and approved medical residency training programs in oral surgery; (4) individuals with leadership experience from each of the fields of advanced practice nursing, physician assistants, and podiatric medicine; (5) individuals with substantial experience in the study of issues regarding the composition of the U.S. health care workforce; and (6) individuals with expertise on the financing of health care.

The Commission would be required to submit a report to the Congress no later than 2 years after enactment providing its recommendations under this section and the reasons and justifications for such recommendations.

Section 4737. Medicare special reimbursement rule for certain combined residency programs

This provision establishes that residents enrolled in a combined medical residency training programs in which all of the individual programs (that are combined) are for training a primary care resident, the period of board eligibility will be the minimum number of years of formal training required to satisfy the requirements for initial board eligibility in the longest of the individual programs plus one additional year. This provision applies to residents enrolled in a combined medical residency training program that includes an obstetrics and gynecology program so long as the program with which the obstetrics and gynecology program is combined is a primary care training program.

Chapter 5—Other Provisions

Section 4741. Centers of excellence

Current Law. No provision.

Explanation of Provision. The provision would create a new program, the Centers of Excellence, under which the Secretary would be required to use a competitive process to contract with specific hospitals or other entities for furnishing services related to surgical procedures, and for furnishing services (unrelated to surgical procedures) to hospital inpatients that the Secretary determines to be appropriate. The services could include any services covered by Medicare that the Secretary determined were appropriate, including post-hospital services. The Secretary would be required to contract with entities that meet quality standards established by the Secretary, and contracting entities would be required to implement a quality improvement plan approved by the Secretary.

Payment for services provided under the program would be made on the basis of a negotiated all-inclusive rate. The amount of payment made for services covered under a contract would be required to be equal to or less than the aggregate amount of payments that would have been made otherwise for these same services. The contract period would be required to be 3 years, and could be renewed as long as the entity continued to meet quality and other contractual standards. The Secretary would be prohibited from considering price as a factor in selecting hospitals or other entities to participate in the program, except to ensure that payments would be equal to or less than would have been otherwise. Entities under these contracts would be permitted to furnish additional services (at no cost to a Medicare beneficiary) or waive costsharing, subject to approval by the Secretary. The Secretary would be required to limit the number of centers in a geographic area to the number needed to meet project demand for contracted services.

Section 4742. Medicare Part B special enrollment period and waiver of Part B late enrollment penalty and Medigap special open enrollment period for certain military retirees and dependents

Current Law. Persons generally enroll in Part B when they turn 65. Persons who delay enrollment in the program after their initial enrollment period are subject to a premium penalty. This penalty is a surcharge equal to 10 percent of the premium amount for each 12 months of delayed enrollment. There is no upper limit on the amount of penalty that may apply. Further, the penalty continues to apply for the entire time the individual is enrolled in Part B.

Some persons declined Part B coverage because they thought they would be able to get health care coverage at a nearby military base; many of these bases subsequently closed.

Explanation of Provision. The provision would waive the delayed enrollment penalty for certain persons who enroll during a special 6-month enrollment period which begins with the first month that begins at least 45 days after enactment. An individual covered under this provision is one: (1) who, on the date of enactment is at least 65 and eligible to enroll in Part B; (2) who, at the time the individual first met the enrollment requirements was a "covered beneficiary" under the military medical and dental care program. Covered beneficiary as defined in Section 1072(5) of Title 10 of the U.S. Code excludes an active duty beneficiary. Part B coverage would begin the month after enrollment.

The provision would also guarantee issuance of a Medigap type "A", "B", "C", or "F" policy to an individual who enrolls with a Medigap plan during the same 6-month enrollment period.

Section 4743. Competitive bidding

Current Law. Medicare does not use competitive bidding for the selection of providers authorized to provide covered services to beneficiaries.

Explanation of Provision. The provision would require the Secretary, within 1 year of enactment, to establish and operate, over a 2-year period, demonstration projects in two geographic areas selected by the Secretary. Under the demonstration, the amount of payment for selected items or services furnished in the region

would be the amount determined pursuant to a competitive bidding process. The process would have to meet the requirements imposed by the Secretary to ensure cost-effective delivery to beneficiaries of items and services of high quality.

The Secretary would select the items and services based on a determination that the use of competitive bidding would be appropriate and cost effective. The Secretary would be required to consult with an advisory task force which included representatives of providers and suppliers (including small business providers and suppliers) in each project region.

SUBTITLE I—MEDICAL LIABILITY REFORM

Chapter 1—General Provisions

Section 4801. Federal reform of health care liability actions

Current Law. There are no uniform Federal standards governing health care liability actions.

Explanation of Provision. The provision would provide for Federal standards in health care liability actions. It would govern any health care liability action brought in any State or Federal court. The provisions would not apply to any action for damages arising from a vaccine-related injury or death or to the extent that the provisions of the National Vaccine Injury Compensation Program apply. The provisions would preempt State or applicable Federal law to the extent State law provisions were inconsistent with the new requirements. However, it would not preempt State law or applicable Federal law to the extent such law provisions were more stringent. The provision would not affect or waive the defense of sovereign immunity asserted by any State or the U.S., affect the applicability of the Foreign Sovereign Immunities Act of 1976, preempt State choice-of-law rules with respect to claims brought by a foreign nation or citizen, or affect the right of any court to transfer venue.

Section 4802. Definitions

Current Law. No provision.

Explanation of Provision. The provision would define the following terms for purposes of the reforms: actual damages; alternative dispute resolution system; claimant; clear and convincing evidence; collateral source payments; device; drug; economic loss; harm; health care liability action; health care liability claim; health care provider; manufacturer; noneconomic damages; person; product seller; punitive damages; and State.

Section 4803. Effective date

Current Law. No provision.

Explanation of Provision. The provision would specify that Federal reforms apply to any health care liability action brought in any State or Federal court that is initiated on or after the date of enactment. The provision would also apply to any health care liability claim subject to an alternative dispute resolution system.

Chapter 2—Uniform Standards for Health Care Liability Actions

Section 4811. Statute of limitations

Current Law. To date, reforms of the malpractice system have occurred primarily at the State level and have generally involved changes in the rules governing tort cases. (A tort case is a civil action to recover damages, other than for a breach of contract.)

Explanation of Provision. The provision would establish uniform standards for health care liability claims. It would establish a uniform statute of limitations. Actions could not be brought more than 2 years after the harm was discovered or reasonably should have been discovered. A person with a legal disability could file an action not later than 2 years after the person ceased to have a legal disability. If either of these provisions shortened the time period otherwise available, a claim could be brought up to 2 years after enactment.

Section 4812. Calculation and payment of damages

Current Law. No provision.

Explanation of Provision. The provision would limit noneconomic damages to \$250,000 in a particular case. The limit would apply regardless of the number of persons against whom the action was brought or the number of actions brought.

The provision would specify that a defendant would only be liable for the amount of noneconomic damages attributable to that defendant's proportionate share of the fault or responsibility for the harm to that claimant. The court would render a separate judgment against each defendant. The trier of fact would determine the percentage of responsibility of each person responsible for the harm, whether or not the person is party to the action.

The provision would permit the award of punitive damages (to the extent allowed under applicable law) only if the claimant established by clear and convincing evidence that the harm was the result of conduct that manifested a conscious flagrant indifference to the rights or safety of others. The amount of punitive damages awarded could not exceed \$250,000 or three times the amount of economic damages, whichever was greater. The determination of punitive damages would be determined by the court and not be disclosed to the jury.

The provision would permit either party to request a separate proceeding (bifurcation), held subsequent to determination of compensatory damages, on the issue of whether punitive damages should be awarded and in what amount. If a separate proceeding was requested, evidence related only to the claim of punitive damages would be inadmissible in any proceeding to determine whether compensatory damages should be awarded.

The provision would prohibit the award of punitive damages against a manufacturer or product seller in a case where a drug or device was subject to premarket approval by the Food and Drug Administration (FDA) (or generally recognized as safe and effective according to conditions established by the FDA), unless there was misrepresentation or fraud. A manufacturer would not be held liable for punitive damages related to adequacy of required tamper resistant packaging unless the packaging or labeling was found by

clear and convincing evidence to be substantially out of compliance with the regulations.

The provision would permit the periodic (rather than lump sum) payment of future losses in excess of \$50,000. The judgment of a court awarding periodic payments could not, in the absence of fraud, be reopened at any time to contest, amend, or modify the schedule or amount of payments. The provision would not preclude a lump sum settlement.

The provision would permit a defendant to introduce evidence of collateral source payments. Such payments are those which are paid or reasonably likely to be paid by health or accident insurance, disability coverage, workers compensation, or other third party sources. If such evidence was introduced, the claimant could introduce evidence of any amount paid or reasonably likely to be paid to secure the right to such collateral source payments. No provider of collateral source payments would be permitted to recover any amount against the claimant or against the claimant's recovery.

Section 4813. Alternative dispute resolution

Current Law. No provision.

Explanation of Provision. The provision would require that any alternative dispute resolution system used to resolve health care liability actions or claims must include provisions identical to those specified in the bill relating to statute of limitations, non-economic damages, joint and several liability, punitive damages, collateral source rule, and periodic payments.

CHANGES IN EXISTING LAW MADE BY TITLE IV

SOCIAL SECURITY ACT

* * * * *

TITLE XI—GENERAL PROVISIONS, PEER REVIEW, AND ADMINISTRATIVE SIMPLIFICATION

* * * * *

PART A—GENERAL PROVISIONS

* * * * *

DISCLOSURE OF OWNERSHIP AND RELATED INFORMATION

SEC. 1124. (a)(1) The Secretary shall by regulation or by contract provision provide that each disclosing entity (as defined in paragraph (2)) shall—

(A) as a condition of the disclosing entity's participation in, or certification or recertification under, any of the programs established by titles V, XVIII, and XIX, or

(B) as a condition for the approval or renewal of a contract or agreement between the disclosing entity and the Secretary or the appropriate State agency under any of the programs established under titles V, XVIII, and XIX, supply the Secretary or the appropriate State agency with full and complete information as to the identity of each person with an own-

ership or control interest (as defined in paragraph (3)) in the entity or in any subcontractor (as defined by the Secretary in regulations) in which the entity directly or indirectly has a 5 per centum or more ownership interest *and supply the Secretary with both the employer identification number (assigned pursuant to section 6109 of the Internal Revenue Code of 1986) and social security account number (assigned under section 205(c)(2)(B)) of the disclosing entity, each person with an ownership or control interest (as defined in subsection (a)(3)), and any subcontractor in which the entity directly or indirectly has a 5 percent or more ownership interest.*

* * * * *

DISCLOSURE REQUIREMENTS FOR OTHER PROVIDERS UNDER PART B OF MEDICARE

SEC. 1124A. (a) DISCLOSURE REQUIRED TO RECEIVE PAYMENT.—No payment may be made under part B of title XVIII for items or services furnished by any disclosing part B provider unless such provider has provided the Secretary with full and complete information—

(1) on the identity of each person with an ownership or control interest in the provider or in any subcontractor (as defined by the Secretary in regulations) in which the provider directly or indirectly has a 5 percent or more ownership interest; **[and]**

(2) with respect to any person identified under paragraph (1) or any managing employee of the provider—

(A) on the identity of any other entities providing items or services for which payment may be made under title XVIII with respect to which such person or managing employee is a person with an ownership or control interest at the time such information is supplied or at any time during the 3-year period ending on the date such information is supplied, and

(B) as to whether any penalties, assessments, or exclusions have been assessed against such person or managing employee under section 1128, 1128A, or 1128B~~].~~; and

(3) *including the employer identification number (assigned pursuant to section 6109 of the Internal Revenue Code of 1986) and social security account number (assigned under section 205(c)(2)(B)) of the disclosing part B provider and any person, managing employee, or other entity identified or described under paragraph (1) or (2).*

* * * * *

(c) VERIFICATION.—

(1) TRANSMITTAL BY HHS.—*The Secretary shall transmit—*

(A) *to the Commissioner of Social Security information concerning each social security account number (assigned under section 205(c)(2)(B)), and*

(B) *to the Secretary of the Treasury information concerning each employer identification number (assigned pursuant to section 6109 of the Internal Revenue Code of 1986), supplied to the Secretary pursuant to subsection (a)(3) or section 1124(c) to the extent necessary for verification of such information in accordance with paragraph (2).*

(2) VERIFICATION.—The Commissioner of Social Security and the Secretary of the Treasury shall verify the accuracy of, or correct, the information supplied by the Secretary to such official pursuant to paragraph (1), and shall report such verifications or corrections to the Secretary.

(3) FEES FOR VERIFICATION.—The Secretary shall reimburse the Commissioner and Secretary of the Treasury, at a rate negotiated between the Secretary and such official, for the costs incurred by such official in performing the verification and correction services described in this subsection.

[(c)] (d) DEFINITIONS.—For purposes of this section—

(1) the term “disclosing part B provider” means any entity receiving payment on an assignment-related basis (or, for purposes of subsection (a)(3), any entity receiving payment) for furnishing items or services for which payment may be made under part B of title XVIII, except that such term does not include an entity described in section 1124(a)(2);

* * * * *

EXCLUSION OF CERTAIN INDIVIDUALS AND ENTITIES FROM PARTICIPATION IN MEDICARE AND STATE HEALTH CARE PROGRAMS

SEC. 1128. (a) MANDATORY EXCLUSION.—The Secretary shall exclude the following individuals and entities from participation in [any program under title XVIII and shall direct that the following individuals and entities be excluded from participation in any State health care program (as defined in subsection (h))] any Federal health care program (as defined in section 1128B(f)):

(1) * * *

* * * * *

(b) PERMISSIVE EXCLUSION.—The Secretary may exclude the following individuals and entities from participation in [any program under title XVIII and may direct that the following individuals and entities be excluded from participation in any State health care program] any Federal health care program (as defined in section 1128B(f)):

(1) * * *

* * * * *

(8) ENTITIES CONTROLLED BY A SANCTIONED INDIVIDUAL.—Any entity with respect to which the Secretary determines that a person—

(A)(i) who has a direct or indirect ownership or control interest of 5 percent or more in the entity or with an ownership or control interest (as defined in section 1124(a)(3)) in that entity, [or]

(ii) who is an officer, director, agent, or managing employee (as defined in section 1126(b)) of that entity[—]; or

(iii) who was described in clause (i) but is no longer so described because of a transfer of ownership or control interest, in anticipation of (or following) a conviction, assessment, or exclusion described in subparagraph (B) against the person, to an immediate family member (as defined in subsection (j)(1)) or a member of the household of the per-

son (as defined in subsection (j)(2)) who continues to maintain an interest described in such clause—
is a person—

* * * * *

(c) NOTICE, EFFECTIVE DATE, AND PERIOD OF EXCLUSION.—
(1) * * *

* * * * *

(3)(A) The Secretary shall specify, in the notice of exclusion under paragraph (1) and the written notice under section 1128A, the minimum period (or, in the case of an exclusion of an individual under subsection (b)(12) or in the case described in subparagraph (G), the period) of the exclusion.

(B) [In the case] *Subject to subparagraph (G), in the case of an exclusion under subsection (a), the minimum period of exclusion shall be not less than five years, except that, upon the request of a State, the Secretary may waive the exclusion under subsection (a)(1) in the case of an individual or entity that is the sole community physician or sole source of essential specialized services in a community. The Secretary's decision whether to waive the exclusion shall not be reviewable.*

* * * * *

(D) [In the case] *Subject to subparagraph (G), in the case of an exclusion of an individual or entity under paragraph (1), (2), or (3) of subsection (b), the period of the exclusion shall be 3 years, unless the Secretary determines in accordance with published regulations that a shorter period is appropriate because of mitigating circumstances or that a longer period is appropriate because of aggravating circumstances.*

* * * * *

(G) *In the case of an exclusion of an individual under subsection (a) based on a conviction occurring on or after the date of the enactment of this subparagraph, if the individual has (before, on, or after such date and before the date of the conviction for which the exclusion is imposed) been convicted—*

(i) on one previous occasion of one or more offenses for which an exclusion may be effected under such subsection, the period of the exclusion shall be not less than 10 years, or

(ii) on 2 or more previous occasions of one or more offenses for which an exclusion may be effected under such subsection, the period of the exclusion shall be permanent.

* * * * *

(j) DEFINITION OF IMMEDIATE FAMILY MEMBER AND MEMBER OF HOUSEHOLD.—*For purposes of subsection (b)(8)(A)(iii):*

(1) *The term "immediate family member" means, with respect to a person—*

(A) the husband or wife of the person;

(B) the natural or adoptive parent, child, or sibling of the person;

(C) the stepparent, stepchild, stepbrother, or stepsister of the person;

(D) the father-, mother-, daughter-, son-, brother-, or sister-in-law of the person;

(E) the grandparent or grandchild of the person; and

(F) the spouse of a grandparent or grandchild of the person.

(2) The term "member of the household" means, with respect to a person, any individual sharing a common abode as part of a single family unit with the person, including domestic employees and others who live together as a family unit, but not including a roomer or boarder.

CIVIL MONETARY PENALTIES

SEC. 1128A. (a) Any person (including an organization, agency, or other entity, but excluding a beneficiary, as defined in subsection (i)(5)) that—

(1) knowingly presents or causes to be presented to an officer, employee, or agent of the United States, or of any department or agency thereof, or of any State agency (as defined in subsection (i)(1)), a claim (as defined in subsection (i)(2)) that the Secretary determines—

(A) * * *

* * * * *

(D) is for a medical or other item or service furnished, ordered, or prescribed by such person during a period in which the person was excluded (pursuant to this title or title XVIII) from the program under which the claim was made [pursuant to a determination by the Secretary under this section or under section 1128, 1156, 1160(b) (as in effect on September 2, 1982), 1862(d) (as in effect on the date of the enactment of the Medicare and Medicaid Patient and Program Protection Act of 1987), or 1866(b) or as a result of the application of the provisions of section 1842(j)(2), or],

(E) is for a medical or other item or service ordered or prescribed by a person excluded (pursuant to this title or title XVIII) from the program under which the claim was made, and the person furnishing such item or service knows or should know of such exclusion, or

[(E)] (F) is for a pattern of medical or other items or services that a person knows or should know are not medically necessary;

* * * * *

(4) in the case of a person who is not an organization, agency, or other entity, is excluded from participating in a program under title XVIII or a State health care program in accordance with this subsection or under section 1128 and who, at the time of a violation of this subsection—

(A) retains a direct or indirect ownership or control interest in an entity that is participating in a program under title XVIII or a State health care program, and who knows or should know of the action constituting the basis for the exclusion; or

(B) is an officer or managing employee (as defined in section 1126(b)) of such an entity; **[or]**

(5) offers to or transfers remuneration to any individual eligible for benefits under title XVIII of this Act, or under a State health care program (as defined in section 1128(h)) that such person knows or should know is likely to influence such individual to order or receive from a particular provider, practitioner, or supplier any item or service for which payment may be made, in whole or in part, under title XVIII, or a State health care program (as so defined); *or*

(6) *arranges or contracts (by employment or otherwise) with an individual or entity that the person knows or should know is excluded from participation in a Federal health care program (as defined in section 1128B(f)), for the provision of items or services for which payment may be made under such a program;*

shall be subject, in addition to any other penalties that may be prescribed by law, to a civil money penalty of not more than \$10,000 for each item or service (or, in cases under paragraph (3), \$15,000 for each individual with respect to whom false or misleading information was given; in cases under paragraph (4), \$10,000 for each day the prohibited relationship occurs). In addition, such a person shall be subject to an assessment of not more than 3 times the amount claimed for each such item or service in lieu of damages sustained by the United States or a State agency because of such claim. In addition the Secretary may make a determination in the same proceeding to exclude the person from participation in the Federal health care programs (as defined in section 1128B(f)(1)) and to direct the appropriate State agency to exclude the person from participation in any State health care program.

* * * * *

(i) For the purposes of this section:

(1) * * *

* * * * *

(6) The term “remuneration” includes the waiver of coinsurance and deductible amounts (or any part thereof), and transfers of items or services for free or for other than fair market value. The term “remuneration” does not include—

(A) * * *

(B) differentials in coinsurance and deductible amounts as part of a benefit plan design as long as the differentials have been disclosed in writing to all beneficiaries, third party payers, and providers, to whom claims are presented and as long as the differentials meet the standards as defined in regulations promulgated by the Secretary not later than 180 days after the date of the enactment of the Health Insurance Portability and Accountability Act of 1996; **[or]**

(C) incentives given to individuals to promote the delivery of preventive care as determined by the Secretary in regulations so promulgated**[.]**; *or*

(D) a reduction in the copayment amount for covered OPD services under section 1833(t)(5)(B).

* * * * *

GUIDANCE REGARDING APPLICATION OF HEALTH CARE FRAUD AND ABUSE SANCTIONS

SEC. 1128D. (a) * * *

(b) ADVISORY OPINIONS.—

(1) ISSUANCE OF ADVISORY OPINIONS.—The Secretary, in consultation with the Attorney General, shall issue written advisory opinions as provided in this subsection.

(2) MATTERS SUBJECT TO ADVISORY OPINIONS.—The Secretary shall issue advisory opinions as to the following matters:

(A) * * *

* * * * *

(D) What constitutes an inducement to reduce or limit services to individuals entitled to benefits under title XVIII or title XIX within the meaning of section [1128B(b)] 1128A(b).

* * * * *

HEALTH CARE FRAUD AND ABUSE DATA COLLECTION PROGRAM

SEC. 1128E. (a) * * *

(b) REPORTING OF INFORMATION.—

(1) * * *

* * * * *

(6) SANCTIONS FOR FAILURE TO REPORT.—

(A) HEALTH PLANS.—Any health plan that fails to report information on an adverse action required to be reported under this subsection shall be subject to a civil money penalty of not more than \$25,000 for each such adverse action not reported. Such penalty shall be imposed and collected in the same manner as civil money penalties under subsection (a) of section 1128A are imposed and collected under that section.

(B) GOVERNMENTAL AGENCIES.—The Secretary shall provide for a publication of a public report that identifies those Government agencies that have failed to report information on adverse actions as required to be reported under this subsection.

* * * * *

(g) DEFINITIONS AND SPECIAL RULES.—For purposes of this section:

(1) * * *

* * * * *

(3) GOVERNMENT AGENCY.—The term “Government agency” shall include:

(A) The Department of Justice.

(B) The Department of Health and Human Services.

(C) Any other Federal agency that either administers or provides payment for the delivery of health care services, including, but not limited to the Department of Defense and the [Veterans' Administration] *Department of Veterans Affairs*.

* * * * *

(5) DETERMINATION OF CONVICTION.—For purposes of paragraph (1), the existence of a conviction shall be determined under [paragraph (4)] *paragraphs (1) through (4)* of section 1128(i).

* * * * *

*PUBLIC DISCLOSURE OF CERTAIN INFORMATION ON HOSPITAL
FINANCIAL INTEREST AND REFERRAL PATTERNS*

SEC. 1146. The Secretary shall make available to the public, in a form and manner specified by the Secretary, information disclosed to the Secretary pursuant to section 1866(a)(1)(R).

TITLE XVIII—HEALTH INSURANCE FOR THE AGED AND DISABLED

* * * * *

MEDICARE PAYMENT ADVISORY COMMISSION

SEC. 1805. (a) ESTABLISHMENT.—There is hereby established the Medicare Payment Advisory Commission (in this section referred to as the "Commission").

(b) DUTIES.—

(1) REVIEW OF PAYMENT POLICIES AND ANNUAL REPORTS.—The Commission shall—

(A) review payment policies under this title, including the topics 1833, described in paragraph (2);

(B) make recommendations to Congress concerning such payment policies; and

(C) by not later than March 1 of each year (beginning with 1998), submit a report to Congress containing the results of such reviews and its recommendations concerning such policies and an examination of issues affecting the medicare program.

(2) SPECIFIC TOPICS TO BE REVIEWED.—

(A) MEDICAREPLUS PROGRAM.—Specifically, the Commission shall review, with respect to the MedicarePlus program under part C, the following:

(i) The methodology for making payment to plans under such program, including the making of differential payments and the distribution of differential updates among different payment areas.

(ii) The mechanisms used to adjust payments for risk and the need to adjust such mechanisms to take into account health status of beneficiaries.

(iii) The implications of risk selection both among MedicarePlus organizations and between the

MedicarePlus option and the medicare fee-for-service option.

(iv) The development and implementation of mechanisms to assure the quality of care for those enrolled with MedicarePlus organizations.

(v) The impact of the MedicarePlus program on access to care for medicare beneficiaries.

(vi) Other major issues in implementation and further development of the MedicarePlus program.

(B) FEE-FOR-SERVICE SYSTEM.—Specifically, the Commission shall review payment policies under parts A and B, including—

(i) the factors affecting expenditures for services in different sectors, including the process for updating hospital, skilled nursing facility, physician, and other fees,

(ii) payment methodologies, and

(iii) their relationship to access and quality of care for medicare beneficiaries.

(C) INTERACTION OF MEDICARE PAYMENT POLICIES WITH HEALTH CARE DELIVERY GENERALLY.—Specifically, the Commission shall review the effect of payment policies under this title on the delivery of health care services other than under this title and assess the implications of changes in health care delivery in the United States and in the general market for health care services on the medicare program.

(3) COMMENTS ON CERTAIN SECRETARIAL REPORTS.—If the Secretary submits to Congress (or a committee of Congress) a report that is required by law and that relates to payment policies under this title, the Secretary shall transmit a copy of the report to the Commission. The Commission shall review the report and, not later than 6 months after the date of submittal of the Secretary's report to Congress, shall submit to the appropriate committees of Congress written comments on such report. Such comments may include such recommendations as the Commission deems appropriate.

(4) AGENDA AND ADDITIONAL REVIEWS.—The Commission shall consult periodically with the chairmen and ranking minority members of the appropriate committees of Congress regarding the Commission's agenda and progress towards achieving the agenda. The Commission may conduct additional reviews, and submit additional reports to the appropriate committees of Congress, from time to time on such topics relating to the program under this title as may be requested by such chairmen and members and as the Commission deems appropriate.

(5) AVAILABILITY OF REPORTS.—The Commission shall transmit to the Secretary a copy of each report submitted under this subsection and shall make such reports available to the public.

(6) APPROPRIATE COMMITTEES.—For purposes of this section, the term "appropriate committees of Congress" means the Committees on Ways and Means and Commerce of the House of Representatives and the Committee on Finance of the Senate.

(c) MEMBERSHIP.—

(1) *NUMBER AND APPOINTMENT.*—The Commission shall be composed of 13 members appointed by the Comptroller General.

(2) *QUALIFICATIONS.*—

(A) *IN GENERAL.*—The membership of the Commission shall include individuals with national recognition for their expertise in health finance and economics, actuarial science, health facility management, health plans and integrated delivery systems, reimbursement of health facilities, allopathic and osteopathic physicians, and other providers of health services, and other related fields, who provide a mix of different professionals, broad geographic representation, and a balance between urban and rural representatives.

(B) *INCLUSION.*—The membership of the Commission shall include (but not be limited to) physicians and other health professionals, employers, third party payers, 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.

(C) *MAJORITY NONPROVIDERS.*—Individuals who are directly involved in the provision, or management of the delivery, of items and services covered under this title shall not constitute a majority of the membership of the Commission.

(D) *ETHICAL DISCLOSURE.*—The Comptroller General shall establish a system for public disclosure by members of the Commission of financial and other potential conflicts of interest relating to such members.

(3) *TERMS.*—

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

(4) *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.

(5) 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.

(6) 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—

(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 nonproprietary data of the Commission, immediately upon request.

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

(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 appropriated 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.

PART A—HOSPITAL INSURANCE BENEFITS FOR THE AGED AND DISABLED

* * * * *

SCOPE OF BENEFITS

SEC. 1812. (a) The benefits provided to an individual by the insurance program under this part shall consist of entitlement to have payment made on his behalf or, in the case of payments referred to in section 1814(d)(2) to him (subject to the provisions of this part) for—

(1) * * *

* * * * *

(3) [home health services] for individuals not enrolled in part B, home health services, and for individuals so enrolled, part A home health services (as defined in subsection (g)); and

(4) in lieu of certain other benefits, hospice care with respect to the individual during up to two periods of 90 days each[, a subsequent period of 30 days, and a subsequent extension period] and an unlimited number of subsequent periods of 60 days each with respect to which the individual makes an election under subsection (d)(1).

* * * * *

CONDITIONS OF AND LIMITATIONS ON PAYMENT FOR SERVICES

Requirement of Requests and Certifications

SEC. 1814. (a) Except as provided in subsections (d) and (g) and in section 1876, payment for services furnished an individual may be made only to providers of services which are eligible therefor under section 1866 and only if—

(1) * * *

(2) a physician, or, in the case of services described in subparagraph (B), a physician, or a nurse practitioner or clinical nurse specialist who does not have a direct or indirect employment relationship with the facility but is working in collaboration with a physician, certifies (and recertifies, where such services are furnished over a period of time, in such cases, with such frequency, and accompanied by such supporting material, appropriate to the case involved, as may be provided by regulations, except that the first of such recertifications shall be required in each case of inpatient hospital services not later than the 20th day of such period) that—

(A) * * *

* * * * *

(C) in the case of home health services, such services are or were required because the individual is or was confined to his home (except when receiving items and services referred to in section 1861(m)(7)) and needs or needed skilled nursing care (*other than solely venipuncture for the purpose of obtaining a blood sample*) on an intermittent basis or physical or speech therapy or, in the case of an individual who has been furnished home health services based on such a need and who no longer has such a need for such care or therapy, continues or continued to need occupational therapy; a plan for furnishing such services to such individual has been established and is periodically reviewed by a physician; and such services are or were furnished while the individual was under the care of a physician; or

* * * * *

Amount Paid to Providers

(b) The amount paid to any provider of services (other than a hospice program providing hospice care, other than a rural primary care hospital providing inpatient rural primary care hospital services, and other than a home health agency with respect to durable medical equipment) with respect to services for which payment may be made under this part shall, subject to the provisions of sections 1813 [and 1886] 1886, and 1895, be—

(1) * * *

* * * * *

PAYMENT TO PROVIDERS OF SERVICES

SEC. 1815. (a) * * *

* * * * *

(e)(1) * * *

(2) The Secretary shall provide (or continue to provide) for payment on a periodic interim payment basis (under the standards established under section 405.454(j) of title 42, Code of Federal Regulations, as in effect on October 1, 1986) with respect to—

(A) * * *

* * * * *

(C) extended care services; and
[(D) home health services; and]
[(E)] (D) hospice care;

if the provider of such services elects to receive, and qualifies for, such payments.

* * * * *

USE OF PUBLIC AGENCIES OR PRIVATE ORGANIZATIONS TO FACILITATE
PAYMENT TO PROVIDERS OF SERVICES

SEC. 1816. (a) * * *

* * * * *

(i)(1) * * *

* * * * *

(4) Nothing in this subsection shall be construed to prohibit reimbursement by an agency or organization under subsection (m).

* * * * *

(m) An agreement with an agency or organization under this section shall require that such agency or organization reimburse the Secretary for any amounts paid by the agency or organization for a service under this title which is furnished, directed, or prescribed by an individual or entity during any period for which the individual or entity is excluded pursuant to section 1128, 1128A, or 1156, from participation in the program under this title, if the amounts are paid after the Secretary notifies the agency or organization of the exclusion.

HOSPITAL INSURANCE BENEFITS FOR UNINSURED ELDERLY
INDIVIDUALS NOT OTHERWISE ELIGIBLE

SEC. 1818. (a) * * *

* * * * *

(d)(1) * * *

(2) The Secretary shall, during September of each year determine and promulgate the dollar amount which shall be applicable for premiums for months occurring in the following year. Subject to [paragraph (4)] paragraphs (4) and (5), the amount of an individual's monthly premium under this section shall be equal to the monthly actuarial rate determined under paragraph (1) for that following year. Any amount determined under the preceding sentence which is not a multiple of \$1 shall be rounded to the nearest multiple of \$1 (or, if it is a multiple of 50 cents but not a multiple of \$1, to the next higher multiple of \$1).

* * * * *

(5)(A) The amount of the monthly premium shall be zero in the case of an individual who is a person described in subparagraph (B) for a month, if—

(i) the individual's premium under this section for the month is not (and will not be) paid for, in whole or in part, by a State (under title XIX or otherwise), a political subdivision of a State,

or an agency or instrumentality of one or more States or political subdivisions thereof; and

(ii) in each of 60 months before such month, the individual was enrolled in this part under this section and the payment of the individual's premium under this section for the month was not paid for, in whole or in part, by a State (under title XIX or otherwise), a political subdivision of a State, or an agency or instrumentality of one or more States or political subdivisions thereof.

(B) A person described in this subparagraph for a month is a person who establishes to the satisfaction of the Secretary that, as of the last day of the previous month—

(i)(I) the person was receiving cash benefits under a qualified State or local government retirement system (as defined in subparagraph (C)) on the basis of the person's employment in one or more positions covered under any such system, and (II) the person would have at least 40 quarters of coverage under title II if remuneration for medicare qualified government employment (as defined in paragraph (1) of section 210(p), but determined without regard to paragraph (3) of such section) paid to such person were treated as wages paid to such person and credited for purposes of determining quarters of coverage under section 213;

(ii)(I) the person was married (and had been married for the previous 1-year period) to an individual who is described in clause (i), or (II) the person met the requirement of clause (i)(II) and was married (and had been married for the previous 1-year period) to an individual described in clause (i)(I);

(iii) the person had been married to an individual for a period of at least 1 year (at the time of such individual's death) if (I) the individual was described in clause (i) at the time of the individual's death, or (II) the person met the requirement of clause (i)(II) and the individual was described in clause (i)(I) at the time of the individual's death; or

(iv) the person is divorced from an individual and had been married to the individual for a period of at least 10 years (at the time of the divorce) if (I) the individual was described in clause (i) at the time of the divorce, or (II) the person met the requirement of clause (i)(II) and the individual was described in clause (i)(I) at the time of the divorce.

(C) For purposes of subparagraph (B)(i)(I), the term "qualified State or local government retirement system" means a retirement system that—

(i) is established or maintained by a State or political subdivision thereof, or an agency or instrumentality of one or more States or political subdivisions thereof;

(ii) covers positions of some or all employees of such a State, subdivision, agency, or instrumentality; and

(iii) does not adjust cash retirement benefits based on eligibility for a reduction in premium under this paragraph.

* * * * *

PART B—SUPPLEMENTARY MEDICAL INSURANCE BENEFITS FOR THE AGED AND DISABLED

SCOPE OF BENEFITS

* * * * *

SEC. 1832. (a) The benefits provided to an individual by the insurance program established by this part shall consist of—

(1) entitlement to have payment made to him or on his behalf (subject to the provisions of this part) for medical and other health services, except those described in subparagraphs (B) and (D) of paragraph **[(2);]** (2), *section 1842(b)(6)(E), and section 1842(b)(6)(F)*; and

(2) entitlement to have payment made on his behalf (subject to the provisions of this part) for—

(A) home health services (other than items described in subparagraph (G) or subparagraph (I));

(B) medical and other health services (other than items described in subparagraph (G) or subparagraph (I)) furnished by a provider of services or by others under arrangement with them made by a provider of services, excluding—

(i) * * *

* * * * *

(iv) services of a nurse practitioner or clinical nurse specialist **[(provided in a rural area (as defined in section 1886(d)(2)(D))]** *but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services*; and

* * * * *

PAYMENT OF BENEFITS

SEC. 1833. (a) Except as provided in section 1876, and subject to the succeeding provisions of this section, there shall be paid from the Federal Supplementary Medical Insurance Trust Fund, in the case of each individual who is covered under the insurance program established by this part and incurs expenses for services with respect to which benefits are payable under this part, amounts equal to—

(1) in the case of services described in section 1832(a)(1)—80 percent of the reasonable charges for the services; except that (A) an organization which provides medical and other health services (or arranges for their availability) on a prepayment basis may elect to be paid 80 percent of the reasonable cost of services for which payment may be made under this part on behalf of individuals enrolled in such organization in lieu of 80 percent of the reasonable charges for such services if the organization undertakes to charge such individuals no more than 20 percent of such reasonable cost plus any amounts payable by them as a result of subsection (b), (B) with respect to items and services described in section 1861(s)(10)(A), the amounts paid shall be 100 percent of the reasonable charges for such items and services, (C) with respect to expenses incurred for those physicians' services for which payment may be made

under this part that are described in section 1862(a)(4), the amounts paid shall be subject to such limitations as may be prescribed by regulations, (D) with respect to clinical diagnostic laboratory tests for which payment is made under this part (i) on the basis of a fee schedule under subsection (h)(1) or section 1834(d)(1), the amount paid shall be equal to 80 percent (or 100 percent, in the case of such tests for which payment is made on an assignment-related basis) of the lesser of the amount determined under such fee schedule, the limitation amount for that test determined under subsection (h)(4)(B), or the amount of the charges billed for the tests, or (ii) on the basis of a negotiated rate established under subsection (h)(6), the amount paid shall be equal to 100 percent of such negotiated rate, (E) with respect to services furnished to individuals who have been determined to have end stage renal disease, the amounts paid shall be determined subject to the provisions of section 1881, (F) with respect to clinical social worker services under section 1861(s)(2)(N), the amounts paid shall be 80 percent of the lesser of (i) the actual charge for the services or (ii) 75 percent of the amount determined for payment of a psychologist under clause (L), (H) with respect to services of a certified registered nurse anesthetist under section 1861(s)(11), the amounts paid shall be 80 percent of the least of the actual charge, the prevailing charge that would be recognized (or, for services furnished on or after January 1, 1992, the fee schedule amount provided under section 1848) if the services had been performed by an anesthesiologist, or the fee schedule for such services established by the Secretary in accordance with subsection (I), (I) with respect to covered items (described in section 1834(a)(13)), the amounts paid shall be the amounts described in section 1834(a)(1), and (J) with respect to expenses incurred for radiologist services (as defined in section 1834(b)(6)), subject to section 1848, the amounts paid shall be 80 percent of the lesser of the actual charge for the services or the amount provided under the fee schedule established under section 1834(b), (K) with respect to certified nurse-midwife services under section 1861(s)(2)(L), the amounts paid shall be 80 percent of the lesser of the actual charge for the services or the amount determined by a fee schedule established by the Secretary for the purposes of this subparagraph (but in no event shall such fee schedule exceed 65 percent of the prevailing charge that would be allowed for the same service performed by a physician, or, for services furnished on or after January 1, 1992, 65 percent of the fee schedule amount provided under section 1848 for the same service performed by a physician), (L) with respect to qualified psychologist services under section 1861(s)(2)(M), the amounts paid shall be 80 percent of the lesser of the actual charge for the services or the amount determined by a fee schedule established by the Secretary for the purposes of this subparagraph, (M) with respect to prosthetic devices and orthotics and prosthetics (as defined in section 1834(h)(4)), the amounts paid shall be the amounts described in section 1834(h)(1), (N) with respect to expenses incurred for physicians' services (as defined in section 1848(j)(3)),

the amounts paid shall be 80 percent of the payment basis determined under section 1848(a)(1), **[(O)** with respect to services described in section 1861(s)(2)(K)(iii) (relating to nurse practitioner or clinical nurse specialist services provided in a rural area), the amounts paid shall be 80 percent of the lesser of the actual charge or the prevailing charge that would be recognized (or, for services furnished on or after January 1, 1992, the fee schedule amount provided under section 1848) if the services had been performed by a physician (subject to the limitation described in subsection (r)(2)), and **]** *(O) with respect to services described in section 1861(s)(2)(K)(ii) (relating to nurse practitioner or clinical nurse specialist services), the amounts paid shall be equal to 80 percent of (i) the lesser of the actual charge or 85 percent of the fee schedule amount provided under section 1848 for the same service provided by a physician who is not a specialist, or (ii) in the case of services as an assistant at surgery, the lesser of the actual charge or 85 percent of the amount that would otherwise be recognized if performed by a physician who is serving as an assistant at surgery;* (P) with respect to surgical dressings, the amounts paid shall be the amounts determined under section 1834(i)**;** **]** and *(Q) with respect to ambulance service, the amounts paid shall be 80 percent of the lesser of the actual charge for the services or the amount determined by a fee schedule established by the Secretary under section 1834(l);*

(2) in the case of services described in section 1832(a)(2) (except those services described in subparagraphs (C), (D), (E), (F), (G), (H), and (I) of such section and unless otherwise specified in section 1881)—

[(A) with respect to home health services (other than a covered osteoporosis drug (as defined in section 1861(kk))), and to items and services described in section 1861(s)(10)(A), the lesser of—

[(i) the reasonable cost of such services, as determined under section 1861(v), or

[(ii) the customary charges with respect to such services,

or, if such services are furnished by a public provider of services, or by another provider which demonstrates to the satisfaction of the Secretary that a significant portion of its patients are low-income (and requests that payment be made under this provision), free of charge or at nominal charges to the public, the amount determined in accordance with section 1814(b)(2); **]**

(A) with respect to home health services (other than a covered osteoporosis drug (as defined in section 1861(kk))), and to items and services described in section 1861(s)(10)(A), the amounts determined under section 1861(v)(1)(L) or section 1893, or, if the services are furnished by a public provider of services, or by another provider which demonstrates to the satisfaction of the Secretary that a significant portion of its patients are low-income (and requests that payment be made under this provision), free of charge, or at nominal charges to the public,

the amount determined in accordance with section 1814(b)(2);

(B) with respect to other items and services (except those described in subparagraph (C), (D), or (E) of this paragraph and except as may be provided in section 1886 or section 1888(e)(9)—

(i) furnished before January 1, 1999, the lesser of—

(I) the reasonable cost of such services, as determined under section 1861(v), or

(II) the customary charges with respect to such services—less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A), but in no case may the payment for such other services exceed 80 percent of such reasonable cost, or

(ii) if such services are furnished before January 1, 1999, by a public provider of services, or by another provider which demonstrates to the satisfaction of the Secretary that a significant portion of its patients are low-income (and requests that payment be made under this clause), free of charge or at nominal charges to the public, 80 percent of the amount determined in accordance with section 1814(b)(2), or

(iii) if such services are furnished on or after January 1, 1999, the amount determined under subsection (t), or

[(iii)] (iv) if (and for so long as) the conditions described in section 1814(b)(3) are met, the amounts determined under the reimbursement system described in such section;

(C) with respect to services described in the second sentence of section 1861(p), 80 percent of the reasonable charges for such services;

(D) with respect to clinical diagnostic laboratory tests for which payment is made under this part (i) on the basis of a fee schedule determined under subsection (h)(1) or section 1834(d)(1), the amount paid shall be equal to 80 percent (or 100 percent, in the case of such tests for which payment is made on an assignment-related basis or to a provider having an agreement under section 1866) of the lesser of the amount determined under such fee schedule, the limitation amount for that test determined under subsection (h)(4)(B), or the amount of the charges billed for the tests, or (ii) on the basis of a negotiated rate established under subsection (h)(6), the amount paid shall be equal to 100 percent of such negotiated rate for such tests;

(E) with respect to—

(i) outpatient hospital radiology services (including diagnostic and therapeutic radiology, nuclear medicine and CAT scan procedures, magnetic resonance imaging, and ultrasound and other imaging services, but excluding screening mammography), and

(ii) effective for procedures performed on or after October 1, 1989, diagnostic procedures (as defined by the

Secretary) described in section 1861(s)(3) (other than diagnostic x-ray tests and diagnostic laboratory tests), the amount determined under subsection (n) *or, for services or procedures performed on or after January 1, 1999, (t); [and]*

(F) with respect to a covered osteoporosis drug (as defined in section 1861(kk)) furnished by a home health agency, 80 percent of the reasonable cost of such service, as determined under section 1861(v); *and*

(G) *with respect to items and services described in section 1861(s)(10)(A), the lesser of—*

(i) the reasonable cost of such services, as determined under section 1861(v), or

(ii) the customary charges with respect to such services,

or, if such services are furnished by a public provider of services, or by another provider which demonstrates to the satisfaction of the Secretary that a significant portion of its patients are low-income (and requests that payment be made under this provision), free of charge or at nominal charges to the public, the amount determined in accordance with section 1814(b)(2);

(3) in the case of services described in [subparagraphs (D) and (E) of section 1832(a)(2)] *section 1832(a)(2)(E)*, the costs which are reasonable and related to the cost of furnishing such services or which are based on such other tests of reasonableness as the Secretary may prescribe in regulations, including those authorized under section 1861(v)(1)(A), less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A), but in no case may the payment for such services (other than for items and services described in section 1861(s)(10)(A)) exceed 80 percent of such costs;

(4) in the case of facility services described in section 1832(a)(2)(F), and outpatient hospital facility services furnished in connection with surgical procedures specified by the Secretary pursuant to section 1833(i)(1)(A), the applicable amount as determined under paragraph (2) or (3) of subsection (i) *or subsection (t)*;

(5) in the case of covered items (described in section 1834(a)(13)) the amounts described in section 1834(a)(1);

(6) in the case of outpatient rural primary care hospital services, the amounts described in section 1834(g); [and]

(7) in the case of prosthetic devices and orthotics and prosthetics (as described in section 1834(h)(4)), the amounts described in section 1834(h)[.];

(8) *in the case of services described in section 1832(a)(2)(C), the amounts described in section 1834(k); and*

(9) *in the case of services described in section 1832(a)(2)(E), the amounts described in section 1834(k).*

(b) Before applying subsection (a) with respect to expenses incurred by an individual during any calendar year, the total amount of the expenses incurred by such individual during such year (which would, except for this subsection, constitute incurred expenses from which benefits payable under subsection (a) are deter-

minable) shall be reduced by a deductible of \$75 for calendar years before 1991 and \$100 for 1991 and subsequent years; except that (1) such total amount shall not include expenses incurred for items and services described in section 1861(s)(10)(A), (2) such deductible shall not apply with respect to home health services (other than a covered osteoporosis drug (as defined in section 1861(kk))), (3) such deductible shall not apply with respect to clinical diagnostic laboratory tests for which payment is made under this part (A) under subsection (a)(1)(D)(i) or (a)(2)(D)(i) on an assignment-related basis, or to a provider having an agreement under section 1866, or (B) on the basis of a negotiated rate determined under subsection (h)(6), [and] (4) such deductible shall not apply to Federally qualified health center services, (5) *such deductible shall not apply with respect to screening mammography (as described in section 1861(jj)), and (6) such deductible shall not apply with respect to screening pap smear and screening pelvic exam (as described in section 1861(nn))*. The total amount of the expenses incurred by an individual as determined under the preceding sentence shall, after the reduction specified in such sentence, be further reduced by an amount equal to the expenses incurred for the first three pints of whole blood (or equivalent quantities of packed red blood cells, as defined under regulations) furnished to the individual during the calendar year, except that such deductible for such blood shall in accordance with regulations be appropriately reduced to the extent that there has been a replacement of such blood (or equivalent quantities of packed red blood cells, as so defined); and for such purposes blood (or equivalent quantities of packed red blood cells, as so defined) furnished such individual shall be deemed replaced when the institution or other person furnishing such blood (or such equivalent quantities of packed red blood cells, as so defined) is given one pint of blood for each pint of blood (or equivalent quantities of packed red blood cells, as so defined) furnished such individual with respect to which a deduction is made under this sentence. The deductible under the previous sentence for blood or blood cells furnished an individual in a year shall be reduced to the extent that a deductible has been imposed under section 1813(a)(2) to blood or blood cells furnished the individual in the year.

* * * * *

[(d) No] *(d)(1) Subject to paragraph (2), no payment may be made under this part with respect to any services furnished an individual to the extent that such individual is entitled (or would be entitled except for section 1813) to have payment made with respect to such services under part A.*

(2) Payment shall be made under this part (rather than under part A), for an individual entitled to benefits under part A, for home health services, other than the first 100 visits of post-hospital home health services furnished to an individual.

* * * * *

(f) In establishing limits under subsection (a) on payment for rural health clinic services provided by [independent rural health clinics] *rural health clinics (other than such clinics in rural hospitals with less than 50 beds)*, the Secretary shall establish such limit, for services provided—

- (1) in 1988, after March 31, at \$46 *per visit*, and
- (2) in a subsequent year, at the limit established under this subsection for the previous year increased by the percentage increase in the MEI (as defined in section 1842(i)(3)) applicable to primary care services (as defined in section 1842(i)(4)) furnished as of the first day of that year.

(g) In the case of [services described in the second sentence of section 1861(p)] *outpatient physical therapy services (other than in a hospital setting)*, with respect to expenses incurred in any calendar year, no more than \$900 shall be considered as incurred expenses for purposes of subsections (a) and (b). In the case of outpatient occupational therapy services [which are described in the second sentence of section 1861(p) through the operation of section 1861(g)], with respect to expenses incurred in any calendar year, no more than \$900 shall be considered as incurred expenses for purposes of subsections (a) and (b).

(h)(1)(A) [The Secretary] *Subject to paragraphs (1) and (4)(A) of section 1834(d), the Secretary shall establish fee schedules for clinical diagnostic laboratory tests (including prostate cancer screening tests under section 1861(o) consisting of prostate-specific antigen blood tests) for which payment is made under this part, other than such tests performed by a provider of services for an inpatient of such provider.*

* * * * *

(2)(A)(i) Except as provided in paragraph (4), the Secretary shall set the fee schedules at 60 percent (or, in the case of a test performed by a qualified hospital laboratory (as defined in paragraph (1)(D)) for outpatients of such hospital, 62 percent) of the prevailing charge level determined pursuant to the third and fourth sentences of section 1842(b)(3) for similar clinical diagnostic laboratory tests for the applicable region, State, or area for the 12-month period beginning July 1, 1984, adjusted annually (to become effective on January 1 of each year) by a percentage increase or decrease equal to the percentage increase or decrease in the Consumer Price Index for All Urban Consumers (United States city average), and subject to such other adjustments as the Secretary determines are justified by technological changes.

(ii) Notwithstanding clause (i)—

(I) * * *

* * * * *

(IV) the annual adjustment in the fee schedules determined under clause (i) for each of the years 1994 and 1995 *and 1998 through 2002* shall be 0 percent.

* * * * *

(4)(A) * * *

(B) For purposes of subsections (a)(1)(D)(i) and (a)(2)(D)(i), the limitation amount for a clinical diagnostic laboratory test performed—

(i) * * *

* * * * *

(vi) after December 31, 1994, and before January 1, 1996, is equal to 80 percent of such median, [and]

(vii) after December 31, 1995, and before January 1, 1998, is equal to 76 percent of such median[.], and
 (viii) after December 31, 1997, is equal to 72 percent of such median.

(i)(1) * * *
 (2)(A) * * *

* * * * *

(C) Notwithstanding the second sentence of subparagraph (A) or the second sentence of subparagraph (B), if the Secretary has not updated amounts established under such subparagraphs with respect to facility services furnished during a fiscal year (beginning with fiscal year 1996), such amounts shall be increased [by the percentage increase in the consumer price index for all urban consumers (U.S. city average) as estimated by the Secretary for the 12-month period ending with the midpoint of the year involved.] as follows:

(i) For fiscal years 1996 and 1997, by the percentage increase in the consumer price index for all urban consumers (U.S. city average) as estimated by the Secretary for the 12-month period ending with the midpoint of the year involved.

(ii) For each succeeding fiscal year by such percentage increase minus 2.0 percentage points.

(3)(A) The aggregate amount of the payments to be made under this part for outpatient hospital facility services or rural primary care hospital services furnished before January 1, 1999, in connection with surgical procedures specified under paragraph (1)(A) [in a cost reporting period] shall be equal to the lesser of—

- (i) the amount determined with respect to such services under subsection (a)(2)(B); or
- (ii) the blend amount (described in subparagraph (B)).

(B)(i) The blend amount for a cost reporting period is the sum of—

- (I) the cost proportion (as defined in clause (ii)(I)) of the amount described in subparagraph (A)(i), and
- (II) the ASC proportion (as defined in clause (ii)(II)) [of 80 percent] of the standard overhead amount payable with respect to the same surgical procedure as if it were provided in an ambulatory surgical center in the same area, as determined under paragraph (2)(A)[.], less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A).

* * * * *

(n)(1)(A) The aggregate amount of the payments to be made for all or part of a cost reporting period for services described in subsection (a)(2)(E)(i) furnished under this part on or after October 1, 1988, and before January 1, 1999, and for services described in subsection (a)(2)(E)(ii) furnished under this part on or after October 1, 1989, and before January 1, 1999, shall be equal to the lesser of—

- (i) the amount determined with respect to such services under subsection (a)(2)(B), or
- (ii) the blend amount for radiology services and diagnostic procedures determined in accordance with subparagraph (B).

(B)(i) The blend amount for radiology services and diagnostic procedures for a cost reporting period is the sum of—

(I) the cost proportion (as defined in clause (ii)) of the amount described in subparagraph (A)(i); and

(II) the charge proportion (as defined in clause (ii)(II)) of 62 percent (for services described in subsection (a)(2)(E)(i)), or (for procedures described in subsection (a)(2)(E)(ii)), 42 percent or such other percent established by the Secretary (or carriers acting pursuant to guidelines issued by the Secretary) based on prevailing charges established with actual charge data, **[of 80 percent]** of the prevailing charge or (for services described in subsection (a)(2)(E)(i) furnished on or after January 1, 1989) the fee schedule amount established for participating physicians for the same services as if they were furnished in a physician's office in the same locality as determined under section 1842(b), *less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A).*

* * * * *

(r)(1) With respect to services described in **[section 1861(s)(2)(K)(iii) (relating to nurse practitioner or clinical nurse specialist services provided in a rural area)]** *section 1861(s)(2)(K)(ii) (relating to nurse practitioner or clinical nurse specialist services)*, payment may be made on the basis of a claim or request for payment presented by the nurse practitioner or clinical nurse specialist furnishing such services, or by a hospital, rural primary care hospital, skilled nursing facility or nursing facility (as defined in section 1919(a)), physician, group practice, or ambulatory surgical center with which the nurse practitioner or clinical nurse specialist has an employment or contractual relationship that provides for payment to be made under this part for such services to such hospital, physician, group practice, or ambulatory surgical center.

[(2)(A)] For purposes of subsection (a)(1)(O), the prevailing charge for services described in section 1861(s)(2)(K)(iii) may not exceed the applicable percentage (as defined in subparagraph (B)) of the prevailing charge (or, for services furnished on or after January 1, 1992, the fee schedule amount provided under section 1848) determined for such services performed by physicians who are not specialists.

[(B)] In subparagraph (A), the term “applicable percentage” means—

[(i)] 75 percent in the case of services performed in a hospital, and

[(ii)] 85 percent in the case of other services.

[(3)] (2) No hospital or rural primary care hospital that presents a claim or request for payment under this part for services described in **[section 1861(s)(2)(K)(iii)]** *section 1861(s)(2)(K)(ii)* may treat any uncollected coinsurance amount imposed under this part with respect to such services as a bad debt of such hospital for purposes of this title.

* * * * *

(t) *PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES.*—

(1) *IN GENERAL.*—With respect to hospital outpatient services designated by the Secretary (in this section referred to as “covered OPD services”) and furnished during a year beginning with 1999, the amount of payment under this part shall be determined under a prospective payment system established by the Secretary in accordance with this subsection.

(2) *SYSTEM REQUIREMENTS.*—Under the payment system—

(A) the Secretary shall develop a classification system for covered OPD services;

(B) the Secretary may establish groups of covered OPD services, within the classification system described in subparagraph (A), so that services classified within each group are comparable clinically and with respect to the use of resources;

(C) the Secretary shall, using data on claims from 1997 and using data from the most recent available cost reports, establish relative payment weights for covered OPD services (and any groups of such services described in subparagraph (B)) based on median hospital costs and shall determine projections of the frequency of utilization of each such service (or group of services) in 1999;

(D) the Secretary shall determine a wage adjustment factor to adjust the portion of payment and coinsurance attributable to labor-related costs for relative differences in labor and labor-related costs across geographic regions in a budget neutral manner;

(E) the Secretary shall establish other adjustments as determined to be necessary to ensure equitable payments, such as outlier adjustments or adjustments for certain classes of hospitals; and

(F) the Secretary shall develop a method for controlling unnecessary increases in the volume of covered OPD services.

(3) *CALCULATION OF BASE AMOUNTS.*—

(A) *AGGREGATE AMOUNTS THAT WOULD BE PAYABLE IF DEDUCTIBLES WERE DISREGARDED.*—The Secretary shall estimate the total amounts that would be payable from the Trust Fund under this part for covered OPD services in 1999, determined without regard to this subsection, as though the deductible under section 1833(b) did not apply, and as though the coinsurance described in section 1866(a)(2)(A)(ii) (as in effect before the date of the enactment of this subsection) continued to apply.

(B) *UNADJUSTED COPAYMENT AMOUNT.*—For purposes of this subsection, the “unadjusted copayment amount” applicable to a covered OPD service (or group of such services) is 20 percent of national median of the charges for the service (or services within the group) furnished during 1997, updated to 1999 using the Secretary’s estimate of charge growth during the period. The Secretary shall establish rules for establishment of an unadjusted copayment amount for a covered OPD service not furnished during 1997, based upon its classification within a group of such services.

(C) CALCULATION OF CONVERSION FACTORS.—

(i) *FOR 1999.*—On the basis of the weights and frequencies described in paragraph (2)(C), the Secretary shall establish a 1999 conversion factor for determining the medicare pre-deductible OPD fee payment amounts for each covered OPD service (or group of such services) furnished in 1999 so that the sum of the products of the medicare pre-deductible OPD fee payment amounts (taking into account appropriate adjustments described in paragraphs (2)(D) and (2)(E)) and the frequencies, for each service or group (as the case may be), shall equal the total project amount described in subparagraph (A).

(ii) *SUBSEQUENT YEARS.*—Subject to paragraph (8)(B), the Secretary shall establish a conversion factor for covered OPD services furnished in subsequent years in an amount equal to the conversion factor established under this subparagraph and applicable to such services furnished in the previous year increased by the OPD payment increase factor specified under clause (iii) for the year involved.

(iii) *OPD PAYMENT INCREASE FACTOR.*—For purposes of this subparagraph, the “OPD payment increase factor” for services furnished in a year is equal to the market basket percentage increase (applicable under section 1886(b)(3)(B)(iii) to hospital discharges occurring during the fiscal year ending in such year) plus 3.5 percentage points. In applying the previous sentence for years beginning with 2000, the Secretary may substitute for the market basket percentage increase an annual percentage increase that is computed and applied with respect to covered OPD services furnished in a year in the same manner as the market basket percentage increase is determined and applied to inpatient hospital services for discharges occurring in a fiscal year.

(D) PRE-DEDUCTIBLE PAYMENT PERCENTAGE.—The pre-deductible payment percentage for a covered OPD service (or group of such services) furnished in a year is equal to the ratio of—

(i) the conversion factor established under subparagraph (C) for the year, multiplied by the weighting factor established under paragraph (2)(C) for the service (or group), to

(ii) the sum of the amount determined under clause (i) and the unadjusted copayment amount determined under subparagraph (B) for such service or group.

(E) CALCULATION OF MEDICARE OPD FEE SCHEDULE AMOUNTS.—The Secretary shall compute a medicare OPD fee schedule amount for each covered OPD service (or group of such services) furnished in a year, in an amount equal to the product of—

(i) the conversion factor computed under subparagraph (C) for the year, and

(ii) the relative payment weight (determined under paragraph (2)(C)) for the service or group.

(4) **MEDICARE PAYMENT AMOUNT.**—The amount of payment made from the Trust Fund under this part for a covered OPD service (and such services classified within a group) furnished in a year is determined as follows:

(A) **FEE SCHEDULE AND COPAYMENT AMOUNT.**—Add (i) the medicare OPD fee schedule amount (computed under paragraph (3)(E)) for the service or group and year, and (ii) the unadjusted copayment amount (determined under paragraph (3)(B)) for the service or group.

(B) **SUBTRACT APPLICABLE DEDUCTIBLE.**—Reduce by the adjusted sum by the amount of the deductible under section 1833(b), to the extent applicable.

(C) **APPLY PAYMENT PROPORTION TO REMAINDER.**—Multiply the amount so determined under subparagraph (B) by the pre-deductible payment percentage (as determined under paragraph (3)(D)) for the service or group and year involved.

(D) **LABOR-RELATED ADJUSTMENT.**—The amount of payment is the product determined under subparagraph (C) with the labor-related portion of such product adjusted for relative differences in the cost of labor and other factors determined by the Secretary, as computed under paragraph (2)(D).

(5) **COPAYMENT AMOUNT.**—

(A) **IN GENERAL.**—Except as provided in subparagraph (B), the copayment amount under this subsection is determined as follows:

(i) **UNADJUSTED COPAYMENT.**—Compute the amount by which the amount described in paragraph (4)(B) exceeds the amount of payment determined under paragraph (4)(C).

(ii) **LABOR ADJUSTMENT.**—The copayment amount is the difference determined under clause (i) with the labor-related portion of such difference adjusted for relative differences in the cost of labor and other factors determined by the Secretary, as computed under paragraphs (2)(D). The adjustment under this clause shall be made in a manner that does not result in any change in the aggregate copayments made in any year if the adjustment had not been made.

(B) **ELECTION TO OFFER REDUCED COPAYMENT AMOUNT.**—The Secretary shall establish a procedure under which a hospital, before the beginning of a year (beginning with 1999), may elect to reduce the copayment amount otherwise established under subparagraph (A) for some or all covered OPD services to an amount that is not less than 25 percent of the medicare OPD fee schedule amount (computed under paragraph (3)(E)) for the service involved, adjusted for relative differences in the cost of labor and other factors determined by the Secretary, as computed under subparagraphs (D) and (E) of paragraph (2). Under such procedures, such reduced copayment amount may not be further reduced or

increased during the year involved and the hospital may disseminate information on the reduction of copayment amount effected under this subparagraph.

(C) *NO IMPACT ON DEDUCTIBLES.*—Nothing in this paragraph shall be construed as affecting a hospital's authority to waive the charging of a deductible under section 1833(b).

(6) *PERIODIC REVIEW AND ADJUSTMENTS COMPONENTS OF PROSPECTIVE PAYMENT SYSTEM.*—

(A) *PERIODIC REVIEW.*—The Secretary may periodically review and revise the groups, the relative payment weights, and the wage and other adjustments described in paragraph (2) to take into account changes in medical practice, changes in technology, the addition of new services, new cost data, and other relevant information and factors.

(B) *BUDGET NEUTRALITY ADJUSTMENT.*—If the Secretary makes adjustments under subparagraph (A), then the adjustments for a year may not cause the estimated amount of expenditures under this part for the year to increase or decrease from the estimated amount of expenditures under this part that would have been made if the adjustments had not been made.

(C) *UPDATE FACTOR.*—If the Secretary determines under methodologies described in subparagraph (2)(F) that the volume of services paid for under this subsection increased beyond amounts established through those methodologies, the Secretary may appropriately adjust the update to the conversion factor otherwise applicable in a subsequent year.

(7) *SPECIAL RULE FOR AMBULANCE SERVICES.*—The Secretary shall pay for hospital outpatient services that are ambulance services on the basis described in the matter in subsection (a)(1) preceding subparagraph (A).

(8) *SPECIAL RULES FOR CERTAIN HOSPITALS.*—In the case of hospitals described in section 1886(d)(1)(B)(v)—

(A) the system under this subsection shall not apply to covered OPD services furnished before January 1, 2000; and

(B) the Secretary may establish a separate conversion factor for such services in a manner that specifically takes into account the unique costs incurred by such hospitals by virtue of their patient population and service intensity.

(9) *LIMITATION ON REVIEW.*—There shall be no administrative or judicial review under section 1878 or otherwise of—

(A) the development of the classification system under paragraph (2), including the establishment of groups and relative payment weights for covered OPD services, of wage adjustment factors, other adjustments, and methods described in paragraph (2)(F);

(B) the calculation of base amounts under paragraph (3);

(C) periodic adjustments made under paragraph (6); and

(D) the establishment of a separate conversion factor under paragraph (8)(B).

SPECIAL PAYMENT RULES FOR PARTICULAR ITEMS AND SERVICES

SEC. 1834. (a) PAYMENT FOR DURABLE MEDICAL EQUIPMENT.—

(1) * * *

(2) PAYMENT FOR INEXPENSIVE AND OTHER ROUTINELY PURCHASED DURABLE MEDICAL EQUIPMENT.—

(A) * * *

(B) PAYMENT AMOUNT.—For purposes of subparagraph (A), the amount specified in this subparagraph, with respect to the purchase or rental of an item furnished in a carrier service area—

(i) * * *

* * * * *

(iv) in 1993 and each subsequent year is the national limited payment amount for the item or device computed under subparagraph (C)(ii) for that year (*reduced by 10 percent, in the case of a blood glucose testing strip furnished after 1997 for an individual with diabetes*).

* * * * *

(9) MONTHLY PAYMENT AMOUNT RECOGNIZED WITH RESPECT TO OXYGEN AND OXYGEN EQUIPMENT.—For purposes of paragraph (5), the amount that is recognized under this paragraph for payment for oxygen and oxygen equipment is the monthly payment amount described in subparagraph (C) of this paragraph. Such amount shall be computed separately (i) for all items of oxygen and oxygen equipment (other than portable oxygen equipment) and (ii) for portable oxygen equipment (each such group referred to in this paragraph as an “item”).

(A) * * *

* * * * *

(C) MONTHLY PAYMENT AMOUNT RECOGNIZED.—For purposes of paragraph (5), the amount that is recognized under this paragraph as the base monthly payment amount for each item furnished—

(i) in 1989 and in 1990, is 100 percent of the local average monthly payment rate computed under subparagraph (A)(ii) for the item;

(ii) in 1991, is the sum of (I) 67 percent of the local average monthly payment rate computed under subparagraph (A)(ii)(II) for the item for 1991, and (II) 33 percent of the national limited monthly payment rate computed under subparagraph (B)(i) for the item for 1991;

(iii) in 1992, is the sum of (I) 33 percent of the local average monthly payment rate computed under subparagraph (A)(ii)(II) for the item for 1992, and (II) 67 percent of the national limited monthly payment rate computed under subparagraph (B)(ii) for the item for 1992; **[and]**

(iv) in **[a subsequent year]** 1993, 1994, 1995, 1996, and 1997, is the national limited monthly payment rate computed under subparagraph (B) for the item for that year**[.]**;

(v) in each of the years 1998 through 2002, is 80 percent of the national limited monthly payment rate computed under subparagraph (B) for the item for the year; and

(vi) in a subsequent year, is the national limited monthly payment rate computed under subparagraph (B) for the item for the year.

* * * * *

(14) COVERED ITEM UPDATE.—In this subsection, the term “covered item update” means, with respect to a year—

(A) for 1991 and 1992, the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 12-month period ending with June of the previous year reduced by 1 percentage point; [and]

(B) for [a subsequent year] 1993, 1994, 1995, 1996, and 1997, the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 12-month period ending with June of the previous year[.];

(C) for each of the years 1998 through 2002, 0 percentage points; 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.

* * * * *

(16) CONDITIONS FOR ISSUANCE OF PROVIDER NUMBER.—The Secretary shall not provide for the issuance (or renewal) of a provider number for a supplier of durable medical equipment, for purposes of payment under this part for durable medical equipment furnished by the supplier, unless the supplier provides the Secretary on a continuing basis with—

(A)(i) full and complete information as to the identity of each person with an ownership or control interest (as defined in section 1124(a)(3)) in the supplier or in any subcontractor (as defined by the Secretary in regulations) in which the supplier directly or indirectly has a 5 percent or more ownership interest, and

(ii) to the extent determined to be feasible under regulations of the Secretary, the name of any disclosing entity (as defined in section 1124(a)(2)) with respect to which a person with such an ownership or control interest in the supplier is a person with such an ownership or control interest in the disclosing entity; and

(B) a surety bond in a form specified by the Secretary and in an amount that is not less than \$50,000.

The Secretary may waive the requirement of a bond under subparagraph (B) in the case of a supplier that provides a comparable surety bond under State law.

* * * * *

(c) PAYMENTS AND STANDARDS FOR SCREENING MAMMOGRAPHY.—

(1) IN GENERAL.—Notwithstanding any other provision of this part, with respect to expenses incurred for screening mammography (as defined in section 1861(jj))—

(A) * * *

* * * * *

(C) the amount of the payment under this part shall be, subject to the deductible established under section 1833(b), be equal to 80 percent of the least of—

(i) the actual charge for the screening,

(ii) the fee schedule established under subsection (b) or the fee schedule established under section 1848, whichever is applicable, with respect to both the professional and technical components of the screening mammography, or

(iii) the limit established under paragraph (3) for the screening mammography.

(2) FREQUENCY COVERED.—

(A) IN GENERAL.—Subject to revision by the Secretary under subparagraph (B)—

(i) No payment may be made under this part for screening mammography performed on a woman under 35 years of age.

(ii) Payment may be made under this part for only 1 screening mammography performed on a woman over 34 years of age, but under 40 years of age.

[(iii) In the case of a woman over 39 years of age, but under 50 years of age, who—

[(I) is at a high risk of developing breast cancer (as determined pursuant to factors identified by the Secretary), payment may not be made under this part for a screening mammography performed within the 11 months following the month in which a previous screening mammography was performed, or

[(II) is not at a high risk of developing breast cancer, payment may not be made under this part for a screening mammography performed within the 23 months following the month in which a previous screening mammography was performed.

[(iv) In the case of a woman over 49 years of age, but under 65 years of age, payment may not be made under this part for screening mammography performed within 11 months following the month in which a previous screening mammography was performed.

[(v) In the case of a woman over 64 years of age, payment may not be made for screening mammography performed within 23 months following the month in which a previous screening mammography was performed.]

(iii) In the case of a woman over 39 years of age, payment may not be made under this part for screening mammography performed within 11 months following

the month in which a previous screening mammography was performed.

* * * * *

(d) **FREQUENCY AND PAYMENT LIMITS FOR COLORECTAL CANCER SCREENING TESTS.**—

(1) **SCREENING FECAL-OCCULT BLOOD TESTS.**—

(A) **PAYMENT LIMIT.**—In establishing fee schedules under section 1833(h) with respect to colorectal cancer screening tests consisting of screening fecal-occult blood tests, except as provided by the Secretary under paragraph (4)(A), the payment amount established for tests performed—

(i) in 1998 shall not exceed \$5; and

(ii) in a subsequent year, shall not exceed the limit on the payment amount established under this subsection for such tests for the preceding year, adjusted by the applicable adjustment under section 1833(h) for tests performed in such year.

(B) **FREQUENCY LIMIT.**—Subject to revision by the Secretary under paragraph (4)(B), no payment may be made under this part for colorectal cancer screening test consisting of a screening fecal-occult blood test—

(i) if the individual is under 50 years of age; or

(ii) if the test is performed within the 11 months after a previous screening fecal-occult blood test.

(2) **SCREENING FLEXIBLE SIGMOIDOSCOPIES.**—

(A) **FEE SCHEDULE.**—The Secretary shall establish a payment amount under section 1848 with respect to colorectal cancer screening tests consisting of screening flexible sigmoidoscopies 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) **PAYMENT LIMIT.**—In the case of screening flexible sigmoidoscopy services—

(i) the payment amount may not exceed such amount as the Secretary specifies, based upon the rates recognized under this part for diagnostic flexible sigmoidoscopy services; and

(ii) that, in accordance with regulations, may be performed in an ambulatory surgical center and for which the Secretary permits ambulatory surgical center payments under this part and that are performed in an ambulatory surgical center or hospital outpatient department, the payment amount under this part may not exceed the lesser of (I) the payment rate that would apply to such services if they were performed in a hospital outpatient department, or (II) the payment rate that would apply to such services if they were performed in an ambulatory surgical center.

(C) **SPECIAL RULE FOR DETECTED LESIONS.**—If during the course of such screening flexible sigmoidoscopy, a lesion or growth is detected which results in a biopsy or removal of the lesion or growth, payment under this part shall not be made for the screening flexible sigmoidoscopy but shall be

made for the procedure classified as a flexible sigmoidoscopy with such biopsy or removal.

(D) *FREQUENCY LIMIT.*—Subject to revision by the Secretary under paragraph (4)(B), no payment may be made under this part for a colorectal cancer screening test consisting of a screening flexible sigmoidoscopy—

- (i) if the individual is under 50 years of age; or
- (ii) if the procedure is performed within the 47 months after a previous screening flexible sigmoidoscopy.

(3) *SCREENING COLONOSCOPY FOR INDIVIDUALS AT HIGH RISK FOR COLORECTAL CANCER.*—

(A) *FEE SCHEDULE.*—The Secretary shall establish a payment amount under section 1848 with respect to colorectal cancer screening test consisting of a screening colonoscopy for individuals at high risk for colorectal cancer (as defined in section 1861(pp)(2)) 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) *PAYMENT LIMIT.*—In the case of screening colonoscopy services—

- (i) the payment amount may not exceed such amount as the Secretary specifies, based upon the rates recognized under this part for diagnostic colonoscopy services; and
- (ii) that are performed in an ambulatory surgical center or hospital outpatient department, the payment amount under this part may not exceed the lesser of (I) the payment rate that would apply to such services if they were performed in a hospital outpatient department, or (II) the payment rate that would apply to such services if they were performed in an ambulatory surgical center.

(C) *SPECIAL RULE FOR DETECTED LESIONS.*—If during the course of such screening colonoscopy, a lesion or growth is detected which results in a biopsy or removal of the lesion or growth, payment under this part shall not be made for the screening colonoscopy but shall be made for the procedure classified as a colonoscopy with such biopsy or removal.

(D) *FREQUENCY LIMIT.*—Subject to revision by the Secretary under paragraph (4)(B), no payment may be made under this part for a colorectal cancer screening test consisting of a screening colonoscopy for individuals at high risk for colorectal cancer if the procedure is performed within the 23 months after a previous screening colonoscopy.

(4) *REDUCTIONS IN PAYMENT LIMIT AND REVISION OF FREQUENCY.*—

(A) *REDUCTIONS IN PAYMENT LIMIT FOR SCREENING FECAL-OCCULT BLOOD TESTS.*—The Secretary shall review from time to time the appropriateness of the amount of the payment limit established for screening fecal-occult blood

tests under paragraph (1)(A). The Secretary may, with respect to tests performed in a year after 2000, reduce the amount of such limit as it applies nationally or in any area to the amount that the Secretary estimates is required to assure that such tests of an appropriate quality are readily and conveniently available during the year.

(B) REVISION OF FREQUENCY.—

(i) REVIEW.—The Secretary shall review periodically the appropriate frequency for performing colorectal cancer screening tests based on age and such other factors as the Secretary believes to be pertinent.

(ii) 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 may be paid for under this subsection, but no such revision shall apply to tests performed before January 1, 2001.

(5) LIMITING CHARGES OF NONPARTICIPATING PHYSICIANS.—

(A) IN GENERAL.—In the case of a colorectal cancer screening test consisting of a screening flexible sigmoidoscopy or a screening colonoscopy provided to an individual at high risk for colorectal cancer for which payment may be made under this part, if a nonparticipating physician provides the procedure to an individual enrolled under this part, the physician may not charge the individual more than the limiting charge (as defined in section 1848(g)(2)).

(B) ENFORCEMENT.—If a physician or supplier knowing and willfully imposes a charge in violation of subparagraph (A), the Secretary may apply sanctions against such physician or supplier in accordance with section 1842(j)(2).

* * * * *

(h) PAYMENT FOR PROSTHETIC DEVICES AND ORTHOTICS AND PROSTHETICS.—

(1) GENERAL RULE FOR PAYMENT.—

(A) * * *

* * * * *

(E) EXCEPTION FOR CERTAIN ITEMS.—Payment for ostomy supplies, tracheostomy supplies, and urologicals shall be made in accordance with subparagraphs (B) and (C) of section 1834(a)(2). Payment for cochlear implants shall be made in accordance with subsection (a)(4), and, in applying such subsection to cochlear implants, carriers shall take into consideration technological innovations and data on charges to the extent that such charges reflect such innovations.

* * * * *

(4) DEFINITIONS.—In this subsection—

(A) the term “applicable percentage increase” means—

(i) * * *

* * * * *

(iii) for 1994 and 1995, 0 percent[, and];

(iv) for [a subsequent year] 1996 and 1997, the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period ending with June of the previous year;

(v) for each of the years 1998 through 2002, 1 percent, and

(vi) for a subsequent year, the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period ending with June of the previous year;

* * * * *

(k) PAYMENT FOR OUTPATIENT THERAPY SERVICES AND COMPREHENSIVE OUTPATIENT REHABILITATION FACILITY SERVICES.—

(1) IN GENERAL.—With respect to outpatient physical therapy services (which includes outpatient speech-language pathology services) and outpatient occupational therapy services and with respect to comprehensive outpatient rehabilitation facility services for which payment is determined under this subsection, the payment basis shall be—

(A) for services furnished during 1998, the amount determined under paragraph (2); or

(B) for services furnished during a subsequent year, 80 percent of the lesser of—

(i) the actual charge for the services, or

(ii) the applicable fee schedule amount (as defined in paragraph (3)) for the services.

(2) PAYMENT IN 1998 BASED UPON BLENDED RATE.—The amount under this paragraph for services is the least of the following amounts, less 20 percent of the amount of the charges imposed for such services:

(A) CHARGES.—The charges imposed for the services.

(B) ADJUSTED REASONABLE COSTS.—The adjusted reasonable costs (as defined in paragraph (4)) for the services.

(C) BLENDED RATE.—An amount equal to the sum of—

(i) 50 percent of the lesser of the amount of the charges or the adjusted reasonable costs for the services, and

(ii) 50 percent of the applicable fee schedule amount for the services.

(3) APPLICABLE FEE SCHEDULE AMOUNT.—In this paragraph, the term “applicable fee schedule amount” means, with respect to services furnished in a year, the fee schedule amount established under section 1848(b) for such services furnished during the year or, if there is no such fee schedule amount established for such services, for such comparable services as the Secretary specifies.

(4) ADJUSTED REASONABLE COSTS.—In paragraph (2), the term “adjusted reasonable costs” means reasonable costs determined reduced by—

(A) 5.8 percent of the reasonable costs for operating costs, and

(B) 10 percent of the reasonable costs for capital costs.

(l) ESTABLISHMENT OF FEE SCHEDULE FOR AMBULANCE SERVICES.—

(1) IN GENERAL.—The Secretary shall establish a fee schedule for payment for ambulance services under this part through a negotiated rulemaking process described in title 5, United States Code, and in accordance with the requirements of this subsection.

(2) CONSIDERATIONS.—In establishing such fee schedule the Secretary shall—

(A) establish mechanisms to control increases in expenditures for ambulance services under this part;

(B) establish definitions for ambulance services which link payments to the type of services provided;

(C) consider appropriate regional and operational differences;

(D) consider adjustments to payment rates to account for inflation and other relevant factors; and

(E) phase in the application of the payment rates under the fee schedule in an efficient and fair manner.

(3) SAVINGS.—In establishing such fee schedule the Secretary shall—

(A) ensure that the aggregate amount of payments made for ambulance services under this part during 2000 does not exceed the aggregate amount of payments which would have been made for such services under this part during such year if the amendments made by section 10431 of the Medicare Amendments Act of 1997 had not been made; and

(B) set the payment amounts provided under the fee schedule for services furnished in 2001 and each subsequent year at amounts equal to the payment amounts under the fee schedule for service furnished during the previous year, increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 12-month period ending with June of the previous year.

(3) CONSULTATION.—In establishing the fee schedule for ambulance services under this subsection, the Secretary shall consult with various national organizations representing individuals and entities who furnish and regulate ambulance services and share with such organizations relevant data in establishing such schedule.

(4) LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1878 or otherwise of the amounts established under the fee schedule for ambulance services under this subsection, including matters described in paragraph (2).

(m) SPECIAL RULES FOR PAYMENT FOR ORAL ANTI-NAUSEA DRUGS.—

(1) LIMITATION ON PER DOSE PAYMENT BASIS.—Subject to paragraph (2), the per dose payment basis under this part for oral anti-nausea drugs (as defined in paragraph (3)) administered during a year shall not exceed 90 percent of the average per dose payment basis for the equivalent intravenous anti-

emetics administered during the year, as computed based on payment basis applied during 1996.

(2) *AGGREGATE LIMIT.—The Secretary shall make such adjustment in the coverage of, or payment basis for, oral anti-nausea drugs so that coverage of such drugs under this part does not result in any increase in aggregate payments per capita under this part above the levels of such payments per capita that would otherwise have been made if there were no coverage for such drugs under this part.*

(3) *ORAL ANTI-NAUSEA DRUGS DEFINED.—For purposes of this subsection, the term “oral anti-nausea drugs” means drugs for which coverage is provided under this part pursuant to section 1861(s)(2)(P).*

PROCEDURE FOR PAYMENT OF CLAIMS OF PROVIDERS OF SERVICES

SEC. 1835. (a) Except as provided in subsections (b), (c), and (e), payment for services described in section 1832(a)(2) furnished an individual may be made only to providers of services which are eligible therefor under section 1866(a), and only if—

(1) written request, signed by such individual, except in cases in which the Secretary finds it impracticable for the individual to do so, is filed for such payment in such form, in such manner and by such person or persons as the Secretary may by regulation prescribe, no later than the close of the period of 3 calendar years following the year in which such services are furnished (deeming any services furnished in the last 3 calendar months of any calendar year to have been furnished in the succeeding calendar year) except that, where the Secretary deems that efficient administration so requires, such period may be reduced to not less than 1 calendar year; and

(2) a physician certifies (and recertifies, where such services are furnished over a period of time, in such cases, with such frequency, and accompanied by such supporting material, appropriate to the case involved, as may be provided by regulations) that—

(A) in the case of home health services (i) such services are or were required because the individual is or was confined to his home (except when receiving items and services referred to in section 1861(m)(7)) and needs or needed skilled nursing care (*other than solely venipuncture for the purpose of obtaining a blood sample*) on an intermittent basis or physical or speech therapy or, in the case of an individual who has been furnished home health services based on such a need and who no longer has such a need for such care or therapy, continues or continued to need occupational therapy, (ii) a plan for furnishing such services to such individual has been established and is periodically reviewed by a physician, and (iii) such services are or were furnished while the individual is or was under the care of a physician;

* * * * *

ENROLLMENT PERIODS

SEC. 1837. (a) * * *

* * * * *

(i)(1) In the case of an individual who—

(A) * * *

* * * * *

there shall be a special enrollment period described in paragraph (3). In the case of an individual not described in the previous sentence who has not attained the age of 65, at the time the individual first satisfies paragraph (1) of section 1836, is enrolled in a large group health plan (as that term is defined in section **1862(b)(1)(B)(iv)** *1862(b)(1)(B)(iii)*) by reason of the individual's current employment status (or the current employment status of a family member of the individual), and has elected not to enroll (or to be deemed enrolled) under this section during the individual's initial enrollment period, there shall be a special enrollment period described in paragraph (3)(B).

(2) In the case of an individual who—

(A) * * *

* * * * *

there shall be a special enrollment period described in paragraph (3). In the case of an individual not described in the previous sentence who has not attained the age of 65, has enrolled (or has been deemed to have enrolled) in the medical insurance program established under this part during the individual's initial enrollment period, or is an individual described in the second sentence of paragraph (1), has enrolled in such program during any subsequent special enrollment period under this subsection during which the individual was not enrolled in a large group health plan (as that term is defined in section **1862(b)(1)(B)(iv)** *1862(b)(1)(B)(iii)*) by reason of the individual's current employment status (or the current employment status of a family member of the individual), and has not terminated enrollment under this section at any time at which the individual is not enrolled in such a large group health plan by reason of the individual's current employment status (or the current employment status of a family member of the individual), there shall be a special enrollment period described in paragraph (3)(B).

(3)(A) * * *

(B) The special enrollment period referred to in the second sentences of paragraphs (1) and (2) is the period including each month during any part of which the individual is enrolled in a large group health plan (as that term is defined in section **1862(b)(1)(B)(iv)** *1862(b)(1)(B)(iii)*) by reason of the individual's current employment status (or the current employment status of a family member of the individual) ending with the last day of the eighth consecutive month in which the individual is at no time so enrolled.

* * * * *

AMOUNTS OF PREMIUMS

SEC. 1839. (a)(1) * * *

(2) The monthly premium of each individual enrolled under this part for each month after December 1983 shall, except as provided in subsections [(b) and (e)] (b), (c), and (f), be the amount determined under paragraph (3).

(3) [The Secretary shall, during September of 1983 and of each year thereafter, determine and promulgate the monthly premium applicable for individuals enrolled under this part for the succeeding calendar year. The monthly premium shall (except as otherwise provided in subsection (e)) be equal to the smaller of—

[(A) the monthly actuarial rate for enrollees age 65 and over, determined according to paragraph (1) of this subsection, for that calendar year, or

[(B) the monthly premium rate most recently promulgated by the Secretary under this paragraph, increased by a percentage determined as follows: The Secretary shall ascertain the primary insurance amount computed under section 215(a)(1), based upon average indexed monthly earnings of \$900, that applied to individuals who became eligible for and entitled to old-age insurance benefits on November 1 of the year before the year of the promulgation. He shall increase the monthly premium rate by the same percentage by which that primary insurance amount is increased when, by reason of the law in effect at the time the promulgation is made, it is so computed to apply to those individuals for the following November 1.] *The Secretary, during September of each year, shall determine and promulgate a monthly premium rate for the succeeding calendar year. That monthly premium rate shall be equal to 50 percent of the monthly actuarial rate for enrollees age 65 and over, determined according to paragraph (1), for that succeeding calendar year (except as provided in paragraph (5)(B)).*

* * * * *

(5)(A) *The Secretary shall, at the time of determining the monthly actuarial rate under paragraph (1) for 1998 through 2003, shall determine a transitional monthly actuarial rate for enrollees age 65 and over in the same manner as such rate is determined under paragraph (1), except that there shall be excluded from such determination an estimate of any benefits and administrative costs attributable to home health services for which payment would have been made under part A during the year but for paragraph (2) of section 1833(d).*

(B) *The monthly premium for each individual enrolled under this part for each month for a year (beginning with 1998 and ending with 2003) shall be equal to 50 percent of the monthly actuarial rate determined under subparagraph (A) increased by the following proportion of the difference between such premium and the monthly premium otherwise determined under paragraph (3) (without regard to this paragraph):*

- (i) *For a month in 1998, $\frac{1}{7}$.*
- (ii) *For a month in 1999, $\frac{2}{7}$.*
- (iii) *For a month in 2000, $\frac{3}{7}$.*
- (iv) *For a month in 2001, $\frac{4}{7}$.*
- (v) *For a month in 2002, $\frac{5}{7}$.*
- (vi) *For a month in 2003, $\frac{6}{7}$.*

Whenever the Secretary promulgates the dollar amount which shall be applicable as the monthly premium *rate* for any period, he shall, at the time such promulgation is announced, issue a public statement setting forth the actuarial assumptions and bases employed by him in arriving at the amount of an adequate actuarial rate for enrollees age 65 and older as provided in paragraph (1) **and the derivation of the dollar amounts specified in this paragraph**].

(b) In the case of an individual whose coverage period began pursuant to an enrollment after his initial enrollment period (determined pursuant to subsection (c) or (d) of section 1837), the monthly premium determined under subsection (a) or (e) shall be increased by 10 percent of the monthly premium so determined for each full 12 months (in the same continuous period of eligibility) in which he could have been but was not enrolled. For purposes of the preceding sentence, there shall be taken into account (1) the months which elapsed between the close of his initial enrollment period and the close of the enrollment period in which he enrolled, plus (in the case of an individual who reenrolls) (2) the months which elapsed between the date of termination of a previous coverage period and the close of the enrollment period in which he reenrolled, but there shall not be taken into account months for which the individual can demonstrate that the individual was enrolled in a group health plan described in section 1862(b)(1)(A)(v) by reason of the individual's (or the individual's spouse's) current employment or months during which the individual has not attained the age of 65 and for which the individual can demonstrate that the individual was enrolled in a large group health plan as an active individual (as those terms are defined in section **1862(b)(1)(B)(iv)** *1862(b)(1)(B)(iii)*). Any increase in an individual's monthly premium under the first sentence of this subsection with respect to a particular continuous period of eligibility shall not be applicable with respect to any other continuous period of eligibility which such individual may have.

* * * * *

[(e)(1)(A) Notwithstanding the provisions of subsection (a), the monthly premium for each individual enrolled under this part for each month after December 1995 and prior to January 1999 shall be an amount equal to 50 percent of the monthly actuarial rate for enrollees age 65 and over, as determined under subsection (a)(1) and applicable to such month.

[(B) Notwithstanding the provisions of subsection (a), the monthly premium for each individual enrolled under this part for each month in—

- [(i)** 1991 shall be \$29.90,
- [(ii)** 1992 shall be \$31.80,
- [(iii)** 1993 shall be \$36.60,
- [(iv)** 1994 shall be \$41.10, and
- [(v)** 1995 shall be \$46.10.

[(2) Any increases in premium amounts taking effect prior to January 1998 by reason of paragraph (1) shall be taken into ac-

count for purposes of determining increases thereafter under subsection (a)(3).】

* * * * *

【(g) (e)(1) Upon the request of a State, the Secretary may enter into an agreement with the State under which the State agrees to pay on a quarterly or other periodic basis to the Secretary (to be deposited in the Treasury to the credit of the Federal Supplementary Medical Insurance Trust Fund) an amount equal to the amount of the part B late enrollment premium increases with respect to the premiums for eligible individuals (as defined in paragraph (3)(A)).

* * * * *

USE OF CARRIERS FOR ADMINISTRATION OF BENEFITS

SEC. 1842. (a) * * *

(b)(1) * * *

* * * * *

(3) Each such contract shall provide that the carrier—

(A) * * *

* * * * *

(I) will submit annual reports to the Secretary describing the steps taken to recover payments made under this part for items or services for which payment has been or could be made under a primary plan (as defined in section 1862(b)(2)(A)); **【and】**

(J) will reimburse the Secretary for any amounts paid by the carrier for an item or service under this part which is furnished, directed, or prescribed by an individual or entity during any period for which the individual or entity is excluded pursuant to section 1128, 1128A, or 1156, from participation in the program under this title, if the amounts are paid after the Secretary notifies the carrier of the exclusion, and

* * * * *

(6) No payment under this part for a service provided to any individual shall (except as provided in section 1870) be made to anyone other than such individual or (pursuant to an assignment described in subparagraph (B)(ii) of paragraph (3)) the physician or other person who provided the service, except that (A) payment may be made (i) to the employer of such physician or other person if such physician or other person is required as a condition of his employment to turn over his fee for such service to his employer, or (ii) (where the service was provided in a hospital, rural primary care hospital, clinic, or other facility) to the facility in which the service was provided if there is a contractual arrangement between such physician or other person and such facility under which such facility submits the bill for such service, (B) payment may be made to an entity (i) which provides coverage of the services under a health benefits plan, but only to the extent that payment is not made under this part, (ii) which has paid the person who provided the service an amount (including the amount payable under this part) which that person has accepted as payment in full for the

service, and (iii) to which the individual has agreed in writing that payment may be made under this part, (C) in the case of services described in [clauses (i), (ii), or (iv)] *clause (i)* of section 1861(s)(2)(K) payment shall be made to the employer of the physician assistant [or nurse practitioner] involved, [and] (D) payment may be made to a physician for physicians' services (and services furnished incident to such services) furnished by a second physician to patients of the first physician if (i) the first physician is unavailable to provide the services; (ii) the services are furnished pursuant to an arrangement between the two physicians that (I) is informal and reciprocal, or (II) involves per diem or other fee-for-time compensation for such services; (iii) the services are not provided by the second physician over a continuous period of more than 60 days; and (iv) the claim form submitted to the carrier for such services includes the second physician's unique identifier (provided under the system established under subsection (r)) and indicates that the claim meets the requirements of this subparagraph for payment to the first physician. No payment which under the preceding sentence may be made directly to the physician or other person providing the service involved (pursuant to an assignment described in subparagraph (B)(ii) of paragraph (3)) shall be made to anyone else under a reassignment or power of attorney (except to an employer or facility as described in clause (A) of such sentence); but nothing in this subsection shall be construed (i) to prevent the making of such a payment in accordance with an assignment from the individual to whom the service was provided or a reassignment from the physician or other person providing such service if such assignment or reassignment is made to a governmental agency or entity or is established by or pursuant to the order of a court of competent jurisdiction, or (ii) to preclude an agent of the physician or other person providing the service from receiving any such payment if (but only if) such agent does so pursuant to an agency agreement under which the compensation to be paid to the agent for his services for or in connection with the billing or collection of payments due such physician or other person under this title is unrelated (directly or indirectly) to the amount of such payments or the billings therefor, and is not dependent upon the actual collection of any such payment[.], (E) *in the case of an item or service (other than services described in section 1888(e)(2)(A)(ii)) furnished to an individual who (at the time the item or service is furnished) is a resident of a skilled nursing facility, payment shall be made to the facility (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), and (F) in the case of home health services furnished to an individual who (at the time the item or service is furnished) is under a plan of care of a home health agency, payment shall be made to the agency (without regard to whether or not the item or service was furnished by the agency, by others under arrangement with them made by the agency, or when any other contracting or consulting arrangement, or otherwise). For purposes of clause (C) of the first sentence of this paragraph, an employment relationship may include any independent contractor arrangement, and employer status shall be determined in accordance with the law*

of the State in which the services described in such clause are performed.

* * * * *

[(12)(A) With respect to services described in clauses (i), (ii), or (iv) of section 1861(s)(2)(K) (relating to a physician assistants and nurse practitioners)—

[(i) payment under this part may only be made on an assignment-related basis; and

[(ii) the prevailing charges determined under paragraph (3) shall not exceed—

[(I) in the case of services performed as an assistant at surgery, 65 percent of the amount that would otherwise be recognized if performed by a physician who is serving as an assistant at surgery, or

[(II) in other cases, the applicable percentage (as defined in subparagraph (B)) of the prevailing charge rate determined for such services (or, for services furnished on or after January 1, 1992, the fee schedule amount specified in section 1848) performed by physicians who are not specialists.

[(B) In subparagraph (A)(ii)(II), the term “applicable percentage” means—

[(i) 75 percent in the case of services performed (other than as an assistant at surgery) in a hospital, and

[(ii) 85 percent in the case of other services.]

(12) *With respect to services described in section 1861(s)(2)(K)(i)—*

(A) payment under this part may only be made on an assignment-related basis; and

(B) the amounts paid under this part shall be equal to 80 percent of (i) the lesser of the actual charge or 85 percent of the fee schedule amount provided under section 1848 for the same service provided by a physician who is not a specialist; or (ii) in the case of services as an assistant at surgery, the lesser of the actual charge or 85 percent of the amount that would otherwise be recognized if performed by a physician who is serving as an assistant at surgery.

* * * * *

(19) For purposes of section 1833(a)(1), the reasonable charge for ambulance services (as described in section 1861(s)(7)) provided during a fiscal year (beginning with fiscal year 1998 and ending with fiscal year 2002) may not exceed the reasonable charge for such services provided during the previous fiscal year, increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) as estimated by the Secretary for the 12-month period ending with the midpoint of the year involved reduced (in the case of each of fiscal years 1998 and 1999) by 1 percentage point.

* * * * *

(o) If a physician’s, supplier’s, or any other person’s bill or request for payment for services includes a charge for a drug or biological for which payment may be made under this part and the drug or biological is not paid on a cost or prospective payment basis

as otherwise provided in this part, the amount payable for the drug or biological shall not exceed 95 percent of the average wholesale price, as specified by the Secretary.

* * * * *

(s) The Secretary may refuse to enter into an agreement with a physician or supplier under subsection (h) or may terminate or refuse to renew such agreement, in the event that such physician or supplier has been convicted of a felony under Federal or State law for an offense which the Secretary determines is inconsistent with the best interests of program beneficiaries.

* * * * *

APPROPRIATIONS TO COVER GOVERNMENT CONTRIBUTIONS AND CONTINGENCY RESERVE

SEC. 1844. (a) There are authorized to be appropriated from time to time, out of any moneys in the Treasury not otherwise appropriated, to the Federal Supplementary Medical Insurance Trust Fund—

(1)(A) a Government contribution equal to the aggregate premiums payable for a month for enrollees age 65 and over under this part and deposited in the Trust Fund, multiplied by the ratio of—

(i) twice the dollar amount of the actuarially adequate rate per enrollee age 65 and over as determined under section 1839(a)(1) for such month minus the dollar amount of the premium per enrollee for such month, as determined under section 1839(a)(3) [or 1839(e), as the case may be], to

(ii) the dollar amount of the premium per enrollee for such month, plus

(B) a Government contribution equal to the aggregate premiums payable for a month for enrollees under age 65 under this part and deposited in the Trust Fund, multiplied by the ratio of—

(i) twice the dollar amount of the actuarially adequate rate per enrollee under age 65 as determined under section 1839(a)(4) for such month minus the dollar amount of the premium per enrollee for such month, as determined under section 1839(a)(3) [or 1839(e), as the case may be], to

* * * * *

[PHYSICIAN PAYMENT REVIEW COMMISSION

[SEC. 1845. (a)(1) The Director of the Congressional Office of Technology Assessment (hereinafter in this section referred to as the “Director” and the “Office”, respectively) shall provide for the appointment of a Physician Payment Review Commission (hereinafter in this section referred to as the “Commission”), to be composed of individuals with national recognition for their expertise in health economics, physician reimbursement, medical practice, and other related fields appointed by the Director (without regard to the provisions of title 5, United States Code, governing appointments in the competitive service).

[(2) The Commission shall consist of 13 individuals. Members of the Commission shall first be appointed no later than May 1, 1986, for a term of three years, except that the Director may provide initially for such shorter terms as will insure that (on a continuing basis) the terms of no more than four members expire in any one year.

[(3) The membership of the Commission shall include (but need not be limited to) physicians, other health professionals, individuals skilled in the conduct and interpretation of biomedical, health services, and health economics research, and representatives of consumers and the elderly.

[(b)(1) The Commission shall make recommendations to the Congress, not later than March 31 of each year (beginning with 1987), regarding adjustments to the reasonable charge levels for physicians' services recognized under section 1842(b) and changes in the methodology for determining the rates of payment, and for making payment, for physicians' services under this title and other items and services under this part.

[(2) In making its recommendations, the Commission shall—

[(A) assess the likely impact of different adjustments in payment rates, particularly their impact on physician participation in the participation program established under section 1842(h) and on beneficiary access to necessary physicians' services;

[(B) make recommendations on ways to increase physician participation in that participation program and the acceptance of payment under this part on an assignment-related basis;

[(C) identify those procedures, involving the use of assistants at surgery, for which payment for those assistants should not be made under this title without prior approval;

[(D) identify those procedures for which an opinion of a second physician should be required before payment is made under this title;

[(E) consider policies for moderating the rate of increase in expenditures under this part and the rate of increase in utilization of services under this part;

[(F) make recommendations regarding major issues in the implementation of the resource-based relative value scale established under section 1848(c);

[(G) make recommendations regarding further development of the volume performance standards established under section 1848(f), including the development of State-based programs;

[(H) consider policies to provide payment incentives to increase patient access to primary care and other physician services in large urban and rural areas, including policies regarding payments to physicians pursuant to title XIX;

[(I) review and consider the number and practice specialties of physicians in training and payments under this title for graduate medical education costs;

[(J) make recommendations regarding issues relating to utilization review and quality of care, including the effectiveness of peer review procedures and other quality assurance programs applicable to physicians and providers under this title and physician certification and licensing standards and procedures;

[(K) make recommendations regarding options to help constrain the costs of health insurance to employers, including incentives under this title;

[(L) comment on the recommendations affecting physician payment under the medicare program that are included in the budget submitted by the President pursuant to section 1105 of title 31, United States Code; and

[(M) make recommendations regarding medical malpractice liability reform and physician certification and licensing standards and procedures.

[(c)(1) The following provisions of section 1886(e)(6) shall apply to the Commission in the same manner as they apply to the Prospective Payment Assessment Commission:

[(A) Subparagraph (C) (relating to staffing and administration generally).

[(B) Subparagraph (D) (relating to compensation of members).

[(C) Subparagraph (F) (relating to access to information).

[(D) Subparagraph (G) (relating to use of funds).

[(E) Subparagraph (H) (relating to periodic GAO audits).

[(F) Subparagraph (J) (relating to requests for appropriations).

[(2) In order to carry out its functions, the Commission shall collect and assess information on medical and surgical procedures and services, including information on regional variations of medical practice. In collecting and assessing information, the Commission shall—

[(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 for the development of useful and valid guidelines by the Commission, and

[(C) adopt procedures allowing any interested party to submit information with respect to physicians' services (including new practices, such as the use of new technologies and treatment modalities), which information the Commission shall consider in making reports and recommendations to the Secretary and Congress.

[(d) There are authorized to be appropriated such sums as may be necessary to carry out the provisions of this section. Such sums shall be payable from the Federal Supplementary Medical Insurance Trust Fund.

[(e)(1) Not later than December 31st of each year (beginning with 1988), the Secretary shall transmit to the Physician Payment Review Commission, to the Congressional Budget Office, and to the Congressional Research Service of the Library of Congress national data (known as the Part B Medicare Annual Data System) for the previous year respecting part B of this title.

[(2) The Secretary, in consultation with the Physician Payment Review Commission, the Congressional Budget Office, and the Congressional Research Service of the Library of Congress, shall estab-

lish and annually revise standards for the data reporting system described in paragraph (1).

[(3) The Secretary shall also provide to the entities described in paragraph (1) additional data respecting the program under this part as may be reasonably requested by them on an agreed-upon schedule.]

[(4) The Secretary shall develop, in consultation with the Physician Payment Review Commission, the Congressional Budget Office, and the Congressional Research Service of the Library of Congress, a system for providing to each of such entities on a quarterly basis summary data on aggregate expenditures under this part by type of service and by type of provider. Such data shall be provided not later than 90 days after the end of each quarter (for quarters beginning with the calendar quarter ending on March 31, 1989).]

* * * * *

PAYMENT FOR PHYSICIANS' SERVICES

SEC. 1848. (a) PAYMENT BASED ON FEE SCHEDULE.—

(1) * * *

(2) TRANSITION TO FULL FEE SCHEDULE.—

(A) LIMITING REDUCTIONS AND INCREASES TO 15 PERCENT IN 1992.—

(i) LIMIT ON INCREASE.—In the case of a service (*other than a colorectal cancer screening test consisting of a screening colonoscopy provided to an individual at high risk for colorectal cancer or a screening flexible sigmoidoscopy*) in a fee schedule area (as defined in subsection (j)(2)) for which the adjusted historical payment basis (as defined in subparagraph (D)) is less than 85 percent of the fee schedule amount for services furnished in 1992, there shall be substituted for the fee schedule amount an amount equal to the adjusted historical payment basis plus 15 percent of the fee schedule amount otherwise established (without regard to this paragraph).

(ii) LIMIT IN REDUCTION.—In the case of a service (*other than a colorectal cancer screening test consisting of a screening colonoscopy provided to an individual at high risk for colorectal cancer or a screening flexible sigmoidoscopy*) in a fee schedule area for which the adjusted historical payment basis exceeds 115 percent of the fee schedule amount for services furnished in 1992, there shall be substituted for the fee schedule amount an amount equal to the adjusted historical payment basis minus 15 percent of the fee schedule amount otherwise established (without regard to this paragraph).

* * * * *

(c) DETERMINATION OF RELATIVE VALUES FOR PHYSICIANS' SERVICES.—

(1) * * *

(2) DETERMINATION OF RELATIVE VALUES.—

(A) * * *

(B) PERIODIC REVIEW AND ADJUSTMENTS IN RELATIVE VALUES.—

(i) * * *

* * * * *

(iii) CONSULTATION.—The Secretary, in making adjustments under clause (ii), shall consult with the [Physician Payment Review Commission] Medicare Payment Advisory Commission and organizations representing physicians.

(C) COMPUTATION OF RELATIVE VALUE UNITS FOR COMPONENTS.—For purposes of this section for each physicians' service—

(i) * * *

(ii) PRACTICE EXPENSE RELATIVE VALUE UNITS.—The Secretary shall determine a number of practice expense relative value units for the service for years before [1998] 1999 equal to the product of—

(I) the base allowed charges (as defined in subparagraph (D)) for the service, and

(II) the practice expense percentage for the service (as determined under paragraph (3)(C)(ii)), and for years beginning with [1998] 1999 based, to the extent provided under subparagraph (G), on the relative practice expense resources involved in furnishing the service.

(3) COMPONENT PERCENTAGES.—For purposes of paragraph (2), the Secretary shall determine a work percentage, a practice expense percentage, and a malpractice percentage for each physician's service as follows:

(A) * * *

* * * * *

(C) DETERMINATION OF COMPONENT PERCENTAGES.—

(i) * * *

(ii) PRACTICE EXPENSE PERCENTAGE.—For years before [1998] 2002, the practice expense percentage for a service (or class of services) is equal to the sum (for all physician specialties) of—

(I) the average percentage division for the practice expense component for each physician specialty (determined under subparagraph (B)), multiplied by

(II) the proportion (determined under subparagraph (A)) of such service (or services) performed by physicians in that specialty.

* * * * *

(d) CONVERSION FACTORS.—

(1) ESTABLISHMENT.—

(A) IN GENERAL.—The conversion factor [(or factors)] for each year shall be the conversion factor [(or factors)] established under this subsection for the previous year (or, in the case of 1992, specified in subparagraph (B)) adjusted

by the update **[or updates]** (established under paragraph (3)) for the year involved.

* * * * *

(C) SPECIAL RULES FOR 1998.—Except as provided in subparagraph (D), the single conversion factor for 1998 under this subsection shall be the conversion factor for primary care services for 1997, increased by the Secretary's estimate of the weighted average of the three separate updates that would otherwise occur were it not for the enactment of chapter 1 of subtitle G of title X of the Balanced Budget Act of 1997.

(D) SPECIAL RULES FOR ANESTHESIA SERVICES.—The separate conversion factor for anesthesia services for a year shall be equal to 46 percent of the single conversion factor established for other physicians' services, except as adjusted for changes in work, practice expense, or malpractice relative value units.

[(C)] (E) PUBLICATION.—The Secretary shall cause to have published in the Federal Register, during the last 15 days of October of—

(i) 1991, the conversion factor which will apply to physicians' services for 1992, and the update (or updates) determined under paragraph (3) for 1992 and

(ii) each succeeding year, the conversion factor **[(or factors)]** which will apply to physicians' services for the following year and the update **[(or updates)]** determined under paragraph (3) for such year.

[(2) RECOMMENDATION OF UPDATE.—

[(A) IN GENERAL.—Not later than April 15 of each year (beginning with 1991), the Secretary shall transmit to the Congress a report that includes a recommendation on the appropriate update (or updates) in the conversion factor (or factors) for all physicians' services (as defined in subsection (f)(5)(A)) in the following year. The Secretary may recommend a uniform update or different updates for different categories or groups of services. In making the recommendation, the Secretary shall consider—

[(i) the percentage change in the medicare economic index (described in the fourth sentence of section 1842(b)(3)) for that year;

[(ii) the percentage by which actual expenditures for all physicians' services and for the services involved under this part for the fiscal year ending in the year preceding the year in which such recommendation is made were greater or less than actual expenditures for such services in the fiscal year ending in the second preceding year;

[(iii) the relationship between the percentage determined under clause (ii) for a fiscal year and the performance standard rate of increase (established under subsection (f)(2)) for that fiscal year;

[(iv) changes in volume or intensity of services;

[(v) access to services; and

[(vi) other factors that may contribute to changes in volume or intensity of services or access to services.

For purposes of making the comparison under clause (iii), the Secretary shall adjust the performance standard rate of increase for a fiscal year to reflect changes in the actual proportion of individuals who are enrolled under this part who are HMO enrollees (as defined in subsection (f)(5)(B)) in that fiscal year compared with such proportion for the previous fiscal year.

[(B) ADDITIONAL CONSIDERATIONS.—In making recommendations under subparagraph (A), the Secretary may also consider—

[(i) unexpected changes by physicians in response to the implementation of the fee schedule;

[(ii) unexpected changes in outlay projections;

[(iii) changes in the quality or appropriateness of care; and

[(v) any other relevant factors not measured in the resource-based payment methodology.

[(C) SPECIAL RULE FOR 1992 UPDATE.—In considering the update for 1992, the Secretary shall make a separate determination of the percentage and relationship described in clauses (ii) and (iii) of subparagraph (A) with respect to the category of surgical services (as defined by the Secretary pursuant to subsection (j)(1)).

[(D) EXPLANATION OF UPDATE.—The Secretary shall include in each report under subparagraph (A)—

[(i) the update recommended for each category of physicians' services (established by the Secretary under subsection (j)(1)) and for each of the following groups of physicians' services: nonsurgical services, visits, consultations, and emergency room services;

[(ii) the rationale for the recommended update (or updates) for each category and group of services described in clause (i); and

[(iii) the data and analyses underlying the update (or updates) recommended.

[(E) COMPUTATION OF BUDGET-NEUTRAL ADJUSTMENT.—

[(i) IN GENERAL.—The Secretary shall include in the report made under subparagraph (A) in a year a statement of the percentage by which (I) the actual expenditures for physicians' services under this part (during the fiscal year ending in the preceding year, as set forth in the most recent annual report made pursuant to section 1841(b)(2)), exceeded, or was less than (II) the expenditures projected for the fiscal year under clause (ii).

[(ii) PROJECTED EXPENDITURES.—For purposes of clause (i), the expenditures projected under this clause for a fiscal year is the actual expenditures for physicians' services made under this part in the second preceding fiscal year—

[(I) increased by the weighted average percentage increase permitted under this part for pay-

ments for physicians' services in the preceding fiscal year;

[(II) adjusted to reflect the percentage change in the average number of individuals enrolled under this part (who are not enrolled with a risk-sharing contract under section 1876) for the preceding fiscal year compared with the second preceding fiscal year;

[(III) adjusted to reflect the average annual percentage growth in the volume and intensity of physicians' services under this part for the five-fiscal-year period ending with the second preceding fiscal year; and

[(IV) adjusted to reflect the percentage change in expenditures for physicians' services under this part in the preceding fiscal year (compared with the second preceding fiscal year) which result from changes in law or regulations.

[(F) COMMISSION REVIEW.—The Physician Payment Review Commission shall review the report submitted under subparagraph (A) in a year and shall submit to the Congress, by not later than May 15 of the year, a report including its recommendations respecting the update (or updates) in the conversion factor (or factors) for the following year.

[(3) UPDATE.—

[(A) BASED ON INDEX.—

[(i) IN GENERAL.—Unless Congress otherwise provides, subject to subparagraph (B), except as provided in clauses (iii) through (v), for purposes of this section the update for a year is equal to the Secretary's estimate of the percentage increase in the appropriate update index (as defined in clause (ii)) for the year.

[(ii) APPROPRIATE UPDATE INDEX DEFINED.—In clause (i), the term "appropriate update index" means—

[(I) for services for which prevailing charges in 1989 were subject to a limit under the fourth sentence of section 1842(b)(3), the medicare economic index (referred to in that sentence), and

[(II) for other services, such index (such as the consumer price index) that was applicable under this part in 1989 to increases in the payment amounts recognized under this part with respect to such services.

[(iii) ADJUSTMENT IN PERCENTAGE INCREASE.—In applying clause (i) for services furnished in 1992 for which the appropriate update index is the index described in clause (ii)(I), the percentage increase in the appropriate update index shall be reduced by 0.4 percentage points.

[(iv) ADJUSTMENT IN PERCENTAGE INCREASE FOR 1994.—In applying clause (i) for services furnished in

1994, the percentage increase in the appropriate update index shall be reduced by—

【(I) 3.6 percentage points for services included in the category of surgical services (as defined for purposes of subsection (j)(1)), and

【(II) 2.6 percentage points for other services.

【(v) ADJUSTMENT IN PERCENTAGE INCREASE FOR 1995.—In applying clause (i) for services furnished in 1995, the percentage increase in the appropriate update index shall be reduced by 2.7 percentage points.

【(vi) EXCEPTION FOR CATEGORY OF PRIMARY CARE SERVICES.—Clauses (iv) and (v) shall not apply to services included in the category of primary care services (as defined for purposes of subsection (j)(1)).

【(B) ADJUSTMENT IN UPDATE.—

【(i) IN GENERAL.— The update for a category of physicians' services for a year provided under subparagraph (A) shall, subject to clause (ii), be increased or decreased by the same percentage by which (I) the percentage increase in the actual expenditures for services in such category in the second previous fiscal year over the third previous fiscal year, was less or greater, respectively, than (II) the performance standard rate of increase (established under subsection (f)) for such category of services for the second previous fiscal year.

【(ii) RESTRICTIONS ON ADJUSTMENT.—The adjustment made under clause (i) for a year may not result in a decrease of more than—

【(I) 2 percentage points for the update for 1992 or 1993,

【(II) 2½ percentage points for the update for 1994, and

【(III) 5 percentage points for the update for any succeeding year.】

(3) UPDATE.—

(A) IN GENERAL.—*Unless otherwise provided by law, subject to subparagraph (D) and the budget-neutrality factor determined by the Secretary under subsection (c)(2)(B)(ii), the update to the single conversion factor established in paragraph (1)(C) for a year beginning with 1999 is equal to the product of—*

(i) 1 plus the Secretary's estimate of the percentage increase in the MEI (as defined in section 1842(i)(3)) for the year (divided by 100), and

(ii) 1 plus the Secretary's estimate of the update adjustment factor for the year (divided by 100), minus 1 and multiplied by 100.

(B) UPDATE ADJUSTMENT FACTOR.—*For purposes of subparagraph (A)(ii), the "update adjustment factor" for a year is equal to the quotient (as estimated by the Secretary) of—*

(i) the difference between (I) the sum of the allowed expenditures for physicians' services (as determined under subparagraph (C)) during the period beginning

July 1, 1997, and ending on June 30 of the year involved, and (II) the sum of the amount of actual expenditures for physicians' services furnished during the period beginning July 1, 1997, and ending of June 30 of the preceding year; divided by

(ii) the allowed expenditures for physicians' services for the 12-month period ending on June 30 of the year involved.

(C) DETERMINATION OF ALLOWED EXPENDITURES.—For purposes of this paragraph, the allowed expenditures for physicians' services for the 12-month period ending with June 30 of—

(i) 1997 is equal to the actual expenditures for physicians' services furnished during such 12-month period, as estimated by the Secretary; or

(ii) a subsequent year is equal to the allowed expenditures for physicians' services for the previous year, increased by the sustainable growth rate under subsection (f) for the fiscal year which begins during such 12-month period.

(D) RESTRICTION ON VARIATION FROM MEDICARE ECONOMIC INDEX.—Notwithstanding the amount of the update adjustment factor determined under subparagraph (B) for a year, the update in the conversion factor under this paragraph for the year may not be—

(i) greater than 100 times the following amount: $(1.04 + (MEI \text{ percentage} / 100)) - 1$; or

(ii) less than 100 times the following amount: $(0.94 + (MEI \text{ percentage} / 100)) - 1$,

where "MEI percentage" means the Secretary's estimate of the percentage increase in the MEI (as defined in section 1842(i)(2)) for the year involved.

* * * * *

(f) MEDICARE [VOLUME PERFORMANCE STANDARD RATES OF INCREASE] SUSTAINABLE GROWTH RATE.—

(1) PROCESS FOR ESTABLISHING MEDICARE [VOLUME PERFORMANCE STANDARD RATES OF INCREASE] SUSTAINABLE GROWTH RATE.—

[(A) SECRETARY'S RECOMMENDATION.—By not later than April 15 of each year (beginning with 1990), the Secretary shall transmit to the Congress a recommendation on performance standard rates of increase for all physicians' services and for each category of such services for the fiscal year beginning in such year. In making the recommendation, the Secretary shall confer with organizations representing physicians and shall consider—

[(i) inflation,

[(ii) changes in numbers of enrollees (other than HMO enrollees) under this part,

[(iii) changes in the age composition of enrollees (other than HMO enrollees) under this part,

[(iv) changes in technology,

[(v) evidence of inappropriate utilization of services,

[(vi) evidence of lack of access to necessary physicians' services, and

[(vii) such other factors as the Secretary considers appropriate.

[(B) COMMISSION REVIEW.—The Physician Payment Review Commission shall review the recommendation transmitted during a year under subparagraph (A) and shall make its recommendation to Congress, by not later than May 15 of the year, respecting the performance standard rates of increase for the fiscal year beginning in that year.]

(C) PUBLICATION OF [PERFORMANCE STANDARD RATES OF INCREASE] *SUSTAINABLE GROWTH RATE*.—The Secretary shall cause to have published in the Federal Register, in the last 15 days of October of each year (beginning [with 1991], the performance standard rates of increase for all physicians' services and for each category of physicians' services for the fiscal year beginning in that year.] *with 1999*), the sustainable growth rate for the fiscal year beginning in that year. The Secretary shall cause to have published in the Federal Register, by not later than [January 1, 1990, the performance standard rate of increase under subparagraph (D) for fiscal year 1990] *January 1, 1999*, the sustainable growth rate for fiscal year 1999.

* * * * *

[(2) SPECIFICATION OF PERFORMANCE STANDARD RATES OF INCREASE FOR SUBSEQUENT FISCAL YEARS.—

[(A) IN GENERAL.—Unless Congress otherwise provides, subject to paragraph (4), the performance standard rate of increase, for all physicians' services and for each category of physicians' services, for a fiscal year (beginning with fiscal year 1991) shall be equal to 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 or for the category of physicians' services, respectively,) 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 or of the category of physicians' services, respectively, under this part for the 5-fiscal-year period ending with the preceding fiscal year (based upon information contained in the most recent annual report made pursuant to section 1841(b)(2)), and

[(iv) 1 plus the Secretary's estimate of the percentage increase or decrease (divided by 100) in expenditures for all physicians' services or of the category of

physicians' services, respectively, in the fiscal year (compared with the preceding fiscal year) which will result from changes in law or regulations including changes in law and regulations affecting the percentage increase described in clause (i) and which 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 (B)). In clause (i), the term "fees" means, with respect to 1991, reasonable charges and, with respect to any succeeding year, fee schedule amounts.

[(B) PERFORMANCE STANDARD FACTOR.—For purposes of subparagraph (A), the performance standard factor—

[(i) for 1991 is 1 percentage point,

[(ii) for 1992 is 1½ percentage points,

[(iii) for 1993 is 2 percentage points,

[(iv) for 1994 is 3½ percentage points, and

[(v) for each succeeding year is 4 percentage points.

[(C) PERFORMANCE STANDARD RATES OF INCREASE FOR FISCAL YEAR 1991.—Notwithstanding subparagraph (A), the performance standard rate of increase for a category of physicians' services for fiscal year 1991 shall be the sum of—

[(i) the Secretary's estimate of the percentage by which actual expenditures for the category of physicians' services under this part for fiscal year 1991 exceed actual expenditures for such category of services in fiscal year 1990 (determined without regard to the amendments made by the Omnibus Budget Reconciliation Act of 1990), and

[(ii) the Secretary's estimate of the percentage increase or decrease in expenditures for the category of services in fiscal year 1991 (compared with fiscal year 1990) that will result from changes in law and regulations (including the Omnibus Budget Reconciliation Act of 1990), reduced by 2 percentage points.

[(3) QUARTERLY REPORTING.—The Secretary shall establish procedures for providing, on a quarterly basis to the Physician Payment Review Commission, the Congressional Budget Office, the Congressional Research Service, the Committees on Ways and Means and Energy and Commerce of the House of Representatives, and the Committee on Finance of the Senate, information on compliance with performance standard rates of increase established under this subsection.

[(4) SEPARATE GROUP-SPECIFIC PERFORMANCE STANDARD RATES OF INCREASE.—

[(A) IMPLEMENTATION OF PLAN.—Subject to subparagraph (B), the Secretary shall, after completion of the study required under section 6102(e)(3) of the Omnibus Budget Reconciliation Act of 1989, but not before October 1, 1991, implement a plan under which qualified physician groups could elect annually separate performance standard rates of increase other than the performance standard rate

of increase established for the year under paragraph (2) for such physicians. The Secretary shall develop criteria to determine which physician groups are eligible to elect to have applied to such groups separate performance standard rates of increase and the methods by which such group-specific performance standard rates of increase would be accomplished. The Secretary shall report to the Congress on the criteria and methods by April 15, 1991. The Physician Payment Review Commission shall review and comment on such recommendations by May 15, 1991. Before implementing group-specific performance standard rates of increase, the Secretary shall provide for notice and comment in the Federal Register and consult with organizations representing physicians.

[(B) APPROVAL.—The Secretary may not implement the plan described in subparagraph (A), unless specifically approved by law.]

[(5) DEFINITIONS.—In this subsection:

[(A) SERVICES INCLUDED IN PHYSICIANS' SERVICES.—The term "physicians' services" includes other items and services (such as clinical diagnostic laboratory tests and radiology services), specified by the Secretary, that are commonly performed or furnished by a physician or in a physician's office, but does not include services furnished to an HMO enrollee under a risk-sharing contract under section 1876.]

[(B) HMO ENROLLEE.—The term "HMO enrollee" means, with respect to a fiscal year, an individual enrolled under this part who is enrolled with an entity under a risk-sharing contract under section 1876 in the fiscal year.]

(2) SPECIFICATION OF GROWTH RATE.—*The sustainable growth rate for all physicians' services for a fiscal year (beginning with fiscal year 1998) shall be equal to the product of—*

(A) *1 plus the Secretary's estimate of the weighted average percentage increase (divided by 100) in the fees for all physicians' services in the fiscal year involved,*

(B) *1 plus the Secretary's estimate of the percentage change (divided by 100) in the average number of individuals enrolled under this part (other than MedicarePlus plan enrollees) from the previous fiscal year to the fiscal year involved,*

(C) *1 plus the Secretary's estimate of the projected percentage growth in real gross domestic product per capita (divided by 100) from the previous fiscal year to the fiscal year involved, and*

(D) *1 plus the Secretary's estimate of the percentage change (divided by 100) in expenditures for all physicians' services in the fiscal year (compared with the previous fiscal year) which will result from changes in law and regulations, determined without taking into account estimated changes in expenditures due to changes in the volume and intensity of physicians' services resulting from changes in the update to the conversion factor under subsection (d)(3), minus 1 and multiplied by 100.*

(3) *DEFINITIONS.—In this subsection:*

(A) *SERVICES INCLUDED IN PHYSICIANS’ SERVICES.—The term “physicians’ services” includes other items and services (such as clinical diagnostic laboratory tests and radiology services), specified by the Secretary, that are commonly performed or furnished by a physician or in a physician’s office, but does not include services furnished to a MedicarePlus plan enrollee.*

(B) *MEDICAREPLUS PLAN ENROLLEE.—The term “MedicarePlus plan enrollee” means, with respect to a fiscal year, an individual enrolled under this part who has elected to receive benefits under this title for the fiscal year through a MedicarePlus plan offered under part C, and also includes an individual who is receiving benefits under this part through enrollment with an eligible organization with a risk-sharing contract under section 1876.*

(g) *LIMITATION ON BENEFICIARY LIABILITY.—*

(1) * * *

* * * * *

(6) *MONITORING OF CHARGES.—*

(A) * * *

* * * * *

(C) *PLAN.—If the Secretary finds that there has been a significant decrease in the proportions described in subclauses (I) and (II) of subparagraph (A)(ii) or an increase in the amounts described in subclause (III) of that subparagraph, the Secretary shall develop a plan to address such a problem and transmit to Congress recommendations regarding the plan. The [Physician Payment Review Commission] Medicare Payment Advisory Commission shall review the Secretary’s plan and recommendations and transmit to Congress its comments regarding such plan and recommendations.*

(7) *MONITORING OF UTILIZATION AND ACCESS.—*

(A) * * *

* * * * *

(C) *RECOMMENDATIONS.—The Secretary shall include in each annual report under subparagraph (B) recommendations—*

- (i) addressing any identified patterns of inappropriate utilization,
- (ii) on utilization review,
- (iii) on physician education or patient education,
- (iv) addressing any problems of beneficiary access to care made evident by the monitoring process, and
- (v) on such other matters as the Secretary deems appropriate.

The [Physician Payment Review Commission] Medicare Payment Advisory Commission shall comment on the Secretary’s recommendations and in developing its comments, the Commission shall convene and consult a panel of physician experts to evaluate the implications of medical utili-

zation patterns for the quality of and access to patient care.

* * * * *

(i) MISCELLANEOUS PROVISIONS.—

(1) RESTRICTION ON ADMINISTRATIVE AND JUDICIAL REVIEW.— There shall be no administrative or judicial review under section 1869 or otherwise of—

(A) * * *

* * * * *

(C) the determination of [conversion factors] *the conversion factor* under subsection (d),

* * * * *

(j) DEFINITIONS.—In this section:

(1) CATEGORY.—The term “category” means, with respect to physicians’ services, surgical services (as defined by the Secretary [and including anesthesia services]), primary care services (as defined in section 1842(i)(4)), and all other physicians’ services. The Secretary shall define surgical services and publish such definitions in the Federal Register no later than May 1, 1990, after consultation with organizations representing physicians (*including anesthesia services*).

* * * * *

PART C—MEDICAREPLUS PROGRAM

ELIGIBILITY, ELECTION, AND ENROLLMENT

SEC. 1851. (a) CHOICE OF MEDICARE BENEFITS THROUGH MEDICAREPLUS PLANS.—

(1) IN GENERAL.—Subject to the provisions of this section, each MedicarePlus eligible individual (as defined in paragraph (3)) is entitled to elect to receive benefits under this title—

(A) through the medicare fee-for-service program under parts A and B, or

(B) through enrollment in a MedicarePlus plan under this part.

(2) TYPES OF MEDICAREPLUS PLANS THAT MAY BE AVAILABLE.—A MedicarePlus plan may be any of the following types of plans of health insurance:

(A) COORDINATED CARE PLANS.—Coordinated care plans which provide health care services, including health maintenance organization plans and preferred provider organization plans.

(B) PLANS OFFERED BY PROVIDER-SPONSORED ORGANIZATION.—A MedicarePlus plan offered by a provider-sponsored organization, as defined in section 1855(e).

(C) COMBINATION OF MSA PLAN AND CONTRIBUTIONS TO MEDICAREPLUS MSA.—An MSA plan, as defined in section 1859(b)(2), and a contribution into a MedicarePlus medical savings account (MSA).

(3) MEDICAREPLUS ELIGIBLE INDIVIDUAL.—

(A) IN GENERAL.—In this title, subject to subparagraph (B), the term “MedicarePlus eligible individual” means an

individual who is entitled to benefits under part A and enrolled under part B.

(B) *SPECIAL RULE FOR END-STAGE RENAL DISEASE.*—Such term shall not include an individual medically determined to have end-stage renal disease, except that an individual who develops end-stage renal disease while enrolled in a MedicarePlus plan may continue to be enrolled in that plan.

(b) *SPECIAL RULES.*—

(1) *RESIDENCE REQUIREMENT.*—

(A) *IN GENERAL.*—Except as the Secretary may otherwise provide, an individual is eligible to elect a MedicarePlus plan offered by a MedicarePlus organization only if the organization serves the geographic area in which the individual resides.

(B) *CONTINUATION OF ENROLLMENT PERMITTED.*—Pursuant to rules specified by the Secretary, the Secretary shall provide that an individual may continue enrollment in a plan, notwithstanding that the individual no longer resides in the service area of the plan, so long as the plan provides benefits for enrollees located in the area in which the individual resides.

(2) *SPECIAL RULE FOR CERTAIN INDIVIDUALS COVERED UNDER FEHBP OR ELIGIBLE FOR VETERANS OR MILITARY HEALTH BENEFITS, VETERANS.*—

(A) *FEHBP.*—An individual who is enrolled in a health benefit plan under chapter 89 of title 5, United States Code, is not eligible to enroll in an msa plan until such time as the Director of the Office of Management and Budget certifies to the Secretary that the Office of Personnel Management has adopted policies which will ensure that the enrollment of such individuals in such plans will not result in increased expenditures for the Federal Government for health benefit plans under such chapter.

(B) *VA AND DOD.*—The Secretary may apply rules similar to the rules described in subparagraph (A) in the case of individuals who are eligible for health care benefits under chapter 55 of title 10, United States Code, or under chapter 17 of title 38 of such Code.

(3) *LIMITATION ON ELIGIBILITY OF QUALIFIED MEDICARE BENEFICIARIES AND OTHER MEDICAID BENEFICIARIES TO ENROLL IN AN MSA PLAN.*—An individual who is a qualified medicare beneficiary (as defined in section 1905(p)(1)), a qualified disabled and working individual (described in section 1905(s)), an individual described in section 1902(a)(10)(E)(iii), or otherwise entitled to medicare cost-sharing under a State plan under title XIX is not eligible to enroll in an MSA plan.

(4) *COVERAGE UNDER MSA PLANS ON A DEMONSTRATION BASIS.*—

(A) *IN GENERAL.*—An individual is not eligible to enroll in an MSA plan under this part—

(i) on or after January 1, 2003, unless the enrollment is the continuation of such an enrollment in effect as of such date; or

(ii) as of any date if the number of such individuals so enrolled as of such date has reached 500,000.

Under rules established by the Secretary, an individual is not eligible to enroll (or continue enrollment) in an MSA plan for a year unless the individual provides assurances satisfactory to the Secretary that the individual will reside in the United States for at least 183 days during the year.

(B) *EVALUATION.*—The Secretary shall regularly evaluate the impact of permitting enrollment in MSA plans under this part on selection (including adverse selection), use of preventive care, access to care, and the financial status of the Trust Funds under this title.

(C) *REPORTS.*—The Secretary shall submit to Congress periodic reports on the numbers of individuals enrolled in such plans and on the evaluation being conducted under subparagraph (B). The Secretary shall submit such a report, by not later than March 1, 2002, on whether the time limitation under subparagraph (A)(i) should be extended or removed and whether to change the numerical limitation under subparagraph (A)(ii).

(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) *COORDINATION THROUGH MEDICAREPLUS ORGANIZATIONS.*—

(A) *ENROLLMENT.*—Such process shall permit an individual who wishes to elect a MedicarePlus plan offered by a MedicarePlus 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 MedicarePlus plan offered by a MedicarePlus organization and who wishes to terminate such election, to terminate such election through the filing of an appropriate election form with the organization.

(3) *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 medicare fee-for-service program option.

(ii) *SEAMLESS CONTINUATION OF COVERAGE.*—The Secretary may establish procedures under which an individual who is enrolled in a health plan (other than MedicarePlus plan) offered by a MedicarePlus organization at the time of the initial election period and who fails to elect to receive coverage other than through the organization is deemed to have elected the MedicarePlus plan offered by the organization (or, if

the organization offers more than one such plan, such plan or plans as the Secretary identifies under such procedures).

(B) CONTINUING PERIODS.—An individual who has made (or is 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 MedicarePlus plan is discontinued, if the individual had elected such plan at the time of the discontinuation.

(d) PROVIDING INFORMATION TO PROMOTE INFORMED CHOICE.—

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

(2) PROVISION OF NOTICE.—

(A) OPEN SEASON NOTIFICATION.—At least 30 days before the beginning of each annual, coordinated election period (as defined in subsection (e)(3)(B)), the Secretary shall mail to each MedicarePlus eligible individual residing in an area the following:

(i) GENERAL INFORMATION.—The general information described in paragraph (3).

(ii) LIST OF PLANS AND COMPARISON OF PLAN OPTIONS.—A list identifying the MedicarePlus plans that are (or will be) available to residents of the area and information described in paragraph (4) concerning such plans. Such information shall be presented in a comparative form.

(iii) MEDICAREPLUS MONTHLY CAPITATION RATE.—The amount of the monthly MedicarePlus capitation rate for the area.

(iv) ADDITIONAL INFORMATION.—Any other information that the Secretary determines will assist the individual in making the election under this section.

The mailing of such information shall be coordinated with the mailing of any annual notice under section 1804.

(B) NOTIFICATION TO NEWLY MEDICAREPLUS ELIGIBLE INDIVIDUALS.—To the extent practicable, the Secretary shall, not later than 2 months before the beginning of the initial MedicarePlus enrollment period for an individual described in subsection (e)(1), mail to the individual the information described in subparagraph (A).

(C) FORM.—The information disseminated under this paragraph shall be written and formatted using language that is easily understandable by medicare beneficiaries.

(D) PERIODIC UPDATING.—The information described in subparagraph (A) shall be updated on at least an annual basis to reflect changes in the availability of MedicarePlus plans and the benefits and monthly premiums (and net monthly premiums) for such plans.

(3) *GENERAL INFORMATION.*—General information under this paragraph, with respect to coverage under this part during a year, shall include the following:

(A) *BENEFITS UNDER FEE-FOR-SERVICE PROGRAM OPTION.*—A general description of the benefits covered (and not covered) under the medicare fee-for-service program under parts A and B, including—

(i) covered items and services,

(ii) beneficiary cost sharing, such as deductibles, co-insurance, and copayment amounts, and

(iii) any beneficiary liability for balance billing.

(B) *PART B PREMIUM.*—The part B premium rates that will be charged for part B coverage.

(C) *ELECTION PROCEDURES.*—Information and instructions on how to exercise election options under this section.

(D) *RIGHTS.*—The general description of procedural rights (including grievance and appeals procedures) of beneficiaries under the medicare fee-for-service program and the MedicarePlus program and right to be protected against discrimination based on health status-related factors under section 1852(b).

(E) *INFORMATION ON MEDIGAP AND MEDICARE SELECT.*—A general description of the benefits, enrollment rights, and other requirements applicable to medicare supplemental policies under section 1882 and provisions relating to medicare select policies described in section 1882(t).

(F) *POTENTIAL FOR CONTRACT TERMINATION.*—The fact that a MedicarePlus organization may terminate or refuse to renew its contract under this part and the effect the termination or nonrenewal of its contract may have on individuals enrolled with the MedicarePlus plan under this part.

(4) *INFORMATION COMPARING PLAN OPTIONS.*—Information under this paragraph, with respect to a MedicarePlus plan for a year, shall include the following:

(A) *BENEFITS.*—The benefits covered (and not covered) under the plan, including—

(i) covered items and services beyond those provided under the medicare fee-for-service program,

(ii) any beneficiary cost sharing,

(iii) any maximum limitations on out-of-pocket expenses, and

(iv) in the case of an MSA plan, differences in cost sharing under such a plan compared to under other MedicarePlus plans.

(v) the use of provider networks and the restriction on payments for services furnished other than by other through the organization,

(vi) the organization's coverage of emergency and urgently needed care,

(vii) the appeal and grievance rights of enrollees,

(viii) number of grievances and appeals, and information on their disposition in the aggregate,

(ix) procedures used by the organization to control utilization of services and expenditures, and

(x) any exclusions in the types of providers participating in the plan's network.

(B) PREMIUMS.—The monthly premium (and net monthly premium), if any, for the plan.

(C) SERVICE AREA.—The service area of the plan.

(D) QUALITY AND PERFORMANCE.—To the extent available, plan quality and performance indicators for the benefits under the plan (and how they compare to such indicators under the medicare fee-for-service program under parts A and B in the area involved), including—

(i) disenrollment rates for medicare enrollees electing to receive benefits through the plan for the previous 2 years (excluding disenrollment due to death or moving outside the plan's service area),

(ii) information on medicare enrollee satisfaction,

(iii) information on health outcomes, and

(iv) the recent record regarding compliance of the plan with requirements of this part (as determined by the Secretary).

(E) SUPPLEMENTAL BENEFITS OPTIONS.—Whether the organization offering the plan offers optional supplemental benefits and the terms and conditions (including premiums) for such coverage.

(5) MAINTAINING A TOLL-FREE NUMBER AND INTERNET SITE.—The Secretary shall maintain a toll-free number for inquiries regarding MedicarePlus options and the operation of this part in all areas in which MedicarePlus plans are offered and an Internet site through which individuals may electronically obtain information on such options and MedicarePlus plans.

(6) USE OF NONFEDERAL ENTITIES.—The Secretary may enter into contracts with non-Federal entities to carry out activities under this subsection.

(7) PROVISION OF INFORMATION.—A MedicarePlus organization shall provide the Secretary with such information on the organization and each MedicarePlus plan it offers as may be required for the preparation of the information referred to in paragraph (2)(A).

(e) COVERAGE ELECTION PERIODS.—

(1) INITIAL CHOICE UPON ELIGIBILITY TO MAKE ELECTION IF MEDICAREPLUS PLANS AVAILABLE TO INDIVIDUAL.—If, at the time an individual first becomes entitled to benefits under part A and enrolled under part B, there is one or more MedicarePlus plans offered in the area in which the individual resides, 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 such time. Such period shall be specified in a manner so that, in the case of an individual who elects a MedicarePlus plan during the period, coverage under the plan becomes effective as of the first date on which the individual may receive such coverage.

(2) OPEN ENROLLMENT AND DISENROLLMENT OPPORTUNITIES.—Subject to paragraph (5)—

(A) *CONTINUOUS OPEN ENROLLMENT AND DISENROLLMENT THROUGH 2000.*—At any time during 1998, 1999, and 2000, a MedicarePlus eligible individual may change the election under subsection (a)(1).

(B) *CONTINUOUS OPEN ENROLLMENT AND DISENROLLMENT FOR FIRST 6 MONTHS DURING 2001.*—

(i) *IN GENERAL.*—Subject to clause (ii), at any time during the first 6 months of 2001, or, if the individual first becomes a MedicarePlus eligible individual during 2001, during the first 6 months during 2001 in which the individual is a MedicarePlus eligible individual, a MedicarePlus eligible individual may change the election under subsection (a)(1).

(ii) *LIMITATION OF ONE CHANGE PER YEAR.*—An individual may exercise the right under clause (i) only once during 2001. The limitation under this clause shall not apply to changes in elections effected during an annual, coordinated election period under paragraph (3) or during a special enrollment period under paragraph (4).

(C) *CONTINUOUS OPEN ENROLLMENT AND DISENROLLMENT FOR FIRST 3 MONTHS IN SUBSEQUENT YEARS.*—

(i) *IN GENERAL.*—Subject to clause (ii), at any time during the first 3 months of a year after 2001, or, if the individual first becomes a MedicarePlus eligible individual during a year after 2001, during the first 3 months of such year in which the individual is a MedicarePlus eligible individual, a MedicarePlus eligible individual may change the election under subsection (a)(1).

(ii) *LIMITATION OF ONE CHANGE PER YEAR.*—An individual may exercise the right under clause (i) only once a year. The limitation under this clause shall not apply to changes in elections effected during an annual, coordinated election period under paragraph (3) or during a special enrollment period under paragraph (4).

(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 an annual, coordinated election period.

(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 2001), the month of October before such year.

(C) *MEDICAREPLUS HEALTH FAIRS.*—In the month of October of each year (beginning with 1998), the Secretary shall provide for a nationally coordinated educational and publicity campaign to inform MedicarePlus eligible individuals about MedicarePlus plans and the election process provided under this section.

(4) *SPECIAL ELECTION PERIODS.*—Effective as of January 1, 2001, an individual may discontinue an election of a

MedicarePlus plan offered by a MedicarePlus organization other than during an annual, coordinated election period and make a new election under this section if—

(A) the organization's or plan's certification under this part has been terminated or the organization has terminated or otherwise discontinued providing the plan;

(B) the individual is no longer eligible to elect the plan 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 the individual's enrollment on the basis described in clause (i) or (ii) of subsection (g)(3)(B));

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

(i) the organization offering the plan substantially violated a material provision of the organization's contract under this part in relation to the individual (including the failure to provide an enrollee on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide such covered care in accordance with applicable quality standards); or

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

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

(5) SPECIAL RULES FOR MSA PLANS.—Notwithstanding the preceding provisions of this subsection, an individual—

(A) may elect an MSA plan only during—

(i) an initial open enrollment period described in paragraph (1),

(ii) an annual, coordinated election period described in paragraph (3)(B), or

(iii) the months of October 1998 and October 1999;
and

(B) may not discontinue an election of an MSA plan except during the periods described in clause (ii) or (iii) of subparagraph (A) and under paragraph (4).

(f) EFFECTIVENESS OF ELECTIONS AND CHANGES OF ELECTIONS.—

(1) DURING INITIAL COVERAGE ELECTION PERIOD.—An election of coverage made during the initial coverage election period under subsection (e)(1) 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 CONTINUOUS OPEN ENROLLMENT PERIODS.—An election or change of coverage made under subsection (e)(2) shall take effect with the first day of the first calendar month following the date on which the election is made.

(3) ANNUAL, COORDINATED ELECTION PERIOD.—An election or change of coverage made during an annual, coordinated elec-

tion 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 or change of coverage made during any other period under subsection (e)(4) 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) *GUARANTEED ISSUE AND RENEWAL.*—

(1) *IN GENERAL.*—Except as provided in this subsection, a MedicarePlus organization shall provide that at any time during which elections are accepted under this section with respect to a MedicarePlus plan 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 MedicarePlus organization, in relation to a MedicarePlus plan it offers, has a capacity limit and the number of MedicarePlus eligible individuals who elect the plan under this section exceeds the capacity limit, the organization may limit the election of individuals of the plan under this section but only if priority in election is provided—

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

(B) then to other such individuals in such a manner that does not discriminate, on a basis described in section 1852(b), among the individuals (who seek to elect the plan).

The preceding sentence shall not apply if it would result in the enrollment of enrollees substantially nonrepresentative, as determined in accordance with regulations of the Secretary, of the medicare population in the service area of the plan.

(3) *LIMITATION ON TERMINATION OF ELECTION.*—

(A) *IN GENERAL.*—Subject to subparagraph (B), a MedicarePlus organization may not for any reason terminate the election of any individual under this section for a MedicarePlus plan it offers.

(B) *BASIS FOR TERMINATION OF ELECTION.*—A MedicarePlus organization may terminate an individual's election under this section with respect to a MedicarePlus plan it offers if—

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

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

(iii) the plan is terminated with respect to all individuals under this part in the area in which the individual resides.

(C) *CONSEQUENCE OF TERMINATION.*—

(i) *TERMINATIONS FOR CAUSE.*—Any individual whose election is terminated under clause (i) or (ii) of subparagraph (B) is deemed to have elected the medi-

care fee-for-service program option described in subsection (a)(1)(A).

(ii) *TERMINATION BASED ON PLAN TERMINATION OR SERVICE AREA REDUCTION.*—Any individual whose election is terminated under subparagraph (B)(iii) shall have a special election period under subsection (e)(4)(A) in which to change coverage to coverage under another MedicarePlus plan. Such an individual who fails to make an election during such period is deemed to have chosen to change coverage to the medicare fee-for-service program option described in subsection (a)(1)(A).

(D) *ORGANIZATION OBLIGATION WITH RESPECT TO ELECTION FORMS.*—Pursuant to a contract under section 1857, each MedicarePlus organization receiving an election form under subsection (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.

(h) *APPROVAL OF MARKETING MATERIAL AND APPLICATION FORMS.*—

(1) *SUBMISSION.*—No marketing material or application form may be distributed by a MedicarePlus organization to (or for the use of) MedicarePlus eligible individuals unless—

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

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

(2) *REVIEW.*—The standards established under section 1856 shall include guidelines for the review of all such material or form submitted and under such guidelines the Secretary shall disapprove (or later require the correction of) such material or form if the material or form is materially inaccurate or misleading or otherwise makes a material misrepresentation.

(3) *DEEMED APPROVAL (1-STOP SHOPPING).*—In the case of material or form 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 material or form under paragraph (1)(B) with respect to a MedicarePlus plan in an area, the Secretary is deemed not to have disapproved such distribution in all other areas covered by the plan and organization except to the extent that such material or form is specific only to an area involved.

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

(i) *EFFECT OF ELECTION OF MEDICAREPLUS PLAN OPTION.*—Subject to sections 1852(a)(5), 1857(f)(2), and 1857(g)—

(1) *payments under a contract with a MedicarePlus organization under section 1853(a) with respect to an individual electing a MedicarePlus plan offered by the organization 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, and*

(2) *subject to subsections (e) and (f) of section 1853, only the MedicarePlus organization shall be entitled to receive payments from the Secretary under this title for services furnished to the individual.*

BENEFITS AND BENEFICIARY PROTECTIONS

SEC. 1852. (a) BASIC BENEFITS.—

(1) *IN GENERAL.—Except as provided in section 1859(b)(2) for MSA plans, each MedicarePlus plan shall provide to members enrolled under this part, through providers and other persons that meet the applicable requirements of this title and part A of title XI—*

(A) *those items and services for which benefits are available under parts A and B to individuals residing in the area served by the plan, and*

(B) *additional benefits required under section 1854(f)(1)(A).*

(2) *SATISFACTION OF REQUIREMENT.—A MedicarePlus plan (other than an MSA plan) offered by a MedicarePlus organization satisfies paragraph (1)(A), with respect to benefits for items and services furnished other than through a provider that has a contract with the organization offering the plan, if the plan provides (in addition to any cost sharing provided for under the plan) for at least the total dollar amount of payment for such items and services as would otherwise be authorized under parts A and B (including any balance billing permitted under such parts).*

(3) *SUPPLEMENTAL BENEFITS.—*

(A) *BENEFITS INCLUDED SUBJECT TO SECRETARY'S APPROVAL.—Each MedicarePlus organization may provide to individuals enrolled under this part (without affording those individuals an option to decline the coverage) supplemental health care benefits that the Secretary may approve. The Secretary shall approve any such supplemental benefits unless the Secretary determines that including such supplemental benefits would substantially discourage enrollment by MedicarePlus eligible individuals with the organization.*

(B) *AT ENROLLEES' OPTION.—A MedicarePlus organization may provide to individuals enrolled under this part (other than under an MSA plan), supplemental health care benefits that the individuals may elect, at their option, to have covered.*

(4) *ORGANIZATION AS SECONDARY PAYER.—Notwithstanding any other provision of law, a MedicarePlus organization may (in the case of the provision of items and services to an individual under a MedicarePlus plan 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 a law, plan, 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.

(5) NATIONAL COVERAGE DETERMINATIONS.—If there is a national coverage determination made in the period beginning on the date of an announcement under section 1853(b) and ending on the date of the next announcement under such section and the Secretary projects that the determination will result in a significant change in the costs to a MedicarePlus organization of providing the benefits that are the subject of such national coverage determination and that such change in costs was not incorporated in the determination of the annual MedicarePlus capitation rate under section 1853 included in the announcement made at the beginning of such period—

(A) such determination shall not apply to contracts under this part until the first contract year that begins after the end of such period, and

(B) if such coverage determination provides for coverage of additional benefits or coverage under additional circumstances, section 1851(i) shall not apply to payment for such additional benefits or benefits provided under such additional circumstances until the first contract year that begins after the end of such period,

unless otherwise required by law.

(b) ANTIDISCRIMINATION.—

(1) IN GENERAL.—A MedicarePlus organization may not deny, limit, or condition the coverage or provision of benefits under this part, for individuals permitted to be enrolled with the organization under this part, based on any health status-related factor described in section 2702(a)(1) of the Public Health Service Act.

(2) CONSTRUCTION.—Paragraph (1) shall not be construed as requiring a MedicarePlus organization to enroll individuals who are determined to have end-stage renal disease, except as provided under section 1851(a)(3)(B).

(c) DETAILED DESCRIPTION OF PLAN PROVISIONS.—A MedicarePlus organization shall disclose, in clear, accurate, and standardized form to each enrollee with a MedicarePlus plan offered by the organization under this part at the time of enrollment and at least annually thereafter, the following information regarding such plan:

(1) SERVICE AREA.—The plan's service area.

(2) BENEFITS.—Benefits offered (and not offered) under the plan offered, including information described in section 1851(d)(3)(A) and exclusions from coverage and, if it is an MSA plan, a comparison of benefits under such a plan with benefits under other MedicarePlus plans.

(3) ACCESS.—The number, mix, and distribution of plan providers and any point-of-service option (including the supplemental premium for such option).

(4) *OUT-OF-AREA COVERAGE.*—*Out-of-area coverage provided by the plan.*

(5) *EMERGENCY COVERAGE.*—*Coverage of emergency services and urgently needed care, including—*

(A) *the appropriate use of emergency services, including use of the 911 telephone system or its local equivalent in emergency situations and an explanation of what constitutes an emergency situation;*

(B) *the process and procedures of the plan for obtaining emergency services; and*

(C) *the locations of (i) emergency departments, and (ii) other settings, in which plan physicians and hospitals provide emergency services and post-stabilization care.*

(6) *SUPPLEMENTAL BENEFITS.*—*Supplemental benefits available from the organization offering the plan, including—*

(A) *whether the supplemental benefits are optional,*

(B) *the supplemental benefits covered, and*

(C) *the premium price for the supplemental benefits.*

(7) *PRIOR AUTHORIZATION RULES.*—*Rules regarding prior authorization or other review requirements that could result in nonpayment.*

(8) *PLAN GRIEVANCE AND APPEALS PROCEDURES.*—*Any appeal or grievance rights and procedures.*

(9) *QUALITY ASSURANCE PROGRAM.*—*A description of the organization's quality assurance program under subsection (e).*

(d) *ACCESS TO SERVICES.*—

(1) *IN GENERAL.*—*A MedicarePlus organization offering a MedicarePlus plan may select the providers from whom the benefits under the plan are provided so long as—*

(A) *the organization makes such benefits available and accessible to each individual electing the plan within the plan service area with reasonable promptness and in a manner which assures continuity in the provision of benefits;*

(B) *when medically necessary in the opinion of the treating health care provider the organization makes such benefits available and accessible 24 hours a day and 7 days a week;*

(C) *the plan 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 in the opinion of the treating health care provider and immediately required because of an unforeseen illness, injury, or condition, and it was not reasonable given the circumstances to obtain the services through the organization,*

(ii) *the services were renal dialysis services and were provided other than through the organization because the individual was temporarily out of the plan's service area, or*

(iii) the services are maintenance care or post-stabilization care covered under the guidelines established under paragraph (2);

(D) the organization provides access to appropriate providers, including credentialed specialists, for treatment and services when such treatment and services are determined to be medically necessary in the professional opinion of the treating health care provider, in consultation with the individual; and

(E) coverage is provided for emergency services (as defined in paragraph (3)) without regard to prior authorization or the emergency care provider's contractual relationship with the organization.

(2) **GUIDELINES RESPECTING COORDINATION OF POST-STABILIZATION CARE.**—A MedicarePlus plan shall comply with such guidelines as the Secretary may prescribe relating to promoting efficient and timely coordination of appropriate maintenance and post-stabilization care of an enrollee after the enrollee has been determined to be stable under section 1867.

(3) **DEFINITION OF EMERGENCY SERVICES.**—In this subsection—

(A) **IN GENERAL.**—The term “emergency services” means, with respect to an individual enrolled with an organization, covered inpatient and outpatient services that—

(i) are furnished by a provider that is qualified to furnish such services under this title, and

(ii) are needed to evaluate or stabilize an emergency medical condition (as defined in subparagraph (B)).

(B) **EMERGENCY MEDICAL CONDITION BASED ON PRUDENT LAYPERSON.**—The term “emergency medical condition” means a medical condition manifesting itself by acute symptoms of sufficient severity such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in—

(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,

(ii) serious impairment to bodily functions, or

(iii) serious dysfunction of any bodily organ or part.

(4) **DETERMINATION OF HOSPITAL LENGTH OF STAY.**—

(A) **IN GENERAL.**—A MedicarePlus organization shall cover the length of an inpatient hospital stay under this part as determined by the attending physician (or other attending health care provider to the extent permitted under State law) in consultation with the patient to be medically appropriate.

(B) **CONSTRUCTION.**—Nothing in this paragraph shall be construed—

(i) as requiring the provision of inpatient coverage if the attending physician (or other attending health care provider to the extent permitted under State law) and patient determine that a shorter period of hospital stay is medically appropriate, or

(ii) as affecting the application of deductibles and co-insurance.

(e) **QUALITY ASSURANCE PROGRAM.**—

(1) **IN GENERAL.**—Each MedicarePlus organization must have arrangements, consistent with any regulation, for an ongoing quality assurance program for health care services it provides to individuals enrolled with MedicarePlus plans of the organization.

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

(A) stress health outcomes and provide for the collection, analysis, and reporting of data (in accordance with a quality measurement system that the Secretary recognizes) that will permit measurement of outcomes and other indices of the quality of MedicarePlus plans and organizations;

(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) monitor and evaluate high volume and high risk services and the care of acute and chronic conditions;

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

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

(G) after identifying areas for improvement, establish or alter practice parameters;

(H) take action to improve quality and assesses the effectiveness of such action through systematic followup;

(I) make 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) be evaluated on an ongoing basis as to its effectiveness;

(K) include measures of consumer satisfaction; and

(L) provide the Secretary with such access to information collected as may be appropriate to monitor and ensure the quality of care provided under this part.

(3) **EXTERNAL REVIEW.**—Each MedicarePlus organization shall, for each MedicarePlus plan it operates, have an agreement with an independent quality review and improvement organization approved by the Secretary to perform functions of the type described in sections 1154(a)(4)(B) and 1154(a)(14) with respect to services furnished by MedicarePlus plans for which payment is made under this title.

(4) **TREATMENT OF ACCREDITATION.**—The Secretary shall provide that a MedicarePlus organization is deemed to meet requirements of paragraphs (1) through (3) of this subsection and subsection (h) (relating to confidentiality and accuracy of enrollee records) if the organization is accredited (and periodically

reaccredited) by a private organization under a process that the Secretary has determined assures that the organization, as a condition of accreditation, applies and enforces standards with respect to the requirements involved that are no less stringent than the standards established under section 1856 to carry out the respective requirements.

(f) **COVERAGE DETERMINATIONS.**—

(1) **DECISIONS ON NONEMERGENCY CARE.**—A MedicarePlus organization shall make determinations regarding authorization requests for nonemergency care on a timely basis, depending on the urgency of the situation. The organization shall provide notice of any coverage denial, which notice shall include a statement of the reasons for the denial and a description of the grievance and appeals processes available.

(2) **RECONSIDERATIONS.**—

(A) **IN GENERAL.**—Subject to subsection (g)(4), a reconsideration of a determination of an organization denying coverage shall be made within 30 days of the date of receipt of medical information, but not later than 60 days after the date of the determination.

(B) **PHYSICIAN DECISION ON CERTAIN RECONSIDERATIONS.**—A reconsideration relating to a determination to deny coverage based on a lack of medical necessity shall be made only by a physician with appropriate expertise in the field of medicine which necessitates treatment who is other than a physician involved in the initial determination.

(g) **GRIEVANCES AND APPEALS.**—

(1) **GRIEVANCE MECHANISM.**—Each MedicarePlus 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 with MedicarePlus plans of the organization under this part.

(2) **APPEALS.**—An enrollee with a MedicarePlus plan of a MedicarePlus 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 paragraph, 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) **INDEPENDENT REVIEW OF COVERAGE DENIALS.**—The Secretary shall contract with an independent, outside entity to re-

view and resolve in a timely manner reconsiderations that affirm denial of coverage.

(4) *EXPEDITED DETERMINATIONS AND RECONSIDERATIONS.*—

(A) *RECEIPT OF REQUESTS.*—An enrollee in a MedicarePlus plan may request, either in writing or orally, an expedited determination or reconsideration by the MedicarePlus organization regarding a matter described in paragraph (2). The organization shall also permit the acceptance of such requests by physicians.

(B) *ORGANIZATION PROCEDURES.*—

(i) *IN GENERAL.*—The MedicarePlus organization shall maintain procedures for expediting organization determinations and reconsiderations when, upon request of an enrollee, the organization determines that the application of normal time frames for making a determination (or a reconsideration involving a determination) could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

(ii) *TIMELY RESPONSE.*—In an urgent case described in clause (i), the organization shall notify the enrollee (and the physician involved, as appropriate) of the determination (or determination on the reconsideration) as expeditiously as the enrollee's health condition requires, but not later than 72 hours (or 24 hours in the case of a reconsideration) of the time of receipt of the request for the determination or reconsideration (or receipt of the information necessary to make the determination or reconsideration), or such longer period as the Secretary may permit in specified cases.

(iii) *SECRETARIAL REPORT.*—The Secretary shall annually report publicly on the number and disposition of denials and appeals within each MedicarePlus organization, and those reviewed and resolved by the independent entities under this subsection.

(h) *CONFIDENTIALITY AND ACCURACY OF ENROLLEE RECORDS.*—Each MedicarePlus organization shall establish procedures—

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

(2) to maintain accurate and timely medical records and other health information for enrollees, and

(3) to assure timely access of enrollees to their medical information.

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

(j) *RULES REGARDING PHYSICIAN PARTICIPATION.*—

(1) *PROCEDURES.*—Each MedicarePlus organization shall establish reasonable procedures relating to the participation (under an agreement between a physician and the organization) of physicians under MedicarePlus plans 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 such adverse decisions, including the presentation of information and views of the physician regarding such decision.

(2) *CONSULTATION IN MEDICAL POLICIES.*—A MedicarePlus 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) *PROHIBITING INTERFERENCE WITH PROVIDER ADVICE TO ENROLLEES.*—

(A) *IN GENERAL.*—Subject to subparagraphs (B) and (C), a MedicarePlus organization (in relation to an individual enrolled under a MedicarePlus plan offered by the organization under this part) shall not prohibit or otherwise restrict a covered health care professional (as defined in subparagraph (D)) from advising such an individual who is a patient of the professional about the health status of the individual or medical care or treatment for the individual's condition or disease, regardless of whether benefits for such care or treatment are provided under the plan, if the professional is acting within the lawful scope of practice.

(B) *CONSCIENCE PROTECTION.*—Subparagraph (A) shall not be construed as requiring a MedicarePlus plan to provide, reimburse for, or provide coverage of a counseling or referral service if the MedicarePlus organization offering the plan—

(i) objects to the provision of such service on moral or religious grounds; and

(ii) in the manner and through the written instrumentalities such MedicarePlus organization deems appropriate, makes available information on its policies regarding such service to prospective enrollees before or during enrollment and to enrollees within 90 days after the date that the organization or plan adopts a change in policy regarding such a counseling or referral service.

(C) *CONSTRUCTION.*—Nothing in subparagraph (B) shall be construed to affect disclosure requirements under State law or under the Employee Retirement Income Security Act of 1974.

(D) *HEALTH CARE PROFESSIONAL DEFINED.*—For purposes of this paragraph, the term “health care professional” means a physician (as defined in section 1861(r)) or other health care professional if coverage for the professional's services is provided under the MedicarePlus plan for the services of the professional. Such term includes a podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist and therapy assistant, speech-language pathologist, audiologist, registered or licensed practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse

anesthetist, and certified nurse-midwife), licensed certified social worker, registered respiratory therapist, and certified respiratory therapy technician.

(4) *LIMITATIONS ON HEALTH CARE PROVIDER INCENTIVE PLANS.*—

(A) *IN GENERAL.*—No MedicarePlus organization may operate any health care provider 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 health care provider or health care provider 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 health care provider or health care provider group at substantial financial risk (as determined by the Secretary) for services not provided by the health care provider or health care provider group, the organization—

(I) provides stop-loss protection for the health care provider or group that is adequate and appropriate, based on standards developed by the Secretary that take into account the number of health care providers 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 health care provider or 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) *HEALTH CARE PROVIDER INCENTIVE PLAN DEFINED.*—In this paragraph, the term “health care provider incentive plan” means any compensation arrangement between a MedicarePlus organization and a health care provider or health care provider 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.

(C) *HEALTH CARE PROVIDER DEFINED.*—For the purposes of this paragraph, the term “health care provider” has the meaning given the term “health care professional” in paragraph (3)(D).

(5) *LIMITATION ON PROVIDER INDEMNIFICATION.*—A MedicarePlus organization may not provide (directly or indirectly) for a provider (or group of providers) to indemnify the

organization against any liability resulting from a civil action brought for any damage caused to an enrollee with a MedicarePlus plan of the organization under this part by the organization's denial of medically necessary care.

(6) *LIMITATION ON NON-COMPETE CLAUSE.*—A MedicarePlus organization may not (directly or indirectly) seek to enforce any contractual provision which prevents a provider whose contractual obligations to the organization for the provision of services through the organization have ended from joining or forming any competing MedicarePlus organization that is a provider-sponsored organization in the same area.

(k) *TREATMENT OF SERVICES FURNISHED BY CERTAIN PROVIDERS.*—A physician or other entity (other than a provider of services) that does not have a contract establishing payment amounts for services furnished to an individual enrolled under this part with a MedicarePlus organization shall accept as payment in full for covered services under this title that are furnished to such an individual the amounts that the physician or other entity could collect if the individual were not so enrolled. Any penalty or other provision of law that applies to such a payment with respect to an individual entitled to benefits under this title (but not enrolled with a MedicarePlus organization under this part) also applies with respect to an individual so enrolled.

(l) *DISCLOSURE OF USE OF DSH AND TEACHING HOSPITALS.*—Each MedicarePlus organization shall provide the Secretary with information on—

(1) the extent to which the organization provides inpatient and outpatient hospital benefits under this part—

(A) through the use of hospitals that are eligible for additional payments under section 1886(d)(5)(F)(i) (relating to so-called DSH hospitals), or

(B) through the use of teaching hospitals that receive payments under section 1886(h); and

(2) the extent to which differences between payment rates to different hospitals reflect the disproportionate share percentage of low-income patients and the presence of medical residency training programs in those hospitals.

(m) *OUT-OF-NETWORK ACCESS.*—If an organization offers to members enrolled under this section one plan which provides for coverage of services covered under parts A and B primarily through providers and other persons who are members of a network of providers and other persons who have entered into a contract with the organization to provide such services, nothing in this section shall be construed as preventing the organization from offering such members (at the time of enrollment) another plan which provides for coverage of such items which are not furnished through such network providers.

(n) *NON-PREEMPTION OF STATE LAW.*—A State may establish or enforce requirements with respect to beneficiary protections in this section, but only if such requirements are more stringent than the requirements established under this section.

(o) *NONDISCRIMINATION IN SELECTION OF NETWORK HEALTH PROFESSIONALS.*—

(1) *IN GENERAL.*—A MedicarePlus organization offering a MedicarePlus plan offering network coverage shall not discriminate in selecting the members of its health professional network (or in establishing the terms and conditions for membership in such network) on the basis of the race, national origin, gender, age, or disability (other than a disability that impairs the ability of an individual to provide health care services or that may threaten the health of enrollees) of the health professional.

(2) *APPROPRIATE RANGE OF SERVICES.*—A MedicarePlus organization shall not deny any health care professionals, based solely on the license or certification as applicable under State law, the ability to participate in providing covered health care services, or be reimbursed or indemnified by a network plan for providing such services under this part.

(2) *DEFINITIONS.*—For purposes of this subsection:

(A) *NETWORK.*—The term “network” means, with respect to a MedicarePlus organization offering a MedicarePlus plan, the participating health professionals and providers through whom the organization provides health care items and services to enrollees.

(B) *NETWORK COVERAGE.*—The term “network coverage” means a MedicarePlus plan offered by a MedicarePlus organization that provides or arranges for the provision of health care items and services to enrollees through participating health professionals and providers.

(C) *PARTICIPATING.*—The term “participating” means, with respect to a health professional or provider, a health professional or provider that provides health care items and services to enrollees under network coverage under an agreement with the MedicarePlus organization offering the coverage.

(p) *SPECIAL RULE FOR UNRESTRICTED FEE-FOR-SERVICE MSA PLANS.*—Subsections (j)(1) and (k) shall not apply to a MedicarePlus organization with respect to an MSA plan it offers if the plan does not limit the providers through whom benefits may be obtained under the plan.

PAYMENTS TO MEDICAREPLUS ORGANIZATIONS

SEC. 1853. (a) *PAYMENTS TO ORGANIZATIONS.*—

(1) *MONTHLY PAYMENTS.*—

(A) *IN GENERAL.*—Under a contract under section 1857 and subject to subsections (e) and (f), the Secretary shall make monthly payments under this section in advance to each MedicarePlus organization, with respect to coverage of an individual under this part in a MedicarePlus payment area for a month, in an amount equal to $\frac{1}{12}$ of the annual MedicarePlus capitation rate (as calculated under subsection (c)) with respect to that individual for that area, adjusted for such risk factors as age, disability status, gender, institutional status, 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 factors, if such changes will improve the determination of actuarial equivalence.

(B) SPECIAL RULE FOR END-STAGE RENAL DISEASE.—The Secretary shall establish separate rates of payment to a MedicarePlus organization with respect to classes of individuals determined to have end-stage renal disease and enrolled in a MedicarePlus plan of the organization. Such rates of payment shall be actuarially equivalent to rates paid to other enrollees in the MedicarePlus payment area (or such other area as specified by the Secretary). In accordance with regulations, the Secretary shall provide for the application of the seventh sentence of section 1881(b)(7) to payments under this section covering the provision of renal dialysis treatment in the same manner as such sentence applies to composite rate payments described in such sentence.

(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 MedicarePlus organization under a plan 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 information required to be disclosed under section 1852(c) at the time the individual enrolled with the organization.

(3) ESTABLISHMENT OF RISK ADJUSTMENT FACTORS.—

(A) REPORT.—The Secretary shall develop, and submit to Congress by not later than October 1, 1999, a report on a method of risk adjustment of payment rates under this section that accounts for variations in per capita costs based on health status. Such report shall include an evaluation of such method by an outside, independent actuary of the actuarial soundness of the proposal.

(B) DATA COLLECTION.—In order to carry out this paragraph, the Secretary shall require MedicarePlus organizations (and eligible organizations with risk-sharing contracts under section 1876) to submit, for periods beginning on or after January 1, 1998, data regarding inpatient hos-

pital services and other services and other information the Secretary deems necessary.

(C) *INITIAL IMPLEMENTATION.*—The Secretary shall first provide for implementation of a risk adjustment methodology that accounts for variations in per capita costs based on health status and other demographic factors for payments by no later than January 1, 2000.

(b) *ANNUAL ANNOUNCEMENT OF PAYMENT RATES.*—

(1) *ANNUAL ANNOUNCEMENT.*—The Secretary shall annually determine, and shall announce (in a manner intended to provide notice to interested parties) not later than August 1 before the calendar year concerned—

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

(B) the risk and other factors to be used in adjusting such rates under subsection (a)(1)(A) for payments for months in that year.

(2) *ADVANCE NOTICE OF METHODOLOGICAL CHANGES.*—At least 45 days before making the announcement under paragraph (1) for a year, the Secretary shall provide for notice to MedicarePlus organizations of proposed changes to be made in the methodology from the methodology and assumptions used in the previous announcement and shall provide such organizations an opportunity to comment on such proposed changes.

(3) *EXPLANATION OF ASSUMPTIONS.*—In each announcement made under paragraph (1), the Secretary shall include an explanation of the assumptions and changes in methodology used in the announcement in sufficient detail so that MedicarePlus organizations can compute monthly adjusted MedicarePlus capitation rates for individuals in each MedicarePlus payment area which is in whole or in part within the service area of such an organization.

(c) *CALCULATION OF ANNUAL MEDICAREPLUS CAPITATION RATES.*—

(1) *IN GENERAL.*—For purposes of this part, each annual MedicarePlus capitation rate, for a MedicarePlus payment area for a contract year consisting of a calendar year, is equal to the largest of the amounts specified in the following subparagraphs (A), (B), or (C):

(A) *BLENDED CAPITATION RATE.*—The sum of—

(i) area-specific percentage for the year (as specified under paragraph (2) for the year) of the annual area-specific MedicarePlus capitation rate for the year for the MedicarePlus payment area, as determined under paragraph (3), and

(ii) national percentage (as specified under paragraph (2) for the year) of the input-price-adjusted annual national MedicarePlus capitation rate for the year, as determined under paragraph (4), multiplied by the payment adjustment factors described in subparagraphs (A) and (B) of paragraph (5).

(B) *MINIMUM AMOUNT.*—12 multiplied by the following amount:

(i) For 1998, \$350 (but not to exceed, in the case of an area outside the 50 States and the District of Columbia, 150 percent of the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) for the area).

(ii) For a succeeding year, the minimum amount specified in this clause (or clause (i)) for the preceding year increased by the national per capita MedicarePlus growth percentage, specified under paragraph (6) for that succeeding year.

(C) MINIMUM PERCENTAGE INCREASE.—

(i) For 1998, the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) for the MedicarePlus payment area.

(ii) For 1999 and 2000, 101 percent of the annual MedicarePlus capitation rate under this paragraph for the area for the previous year.

(iii) For a subsequent year, 102 percent of the annual MedicarePlus capitation rate under this paragraph for the area for the previous year.

(2) AREA-SPECIFIC AND NATIONAL PERCENTAGES.—For purposes of paragraph (1)(A)—

(A) for 1998, the “area-specific percentage” is 90 percent and the “national percentage” is 10 percent,

(B) for 1999, the “area-specific percentage” is 85 percent and the “national percentage” is 15 percent,

(C) for 2000, the “area-specific percentage” is 80 percent and the “national percentage” is 20 percent,

(D) for 2001, the “area-specific percentage” is 75 percent and the “national percentage” is 25 percent, and

(E) for a year after 2001, the “area-specific percentage” is 70 percent and the “national percentage” is 30 percent.

(3) ANNUAL AREA-SPECIFIC MEDICAREPLUS CAPITATION RATE.—

(A) IN GENERAL.—For purposes of paragraph (1)(A), subject to subparagraph (B), the annual area-specific MedicarePlus capitation rate for a MedicarePlus payment area—

(i) for 1998 is the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) for the area, increased by the national per capita MedicarePlus growth percentage for 1998 (as defined in paragraph (6)); or

(ii) for a subsequent year is the annual area-specific MedicarePlus capitation rate for the previous year determined under this paragraph for the area, increased by the national per capita MedicarePlus growth percentage for such subsequent year.

(B) REMOVAL OF MEDICAL EDUCATION AND DISPROPORTIONATE SHARE HOSPITAL PAYMENTS FROM CALCULATION OF ADJUSTED AVERAGE PER CAPITA COST.—

(i) IN GENERAL.—In determining the area-specific MedicarePlus capitation rate under subparagraph (A), for a year (beginning with 1998), the annual per capita

rate of payment for 1997 determined under section 1876(a)(1)(C) shall be adjusted to exclude from the rate the applicable percent (specified in clause (ii)) of the payment adjustments described in subparagraph (C).

(ii) *APPLICABLE PERCENT.*—For purposes of clause (i), the applicable percent for—

(I) 1998 is 20 percent,

(II) 1999 is 40 percent,

(III) 2000 is 60 percent,

(IV) 2001 is 80 percent, and

(V) a succeeding year is 100 percent.

(C) *PAYMENT ADJUSTMENT.*—The payment adjustments described in this subparagraph are payment adjustments which the Secretary estimates were payable during 1997—

(i) under section 1886(d)(5)(F) for hospitals serving a disproportionate share of low-income patients,

(ii) for the indirect costs of medical education under section 1886(d)(5)(B), and

(iii) for direct graduate medical education costs under section 1886(h),

multiplied by a ratio (estimated by the Secretary) of total payments under subsection (h) and section 1858 in 1998 to payments under such subsection and payments under such section in such year for hospitals not reimbursed under section 1814(b)(3).

(4) *INPUT-PRICE-ADJUSTED ANNUAL NATIONAL MEDICAREPLUS CAPITATION RATE.*—

(A) *IN GENERAL.*—For purposes of paragraph (1)(A), the input-price-adjusted annual national MedicarePlus capitation rate for a MedicarePlus 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 service) of—

(i) the national standardized annual MedicarePlus 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 ANNUAL MEDICAREPLUS CAPITATION RATE.*—In subparagraph (A)(i), the “national standardized annual MedicarePlus capitation rate” for a year is equal to—

(i) the sum (for all MedicarePlus payment areas) of the product of—

(I) the annual area-specific MedicarePlus capitation rate for that year for the area under paragraph (3), and

(II) the average number of medicare beneficiaries residing in that area in the year, multiplied by the average of the risk factor weights used to adjust payments under subsection (a)(1)(A) for such beneficiaries in such area; divided by

(ii) the sum of the products described in clause (i)(II) for all areas for that year.

(C) SPECIAL RULES FOR 1998.—In applying this paragraph for 1998—

(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)—

(I) for part A services shall be the ratio (expressed as a percentage) of the national average annual per capita rate of payment for part A for 1997 to the total national average annual per capita rate of payment for parts A and B for 1997, and

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

(iii) for 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, 40 percent shall be adjusted by the index described in clause (iii); and

(v) the index values shall be computed based only on the beneficiary population who are 65 years of age or older and who are not determined to have end stage renal disease.

The Secretary may continue to apply the rules described in this subparagraph (or similar rules) for 1999.

(5) PAYMENT ADJUSTMENT BUDGET NEUTRALITY FACTORS.—For purposes of paragraph (1)(A)—

(A) BLENDED RATE PAYMENT ADJUSTMENT FACTOR.—For each year, the Secretary shall compute a blended rate payment adjustment factor such that, not taking into account subparagraphs (B) and (C) of paragraph (1) and the application of the payment adjustment factor described in subparagraph (B) but taking into account paragraph (7), the aggregate of the payments that would be made under this part is equal to the aggregate payments that would have

been made under this part (not taking into account such subparagraphs and such other adjustment factor) if the area-specific percentage under paragraph (1) for the year had been 100 percent and the national percentage had been 0 percent.

(B) FLOOR-AND-MINIMUM-UPDATE PAYMENT ADJUSTMENT FACTOR.—For each year, the Secretary shall compute a floor-and-minimum-update payment adjustment factor so that, taking into account the application of the blended rate payment adjustment factor under subparagraph (A) and subparagraphs (B) and (C) of paragraph (1) and the application of the adjustment factor under this subparagraph, the aggregate of the payments under this part shall not exceed the aggregate payments that would have been made under this part if subparagraphs (B) and (C) of paragraph (1) did not apply and if the floor-and-minimum-update payment adjustment factor under this subparagraph was 1.

(6) NATIONAL PER CAPITA MEDICAREPLUS GROWTH PERCENTAGE DEFINED.—

(A) IN GENERAL.—In this part, the “national per capita MedicarePlus growth percentage” for a year is the percentage determined by the Secretary, by April 30th before the beginning of the year involved, to reflect the Secretary’s estimate of the projected per capita rate of growth in expenditures under this title for an individual entitled to benefits under part A and enrolled under part B, reduced by the number of percentage points specified in subparagraph (B) for the year. Separate determinations may be made for aged enrollees, disabled enrollees, and enrollees with end-stage renal disease. Such percentage shall include an adjustment for over or under projection in the growth percentage for previous years.

(B) ADJUSTMENT.—The number of percentage points specified in this subparagraph is—

- (i) for 1998, 0.5 percentage points,
- (ii) for 1999, 0.5 percentage points,
- (iii) for 2000, 0.5 percentage points,
- (iv) for 2001, 0.5 percentage points,
- (v) for 2002, 0.5 percentage points, and
- (vi) for a year after 2002, 0 percentage points.

(7) TREATMENT OF AREAS WITH HIGHLY VARIABLE PAYMENT RATES.—In the case of a MedicarePlus payment area for which the annual per capita rate of payment determined under section 1876(a)(1)(C) for 1997 varies by more than 20 percent from such rate for 1996, for purposes of this subsection the Secretary may substitute for such rate for 1997 a rate that is more representative of the costs of the enrollees in the area.

(d) MEDICAREPLUS PAYMENT AREA DEFINED.—

(1) IN GENERAL.—In this part, except as provided in paragraph (3), the term “MedicarePlus payment area” means a county, or equivalent area specified by the Secretary.

(2) RULE FOR ESRD BENEFICIARIES.—In the case of individuals who are determined to have end stage renal disease, the

MedicarePlus payment area shall be a State or such other payment area as the Secretary specifies.

(3) *GEOGRAPHIC ADJUSTMENT.—*

(A) *IN GENERAL.—*Upon written request of the chief executive officer of a State for a contract year (beginning after 1998) made at least 7 months before the beginning of the year, the Secretary shall make a geographic adjustment to a MedicarePlus payment area in the State otherwise determined under paragraph (1)—

- (i) to a single statewide MedicarePlus payment area,
- (ii) to the metropolitan based system described in subparagraph (C), or
- (iii) to consolidating into a single MedicarePlus payment area noncontiguous counties (or equivalent areas described in paragraph (1)) within a State.

Such adjustment shall be effective for payments for months beginning with January of the year following the year in which the request is received.

(B) *BUDGET NEUTRALITY ADJUSTMENT.—*In the case of a State requesting an adjustment under this paragraph, the Secretary shall adjust the payment rates otherwise established under this section for MedicarePlus payment areas in the State in a manner so that the aggregate of the payments under this section in the State shall not exceed the aggregate payments that would have been made under this section for MedicarePlus payment areas in the State in the absence of the adjustment under this paragraph.

(C) *METROPOLITAN BASED SYSTEM.—*The metropolitan based system described in this subparagraph is one in which—

- (i) all the portions of each metropolitan statistical area in the State or in the case of a consolidated metropolitan statistical area, all of the portions of each primary metropolitan statistical area within the consolidated area within the State, are treated as a single MedicarePlus payment area, and
- (ii) all areas in the State that do not fall within a metropolitan statistical area are treated as a single MedicarePlus payment area.

(D) *AREAS.—*In subparagraph (C), the terms “metropolitan statistical area”, “consolidated metropolitan statistical area”, and “primary metropolitan statistical area” mean any area designated as such by the Secretary of Commerce.

(e) *SPECIAL RULES FOR INDIVIDUALS ELECTING MSA PLANS.—*

(1) *IN GENERAL.—*If the amount of the monthly premium for an MSA plan for a MedicarePlus payment area for a year is less than $\frac{1}{12}$ of the annual MedicarePlus capitation rate applied under this section for the area and year involved, the Secretary shall deposit an amount equal to 100 percent of such difference in a MedicarePlus MSA established (and, if applicable, designated) by the individual under paragraph (2).

(2) *ESTABLISHMENT AND DESIGNATION OF MEDICAREPLUS MEDICAL SAVINGS ACCOUNT AS REQUIREMENT FOR PAYMENT OF CONTRIBUTION.—*In the case of an individual who has elected

coverage under an MSA plan, no payment shall be made under paragraph (1) 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 MedicarePlus MSA (as defined in section 138(b)(2) of the Internal Revenue Code of 1986), and

(B) if the individual has established more than one such MedicarePlus MSA, has designated one of such accounts as the individual's MedicarePlus 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 an MSA plan effective beginning with a month in a year, the amount of the contribution to the MedicarePlus 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.

(f) PAYMENTS FROM TRUST FUND.—The payment to a MedicarePlus organization under this section for individuals enrolled under this part with the organization and payments to a MedicarePlus MSA under subsection (e)(1) 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. Monthly payments otherwise payable under this section for October 2001 shall be paid on the last business day of September 2001.

(g) SPECIAL RULE FOR CERTAIN INPATIENT HOSPITAL STAYS.—In the case of an individual who is receiving inpatient hospital services from a subsection (d) hospital (as defined in section 1886(d)(1)(B)) as of the effective date of the individual's—

(1) election under this part of a MedicarePlus plan offered by a MedicarePlus organization—

(A) payment for such services until the date of the individual's discharge shall be made under this title through the MedicarePlus plan or the medicare fee-for-service program option described in section 1851(a)(1)(A) (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 MedicarePlus 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 MedicarePlus 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.

(h) PAYMENTS FOR DIRECT COSTS OF GRADUATE MEDICAL EDUCATION PROGRAMS.—

(1) ADDITIONAL PAYMENT TO BE MADE.—Effective January 1, 1998, each contract with a MedicarePlus organization under this section (and each risk-sharing contract with an eligible organization under section 1876) shall provide for an additional payment for Medicare's share of allowable direct graduate medical education costs incurred by such an organization for an approved medical residency program.

(2) ALLOWABLE COSTS.—If the organization has an approved medical residency program that incurs all or substantially all of the costs of the program, subject to section 1858(a)(3), the allowable costs for such a program shall equal the national average per resident amount times the number of full-time-equivalent residents in the program in non-hospital settings.

(3) DEFINITIONS.—As used in this subsection:

(A) The terms "approved medical residency program", "direct graduate medical education costs", and "full-time-equivalent residents" have the same meanings as under section 1886(h).

(B) The term "Medicare's share" means, with respect to a MedicarePlus or eligible organization, the ratio of the number of individuals enrolled with the organization under this part (or enrolled under a risk-sharing contract under section 1876, respectively) to the total number of individuals enrolled with the organization.

(C) The term "national average per resident amount" means an amount estimated by the Secretary to equal the weighted average amount that would be paid per full-time-equivalent resident under section 1886(h) for the calendar year (determined separately for primary care residency programs as defined under section 1886(h) (including obstetrics and gynecology residency programs) and for other residency programs).

PREMIUMS

SEC. 1854. (a) SUBMISSION AND CHARGING OF PREMIUMS.—

(1) IN GENERAL.—Subject to paragraph (3), each MedicarePlus 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 premium for coverage for services under section 1852(a) under each MedicarePlus plan it offers under this part in each MedicarePlus pay-

ment area (as defined in section 1853(d)) in which the plan is being offered; and

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

(2) **TERMINOLOGY.**—In this part—

(A) the term “monthly premium” means, with respect to a MedicarePlus plan offered by a MedicarePlus organization, the monthly premium filed under paragraph (1), not taking into account the amount of any payment made toward the premium under section 1853; and

(B) the term “net monthly premium” means, with respect to such a plan and an individual enrolled with the plan, the premium (as defined in subparagraph (A)) for the plan reduced by the amount of payment made toward such premium under section 1853.

(b) **MONTHLY PREMIUM CHARGED.**—The monthly amount of the premium charged by a MedicarePlus organization for a MedicarePlus plan offered in a MedicarePlus payment area to an individual under this part shall be equal to the net monthly premium plus any monthly premium charged in accordance with subsection (e)(2) for supplemental benefits.

(c) **UNIFORM PREMIUM.**—The monthly premium and monthly amount charged under subsection (b) of a MedicarePlus organization under this part may not vary among individuals who reside in the same MedicarePlus payment area.

(d) **TERMS AND CONDITIONS OF IMPOSING PREMIUMS.**—Each MedicarePlus organization shall permit the payment of net monthly premiums on a monthly basis and may terminate election of individuals for a MedicarePlus plan for failure to make premium payments only in accordance with section 1851(g)(3)(B)(i). A MedicarePlus organization is not authorized to provide for cash or other monetary rebates as an inducement for enrollment or otherwise.

(e) **LIMITATION ON ENROLLEE COST-SHARING.**—

(1) **FOR BASIC AND ADDITIONAL BENEFITS.**—Except as provided in paragraph (2), in no event may—

(A) the net monthly premium (multiplied by 12) and the actuarial value of the deductibles, coinsurance, and copayments applicable on average to individuals enrolled under this part with a MedicarePlus plan of an organization with respect to required benefits described in section 1852(a)(1) and additional benefits (if any) required under subsection (f)(1) for a year, exceed

(B) the actuarial value of the deductibles, coinsurance, and copayments that would be applicable on average to individuals entitled to benefits under part A and enrolled under part B if they were not members of a MedicarePlus organization for the year.

(2) **FOR SUPPLEMENTAL BENEFITS.**—If the MedicarePlus organization provides to its members enrolled under this part supplemental benefits described in section 1852(a)(3), the sum of the monthly premium rate (multiplied by 12) charged for such supplemental benefits and the actuarial value of its deductibles, coinsurance, and copayments charged with respect to such bene-

fits may not exceed the adjusted community rate for such benefits (as defined in subsection (f)(4)).

(3) *EXCEPTION FOR MSA PLANS.*—Paragraphs (1) and (2) do not apply to an MSA plan.

(4) *DETERMINATION ON OTHER BASIS.*—If the Secretary determines that adequate data are not available to determine the actuarial value under paragraph (1)(A) or (2), the Secretary may determine such amount with respect to all individuals in the MedicarePlus payment area, the State, or in the United States, eligible to enroll in the MedicarePlus plan involved under this part or on the basis of other appropriate data.

(f) *REQUIREMENT FOR ADDITIONAL BENEFITS.*—

(1) *REQUIREMENT.*—

(A) *IN GENERAL.*—Each MedicarePlus organization (in relation to a MedicarePlus plan it offers) shall provide that if there is an excess amount (as defined in subparagraph (B)) for the plan 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) in a 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 plan, is the amount (if any) by which—

(i) the average of the capitation payments made to the organization under section 1853 for the plan at the beginning of contract year, exceeds

(ii) the actuarial value of the required benefits described in section 1852(a)(1) under the plan for individuals under this part, as determined based upon an adjusted community rate described in paragraph (4) (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 plan, is the excess amount reduced to reflect any amount withheld and reserved for the organization for the year under paragraph (2).

(D) *NO APPLICATION TO MSA PLANS.*—Subparagraph (A) shall not apply to an MSA plan.

(E) *UNIFORM APPLICATION.*—This paragraph shall be applied uniformly for all enrollees for a plan in a MedicarePlus payment area.

(F) *CONSTRUCTION.*—Nothing in this subsection shall be construed as preventing a MedicarePlus 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) *STABILIZATION FUND.*—A MedicarePlus organization may provide that a part of the value of an excess 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 Sec-

retary 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 offered in those subsequent periods by the organization in accordance with such paragraph. Any of such value of the amount reserved which is not provided as additional benefits described in paragraph (1)(A) to individuals electing the MedicarePlus plan of the organization in accordance with such paragraph prior to the end of such periods, shall revert for the use of such trust funds.

(3) *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.

(4) *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 MedicarePlus organization, either—

(i) the rate of payment for that service or services which the Secretary annually determines would apply to an individual electing a MedicarePlus plan 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 plan (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 MedicarePlus coverage, or MedicarePlus eligible individuals in the area, in the State, or in the United States, eligible to elect MedicarePlus 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 MedicarePlus organization that is a provider-sponsored organization, the adjusted community rate under subparagraph (A) for a MedicarePlus plan of the organization 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 plan.

(g) *PERIODIC AUDITING.*—The Secretary shall provide for the annual auditing of the financial records (including data relating to medicare utilization, costs, and computation of the adjusted community rate) of at least one-third of the MedicarePlus organizations offering MedicarePlus plans under this part. The Comptroller General shall monitor auditing activities conducted under this subsection.

(h) *PROHIBITION OF STATE IMPOSITION OF PREMIUM TAXES.*—No State may impose a premium tax or similar tax with respect to premiums on MedicarePlus plans or the offering of such plans.

ORGANIZATIONAL AND FINANCIAL REQUIREMENTS FOR MEDICAREPLUS ORGANIZATIONS; PROVIDER-SPONSORED ORGANIZATIONS

SEC. 1855. (a) ORGANIZED AND LICENSED UNDER STATE LAW.—

(1) *IN GENERAL.*—Subject to paragraphs (2) and (3), a MedicarePlus organization shall be organized and licensed under State law as a risk-bearing entity eligible to offer health insurance or health benefits coverage in each State in which it offers a MedicarePlus plan.

(2) *SPECIAL EXCEPTION FOR PROVIDER-SPONSORED ORGANIZATIONS.*—

(A) *IN GENERAL.*—In the case of a provider-sponsored organization that seeks to offer a MedicarePlus plan in a State, the Secretary shall waive the requirement of paragraph (1) that the organization be licensed in that State if—

(i) the organization files an application for such waiver with the Secretary, and

(ii) the Secretary determines, based on the application and other evidence presented to the Secretary, that any of the grounds for approval of the application described in subparagraph (B), (C), or (D) has been met.

(B) *FAILURE TO ACT ON LICENSURE APPLICATION ON A TIMELY BASIS.*—A ground for approval of such a waiver application is that the State has failed to complete action on a licensing application of the organization within 90 days of the date of the State's receipt of the completed application. No period before the date of the enactment of this section shall be included in determining such 90-day period.

(C) *DENIAL OF APPLICATION BASED ON DISCRIMINATORY TREATMENT.*—A ground for approval of such a waiver application is that the State has denied such a licensing application and—

(i) the State has imposed documentation or information requirements not related to solvency requirements that are not generally applicable to other entities engaged in substantially similar business, or

(ii) the standards or review process imposed by the State as a condition of approval of the license imposes any material requirements, procedures, or standards (other than requirements and standards relating to solvency) to such organizations that are not generally ap-

plicable to other entities engaged in substantially similar business.

(D) DENIAL OF APPLICATION BASED ON APPLICATION OF SOLVENCY REQUIREMENTS.—*A ground for approval of such a waiver application is that the State has denied such a licensing application based (in whole or in part) on the organization’s failure to meet applicable solvency requirements and—*

(i) such requirements are not the same as the solvency standards established under section 1856(a); or

(ii) the State has imposed as a condition of approval of the license any documentation or information requirements relating to solvency or other material requirements, procedures, or standards relating to solvency that are different from the requirements, procedures, and standards applied by the Secretary under subsection (d)(2).

For purposes of this subparagraph, the term “solvency requirements” means requirements relating to solvency and other matters covered under the standards established under section 1856(a).

(E) TREATMENT OF WAIVER.—*In the case of a waiver granted under this paragraph for a provider-sponsored organization—*

(i) the waiver shall be effective for a 36-month period, except it may be renewed based on a subsequent application filed during the last 6 months of such period,

(ii) the waiver is conditioned upon the pendency of the licensure application during the period the waiver is in effect, and

(iii) any provisions of State law which relate to the licensing of the organization and which prohibit the organization from providing coverage pursuant to a contract under this part shall be superseded.

Nothing in this subparagraph shall be construed as limiting the number of times such a waiver may be renewed. Nothing in clause (iii) shall be construed as waiving any provision of State law which relates to quality of care or consumer protection (and does not relate to solvency standards) and which is imposed on a uniform basis and is generally applicable to other entities engaged in substantially similar business.

(F) PROMPT ACTION ON APPLICATION.—*The Secretary shall grant or deny such a waiver application within 60 days after the date the Secretary determines that a substantially complete application has been filed. Nothing in this section shall be construed as preventing an organization which has had such a waiver application denied from submitting a subsequent waiver application.*

(3) EXCEPTION IF REQUIRED TO OFFER MORE THAN MEDICAREPLUS PLANS.—*Paragraph (1) shall not apply to a MedicarePlus organization in a State if the State requires the*

organization, as a condition of licensure, to offer any product or plan other than a MedicarePlus plan.

(4) *LICENSURE DOES NOT SUBSTITUTE FOR OR CONSTITUTE CERTIFICATION.*—The fact that an organization is licensed in accordance with paragraph (1) does not deem the organization to meet other requirements imposed under this part.

(b) *PREPAID PAYMENT.*—A MedicarePlus organization shall be compensated (except for premiums, deductibles, coinsurance, and copayments) for the provision of health care services to enrolled members under the contract under this part 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.

(c) *ASSUMPTION OF FULL FINANCIAL RISK.*—The MedicarePlus organization shall assume full financial risk on a prospective basis for the provision of the health care services (except, at the election of the organization, 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.

(d) *CERTIFICATION OF PROVISION AGAINST RISK OF INSOLVENCY FOR UNLICENSED PSOS.*—

(1) *IN GENERAL.*—Each MedicarePlus organization that is a provider-sponsored organization, that is not licensed by a State under subsection (a), and for which a waiver application has been approved under subsection (a)(2), shall meet standards established under section 1856(a) relating to the financial solvency and capital adequacy of the organization.

(2) *CERTIFICATION PROCESS FOR SOLVENCY STANDARDS FOR PSOS.*—The Secretary shall establish a process for the receipt and approval of applications of a provider-sponsored organization described in paragraph (1) for certification (and periodic recertification) of the organization as meeting such solvency standards. Under such process, the Secretary shall act upon such an application not later than 60 days after the date the application has been received.

(e) *PROVIDER-SPONSORED ORGANIZATION DEFINED.*—

(1) *IN GENERAL.*—In this part, the term “provider-sponsored organization” means a public or private entity—

(A) that is established or organized by a health care provider, or group of affiliated health care providers,

(B) that provides a substantial proportion (as defined by the Secretary in accordance with paragraph (2)) of the health care items and services under the contract under this part directly through the provider or affiliated group of providers, and

(C) with respect to which those affiliated providers that share, directly or indirectly, substantial financial risk with respect to the provision of such items and services have at least a majority financial interest in the entity.

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

(A) shall take into account (i) the need for such an organization to assume responsibility for a substantial proportion of services in order to assure financial stability and (ii) 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) both providers are part of a controlled group of corporations under section 1563 of the Internal Revenue Code of 1986, or

(C) 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.

(5) *HEALTH CARE PROVIDER DEFINED.*—In this subsection, the term “health care provider” means—

(A) any individual who is engaged in the delivery of health care services in a State and who 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, and

(B) any entity that is engaged in the delivery of health care services in a State and that, if it 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, is so licensed.

(6) *REGULATIONS.*—The Secretary shall issue regulations to carry out this subsection.

ESTABLISHMENT OF STANDARDS

SEC. 1856. (a) ESTABLISHMENT OF SOLVENCY STANDARDS FOR PROVIDER-SPONSORED ORGANIZATIONS.—

(1) ESTABLISHMENT.—

(A) *IN GENERAL.*—The Secretary shall establish, on an expedited basis and using a negotiated rulemaking process under subchapter III of chapter 5 of title 5, United States Code, standards described in section 1855(d)(1) (relating to the financial solvency and capital adequacy of the organization) that entities must meet to qualify as provider-sponsored organizations under this part.

(B) *FACTORS TO CONSIDER FOR SOLVENCY STANDARDS.*—In establishing solvency standards under subparagraph (A) for provider-sponsored organizations, the Secretary shall consult with interested parties and shall take into account—

(i) the delivery system assets of such an organization and ability of such an organization to provide services directly to enrollees through affiliated providers, and

(ii) alternative means of protecting against insolvency, including reinsurance, unrestricted surplus, letters of credit, guarantees, organizational insurance coverage, partnerships with other licensed entities, and valuation attributable to the ability of such an organization to meet its service obligations through direct delivery of care.

(C) *ENROLLEE PROTECTION AGAINST INSOLVENCY.*—Such standards shall include provisions to prevent enrollees from being held liable to any person or entity for the MedicarePlus organization's debts in the event of the organization's insolvency.

(2) *PUBLICATION OF NOTICE.*—In carrying out the rulemaking process under this subsection, the Secretary, after consultation with the National Association of Insurance Commissioners, the American Academy of Actuaries, organizations representative of medicare beneficiaries, and other interested parties, shall publish the notice provided for under section 564(a) of title 5, United States Code, by not later than 45 days after the date of the enactment of this section.

(3) *TARGET DATE FOR PUBLICATION OF RULE.*—As part of the notice under paragraph (2), and for purposes of this subsection, the "target date for publication" (referred to in section 564(a)(5) of such title) shall be April 1, 1998.

(4) *ABBREVIATED PERIOD FOR SUBMISSION OF COMMENTS.*—In applying section 564(c) of such title under this subsection, "15 days" shall be substituted for "30 days".

(5) *APPOINTMENT OF NEGOTIATED RULEMAKING COMMITTEE AND FACILITATOR.*—The Secretary shall provide for—

(A) the appointment of a negotiated rulemaking committee under section 565(a) of such title by not later than 30 days after the end of the comment period provided for under section 564(c) of such title (as shortened under paragraph (4)), and

(B) the nomination of a facilitator under section 566(c) of such title by not later than 10 days after the date of appointment of the committee.

(6) *PRELIMINARY COMMITTEE REPORT.*—The negotiated rule-making committee appointed under paragraph (5) shall report to the Secretary, by not later than January 1, 1998, regarding the committee's progress on achieving a consensus with regard to the rulemaking proceeding and whether such consensus is likely to occur before one month before the target date for publication of the rule. If the committee reports that the committee has failed to make significant progress towards such consensus or is unlikely to reach such consensus by the target date, the Secretary may terminate such process and provide for the publication of a rule under this subsection through such other methods as the Secretary may provide.

(7) *FINAL COMMITTEE REPORT.*—If the committee is not terminated under paragraph (6), the rulemaking committee shall submit a report containing a proposed rule by not later than one month before the target date of publication.

(8) *INTERIM, FINAL EFFECT.*—The Secretary shall publish a rule under this subsection in the Federal Register by not later than the target date of publication. Such rule shall be effective and final immediately on an interim basis, but is subject to change and revision after public notice and opportunity for a period (of not less than 60 days) for public comment. In connection with such rule, the Secretary shall specify the process for the timely review and approval of applications of entities to be certified as provider-sponsored organizations pursuant to such rules and consistent with this subsection.

(9) *PUBLICATION OF RULE AFTER PUBLIC COMMENT.*—The Secretary shall provide for consideration of such comments and republication of such rule by not later than 1 year after the target date of publication.

(b) *ESTABLISHMENT OF OTHER STANDARDS.*—

(1) *IN GENERAL.*—The Secretary shall establish by regulation other standards (not described in subsection (a)) for MedicarePlus organizations and plans consistent with, and to carry out, this part.

(2) *USE OF CURRENT STANDARDS.*—Consistent with the requirements of this part, standards established under this subsection shall be based on standards established under section 1876 to carry out analogous provisions of such section. The Secretary shall also consider State model and other standards relating to consumer protection and assuring quality of care.

(3) *USE OF INTERIM STANDARDS.*—For the period in which this part is in effect and standards are being developed and established under the preceding provisions of this subsection, the Secretary shall provide by not later than June 1, 1998, for the application of such interim standards (without regard to any requirements for notice and public comment) as may be appropriate to provide for the expedited implementation of this part. Such interim standards shall not apply after the date standards are established under the preceding provisions of this subsection.

(4) *APPLICATION OF NEW STANDARDS TO ENTITIES WITH A CONTRACT.*—In the case of a MedicarePlus 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).

(5) *RELATION TO STATE LAWS.*—Subject to section 1852(m), the standards established under this subsection shall supersede any State law or regulation with respect to MedicarePlus plans which are offered by MedicarePlus organizations under this part to the extent such law or regulation is inconsistent with such standards. The previous sentence shall not be construed as superseding a State law or regulation that is not related to solvency, that is applied on a uniform basis and is generally applicable to other entities engaged in substantially similar business, and that provides consumer protections in addition to, or more stringent than, those provided under the standards under this subsection.

CONTRACTS WITH MEDICAREPLUS ORGANIZATIONS

SEC. 1857. (a) IN GENERAL.—The Secretary shall not permit the election under section 1851 of a MedicarePlus plan offered by a MedicarePlus organization under this part, and no payment shall be made under section 1853 to an organization, unless the Secretary has entered into a contract under this section with the organization with respect to the offering of such plan. Such a contract with an organization may cover more than one MedicarePlus plan. 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) *MINIMUM ENROLLMENT REQUIREMENTS.*—

(1) *IN GENERAL.*—Subject to paragraphs (2) and (3), the Secretary may not enter into a contract under this section with a MedicarePlus organization 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.

(2) *EXCEPTION FOR MSA PLAN.*—Paragraph (1) shall not apply with respect to a contract that relates only to an MSA plan.

(3) *ALLOWING TRANSITION.*—The Secretary may waive the requirement of paragraph (1) during the first 3 contract years with respect to an organization.

(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 subsection (g)(3) on the MedicarePlus 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;

or

(C) 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, except that in no case shall a contract under this section which provides for coverage under an MSA plan be effective before January 1998 with respect to such coverage.

(4) *PREVIOUS TERMINATIONS.*—The Secretary may not enter into a contract with a MedicarePlus 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) *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 MedicarePlus 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 MedicarePlus 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 MedicarePlus 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 MedicarePlus 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 MedicarePlus 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.

(e) ADDITIONAL CONTRACT TERMS.—

(1) IN GENERAL.—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.

(2) COST-SHARING IN ENROLLMENT-RELATED COSTS.—The contract with a MedicarePlus organization shall require the payment to the Secretary for the organization's pro rata share (as determined by the Secretary) of the estimated costs to be incurred by the Secretary in carrying out section 1851 (relating to enrollment and dissemination of information) and section 4360 of the Omnibus Budget Reconciliation Act of 1990 (relating to the health insurance counseling and assistance program). Such payments are appropriated to defray the costs described in the preceding sentence, to remain available until expended.

(3) NOTICE TO ENROLLEES IN CASE OF DECERTIFICATION.—If a contract with a MedicarePlus organization is terminated under this section, the organization shall notify each enrollee with the organization under this part of such termination.

(f) PROMPT PAYMENT BY MEDICAREPLUS ORGANIZATION.—

(1) REQUIREMENT.—A contract under this part shall require a MedicarePlus organization to provide prompt payment (consistent with the provisions of sections 1816(c)(2) and 1842(c)(2)) of claims submitted for services and supplies furnished to individuals pursuant to the contract, if the services or supplies are not furnished under a contract between the organization and the provider or supplier.

(2) SECRETARY'S OPTION TO BYPASS NONCOMPLYING ORGANIZATION.—In the case of a MedicarePlus eligible organization which the Secretary determines, after notice and opportunity for a hearing, has failed to make payments of amounts in compliance with paragraph (1), the Secretary may provide for direct payment of the amounts owed to providers and suppliers for covered services and supplies furnished to individuals enrolled under this part under the contract. If the Secretary provides for the direct payments, the Secretary shall provide for an appro-

appropriate reduction in the amount of payments otherwise made to the organization under this part to reflect the amount of the Secretary's payments (and the Secretary's costs in making the payments).

(g) INTERMEDIATE SANCTIONS.—

(1) IN GENERAL.—If the Secretary determines that a MedicarePlus 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 net monthly premiums on individuals enrolled under this part in excess of the net monthly 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(j)(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 MedicarePlus 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 (g) during which the deficiency that is the basis of a determination under subsection (c)(2) exists.*

(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.*

(h) **PROCEDURES FOR TERMINATION.**—

(1) **IN GENERAL.**—*The Secretary may terminate a contract with a MedicarePlus organization under this section in accordance with formal investigation and compliance procedures established by the Secretary under which—*

(A) *the Secretary provides the organization with the reasonable 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);*

(B) *the Secretary shall impose more severe sanctions on an organization that has a history of deficiencies or that has not taken steps to correct deficiencies the Secretary has brought to the organization's attention;*

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

(D) *the Secretary provides the organization with reasonable notice and opportunity for hearing (including the right to appeal an initial decision) before terminating the contract.*

(2) *CIVIL MONEY PENALTIES.*—The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under subsection (f) or under paragraph (2) or (3) of subsection (g) in the same manner as they apply to a civil money penalty or proceeding under section 1128A(a).

(3) *EXCEPTION FOR IMMINENT AND SERIOUS RISK TO HEALTH.*—Paragraph (1) shall not apply if the Secretary determines that a delay in termination, resulting from compliance with the procedures specified in such paragraph prior to termination, would pose an imminent and serious risk to the health of individuals enrolled under this part with the organization.

PAYMENTS TO HOSPITALS FOR CERTAIN COSTS ATTRIBUTABLE TO MANAGED CARE ENROLLEES

SEC. 1858. (a) COSTS OF GRADUATE MEDICAL EDUCATION.—

(1) *IN GENERAL.*—For portions of cost reporting periods occurring on or after January 1, 1998, the Secretary shall provide for an additional payment amount for each subsection (d) hospital (as defined in section 1886(d)(1)(B)), each PPS-exempt hospital described in clause (i) through (v) of such section, and for each hospital reimbursed under a reimbursement system authorized section 1814(b)(3) that—

(A) furnishes services to individuals who are enrolled under a risk-sharing contract with an eligible organization under section 1876 and who are entitled to part A and to individuals who are enrolled with a MedicarePlus organization under part C, and

(B) has an approved medical residency training program.

(2) *PAYMENT AMOUNT.*—

(A) *IN GENERAL.*—Subject to paragraph (3)(B), the amount of the payment under this subsection shall be the sum of—

(i) the amount determined under subparagraph (B), and

(ii) the amount determined under subparagraph (C).

Clause (ii) shall not apply in the case of a hospital that is not a PPS-exempt hospital described in clause (i) through (v) of section 1886(d)(1)(B),

(B) *DIRECT AMOUNT.*—The amount determined under this subparagraph for a period is equal to the product of—

(i) the aggregate approved amount (as defined in section 1886(h)(3)(B)) for that period; and

(ii) the fraction of the total number of inpatient-bed-days (as established by the Secretary) during the period which are attributable to individuals described in paragraph (1).

(C) *INDIRECT AMOUNT.*—The amount determined under this subparagraph is equal to the product of—

(i) the amount of the indirect teaching adjustment factor applicable to the hospital under section 1886(d)(5)(B); and

(ii) the product of—

(I) the number of discharges attributable to individuals described in paragraph (1), and

(II) the estimated average per discharge amount that would otherwise have been paid under section 1886(d)(1)(A) if the individuals had not been enrolled as described in such paragraph.

(D) *SPECIAL RULE.*—The Secretary shall establish rules for the application of subparagraph (B) and for the computation of the amounts described in subparagraph (C)(i) and subparagraph (C)(ii)(I) to a hospital reimbursed under a reimbursement system authorized under section 1814(b)(3) in a manner similar to the manner of applying such subparagraph and computing such amounts as if the hospital were not reimbursed under such section.

(3) *LIMITATION.*—

(A) *DETERMINATIONS.*—At the beginning of each year, the Secretary shall—

(i) estimate the sum of the amount of the payments under this subsection and the payments under section 1853(h), for services or discharges occurring in the year, and

(ii) determine the amount of the annual payment limit under subparagraph (C) for such year.

(B) *IMPOSITION OF LIMIT.*—If the amount estimated under subparagraph (A)(i) for a year exceeds the amount determined under subparagraph (A)(ii) for the year, then the Secretary shall adjust the amounts of the payments described in subparagraph (A)(i) for the year in a pro rata manner so that the total of such payments in the year do not exceed the annual payment limit determined under subparagraph (A)(ii) for that year.

(C) *ANNUAL PAYMENT LIMIT.*—

(i) *IN GENERAL.*—The annual payment limit under this subparagraph for a year is the sum, over all counties or MedicarePlus payment areas, of the product of—

(I) the annual GME per capita payment rate (described in clause (ii)) for the county or area, and

(II) the Secretary's projection of average enrollment of individuals described in paragraph (1) who are residents of that county or area, adjusted to reflect the relative demographic or risk characteristics of such enrollees.

(ii) *GME PER CAPITA PAYMENT RATE.*—The GME per capita payment rate described in this clause for a particular county or MedicarePlus payment area for a year is the GME proportion (as specified in clause (iii)) of the annual MedicarePlus capitation rate (as calculated under section 1853(c)) for the county or area and year involved.

(iii) *GME PROPORTION.*—For purposes of clause (ii), the GME proportion for a county or area and a year is equal to the phase-in percentage (specified in clause (vi)) of the ratio of (I) the projected GME payment amount for the county or area (as determined under clause (v)), to (II) the average per capita cost for the

county or area for the year (determined under clause (vi)).

(iv) *PHASE-IN PERCENTAGE.*—The phase-in percentage specified in this clause for—

- (I) 1998 is 20 percent,
- (II) 1999 is 40 percent,
- (III) 2000 is 60 percent,
- (IV) 2001 is 80 percent, or
- (V) any subsequent year is 100 percent.

(v) *PROJECTED GME PAYMENT AMOUNT.*—The projected GME payment amount for a county or area—

(I) for 1998, is the amount included in the per capita rate of payment for 1997 determined under section 1876(a)(1)(C) for the payment adjustments described in section 1886(d)(5)(B) and section 1886(h) for that county or area, adjusted by the general GME update factor (as defined in clause (vii)) for 1998, or

(II) for a subsequent year, is the projected GME payment amount for the county or area for the previous year, adjusted by the general GME update factor for such subsequent year.

The Secretary shall determine the amount described in subclause (I) for a county or other area that includes hospitals reimbursed under section 1814(b)(3) as though such hospitals had not been reimbursed under such section.

(vi) *AVERAGE PER CAPITA COST.*—The average per capita cost for the county or area determined under this clause for—

(I) 1998 is the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) for the county or area, increased by the national per capita MedicarePlus growth percentage for 1998 (as defined in section 1853(c)(6), but determined without regard to the adjustment described in subparagraph (B) of such section); or

(II) a subsequent year is the average per capita cost determined under this clause for the previous year increased by the national per capita MedicarePlus growth percentage for the year involved (as defined in section 1853(c)(6), but determined without regard to the adjustment described in subparagraph (B) of such section).

(vii) *GENERAL GME UPDATE FACTOR.*—For purposes of clause (v), the “general GME update factor” for a year is equal to the Secretary’s estimate of the national average percentage change in average per capita payments under sections 1886(d)(5)(B) and 1886(h) from the previous year to the year involved. Such amount takes into account changes in law and regulation affecting payment amounts under such sections.

(b) *DISPROPORTIONATE SHARE HOSPITAL PAYMENTS.*—

(1) *IN GENERAL.*—For portions of cost reporting periods occurring on or after January 1, 1998, the Secretary shall provide for

an additional payment amount for each subsection (d) hospital (as defined in section 1886(d)(1)(B)) and for each hospital reimbursed a demonstration project reimbursement system under section 1814(b)(3) that—

(A) furnishes services to individuals who are enrolled under a risk-sharing contract with an eligible organization under section 1876 and who are entitled to part A and to individuals who are enrolled with a MedicarePlus organization under this part, and

(B) is (or, if it were not reimbursed under section 1814(b)(3), would qualify as) a disproportionate share hospital described in section 1886(d)(5)(F)(i).

(2) AMOUNT OF PAYMENT.—Subject to paragraph (3)(B), the amount of the payment under this subsection shall be the product of—

(A) the amount of the disproportionate share adjustment percentage applicable to the hospital under section 1886(d)(5)(F); and

(B) the product described in subsection (a)(2)(C)(ii).

The Secretary shall establish rules for the computation of the amount described in subparagraph (A) for a hospital reimbursed under section 1814(b)(3).

(3) LIMIT.—

(A) DETERMINATION.—At the beginning of each year, the Secretary shall—

(i) estimate the sum of the payments under this subsection for services or discharges occurring in the year, and

(ii) determine the amount of the annual payment limit under subparagraph (C) for such year.

(B) IMPOSITION OF LIMIT.—If the amount estimated under subparagraph (A)(i) for a year exceeds the amount determined under subparagraph (A)(ii) for the year, then the Secretary shall adjust the amounts of the payments under this subsection for the year in a pro rata manner so that the total of such payments in the year do not exceed the annual payment limit determined under subparagraph (A)(ii) for that year.

(C) ANNUAL PAYMENT LIMIT.—The annual payment limit under this subparagraph for a year shall be determined in the same manner as the annual payment limit is determined under clause (i) of subsection (a)(3)(C), except that, for purposes of this clause, any reference in clauses (i) through (vii) of such subsection—

(i) to a payment adjustment under subsection (a) is deemed a reference to a payment adjustment under this subsection, or

(ii) to payments or payment adjustments under section 1886(d)(5)(B) and 1886(h) is deemed a reference to payments and payment adjustments under section 1886(d)(5)(F).

DEFINITIONS; MISCELLANEOUS PROVISIONS

SEC. 1859. (a) DEFINITIONS RELATING TO MEDICAREPLUS ORGANIZATIONS.—*In this part—*

(1) MEDICAREPLUS ORGANIZATION.—*The term “MedicarePlus organization” means a public or private entity that is certified under section 1856 as meeting the requirements and standards of this part for such an organization.*

(2) PROVIDER-SPONSORED ORGANIZATION.—*The term “provider-sponsored organization” is defined in section 1855(e)(1).*

(b) DEFINITIONS RELATING TO MEDICAREPLUS PLANS.—

(1) MEDICAREPLUS PLAN.—*The term “MedicarePlus plan” means health benefits coverage offered under a policy, contract, or plan by a MedicarePlus organization pursuant to and in accordance with a contract under section 1857.*

(2) MSA PLAN.—

(A) IN GENERAL.—*The term “MSA plan” means a MedicarePlus plan that—*

(i) *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 plan) equal to the amount of an annual deductible (described in subparagraph (B));*

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

(iii) *provides, after such deductible is met for a year and for all subsequent expenses for items and services referred to in clause (i) 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.

(B) DEDUCTIBLE.—*The amount of annual deductible under an MSA plan—*

(i) *for contract year 1999 shall be not more than \$6,000; and*

(ii) *for a subsequent contract year shall be not more than the maximum amount of such deductible for the previous contract year under this subparagraph increased by the national per capita MedicarePlus growth percentage under section 1853(c)(6) for the year.*

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

(c) OTHER REFERENCES TO OTHER TERMS.—

(1) *MEDICAREPLUS ELIGIBLE INDIVIDUAL.*—The term “MedicarePlus eligible individual” is defined in section 1851(a)(3).

(2) *MEDICAREPLUS PAYMENT AREA.*—The term “MedicarePlus payment area” is defined in section 1853(d).

(3) *NATIONAL PER CAPITA MEDICAREPLUS GROWTH PERCENTAGE.*—The “national per capita MedicarePlus growth percentage” is defined in section 1853(c)(6).

(4) *MONTHLY PREMIUM; NET MONTHLY PREMIUM.*—The terms “monthly premium” and “net monthly premium” are defined in section 1854(a)(2).

(d) *COORDINATED ACUTE AND LONG-TERM CARE BENEFITS UNDER A MEDICAREPLUS PLAN.*—Nothing in this part shall be construed as preventing a State from coordinating benefits under a medicaid plan under title XIX with those provided under a MedicarePlus plan 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 plan.

(e) *RESTRICTION ON ENROLLMENT FOR CERTAIN MEDICAREPLUS PLANS.*—

(1) *IN GENERAL.*—In the case of a MedicarePlus religious fraternal benefit society plan described in paragraph (2), notwithstanding any other provision of this part to the contrary and in accordance with regulations of the Secretary, the society offering the plan may restrict the enrollment of individuals under this part to individuals who are members of the church, convention, or group described in paragraph (3)(B) with which the society is affiliated.

(2) *MEDICAREPLUS RELIGIOUS FRATERNAL BENEFIT SOCIETY PLAN DESCRIBED.*—For purposes of this subsection, a MedicarePlus religious fraternal benefit society plan described in this paragraph is a MedicarePlus plan described in section 1851(a)(2)(A) that—

(A) is offered by a religious fraternal benefit society described in paragraph (3) only to members of the church, convention, or group described in paragraph (3)(B); and

(B) permits all such members to enroll under the plan without regard to health status-related factors.

Nothing in this subsection shall be construed as waiving any plan requirements relating to financial solvency. In developing solvency standards under section 1856, the Secretary shall take into account open contract and assessment features characteristic of fraternal insurance certificates.

(3) *RELIGIOUS FRATERNAL BENEFIT SOCIETY DEFINED.*—For purposes of paragraph (2)(A), a “religious fraternal benefit society” described in this section is an organization that—

(A) is exempt from Federal income taxation under section 501(c)(8) of the Internal Revenue Code of 1986;

(B) is affiliated with, carries out the tenets of, and shares a religious bond with, a church or convention or association of churches or an affiliated group of churches;

(C) offers, in addition to a MedicarePlus religious fraternal benefit society plan, health coverage to individuals not

entitled to benefits under this title who are members of such church, convention, or group; and

(D) does not impose any limitation on membership in the society based on any health status-related factor.

(4) PAYMENT ADJUSTMENT.—Under regulations of the Secretary, in the case of individuals enrolled under this part under a MedicarePlus religious fraternal benefit society plan described in paragraph (2), the Secretary shall provide for such adjustment to the payment amounts otherwise established under section 1854 as may be appropriate to assure an appropriate payment level, taking into account the actuarial characteristics and experience of such individuals.

PART [C] D—MISCELLANEOUS PROVISIONS

DEFINITIONS OF SERVICES, INSTITUTIONS, ETC.

SEC. 1861. For purposes of this title—

Spell of Illness

(a) * * *

* * * * *

Inpatient Hospital Services

(b) The term “inpatient hospital services” means the following items and services furnished to an inpatient of a hospital and (except as provided in paragraph (3)) by the hospital—

(1) * * *

* * * * *

excluding, however—

(4) medical or surgical services provided by a physician, resident, or intern, services described by [clauses (i) or (iii) of subsection (s)(2)(K)] *subsection (s)(2)(K)*, certified nurse-midwife services, qualified psychologist services, and services of a certified registered nurse anesthetist; and

* * * * *

Extended Care Services

(h) The term “extended care services” means the following items and services furnished to an inpatient of a skilled nursing facility and (except as provided in [paragraphs (3) and (6)] *paragraphs (3), (6), and (7)*) by such skilled nursing facility—

(1) * * *

* * * * *

(7) such other services necessary to the health of the patients as are generally provided by skilled nursing facilities, or by others under arrangements with them made by the facility; excluding, however, any item or service if it would not be included under subsection (b) if furnished to an inpatient of a hospital.

* * * * *

Home Health Services

(m) The term “home health services” means the following items and services furnished to an individual, who is under the care of a physician, by a home health agency or by others under arrangements with them made by such agency, under a plan (for furnishing such items and services to such individual) established and periodically reviewed by a physician, which items and services are, except as provided in paragraph (7), provided on a visiting basis in a place of residence used as such individual’s home—

(1) * * *

* * * * *

excluding, however, any item or service if it would not be included under subsection (b) if furnished to an inpatient of a hospital. *For purposes of paragraphs (1) and (4), the term “part-time or intermittent services” means skilled nursing and home health aide services furnished any number of days per week as long as they are furnished (combined) less than 8 hours each day and 28 or fewer hours each week (or, subject to review on a case-by-case basis as to the need for care, less than 8 hours each day and 35 or fewer hours per week). For purposes of sections 1814(a)(2)(C) and 1835(a)(2)(A), “intermittent” means skilled nursing care that is either provided or needed on fewer than 7 days each week, or less than 8 hours of each day of skilled nursing and home health aide services combined for periods of 21 days or less (with extensions in exceptional circumstances when the need for additional care is finite and predictable).*

Durable Medical Equipment

(n) The term “durable medical equipment” includes iron lungs, oxygen tents, hospital beds, and wheelchairs (which may include a power-operated vehicle that may be appropriately used as a wheelchair, but only where the use of such a vehicle is determined to be necessary on the basis of the individual’s medical and physical condition and the vehicle meets such safety requirements as the Secretary may prescribe) used in the patient’s home (including an institution used as his home other than an institution that meets the requirements of subsection (e)(1) of this section or section 1819(a)(1)), whether furnished on a rental basis or purchased, *and includes blood-testing strips and blood glucose monitors for individuals with diabetes without regard to whether the individual has Type I or Type II diabetes or to the individual’s use of insulin (as determined under standards established by the Secretary in consultation with the appropriate organizations);* except that such term does not include such equipment furnished by a supplier who has used, for the demonstration and use of specific equipment, an individual who has not met such minimum training standards as the Secretary may establish with respect to the demonstration and use of such specific equipment. With respect to a seat-lift chair, such term includes only the seat-lift mechanism and does not include the chair.

Home Health Agency

(o) The term "home health agency" means a public agency or private organization, or a subdivision of such an agency or organization, which—

(1) * * *

* * * * *

(7) meets such additional requirements (including conditions relating to bonding or establishing of escrow accounts as the Secretary finds necessary for the financial security of the program and including providing the Secretary on a continuing basis with a surety bond in a form specified by the Secretary and in an amount that is not less than \$50,000) as the Secretary finds necessary for the effective and efficient operation of the program;

except that for purposes of part A such term shall not include any agency or organization which is primarily for the care and treatment of mental diseases. *The Secretary may waive the requirement of a bond under paragraph (7) in the case of an agency or organization that provides a comparable surety bond under State law.*

Outpatient Physical Therapy Services

(p) The term "outpatient physical therapy services" means physical therapy services furnished by a provider of services, a clinic, rehabilitation agency, or a public health agency, or by others under an arrangement with, and under the supervision of, such provider, clinic, rehabilitation agency, or public health agency to an individual as an outpatient—

(1) * * *

* * * * *

(4) any such service—

(A) if furnished by a clinic or rehabilitation agency, or by others under arrangements with such clinic or agency, unless such clinic or rehabilitation agency—

(i) * * *

* * * * *

(v) meets such other conditions relating to the health and safety of individuals who are furnished services by such clinic or agency on an outpatient basis, as the Secretary may find necessary, and provides the Secretary, to the extent required by the Secretary, on a continuing basis with a surety bond in a form specified by the Secretary and in an amount that is not less than \$50,000, or The Secretary may waive the requirement of a bond under paragraph (4)(A)(v) in the case of a clinic or agency that provides a comparable surety bond under State law.

* * * * *

Physician

(r) The term “physician”, when used in connection with the performance of any function or action, means (1) a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he performs such function or action (including a physician within the meaning of section 1101(a)(7)), (2) a doctor of dental surgery or of dental medicine who is legally authorized to practice dentistry by the State in which he performs such function and who is acting within the scope of his license when he performs such functions, (3) a doctor of podiatric medicine for the purposes of subsections (k), (m), (p)(1), and (s) of this section and sections 1814(a), 1832(a)(2)(F)(ii), and 1835 but only with respect to functions which he is legally authorized to perform as such by the State in which he performs them, (4) a doctor of optometry, but only with respect to the provision of items or services described in subsection (s) which he is legally authorized to perform as a doctor of optometry by the State in which he performs them, or (5) a chiropractor who is licensed as such by the State (or in a State which does not license chiropractors as such, is legally authorized to perform the services of a chiropractor in the jurisdiction in which he performs such services), and who meets uniform minimum standards promulgated by the Secretary, but only for the purpose of sections 1861(s)(1) and 1861(s)(2)(A) and only with respect to treatment by means of manual manipulation of the spine (to correct a subluxation [demonstrated by X-ray to exist]) which he is legally authorized to perform by the State or jurisdiction in which such treatment is provided. For the purposes of section 1862(a)(4) and subject to the limitations and conditions provided in the previous sentence, such term includes a doctor of one of the arts, specified in such previous sentence, legally authorized to practice such art in the country in which the inpatient hospital services (referred to in such section 1862(a)(4)) are furnished.

Medical and Other Health Services

(s) The term “medical and other health services” means any of the following items or services:

- (1) physicians’ services;
- (2)(A) * * *

* * * * *

(K)(i) services which would be physicians’ services if furnished by a physician (as defined in subsection (r)(1)) and which are performed by a physician assistant (as defined in subsection (aa)(5)) under the supervision of a physician (as so defined) [(I) in a hospital, skilled nursing facility, or nursing facility (as defined in section 1919(a)), (II) as an assistant at surgery, or (III) in a rural area (as defined in section 1886(d)(2)(D)) that is designated, under section 332(a)(1)(A) of the Public Health Service Act, as a health professional shortage area,] and which the physician assistant is legally authorized to perform by the State in which the services are performed, *and such services and supplies furnished as incident to such services as would be covered under subparagraph (A) if*

furnished as an incident to a physician's professional service, but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services,

[(ii) services which would be physicians' services if furnished by a physician (as defined in subsection (r)(1)) and which are performed by a nurse practitioner (as defined in subsection (aa)(5)) working in collaboration (as defined in subsection (aa)(6)) with a physician (as defined in subsection (r)(1)) in a skilled nursing facility or nursing facility (as defined in section 1919(a)) which the nurse practitioner is legally authorized to perform by the State in which the services are performed,

[(iii) services which would be physicians' services if furnished by a physician (as defined in subsection (r)(1)) and which are performed by a nurse practitioner or clinical nurse specialist (as defined in subsection (aa)(5)) working in collaboration (as defined in subsection (aa)(6)) with a physician (as defined in subsection (r)(1)) in a rural area (as defined in section 1886(d)(2)(D)) which the nurse practitioner or clinical nurse specialist is authorized to perform by the State in which the services are performed, and such services and supplies furnished as an incident to such services as would be covered under subparagraph (A) if furnished as an incident to a physician's professional service, and

[(iv) such services and supplies furnished as an incident to services described in clause (i) or (ii) as would be covered under subparagraph (A) if furnished as an incident to a physician's professional service;]

(ii) services which would be physicians' services if furnished by a physician (as defined in subsection (r)(1)) and which are performed by a nurse practitioner or clinical nurse specialist (as defined in subsection (aa)(5)) working in collaboration (as defined in subsection (aa)(6)) with a physician (as defined in subsection (r)(1)) which the nurse practitioner or clinical nurse specialist is legally authorized to perform by the State in which the services are performed, and such services and supplies furnished as an incident to such services as would be covered under subparagraph (A) if furnished incident to a physician's professional service, but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services;

* * * * *

(N) clinical social worker services (as defined in subsection (hh)(2)); [and]

(O) erythropoietin for dialysis patients competent to use such drug without medical or other supervision with respect to the administration of such drug, subject to methods and standards established by the Secretary by regulation for the safe and effective use of such drug, and items related to the administration of such drug; [and]

(P) prostate cancer screening tests (as defined in subsection (oo));

(Q) an oral drug (which is approved by the Federal Food and Drug Administration) prescribed for use as an anticancer chemotherapeutic agent for a given indication, and containing

an active ingredient (or ingredients), which is the same indication and active ingredient (or ingredients) as a drug which the carrier determines would be covered pursuant to subparagraph (A) or (B) if the drug could not be self-administered;

(R) colorectal cancer screening tests (as defined in subsection (pp));

(S) diabetes outpatient self-management training services (as defined in subsection (qq)); and

(T) an oral drug (which is approved by the Federal Food and Drug Administration) prescribed for use as an acute anti-emetic used as part of an anticancer chemotherapeutic regimen if the drug is administered by a physician (or under the supervision of a physician)—

(i) for use immediately before, immediately after, or at the time of the administration of the anticancer chemotherapeutic agent; and

(ii) as a full replacement for the anti-emetic therapy which would otherwise be administered intravenously.

* * * * *

(14) screening pap smear and screening pelvic exam.

* * * * *

Reasonable Cost

(v)(1)(A) * * *

* * * * *

(H) In determining such reasonable cost with respect to home health agencies, the Secretary may not include—

(i) any costs incurred in connection with bonding or establishing an escrow account by any such agency as a result of [the financial security requirement] *the financial security and surety bond requirements* described in subsection (o)(7);

(ii) in the case of home health agencies to which [the financial security requirement] *the financial security and surety bond requirements* described in subsection (o)(7) applies, any costs attributed to interest charged such an agency in connection with amounts borrowed by the agency to repay overpayments made under this title to the agency, except that such costs may be included in reasonable cost if the Secretary determines that the agency was acting in good faith in borrowing the amounts;

* * * * *

(L)(i) The Secretary, in determining the amount of the payments that may be made under this title with respect to services furnished by home health agencies, may not recognize as reasonable (in the efficient delivery of such services) costs for the provision of such services by an agency to the extent these costs exceed (on the aggregate for the agency) for cost reporting periods beginning on or after—

(I) July 1, 1985, and before July 1, 1986, 120 percent of the mean of the labor-related and nonlabor per visit costs for free-standing home health agencies,

(II) July 1, 1986, and before July 1, 1987, 115 percent[, or] of such mean,

(III) July 1, 1987, and before October 1, 1997, 112 percent[,] of such mean, or

【of the mean of the labor-related and nonlabor per visit costs for free standing home health agencies.】

(IV) October 1, 1997, 105 percent of the median of the labor-related and nonlabor per visit costs for freestanding home health agencies.

* * * * *

(iii) Not later than July 1, 1991, and annually thereafter (but not for cost reporting periods beginning on or after July 1, 1994, and before July 1, 1996, or on or after July 1, 1997, and before October 1, 1997), the Secretary shall establish limits under this subparagraph for cost reporting periods beginning on or after such date by utilizing the area wage index applicable under section 1886(d)(3)(E) and determined using the survey of the most recent available wages and wage-related costs of hospitals located in the geographic area in which the home health [agency is located] service is furnished (determined without regard to whether such hospitals have been reclassified to a new geographic area pursuant to section 1886(d)(8)(B), a decision of the Medicare Geographic Classification Review Board under section 1886(d)(10), or a decision of the Secretary).

(iv) In establishing limits under this subparagraph for cost reporting periods beginning after September 30, 1997, the Secretary shall not take into account any changes in the home health market basket, as determined by the Secretary, with respect to cost reporting periods which began on or after July 1, 1994, and before July 1, 1996.

(v) For services furnished by home health agencies for cost reporting periods beginning on or after October 1, 1997, 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 limitation 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 (including nonroutine medical supplies), updated by the home health market basket index.

The per beneficiary limitation in subclause (II) shall be multiplied by the agency's unduplicated census count of patients (entitled to benefits under this title) for the cost reporting period subject to the limitation to determine the aggregate agency specific per beneficiary limitation.

(vi) For services furnished by home health agencies for cost reporting periods beginning on or after October 1, 1997, the following rules apply:

(I) For new providers and those providers without a 12-month cost reporting period ending in calendar year 1994, the per beneficiary limitation shall be equal to the median of these limits (or the Secretary's best estimates thereof) applied to other home health agencies as determined by the Secretary. A home health

agency that has altered its corporate structure or name shall not be considered a new provider for this purpose.

(II) For beneficiaries who use services furnished by more than one home health agency, the per beneficiary limitations shall be prorated among the agencies.

* * * * *

(O)(i) In establishing an appropriate allowance for depreciation and for interest on capital indebtedness **and (if applicable) a return on equity capital** with respect to an asset of a **hospital or skilled nursing facility** *provider of services* which has undergone a change of ownership, such regulations shall provide, except as provided in clause **[(iv)] (iii)**, that the valuation of the asset after such change of ownership shall be **the lesser of the allowable acquisition cost of such asset to the owner of record as of the date of the enactment of this subparagraph (or, in the case of an asset not in existence as of such date, the first owner of record of the asset after such date), or the acquisition cost of such asset to the new owner.]** *the historical cost of the asset, as recognized under this title, less depreciation allowed, to the owner of record as of the date of enactment of the Balanced Budget Act of 1997 (or, in the case of an asset not in existence as of that date, the first owner of record of the asset after that date).*

[(ii) Such regulations shall provide for recapture of depreciation in the same manner as provided under the regulations in effect on June 1, 1984.]

[(iii) (ii) Such regulations shall not recognize, as reasonable in the provision of health care services, costs (including legal fees, accounting and administrative costs, travel costs, and the costs of feasibility studies) attributable to the negotiation or settlement of the sale or purchase of any capital asset (by acquisition or merger) for which any payment has previously been made under this title.

[(iv) (iii) In the case of the transfer of a hospital from ownership by a State to ownership by a nonprofit corporation without monetary consideration, the basis for capital allowances to the new owner shall be the book value of the hospital to the State at the time of the transfer.

* * * * *

(S)(i) Such regulations shall not include provision for specific recognition of any return on equity capital with respect to hospital outpatient departments.

(ii)(I) Such regulations shall provide that, in determining the amount of the payments that may be made under this title with respect to all the capital-related costs of outpatient hospital services, the Secretary shall reduce the amounts of such payments otherwise established under this title by 15 percent for payments attributable to portions of cost reporting periods occurring during fiscal year 1990, by 15 percent for payments attributable to portions of cost reporting periods occurring during fiscal year 1991, and by 10 percent for payments attributable to portions of cost reporting periods occurring during fiscal years 1992 **[through 1998]** *through 1999 and during fiscal year 2000 before January 1, 2000.*

(II) The Secretary shall reduce the reasonable cost of outpatient hospital services (other than the capital-related costs of such serv-

ices) otherwise determined pursuant to section 1833(a)(2)(B)(i)(I) by 5.8 percent for payments attributable to portions of cost reporting periods occurring during fiscal years 1991 **through 1998** *through 1999 and during fiscal year 2000 before January 1, 2000.*

* * * * *

(T) In determining such reasonable costs for hospitals, the amount of bad debts otherwise treated as allowable costs which are attributable to the deductibles and coinsurance amounts under this title shall be reduced—

- (i) for cost reporting periods beginning during fiscal year 1998, by 75 percent,*
- (ii) for cost reporting periods beginning during fiscal year 1999, by 40 percent, and*
- (iii) for cost reporting periods beginning during a subsequent fiscal year, by 50 percent.*

(U) In determining the reasonable cost of ambulance services (as described in section 1861(s)(7)) provided during a fiscal year (beginning with fiscal year 1998 and ending with fiscal year 2002), the Secretary shall not recognize any costs in excess of costs recognized as reasonable for ambulance services provided during the previous fiscal year, increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) as estimated by the Secretary for the 12-month period ending with the midpoint of the fiscal year involved reduced (in the case of each of fiscal years 1998 and 1999) by 1 percentage point.

* * * * *

Rural Health Clinic Services and Federally Qualified Health Center Services

(aa)(1) * * *

(2) The term “rural health clinic” means a facility which —

(A) * * *

* * * * *

[(I) has appropriate procedures for review of utilization of clinic services to the extent that the Secretary determines to be necessary and feasible;]

(I) has a quality assessment and performance improvement program, and appropriate procedures for review of utilization of clinic services, as the Secretary may specify,

* * * * *

For the purposes of this title, such term includes only a facility which (i) is located in an area that is not an urbanized area (as defined by the Bureau of the Census) *and in which there are insufficient numbers of needed health care practitioners (as determined by the Secretary), [and that is designated] and that, within the previous three-year period, has been designated* by the chief executive officer of the State and certified by the Secretary as an area with a shortage of personal health services**[, or that is designated] or designated** by the Secretary either (I) as an area with a shortage of personal health services under section 330(b)(3) or 1302(7) of the Public Health Service Act, (II) as a health professional shortage

area described in section 332(a)(1)(A) of that Act because of its shortage of primary medical care manpower, (III) as a high impact area described in section 329(a)(5) of that Act, of (IV) as an area which includes a population group which the Secretary determines has a health manpower shortage under section 332(a)(1)(B) of that Act, (ii) has filed an agreement with the Secretary by which it agrees not to charge any individual or other person for items or services for which such individual is entitled to have payment made under this title, except for the amount of any deductible or coinsurance amount imposed with respect to such items or services (not in excess of the amount customarily charged for such items and services by such clinic), pursuant to subsections (a) and (b) of section 1833, (iii) employs a physician assistant or nurse practitioner, and (iv) is not a rehabilitation agency or a facility which is primarily for the care and treatment of mental diseases. A facility that is in operation and qualifies as a rural health clinic under this title or title XIX and that subsequently fails to satisfy the requirement of clause (i) shall be considered, for purposes of this title and title XIX, as still satisfying the requirement of such clause *if it is determined, in accordance with criteria established by the Secretary in regulations, to be essential to the delivery of primary care services that would otherwise be unavailable in the geographic area served by the clinic.* If a State agency has determined under section 1864(a) that a facility is a rural health clinic and the facility has applied to the Secretary for approval as such a clinic, the Secretary shall notify the facility of the Secretary's approval or disapproval not later than 60 days after the date of the State agency determination or the application (whichever is later).

* * * * *

(5) [The term "physician assistant", the term "nurse practitioner", and the term "clinical nurse specialist" mean, for purposes of this title, a physician assistant, nurse practitioner, or clinical nurse specialist who performs] (A) *The term "physician assistant" and the term "nurse practitioner" mean, for purposes of this title, a physician assistant or nurse practitioner who performs such services as such individual is legally authorized to perform (in the State in which the individual performs such services) in accordance with State law (or the State regulatory mechanism provided by State law), and who meets such training, education, and experience requirements (or any combination thereof) as the Secretary may prescribe in regulations.*

(B) *The term "clinical nurse specialist" means, for purposes of this title, an individual who—*

(i) is a registered nurse and is licensed to practice nursing in the State in which the clinical nurse specialist services are performed; and

(ii) holds a master's degree in a defined clinical area of nursing from an accredited educational institution.

* * * * *

(7)(A) * * *

(B) The Secretary may not grant such a waiver under subparagraph (A) to a facility if the request for the waiver is made less than 6 months after the date of the expiration of any previous such

waiver for the facility, or if the facility has not yet been determined to meet the requirements (including subparagraph (J) of the first sentence of paragraph (2)) of a rural health clinic.

* * * * *

Comprehensive Outpatient Rehabilitation Facility Services

(cc)(1) * * *

(2) The term “comprehensive outpatient rehabilitation facility” means a facility which—

(A) * * *

* * * * *

(I) meets such other conditions of participation as the Secretary may find necessary in the interest of the health and safety of individuals who are furnished services by such facility, including conditions concerning qualifications of personnel in these facilities and providing the Secretary on a continuing basis with a surety bond in a form specified by the Secretary and in an amount that is not less than \$50,000.

* * * * *

Discharge Planning Process

(ee)(1) A discharge planning process of a hospital shall be considered sufficient if it is applicable to services furnished by the hospital to individuals entitled to benefits under this title and if it meets the guidelines and standards established by the Secretary under paragraph (2).

(2) The Secretary shall develop guidelines and standards for the discharge planning process in order to ensure a timely and smooth transition to the most appropriate type of and setting for post-hospital or rehabilitative care. The guidelines and standards shall include the following:

(A) * * *

* * * * *

(D) A discharge planning evaluation must include an evaluation of a patient’s likely need for appropriate post-hospital services, including hospice services, and the availability of those services, including the availability of home health services through individuals and entities that participate in the program under this title and that serve the area in which the patient resides and that request to be listed by the hospital as available.

* * * * *

(H) Consistent with section 1802, the discharge plan shall—
(i) not specify or otherwise limit the qualified provider which may provide post-hospital home health services, and
(ii) identify (in a form and manner specified by the Secretary) any home health agency (to whom the individual is referred) in which the hospital has a disclosable financial interest (as specified by the Secretary consistent with sec-

tion 1866(a)(1)(R)) or which has such an interest in the hospital.

* * * * *

Screening Pap [Smear] *Smear; Screening Pelvic Exam*

(nn)(1) The term “screening pap smear” means a diagnostic laboratory test consisting of a routine exfoliative cytology test (Papanicolaou test) provided to a woman for the purpose of early detection of cervical cancer and includes a physician’s interpretation of the results of the test, if the individual involved has not had such a test during the preceding [3 years (or such shorter period as the Secretary may specify in the case of a woman who is at high risk of developing cervical cancer (as determined pursuant to factors identified by the Secretary)).] 3 years, or during the preceding year in the case of a woman described in paragraph (3).

(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).

* * * * *

Prostate Cancer Screening Tests

(oo)(1) The term “prostate cancer screening test” means a test that consists of any (or all) of the procedures described in paragraph (2) provided for the purpose of early detection of prostate cancer to a man over 50 years of age who has not had such a test during the preceding year.

(2) The procedures described in this paragraph are as follows:

(A) A digital rectal examination.

(B) A prostate-specific antigen blood test.

(C) For years beginning after 2001, such other procedures as the Secretary finds appropriate for the purpose of early detection of prostate cancer, taking into account changes in technology and standards of medical practice, availability, effectiveness, costs, and such other factors as the Secretary considers appropriate.

Colorectal Cancer Screening Tests

(pp)(1) The term “colorectal cancer screening test” means any of the following procedures furnished to an individual for the purpose of early detection of colorectal cancer:

(A) Screening fecal-occult blood test.

(B) Screening flexible sigmoidoscopy.

(C) In the case of an individual at high risk for colorectal cancer, screening colonoscopy.

(D) Screening barium enema, if found by the Secretary to be an appropriate alternative to screening flexible sigmoidoscopy under subparagraph (B) or screening colonoscopy under subparagraph (C).

(E) For years beginning after 2002, such other procedures as the Secretary finds appropriate for the purpose of early detection of colorectal cancer, taking into account changes in technology and standards of medical practice, availability, effectiveness, costs, and such other factors as the Secretary considers appropriate.

(2) In paragraph (1)(C), an “individual at high risk for colorectal cancer” is an individual who, because of family history, prior experience of cancer or precursor neoplastic polyps, a history of chronic digestive disease condition (including inflammatory bowel disease, Crohn’s Disease, or ulcerative colitis), the presence of any appropriate recognized gene markers for colorectal cancer, or other predisposing factors, faces a high risk for colorectal cancer.

Diabetes Outpatient Self-Management Training Services

(qq)(1) The term “diabetes outpatient self-management training services” means educational and training services furnished to an individual with diabetes by 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 a physician, or other individual or entity designated by the Secretary, 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) a physician, or such other individual or entity, meets the quality standards described in this paragraph if the physician, or individual or entity, meets quality standards established by the Secretary, except that the physician or other individual or entity shall be deemed to have met such standards if the physician or other 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 an organization that represents individuals (including individuals under this title) with diabetes as meeting standards for furnishing the services.

Bone Mass Measurement

(rr)(1) The term “bone mass measurement” means a radiologic or radioisotopic procedure or other procedure approved by the Food and Drug Administration performed on a qualified individual (as

defined in paragraph (2)) for the purpose of identifying bone mass or detecting bone loss or determining bone quality, and includes a physician's interpretation of the results of the procedure.

(2) For purposes of this subsection, the term "qualified individual" means an individual who is (in accordance with regulations prescribed by the Secretary)—

(A) an estrogen-deficient woman at clinical risk for osteoporosis;

(B) an individual with vertebral abnormalities;

(C) an individual receiving long-term glucocorticoid steroid therapy;

(D) an individual with primary hyperparathyroidism; or

(E) an individual being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy.

(3) The Secretary shall establish such standards regarding the frequency with which a qualified individual shall be eligible to be provided benefits for bone mass measurement under this title.

(ss) *POST-HOSPITAL HOME HEALTH SERVICES.*—The term 'post-hospital home health services' means home health services furnished to an individual under a plan of treatment established when the individual was an inpatient of a hospital or rural primary care hospital for not less than 3 consecutive days before discharge, or during a covered post-hospital extended care stay, if home health services are initiated for the individual within 30 days after discharge from the hospital, rural primary care hospital or extended care facility.

EXCLUSIONS FROM COVERAGE AND MEDICARE AS SECONDARY PAYER

SEC. 1862. (a) Notwithstanding any other provision of this title, no payment may be made under part A or part B for any expenses incurred for items or services—

(1)(A) * * *

* * * * *

(D) in the case of clinical care items and services provided with the concurrence of the Secretary and with respect to research and experimentation conducted by, or under contract with, the [Prospective Payment Assessment Commission] Medicare Payment Advisory Commission or the Secretary, which are not reasonable and necessary to carry out the purposes of section 1886(e)(6),

(E) in the case of research conducted pursuant to section 1142, which is not reasonable and necessary to carry out the purposes of that section, [and]

(F) in the case of screening mammography, which is performed more frequently than is covered under section 1834(c)(2) or which is not conducted by a facility described in section 1834(c)(1)(B), and, in the case of screening pap smear and screening pelvic exam, which is performed more frequently than is provided under section 1861(nn)[;],

(G) in the case of prostate cancer screening tests (as defined in section 1861(oo)), which are performed more frequently than is covered under such section,

(H) in the case of colorectal cancer screening tests, which are performed more frequently than is covered under section 1834(d); and

(I) the frequency and duration of home health services which are in excess of normative guidelines that the Secretary shall establish by regulation;

* * * * *

(7) where such expenses are for routine physical checkups, eyeglasses (other than eyewear described in section 1861(s)(8)) or eye examinations for the purpose of prescribing, fitting, or changing eyeglasses, procedures performed (during the course of any eye examination) to determine the refractive state of the eyes, hearing aids or examinations therefor, or immunizations (except as otherwise allowed under section 1861(s)(10) and [paragraph (1)(B) or under paragraph (1)(F)] *subparagraphs (B), (F), (G), or (H) of paragraph (1)*);

* * * * *

(14) which are other than physicians' services (as defined in regulations promulgated specifically for purposes of this paragraph), services described by [section 1861(s)(2)(K)(i) or 1861(s)(2)(K)(iii)] *section 1861(s)(2)(K)*, certified nurse-midwife services, qualified psychologist services, and services of a certified registered nurse anesthetist, and which are furnished to an individual who is a patient of a hospital or rural primary care hospital by an entity other than the hospital or rural primary care hospital, unless the services are furnished under arrangements (as defined in section 1861(w)(1)) with the entity made by the hospital or rural primary care hospital;

(15)(A) which are for services of an assistant at surgery in a cataract operation (including subsequent insertion of an intraocular lens) unless, before the surgery is performed, the appropriate utilization and quality control peer review organization (under part B of title XI) or a carrier under section 1842 has approved of the use of such an assistant in the surgical procedure based on the existence of a complicating medical condition, or

(B) which are for services of an assistant at surgery to which section 1848(i)(2)(B) applies; [or]

(16) in the case in which funds may not be used for such items and services under the Assisted Suicide Funding Restriction Act of 1997[.];

* * * * *

(18) in the case of outpatient occupational therapy services or outpatient physical therapy services furnished as an incident to a physician's professional services (as described in section 1861(s)(2)(A)), that do not meet the standards and conditions under the second sentence of section 1861(g) or 1861(p) as such standards and conditions would apply to such therapy services if furnished by a therapist; or

(19) where such expenses are for home health services furnished to an individual who is under a plan of care of the home

health agency if the claim for payment for such services is not submitted by the agency.

Paragraph (7) shall not apply to Federally qualified health center services described in section 1861(aa)(3)(B).

(b) MEDICARE AS SECONDARY PAYER.—

(1) REQUIREMENTS OF GROUP HEALTH PLANS.—

(A) * * *

(B) DISABLED INDIVIDUALS IN LARGE GROUP HEALTH PLANS.—

(i) IN GENERAL.—A large group health plan (as defined in clause [(iv)] (iii)) may not take into account that an individual (or a member of the individual's family) who is covered under the plan by virtue of the individual's current employment status with an employer is entitled to benefits under this title under section 226(b).

(ii) EXCEPTION FOR INDIVIDUALS WITH END STAGE RENAL DISEASE.—Subparagraph (C) shall apply instead of clause (i) to an item or service furnished in a month to an individual if for the month the individual is, or (without regard to entitlement under section 226) would upon application be, entitled to benefits under section 226A.

[(iii) SUNSET.—Clause (i) shall only apply to items and services furnished on or after January 1, 1987, and before October 1, 1998.]

[(iv)] (iii) LARGE GROUP HEALTH PLAN DEFINED.—In this subparagraph, the term “large group health plan” has the meaning given such term in section 5000(b)(2) of the Internal Revenue Code of 1986, without regard to section 5000(d) of such Code.

(C) INDIVIDUALS WITH END STAGE RENAL DISEASE.—A group health plan (as defined in subparagraph (A)(v))—

(i) may not take into account that an individual is entitled to or eligible for benefits under this title under section 226A during the [12-month] 30-month period which begins with the first month in which the individual becomes entitled to benefits under part A under the provisions of section 226A, or, if earlier, the first month in which the individual would have been entitled to benefits under such part under the provisions of section 226A if the individual had filed an application for such benefits; and

(ii) may not differentiate in the benefits it provides between individuals having end stage renal disease and other individuals covered by such plan on the basis of the existence of end stage renal disease, the need for renal dialysis, or in any other manner;

except that clause (ii) shall not prohibit a plan from paying benefits secondary to this title when an individual is entitled to or eligible for benefits under this title under section 226A after the end of the [12-month] 30-month period described in clause (i). [Effective for items and services furnished on or after February 1, 1991, and before October 1,

1998 (with respect to periods beginning on or after February 1, 1990), this subparagraph shall be applied by substituting "18-month" for "12-month" each place it appears.】

* * * * *

(F) *LIMITATION ON BENEFICIARY LIABILITY.*—An individual who is entitled to benefits under this title and is furnished an item or service for which such benefits are incorrectly paid is not liable for repayment of such benefits under this paragraph unless payment of such benefits was made to the individual.

(2) *MEDICARE SECONDARY PAYER.*—

(A) * * *

(B) *CONDITIONAL PAYMENT.*—

(i) * * *

(ii) *ACTION BY UNITED STATES.*—In order to recover payment under this title for such an item or service, the United States may bring an action against any entity which is required or responsible [under this subsection to pay] (*directly, as a third-party administrator, or otherwise*) to make payment with respect to such item or service (or any portion thereof) under a primary plan (and may, in accordance with paragraph (3)(A) collect double damages against that entity), or against any other entity (including any physician or provider) that has received payment from that entity with respect to the item or service, and may join or intervene in any action related to the events that gave rise to the need for the item or service. *The United States may not recover from a third-party administrator under this clause in cases where the third-party administrator would not be able to recover the amount at issue from the employer or group health plan for whom it provides administrative services due to the insolvency or bankruptcy of the employer or plan.*

* * * * *

(v) *CLAIMS-FILING PERIOD.*—Notwithstanding any other time limits that may exist for filing a claim under an employer group health plan, the United States may seek to recover conditional payments in accordance with this subparagraph where the request for payment is submitted to the entity required or responsible under this subsection to pay with respect to the item or service (or any portion thereof) under a primary plan within the 3-year period beginning on the date on which the item or service was furnished.

* * * * *

(e)(1) * * *

【(2) Where an individual eligible for benefits under this title submits a claim for payment for items or services furnished by an individual or entity excluded from participation in the programs under this title, pursuant to section 1128, 1128A, 1156, 1160 (as in effect

on September 2, 1982), 1842(j)(2), 1862(d) (as in effect on the date of the enactment of the Medicare and Medicaid Patient and Program Protection Act of 1987), or 1866, and such beneficiary did not know or have reason to know that such individual or entity was so excluded, then, to the extent permitted by this title, and notwithstanding such exclusion, payment shall be made for such items or services. In each such case the Secretary shall notify the beneficiary of the exclusion of the individual or entity furnishing the items or services. Payment shall not be made for items or services furnished by an excluded individual or entity to a beneficiary after a reasonable time (as determined by the Secretary in regulations) after the Secretary has notified the beneficiary of the exclusion of that individual or entity.】

(2) *No individual or entity may bill (or collect any amount from) any individual for any item or service for which payment is denied under paragraph (1). No person is liable for payment of any amounts billed for such an item or service in violation of the previous sentence.*

* * * * *

(i) In order to supplement the activities of the 【Prospective Payment Assessment Commission】 *Medicare Payment Advisory Commission* under section 1886(e) in assessing the safety, efficacy, and cost-effectiveness of new and existing medical procedures, the Secretary may carry out, or award grants or contracts for, original research and experimentation of the type described in clause (ii) of section 1886(e)(6)(E) with respect to such a procedure if the Secretary finds that—

(1) * * *

* * * * *

AGREEMENTS WITH PROVIDERS OF SERVICES

SEC. 1866. (a)(1) Any provider of services (except a fund designated for purposes of section 1814(g) and section 1835(e)) shall be qualified to participate under this title and shall be eligible for payments under this title if it files with the Secretary an agreement—

(A) * * *

* * * * *

(H) in the case of hospitals which provide services for which payment may be made under this title and in the case of rural primary care hospitals which provide rural primary care hospital services, to have all items and services (other than physicians' services as defined in regulations for purposes of section 1862(a)(14), and other than services described by 【section 1861(s)(2)(K)(i) or 1861(s)(2)(K)(iii)】 *section 1861(s)(2)(K)*, certified nurse-midwife services, qualified psychologist services, and services of a certified registered nurse anesthetist) (i) that are furnished to an individual who is a patient of the hospital, and (ii) for which the individual is entitled to have payment made under this title, furnished by the hospital or otherwise under arrangements (as defined in section 1861(w)(1)) made by the hospital,

* * * * *

(O) [in the case of hospitals and skilled nursing facilities,] to accept as payment in full for [inpatient hospital and extended care] services that are covered under this title and are furnished to any individual enrolled *with a MedicarePlus organization under part C* or with an eligible organization (i) with a risk-sharing contract under section 1876, under section 1876(i)(2)(A) (as in effect before February 1, 1985), under section 402(a) of the Social Security Amendments of 1967, or under section 222(a) of the Social Security Amendments of 1972, and (ii) which does not have a contract establishing payment amounts for services furnished to members of the organization the amounts [(in the case of hospitals) or limits (in the case of skilled nursing facilities)] that would be made as a payment in full under this title (*less any payments under section 1858*) if the individuals were not so enrolled;

(P) in the case of home health agencies which provide home health services to individuals entitled to benefits under this title who require catheters, catheter supplies, ostomy bags, and supplies related to ostomy care (described in section 1861(m)(5)), to offer to furnish such supplies to such an individual as part of their furnishing of home health services,

(Q) in the case of hospitals, skilled nursing facilities, home health agencies, and hospice programs, to comply with the requirement of subsection (f) (relating to maintaining written policies and procedures respecting advance directives); [and]

(R) to contract only with a health care clearinghouse (as defined in section 1171) that meets each standard and implementation specification adopted or established under part C of title XI on or after the date on which the health care clearinghouse is required to comply with the standard or specification[.]; and

(S) *in the case of a hospital that has a financial interest (as specified by the Secretary in regulations) in a home health agency, or in which such an agency has such a financial interest, or in which another entity has such a financial interest (directly or indirectly) with such hospital and such an agency, to maintain and disclose to the Secretary (in a form and manner specified by the Secretary) information on—*

(i) the nature of such financial interest,

(ii) the number of individuals who were discharged from the hospital and who were identified as requiring home health services, and

(iii) the percentage of such individuals who received such services from such provider (or another such provider).

In the case of a hospital which has an agreement in effect with an organization described in subparagraph (F), which organization's contract with the Secretary under part B of title XI is terminated on or after October 1, 1984, the hospital shall not be determined to be out of compliance with the requirement of such subparagraph during the six month period beginning on the date of the termination of that contract.

(2)(A) A provider of services may charge such individual or other person (i) the amount of any deduction or coinsurance amount imposed pursuant to section 1813(a)(1), (a)(3), or (a)(4), section 1833(b), or section 1861(y)(3) with respect to such items and serv-

ices (not in excess of the amount customarily charged for such items and services by such provider), and (ii) an amount equal to 20 per centum of the reasonable charges for such items and services (not in excess of 20 per centum of the amount customarily charged for such items and services by such provider) for which payment is made under part B or which are durable medical equipment furnished as home health services (but in the case of items and services furnished to individuals with end-stage renal disease, an amount equal to 20 percent of the estimated amounts for such items and services calculated on the basis established by the Secretary). In the case of items and services described in section 1833(c), clause (ii) of the preceding sentence shall be applied by substituting for 20 percent the proportion which is appropriate under such section. A provider of services may not impose a charge under clause (ii) of the first sentence of this subparagraph with respect to items and services described in section 1861(s)(10)(A) and with respect to clinical diagnostic laboratory tests for which payment is made under part B. Notwithstanding the first sentence of this subparagraph, a home health agency may charge such an individual or person, with respect to covered items subject to payment under section 1834(a), the amount of any deduction imposed under section 1833(b) and 20 percent of the payment basis described in section 1834(a)(1)(B). *In the case of items and services for which payment is made under part B under the prospective payment system established under section 1833(t), clause (ii) of the first sentence shall be applied by substituting for 20 percent of the reasonable charge, the applicable copayment amount established under section 1833(t)(5).*

* * * * *

(b)(1)

(2) The Secretary may refuse to enter into an agreement under this section or, upon such reasonable notice to the provider and the public as may be specified in regulations, may refuse to renew or may terminate such an agreement after the Secretary—

(A) * * *

(B) has determined that the provider fails substantially to meet the applicable provisions of section 1861, **[or]**

(C) has excluded the provider from participation in a program under this title pursuant to section 1128 or section 1128A~~[,]~~, or

(D) *has ascertained that the provider has been convicted of a felony under Federal or State law for an offense which the Secretary determines is inconsistent with the best interests of program beneficiaries.*

* * * * *

(f)(1) For purposes of subsection (a)(1)(Q) and sections 1819(c)(2)(E), 1833(s), 1855(i), 1876(c)(8), and 1891(a)(6), the requirement of this subsection is that a provider of services, MedicarePlus organization, or prepaid or eligible organization (as the case may be) maintain written policies and procedures with respect to all adult individuals receiving medical care by or through the provider or organization—

(A) * * *

* * * * *

(2) The written information described in paragraph (1)(A) shall be provided to an adult individual—

(A) * * *

* * * * *

(E) in the case of an eligible organization (as defined in section 1876(b)) or an organization provided payments under section 1833(a)(1)(A) or a MedicarePlus organization, at the time of enrollment of the individual with the organization.

* * * * *

DETERMINATIONS; APPEALS

SEC. 1869. (a) * * *

(b)(1) Any individual dissatisfied with any determination under subsection (a) as to—

(A) * * *

* * * * *

(2) Notwithstanding paragraph (1)(C) and (1)(D), in the case of a claim arising—

(A) * * *

(B) under part B, a hearing shall not be available to an individual under paragraph (1)(C) and (1)(D) if the amount in controversy is less than \$500 (or \$100 in the case of home health services) and judicial review shall not be available to the individual under that paragraph if the aggregate amount in controversy is less than \$1,000.

* * * * *

PAYMENTS TO HEALTH MAINTENANCE ORGANIZATIONS AND COMPETITIVE MEDICAL PLANS

SEC. 1876. (a) * * *

* * * * *

(f)(1) * * *

(2) **【The Secretary】** *Subject to paragraph (4), the Secretary may modify or waive the requirement imposed by paragraph (1) only—*

(A) * * *

* * * * *

(4) *Effective for contract periods beginning after December 31, 1996, the Secretary may waive or modify the requirement imposed by paragraph (1) to the extent the Secretary finds that it is in the public interest.*

* * * * *

(k)(1) *Except as provided in paragraph (3), the Secretary shall not enter into, renew, or continue any risk-sharing contract under this section with an eligible organization for any contract year beginning on or after—*

(A) *the date standards for MedicarePlus organizations and plans are first established under section 1856 with respect to*

MedicarePlus organizations that are insurers or health maintenance organizations, or

(B) in the case of such an organization with such a contract in effect as of the date such standards were first established, 1 year after such date.

(2) The Secretary shall not enter into, renew, or continue any risk-sharing contract under this section with an eligible organization for any contract year beginning on or after January 1, 2000.

(3) An individual who is enrolled in part B only and is enrolled in an eligible organization with a risk-sharing contract under this section on December 31, 1998, may continue enrollment in such organization in accordance with regulations issued by not later than July 1, 1998.

(4) Notwithstanding subsection (a), the Secretary shall provide that payment amounts under risk-sharing contracts under this section for months in a year (beginning with January 1998) shall be computed—

(A) with respect to individuals entitled to benefits under both parts A and B, by substituting payment rates under section 1853(a) for the payment rates otherwise established under subsection 1876(a), and

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

For purposes of carrying out this paragraph for payments for months in 1998, the Secretary shall compute, announce, and apply the payment rates under section 1853(a) (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 under this section not in accordance with such rates.

LIMITATION ON CERTAIN PHYSICIAN REFERRALS

SEC. 1877. (a) * * *

* * * * *

(g) SANCTIONS.—

(1) * * *

* * * * *

(6) ADVISORY OPINIONS.—

(A) IN GENERAL.—The Secretary shall issue written advisory opinions concerning whether a referral relating to designated health services (other than clinical laboratory services) is prohibited under this section.

(B) BINDING AS TO SECRETARY AND PARTIES INVOLVED.—Each advisory opinion issued by the Secretary shall be binding as to the Secretary and the party or parties requesting the opinion.

(C) APPLICATION OF CERTAIN PROCEDURES.—The Secretary shall, to the extent practicable, apply the regulations promulgated under section 1128D(b)(5) to the issuance of advisory opinions under this paragraph.

(D) *APPLICABILITY.*—This paragraph shall apply to requests for advisory opinions made during the period described in section 1128D(b)(6).

* * * * *

LIMITATION ON LIABILITY OF BENEFICIARY WHERE MEDICARE CLAIMS ARE DISALLOWED

SEC. 1879.(a) * * *

* * * * *

- (g) The coverage denial described in this subsection **[is,]** is—
 - (1) with respect to the provision of home health services to an individual, a failure to meet the requirements of section 1814(a)(2)(C) or section 1835(a)(2)(A) in that the individual—
 - [(1)]** (A) is or was not confined to his home, or
 - [(2)]** (B) does or did not need skilled nursing care on an intermittent basis**[.];** and
 - (2) with respect to the provision of hospice care to an individual, a determination that the individual is not terminally ill.

* * * * *

CERTIFICATION OF MEDICARE SUPPLEMENTAL HEALTH INSURANCE POLICIES

SEC. 1882. (a) * * *

* * * * *

(d)(1) * * *

* * * * *

(3)(A)(i) It is unlawful for a person to sell or issue to an individual entitled to benefits under part A or enrolled under part B of this title (*including an individual electing a MedicarePlus plan under section 1851*)—

(I) a health insurance policy with knowledge that the policy duplicates health benefits to which the individual is otherwise entitled under this title or title XIX,

(II) *in the case of an individual not electing a MedicarePlus plan* a medicare supplemental policy with knowledge that the individual is entitled to benefits under another medicare supplemental policy *or in the case of an individual electing a MedicarePlus plan, a medicare supplemental policy with knowledge that the policy duplicates health benefits to which the individual is otherwise entitled under the MedicarePlus plan or under another medicare supplemental policy, or*

(III) a health insurance policy (other than a medicare supplemental policy) with knowledge that the policy duplicates health benefits to which the individual is otherwise entitled, other than benefits to which the individual is entitled under a requirement of State or Federal law.

(B)(i) It is unlawful for a person to issue or sell a medicare supplemental policy to an individual entitled to benefits under part A or enrolled under part B, whether directly, through the mail, or otherwise, unless—

(I) the person obtains from the individual, as part of the application for the issuance or purchase and on a form described in clause (II), a written statement signed by the individual stating, to the best of the individual's knowledge, what health insurance policies (*including any MedicarePlus plan*) the individual has, from what source, and whether the individual is entitled to any medical assistance under title XIX, whether as a qualified medicare beneficiary or otherwise, and

* * * * *

(g)(1) For purposes of this section, a medicare supplemental policy is a health insurance policy or other health benefit plan offered by a private entity to individuals who are entitled to have payment made under this title, which provides reimbursement for expenses incurred for services and items for which payment may be made under this title but which are not reimbursable by reason of the applicability of deductibles, coinsurance amounts, or other limitations imposed pursuant to this title; but does not include *or a MedicarePlus plan or any such policy or plan of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations (or combination thereof), for employees or former employees (or combination thereof) or for members or former members (or combination thereof) of the labor organizations and does not include a policy or plan of an eligible organization (as defined in section 1876(b)) if the policy or plan provides benefits pursuant to a contract under section 1876 or an approved demonstration project described in section 603(c) of the Social Security Amendments of 1983, section 2355 of the Deficit Reduction Act of 1984, or section 9412(b) of the Omnibus Budget Reconciliation Act of 1986, or, during the period beginning on the date specified in subsection (p)(1)(C) and ending on December 31, 1995, a policy or plan of an organization if the policy or plan provides benefits pursuant to an agreement under section 1833(a)(1)(A). For purposes of this section, the term "policy" includes a certificate issued under such policy.*

* * * * *

(s)(1) * * *

(2)(A) * * *

(B) Subject to [subparagraph (C)] *subparagraphs (C) and (D)*, subparagraph (A) shall not be construed as preventing the exclusion of benefits under a policy, during its first 6 months, based on a pre-existing condition for which the policyholder received treatment or was otherwise diagnosed during the 6 months before the policy became effective.

* * * * *

(D) *In the case of a policy issued during the 6-month period described in subparagraph (A) to an individual who is 65 years of age or older as of the date of issuance and who as of the date of the application for enrollment has a continuous period of creditable coverage (as defined in 2701(c) of the Public Health Service Act) of—*

(i) at least 6 months, the policy may not exclude benefits based on a pre-existing condition; or

(ii) of less than 6 months, if the policy excludes benefits based on a preexisting condition, the policy shall reduce the period of any preexisting condition exclusion by the aggregate of the periods of creditable coverage (if any, as so defined) applicable to the individual as of the enrollment date.

The Secretary shall specify the manner of the reduction under clause (ii), based upon the rules used by the Secretary in carrying out section 2701(a)(3) of such Act.

(3)(A) The issuer of a medicare supplemental policy—

(i) may not deny or condition the issuance or effectiveness of a medicare supplemental policy described in subparagraph (C);

(ii) may not discriminate in the pricing of the policy, because of health status, claims experience, receipt of health care, or medical condition; and

(iii) may not impose an exclusion of benefits based on a preexisting condition,

in the case of an individual described in subparagraph (B) who seeks to enroll under the policy not later than 63 days after the date of the termination of enrollment described in such subparagraph and who submits evidence of the date of termination or disenrollment along with the application for such medicare supplemental policy.

(B) An individual described in this subparagraph is an individual described in any of the following clauses:

(i) The individual is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under this title and the plan terminates or ceases to provide any such supplemental health benefits to the individual.

(ii) The individual is enrolled with a MedicarePlus organization under a MedicarePlus plan under part C, with an eligible organization under a contract under section 1876, a similar organization operating under demonstration project authority, with an organization under an agreement under section 1833(a)(1)(A), with an organization under a policy described in subsection (t), or under a medicare supplemental policy under this section, and such enrollment ceases because—

(I) the individual moves outside the service area of the organization under such plan, contract, agreement, or policy;

(II) because of the bankruptcy or insolvency of the organization or issuer or because of other involuntary termination of coverage or enrollment under such plan, contract, agreement, or policy and there is no provision under applicable State law for the continuation of such coverage; or

(III) because the individual elects such termination due to cause.

(iii) The individual was enrolled under a medicare supplemental policy under this section, subsequently terminates such enrollment and enrolls with a MedicarePlus organization under a MedicarePlus plan under part C, with an eligible organization under a contract under section 1876, with a similar organization operating under demonstration project authority, with an organization under an agreement under section 1833(a)(1)(A), or under a policy described in subsection (t), and such subsequent enrollment is terminated by the enrollee during the first

6 months (or 3 months for terminations occurring on or after January 1, 2003) of such enrollment, but only if the individual never was previously so enrolled.

(C) A medicare supplemental policy described in this subparagraph has a benefit package classified as "A", "B", or "C" under the standards established under subsection (p)(2).

(D) At the time of an event described in subparagraph (B) because of which an individual ceases enrollment or loses coverage or benefits under a contract or agreement, policy, or plan, the organization that offers the contract or agreement, the insurer offering the policy, or the administrator of the plan, respectively, shall notify the individual of the rights of the individual, and obligations of issuers of medicare supplemental policies, under subparagraph (A).

[(3)] (4) Any issuer of a medicare supplemental policy that fails to meet the requirements of [paragraphs (1) and (2)] this subsection is subject to a civil money penalty of not to exceed \$5,000 for each such failure. The provisions of section 1128A (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

* * * * *

(u)(1) It is unlawful for a person to sell or issue a policy described in paragraph (2) to an individual with knowledge that the individual has in effect under section 1851 an election of an MSA plan.

(2) A policy described in this subparagraph is a health insurance policy that provides for coverage of expenses that are otherwise required to be counted toward meeting the annual deductible amount provided under the MSA plan.

PAYMENT TO HOSPITALS FOR INPATIENT HOSPITAL SERVICES

SEC. 1886. (a) * * *

* * * * *

(e)(1) * * *

[(2)(A)] The Director of the Congressional Office of Technology Assessment (hereinafter in this subsection referred to as the "Director" and the "Office", respectively) shall provide for appointment of a Prospective Payment Assessment Commission (hereinafter in this subsection referred to as the "Commission"), to be composed of independent experts appointed by the Director (without regard to the provisions of title 5, United States Code, governing appointments in the competitive service). The Commission shall review the applicable percentage increase factor described in subsection (b)(3)(B) and make recommendations to the Secretary on the appropriate percentage change which should be effected for hospital inpatient discharges under subsections (b) and (d) for fiscal years beginning with fiscal year 1986. In making its recommendations, the Commission shall take into account changes in the hospital market-basket described in subsection (b)(3)(B), hospital productivity, technological and scientific advances, the quality of health care provided in hospitals (including the quality and skill level of professional nursing required to maintain quality care), and long-term cost-effectiveness in the provision of inpatient hospital services.

[(B) In order to promote the efficient and effective delivery of high-quality health care services, the Commission shall, in addition to carrying out its functions under subparagraph (A), study and make recommendations for each fiscal year regarding changes in each existing reimbursement policy under this title under which payments to an institution are based upon prospectively determined rates and the development of new institutional reimbursement policies under this title, including recommendations relating to payments during such fiscal year under the prospective payment system established under this section for determining payments for the operating costs of inpatient hospital services, including changes in the number of diagnosis-related groups used to classify inpatient hospital discharges under subsection (d), adjustments to such groups to reflect severity of illness, and changes in the methods by which hospitals are reimbursed for capital-related costs, together with general recommendations on the effectiveness and quality of health care delivery systems in the United States and the effects on such systems of institutional reimbursements under this title.

[(C) By not later than June 1 of each year, the Commission shall submit a report to Congress containing an examination of issues affecting health care delivery in the United States, including issues relating to—

[(i) trends in health care costs;

[(ii) the financial condition of hospitals and the effect of the level of payments made to hospitals under this title on such condition;

[(iii) trends in the use of health care services; and

[(iv) new methods used by employers, insurers, and others to constrain growth in health care costs.]

(3)[(A) The Commission, not later than the March 1 before the beginning of each fiscal year (beginning with fiscal year 1986), shall report its recommendations to Congress on an appropriate change factor which should be used for inpatient hospital services for discharges in that fiscal year, together with its general recommendations under paragraph (2)(B) regarding the effectiveness and quality of health care delivery systems in the United States.

[(B)] The Secretary, not later than April 1, 1987, for fiscal year 1988 and not later than March 1 before the beginning of each fiscal year (beginning with fiscal year 1989), shall report to the Congress the Secretary's initial estimate of the percentage change that the Secretary will recommend under paragraph (4) with respect to that fiscal year.

* * * * *

[(6)(A) The Commission shall consist of 17 individuals. Members of the Commission shall first be appointed no later than April 1, 1984, for a term of three years, except that the Director may provide initially for such shorter terms as will insure that (on a continuing basis) the terms of no more than seven members expire in any one year.

[(B) The membership of the Commission shall include individuals with national recognition for their expertise in health economics, health facility management, reimbursement of health facilities or other providers of services which reflect the scope of the Commission's responsibilities, 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 registered professional nurses, employers, third party payors, individuals skilled in the conduct and interpretation of biomedical, health services, and health economics research, and individuals having expertise in the research and development of technological and scientific advances in health care.

[(C) Subject to such review as the Office deems necessary to assure the efficient administration of the Commission, the Commission may—

[(i) employ and fix the compensation of an Executive Director (subject to the approval of the Director of the Office) and such other personnel (not to exceed 25) 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);

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

[(iii) 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));

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

[(v) provide transportation and subsistence for persons serving without compensation; and

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

Section 10(a)(1) of the Federal Advisory Committee Act shall not apply to any portion of a Commission meeting if the Commission, by majority vote, determines that such portion of such meeting should be closed.

[(D) 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 his 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.

[(E) In order to identify medically appropriate patterns of health resources use in accordance with paragraph (2), the Commission shall collect and assess information on medical and surgical proce-

dures and services, including information on regional variations of medical practice and lengths of hospitalization and on other patient-care data, giving special attention to treatment patterns for conditions which appear to involve excessively costly or inappropriate services not adding to the quality of care provided. In order to assess the safety, efficacy, and cost-effectiveness of new and existing medical and surgical procedures, the Commission shall, in coordination to the extent possible with the Secretary, collect and assess factual information, giving special attention to the needs of updating existing diagnosis-related groups, establishing new diagnosis-related groups, and making recommendations on relative weighting factors for such groups to reflect appropriate differences in resource consumption in delivering safe, efficacious, and cost-effective care. In collecting and assessing information, the Commission shall—

[(i) 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 paragraph;

[(ii) carry out, or award grants or contracts for, original research and experimentation, including clinical research, where existing information is inadequate for the development of useful and valid guidelines by the Commission; and

[(iii) adopt procedures allowing any interested party to submit information with respect to medical and surgical procedures and services (including new practices, such as the use of new technologies and treatment modalities), which information the Commission shall consider in making reports and recommendations to the Secretary and Congress.

[(F) The Commission shall have access to such relevant information and data as may be available from appropriate Federal agencies and shall assure that its activities, especially the conduct of original research and medical studies, are coordinated with the activities of Federal agencies.

[(G)(i) The Office shall have unrestricted access to all deliberations, records, and data of the Commission, immediately upon its request.

[(ii) In order to carry out its duties under this paragraph, the Office is authorized to expend reasonable and necessary funds as mutually agreed upon by the Office and the Commission. The Office shall be reimbursed for such funds by the Commission from the appropriations made with respect to the Commission.

[(H) The Commission shall be subject to periodic audit by the General Accounting Office.

[(I)(i) There are authorized to be appropriated such sums as may be necessary to carry out the provisions of this paragraph.

[(ii) Eighty-five percent of such appropriation shall be payable from the Federal Hospital Insurance Trust Fund, and 15 percent of such appropriation shall be payable from the Federal Supplementary Medical Insurance Trust Fund.

[(J) The Commission shall submit requests for appropriations in the same manner as the Office submits requests for appropriations,

but amounts appropriated for the Commission shall be separate from amounts appropriated for the Office.】

* * * * *
 (h) PAYMENTS FOR DIRECT GRADUATE MEDICAL EDUCATION COSTS.—

(1) * * *

* * * * *

(3) HOSPITAL PAYMENT AMOUNT PER RESIDENT.—

(A) * * *

(B) AGGREGATE APPROVED AMOUNT.—As used in subparagraph (A) *subject to subparagraph (D)*, the term “aggregate approved amount” means, for a hospital cost reporting period, the product of—

(i) the hospital’s approved FTE resident amount (determined under paragraph (2)) for that period, and

(ii) the weighted average number of full-time-equivalent residents (as determined under paragraph (4)) in the hospital’s approved medical residency training programs in that period.

The Secretary shall reduce the aggregate approved amount to the extent payment is made under subsection (k) for residents included in the hospital’s count of full-time equivalent residents and, in the case of residents not included in any such count, the Secretary shall provide for such a reduction in aggregate approved amounts under this subsection as will assure that the application of subsection (k) does not result in any increase in expenditures under this title in excess of those that would have occurred if subsection (k) were not applicable.

* * * * *

(D) PHASED-IN LIMITATION ON HOSPITAL OVERHEAD AND SUPERVISORY PHYSICIAN COMPONENT.—

(i) IN GENERAL.—*In the case of a hospital for which the overhead GME amount (as defined in clause (ii)) for the base period exceeds an amount equal to the 75th percentile of the overhead GME amounts in such period for all hospitals (weighted to reflect the full-time equivalent resident counts for all approved medical residency training programs), subject to clause (iv), the hospital’s approved FTE resident amount (for periods beginning on or after October 1, 1997) shall be reduced from the amount otherwise applicable (as previously reduced under this subparagraph) by an overhead reduction amount. The overhead reduction amount is equal to the lesser of—*

(I) 20 percent of the reference reduction amount (described in clause (iii)) for the period, or

(II) 15 percent of the hospital’s overhead GME amount for the period (as otherwise determined before the reduction provided under this subparagraph for the period involved).

(ii) *OVERHEAD GME AMOUNT.*—For purposes of this subparagraph, the term “overhead GME amount” means, for a hospital for a period, the product of—

(I) the percentage of the hospital’s approved FTE resident amount for the base period that is not attributable to resident salaries and fringe benefits, and

(II) the hospital’s approved FTE resident amount for the period involved.

(iii) *REFERENCE REDUCTION AMOUNT.*—

(I) *IN GENERAL.*—The reference reduction amount described in this clause for a hospital for a cost reporting period is the base difference (described in subclause (II)) updated, in a compounded manner for each period from the base period to the period involved, by the update applied for such period to the hospital’s approved FTE resident amount.

(II) *BASE DIFFERENCE.*—The base difference described in this subclause for a hospital is the amount by which the hospital’s overhead GME amount in the base period exceeded the 75th percentile of such amounts (as described in clause (i)).

(iv) *MAXIMUM REDUCTION TO 75TH PERCENTILE.*—In no case shall the reduction under this subparagraph effected for a hospital for a period (below the amount that would otherwise apply for the period if this subparagraph did not apply for any period) exceed the reference reduction amount for the hospital for the period.

(v) *BASE PERIOD.*—For purposes of this subparagraph, the term “base period” means the cost reporting period beginning in fiscal year 1984 or the period used to establish the hospital’s approved FTE resident amount for hospitals that did not have approved residency training programs in fiscal year 1984.

(vi) *RULES FOR HOSPITALS INITIATING RESIDENCY TRAINING PROGRAMS.*—The Secretary shall establish rules for the application of this subparagraph in the case of a hospital that initiates medical residency training programs during or after the base period.

(4) *DETERMINATION OF FULL-TIME-EQUIVALENT RESIDENTS.*—

(A) * * *

* * * * *

(F) *LIMITATION ON NUMBER OF RESIDENTS FOR CERTAIN FISCAL YEARS.*—Such rules shall provide that for purposes of a cost reporting period beginning on or after October 1, 1997, the total number of full-time equivalent residents before application of weighting factors (as determined under this paragraph) with respect to a hospital’s approved medical residency training program may not exceed the number of full-time equivalent residents with respect to the hospital’s most recent cost reporting period ending on or before December 31, 1996.

(G) COUNTING INTERNS AND RESIDENTS FOR FY 1998 AND SUBSEQUENT YEARS.—

(i) FY 1998.—For the hospital's first cost reporting period beginning during fiscal year 1998, subject to the limit described in subparagraph (F), the total number of full-time equivalent residents, for determining the hospital's graduate medical education payment, shall equal the average of the full-time equivalent resident counts for the cost reporting period and the preceding cost reporting period.

(ii) SUBSEQUENT YEARS.—For each subsequent cost reporting period, subject to the limit described in subparagraph (F), the total number of full-time equivalent residents, for determining the hospital's graduate medical education payment, shall equal the average of the actual full-time equivalent resident counts for the cost reporting period and preceding two cost reporting periods.

(iii) ADJUSTMENT FOR SHORT PERIODS.—If a hospital's cost reporting period beginning on or after October 1, 1997, is not equal to twelve months, the Secretary shall make appropriate modifications to ensure that the average full-time equivalent resident counts pursuant to clause (ii) are based on the equivalent of full 12-month cost reporting periods.

(iv) EXCLUSION OF RESIDENTS IN DENTISTRY.—Residents in an approved medical residency training program in dentistry shall not be counted for purposes of this subparagraph and subparagraph (F).

* * * * *

(6) INCENTIVE PAYMENT UNDER PLANS FOR VOLUNTARY REDUCTION IN NUMBER OF RESIDENTS.—

(A) IN GENERAL.—In the case of a voluntary residency reduction plan for which an application is approved under subparagraph (B), the qualifying entity submitting the plan shall be paid an applicable hold harmless percentage (as specified in subparagraph (E)) of the sum of—

(i) amount (if any) by which—

(I) the amount of payment which would have been made under this subsection if there had been a 5 percent reduction in the number of full-time equivalent residents in the approved medical education training programs of the qualifying entity as of June 30, 1997, exceeds

(II) the amount of payment which is made under this subsection, taking into account the reduction in such number effected under the reduction plan; and

(ii) the amount of the reduction in payment under 1886(d)(5)(B) (for hospitals participating in the qualifying entity) that is attributable to the reduction in number of residents effected under the plan below 95 percent of the number of full-time equivalent residents in such programs of such entity as of June 30, 1997.

(B) APPROVAL OF PLAN APPLICATIONS.—*The Secretary may not approve the application of an qualifying entity unless—*

(i) *the application is submitted in a form and manner specified by the Secretary and by not later than March 1, 2000,*

(ii) *the application provides for the operation of a plan for the reduction in the number of full-time equivalent residents in the approved medical residency training programs of the entity consistent with the requirements of subparagraph (D);*

(iii) *the entity elects in the application whether such reduction will occur over—*

(I) *a period of not longer than 5 residency training years, or*

(II) *a period of 6 residency training years, except that a qualifying entity described in subparagraph (C)(i)(III) may not make the election described in subclause (II); and*

(iv) *the Secretary determines that the application and the entity and such plan meet such other requirements as the Secretary specifies in regulations.*

(C) QUALIFYING ENTITY.—

(i) IN GENERAL.—*For purposes of this paragraph, any of the following may be a qualifying entity:*

(I) *Individual hospitals operating one or more approved medical residency training programs.*

(II) *Subject to clause (ii), two or more hospitals that operate such programs and apply for treatment under this paragraph as a single qualifying entity.*

(III) *Subject to clause (iii), a qualifying consortium (as described in section 4735 of the Balanced Budget Act of 1997).*

(ii) ADDITIONAL REQUIREMENT FOR JOINT PROGRAMS.—*In the case of an application by a qualifying entity described in clause (i)(II), the Secretary may not approve the application unless the application represents that the qualifying entity either—*

(I) *in the case of an entity that meets the requirements of clause (v) of subparagraph (D) will not reduce the number of full-time equivalent residents in primary care during the period of the plan, or*

(II) *in the case of another entity will not reduce the proportion of its residents in primary care (to the total number of residents) below such proportion as in effect as of the applicable time described in subparagraph (D)(vi).*

(iii) ADDITIONAL REQUIREMENT FOR CONSORTIA.—*In the case of an application by a qualifying entity described in clause (i)(III), the Secretary may not approve the application unless the application represents that the qualifying entity will not reduce the proportion of its residents in primary care (to the total number of*

residents) below such proportion as in effect as of the applicable time described in subparagraph (D)(vi).

(D) RESIDENCY REDUCTION REQUIREMENTS.—

(i) **INDIVIDUAL HOSPITAL APPLICANTS.**—In the case of a qualifying entity described in subparagraph (C)(i)(I), the number of full-time equivalent residents in all the approved medical residency training programs operated by or through the entity shall be reduced as follows:

(I) If base number of residents exceeds 750 residents, by a number equal to at least 20 percent of such base number.

(II) Subject to subclause (IV), if base number of residents exceeds 500, but is less than 750, residents, by 150 residents.

(III) Subject to subclause (IV), if base number of residents does not exceed 500 residents, by a number equal to at least 25 percent of such base number.

(IV) In the case of a qualifying entity which is described in clause (v) and which elects treatment under this subclause, by a number equal to at least 20 percent of such base number.

(ii) **JOINT APPLICANTS.**—In the case of a qualifying entity described in subparagraph (C)(i)(II), the number of full-time equivalent residents in all the approved medical residency training programs operated by or through the entity shall be reduced as follows:

(I) Subject to subclause (II), by a number equal to at least 25 percent of such base number.

(II) In the case of a qualifying entity which is described in clause (v) and which elects treatment under this subclause, by a number equal to at least 20 percent of such base number.

(iii) **CONSORTIA.**—In the case of a qualifying entity described in subparagraph (C)(i)(III), the number of full-time equivalent residents in all the approved medical residency training programs operated by or through the entity shall be reduced by a number equal to at least 20 percent of such base number.

(iv) **MANNER OF REDUCTION.**—The reductions specified under the preceding provisions of this subparagraph for a qualifying entity shall be below the base number of residents for that entity and shall be fully effective not later than—

(I) the 5th residency training year in which the application under subparagraph (B) is effective, in the case of an entity making the election described in subparagraph (B)(iii)(I), or

(II) the 6th such residency training year, in the case of an entity making the election described in subparagraph (B)(iii)(II).

(v) *ENTITIES PROVIDING ASSURANCE OF MAINTENANCE OF PRIMARY CARE RESIDENTS.*—An entity is described in this clause if—

(I) the base number of residents for the entity is less than 750;

(II) the number of full-time equivalent residents in primary care included in the base number of residents for the entity is at least 10 percent of such base number; and

(III) the entity represents in its application under subparagraph (B) that there will be no reduction under the plan in the number of full-time equivalent residents in primary care.

If a qualifying entity fails to comply with the representation described in subclause (III), the entity shall be subject to repayment of all amounts paid under this paragraph, in accordance with procedures established to carry out subparagraph (F).

(vi) *BASE NUMBER OF RESIDENTS DEFINED.*—For purposes of this paragraph, the term “base number of residents” means, with respect to a qualifying entity operating approved medical residency training programs, the number of full-time equivalent residents in such programs (before application of weighting factors) of the entity as of the most recent cost reporting period ending before June 30, 1997, or, if less, for any subsequent cost reporting period that ends before the date the entity makes application under this paragraph.

(E) *APPLICABLE HOLD HARMLESS PERCENTAGE.*—

(i) *IN GENERAL.*—For purposes of subparagraph (A), the “applicable hold harmless percentage” is the percentages specified in clause (ii) or clause (iii), as elected by the qualifying entity in the application submitted under subparagraph (B).

(ii) *5-YEAR REDUCTION PLAN.*—In the case of an entity making the election described in subparagraph (B)(iii)(I), the percentages specified in this clause are, for the—

(I) first and second residency training years in which the reduction plan is in effect, 100 percent,

(II) third such year, 75 percent,

(III) fourth such year, 50 percent, and

(IV) fifth such year, 25 percent.

(iii) *6-YEAR REDUCTION PLAN.*—In the case of an entity making the election described in subparagraph (B)(iii)(II), the percentages specified in this clause are, for the—

(I) first residency training year in which the reduction plan is in effect, 100 percent,

(II) second such year, 95 percent,

(III) third such year, 85 percent,

(IV) fourth such year, 70 percent,

(V) fifth such year, 50 percent, and

(VI) sixth such year, 25 percent.

(F) *PENALTY FOR INCREASE IN NUMBER OF RESIDENTS IN SUBSEQUENT YEARS.*—If payments are made under this paragraph to a qualifying entity, if the entity (or any hospital operating as part of the entity) increases the number of full-time equivalent residents above the number of such residents permitted under the reduction plan as of the completion of the plan, then, as specified by the Secretary, the entity is liable for repayment to the Secretary of the total amounts paid under this paragraph to the entity.

(G) *TREATMENT OF ROTATING RESIDENTS.*—In applying this paragraph, the Secretary shall establish rules regarding the counting of residents who are assigned to institutions the medical residency training programs in which are not covered under approved applications under this paragraph.

* * * * *

(k) *PAYMENT TO NON-HOSPITAL PROVIDERS.*—

(1) *REPORT.*—The Secretary shall submit to Congress, not later than 18 months after the date of the enactment of this subsection, a proposal for payment to qualified non-hospital providers for their direct costs of medical education, if those costs are incurred in the operation of an approved medical residency training program described in subsection (h). Such proposal shall specify the amounts, form, and manner in which such payments will be made and the portion of such payments that will be made from each of the trust funds under this title.

(2) *EFFECTIVENESS.*—Except as otherwise provided in law, the Secretary may implement such proposal for residency years beginning not earlier than 6 months after the date of submittal of the report under paragraph (1).

(3) *QUALIFIED NON-HOSPITAL PROVIDERS.*—For purposes of this subsection, the term “qualified non-hospital provider” means—

(A) a Federally qualified health center, as defined in section 1861(aa)(4);

(B) a rural health clinic, as defined in section 1861(aa)(2); and

(C) such other providers (other than hospitals) as the Secretary determines to be appropriate.

* * * * *

CENTERS OF EXCELLENCE

SEC. 1889. (a) *IN GENERAL.*—The Secretary shall use a competitive process to contract with specific hospitals or other entities for furnishing services related to surgical procedures, and for furnishing services (unrelated to surgical procedures) to hospital inpatients that the Secretary determines to be appropriate. The services may include any services covered under this title that the Secretary determines to be appropriate, including post-hospital services.

(b) *QUALITY STANDARDS.*—Only entities that meet quality standards established by the Secretary shall be eligible to contract under this section. Contracting entities shall implement a quality improvement plan approved by the Secretary.

(c) *PAYMENT.*—Payment under this section shall be made on the basis of negotiated all-inclusive rates. The amount of payment made by the Secretary to an entity under this title for services covered under a contract shall be less than the aggregate amount of the payments that the Secretary would have otherwise made for the services.

(d) *CONTRACT PERIOD.*—A contract period shall be 3 years (subject to renewal), so long as the entity continues to meet quality and other contractual standards.

(e) *INCENTIVES FOR USE OF CENTERS.*—Entities under a contract under this section may furnish additional services (at no cost to an individual entitled to benefits under this title) or waive cost-sharing, subject to the approval of the Secretary.

(f) *LIMIT ON NUMBER OF CENTERS.*—The Secretary shall limit the number of centers in a geographic area to the number needed to meet projected demand for contracted services.

CONDITIONS OF PARTICIPATION FOR HOME HEALTH AGENCIES; HOME HEALTH QUALITY

SEC. 1891. (a) * * *

* * * * *

(g) *PAYMENT ON BASIS OF LOCATION OF SERVICE.*—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, as determined by the Secretary.

* * * * *

PROSPECTIVE PAYMENT FOR HOME HEALTH SERVICES

SEC. 1895. (a) *IN GENERAL.*—Notwithstanding section 1861(v), the Secretary shall provide, for cost reporting periods beginning on or after October 1, 1999, for payments for home health services in accordance with a prospective payment system established by the Secretary under this section.

(b) *SYSTEM OF PROSPECTIVE PAYMENT FOR HOME HEALTH SERVICES.*—

(1) *IN GENERAL.*—The Secretary shall establish under this subsection a prospective payment system for payment for all costs of home health services. Under the system under this subsection 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 this section, including medical supplies, shall be paid for on the basis of a prospective payment amount determined under this subsection and applicable to the services involved. In implementing the system, the Secretary may provide for a transition (of not longer than 4 years) during which a portion of such payment is based on agency-specific costs, but only if such transition does not result in aggregate payments under this title that exceed the aggregate payments that would be made if such a transition did not occur.

(2) *UNIT OF PAYMENT.*—In defining a prospective payment amount under the system under this subsection, the Secretary shall consider an appropriate unit of service and the number, type, and duration of visits provided within that unit, potential

changes in the mix of services provided within that unit and their cost, and a general system design that provides for continued access to quality services.

(3) PAYMENT BASIS.—

(A) INITIAL BASIS.—

(i) IN GENERAL.—Under such system the Secretary shall provide for computation of a standard prospective payment amount (or amounts). Such amount (or amounts) shall initially be based on the most current audited cost report data available to the Secretary and shall be computed in a manner so that the total amounts payable under the system for fiscal year 2000 shall be equal to the total amount that would have been made if the system had not been in effect but if the reduction in limits described in clause (ii) had been in effect. Such amount shall be standardized in a manner that eliminates the effect of variations in relative case mix and wage levels among different home health agencies in a budget neutral manner consistent with the case mix and wage level adjustments provided under paragraph (4)(A). Under the system, the Secretary may recognize regional differences or differences based upon whether or not the services or agency are in an urbanized area.

(ii) REDUCTION.—The reduction described in this clause is a reduction by 15 percent in the cost limits and per beneficiary limits described in section 1861(v)(1)(L), as those limits are in effect on September 30, 1999.

(B) ANNUAL UPDATE.—

(i) IN GENERAL.—The standard prospective payment amount (or amounts) shall be adjusted for each fiscal year (beginning with fiscal year 2001) in a prospective manner specified by the Secretary by the home health market basket percentage increase applicable to the fiscal year involved.

(ii) HOME HEALTH MARKET BASKET PERCENTAGE INCREASE.—For purposes of this subsection, the term “home health market basket percentage increase” means, with respect to a fiscal year, a percentage (estimated by the Secretary before the beginning of the fiscal year) determined and applied with respect to the mix of goods and services included in home health services in the same manner as the market basket percentage increase under section 1886(b)(3)(B)(iii) is determined and applied to the mix of goods and services comprising inpatient hospital services for the fiscal year.

(C) ADJUSTMENT FOR OUTLIERS.—*The Secretary shall reduce the standard prospective payment amount (or amounts) under this paragraph applicable to home health services furnished during a period by such proportion as will result in an aggregate reduction in payments for the period equal to the aggregate increase in payments result-*

ing from the application of paragraph (5) (relating to outliers).

(4) *PAYMENT COMPUTATION.*—

(A) *IN GENERAL.*—The payment amount for a unit of home health services shall be the applicable standard prospective payment amount adjusted as follows:

(i) *CASE MIX ADJUSTMENT.*—The amount shall be adjusted by an appropriate case mix adjustment factor (established under subparagraph (B)).

(ii) *AREA WAGE ADJUSTMENT.*—The portion of such amount that the Secretary estimates to be attributable to wages and wage-related costs shall be adjusted for geographic differences in such costs by an area wage adjustment factor (established under subparagraph (C)) for the area in which the services are furnished or such other area as the Secretary may specify.

(B) *ESTABLISHMENT OF CASE MIX ADJUSTMENT FACTORS.*—The Secretary shall establish appropriate case mix adjustment factors for home health services in a manner that explains a significant amount of the variation in cost among different units of services.

(C) *ESTABLISHMENT OF AREA WAGE ADJUSTMENT FACTORS.*—The Secretary shall establish area wage adjustment factors that reflect the relative level of wages and wage-related costs applicable to the furnishing of home health services in a geographic area compared to the national average applicable level. Such factors may be the factors used by the Secretary for purposes of section 1886(d)(3)(E).

(5) *OUTLIERS.*—The Secretary may provide for an addition or adjustment to the payment amount otherwise made in the case of outliers because of unusual variations in the type or amount of medically necessary care. The total amount of the additional payments or payment adjustments made under this paragraph with respect to a fiscal year may not exceed 5 percent of the total payments projected or estimated to be made based on the prospective payment system under this subsection in that year.

(6) *PRORATION OF PROSPECTIVE PAYMENT AMOUNTS.*—If a beneficiary elects to transfer to, or receive services from, another home health agency within the period covered by the prospective payment amount, the payment shall be prorated between the home health agencies involved.

(c) *REQUIREMENTS FOR PAYMENT INFORMATION.*—With respect to home health services furnished on or after October 1, 1998, no claim for such a service may be paid under this title unless—

(1) the claim has the unique identifier (provided under section 1842(r)) for the physician who prescribed the services or made the certification described in section 1814(a)(2) or 1835(a)(2)(A); and

(2) in the case of a service visit described in paragraph (1), (2), (3), or (4) of section 1861(m), the claim has information (coded in an appropriate manner) on the length of time of the service visit, as measured in 15 minute increments.

(d) *LIMITATION ON REVIEW.*—There shall be no administrative or judicial review under section 1869, 1878, or otherwise of—

- (1) the establishment of a transition period under subsection (b)(1);
- (2) the definition and application of payment units under subsection (b)(2);
- (3) the computation of initial standard prospective payment amounts under subsection (b)(3)(A) (including the reduction described in clause (ii) of such subsection);
- (4) the adjustment for outliers under subsection (b)(3)(C);
- (5) case mix and area wage adjustments under subsection (b)(4);
- (6) any adjustments for outliers under subsection (b)(5); and
- (7) the amounts or types of exceptions or adjustments under subsection (b)(7).

* * * * *

TITLE XIX—GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

* * * * *

STATE PLANS FOR MEDICAL ASSISTANCE

SEC. 1902. (a) * * *

* * * * *

(j) Notwithstanding any other requirement of this title, the Secretary may waive or modify any requirement of this title with respect to the medical assistance program in American Samoa and the Northern Mariana Islands, other than a waiver of the Federal medical assistance percentage, the limitation in section 1108(c), or the requirement that payment may be made for medical assistance only with respect to amounts expended by American Samoa or the Northern Mariana Islands for care and services described in paragraphs (1) through [(25)] (26) of section 1905(a).

* * * * *

PAYMENT TO STATES

SEC. 1903. (a) * * *

* * * * *

(f)(1) * * *

* * * * *

(4) The limitations on payment imposed by the preceding provisions of this subsection shall not apply with respect to any amount expended by a State as medical assistance for any individual described in section 1902(a)(10)(A)(i)(III), 1902(a)(10)(A)(i)(IV), 1902(a)(10)(A)(i)(V), 1902(a)(10)(A)(i)(VI), 1902(a)(10)(A)(i)(VII), 1902(a)(10)(A)(ii)(IX), 1902(a)(10)(A)(ii)(X), or 1905(p)(1) or for any individual—

(A) * * *

* * * * *

(C) with respect to whom there is being paid, or who is eligible, or would be eligible if he were not in a medical institution, to have paid with respect to him, a State supplementary pay-

ment and is eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in section 1902(a)(10)(A), or who is a PACE program eligible individual enrolled in a PACE program under section 1932, but only if the income of such individual (as determined under section 1612, but without regard to subsection (b) thereof) does not exceed 300 percent of the supplemental security income benefit rate established by section 1611(b)(1),

at the time of the provision of the medical assistance giving rise to such expenditure.

* * * * *

DEFINITIONS

SEC. 1905. For purposes of this title—

(a) The term “medical assistance” means payment of part or all of the cost of the following care and services (if provided in or after the third month before the month in which the recipient makes application for assistance or, in the case of medicare cost-sharing with respect to a qualified medicare beneficiary described in subsection (p)(1), if provided after the month in which the individual becomes such a beneficiary) for individuals, and, with respect to physicians’ or dentists’ services, at the option of the State, to individuals (other than individuals with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in section 1902(a)(10)(A)) not receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A of title IV, and with respect to whom supplemental security income benefits are not being paid under title XVI, who are—

(i) under the age of 21, or, at the option of the State, under the age of 20, 19, or 18 as the State may choose,

(ii) relatives specified in section 406(b)(1) with whom a child is living if such child is (or would, if needy, be) a dependent child under part A of title IV,

(iii) 65 years of age or older,

(iv) blind, with respect to States eligible to participate in the State plan program established under title XVI,

(v) 18 years of age or older and permanently and totally disabled, with respect to States eligible to participate in the State plan program established under title XVI,

(vi) persons essential (as described in the second sentence of this subsection) to individuals receiving aid or assistance under State plans approved under title I, X, XIV, or XVI,

(vii) blind or disabled as defined in section 1614, with respect to States not eligible to participate in the State plan program established under title XVI,

(viii) pregnant women,

(ix) individuals provided extended benefits under section 1925,

(x) individuals described in section 1902(u)(1), or
 (xi) individuals described in section 1902(z)(1),
 but whose income and resources are insufficient to meet all of such
 cost—

(1) * * *

* * * * *

(24) personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are (A) authorized for the individual by a physician in accordance with a plan of treatment or (at the option of the State) otherwise authorized for the individual in accordance with a service plan approved by the State, (B) provided by an individual who is qualified to provide such services and who is not a member of the individual's family, and (C) furnished in a home or other location; **[and]**

(25) services furnished under a PACE program under section 1932 to PACE program eligible individuals enrolled under the program under such section; and

[(25)] (26) any other medical care, and any other type of remedial care recognized under State law, specified by the Secretary.

except as otherwise provided in paragraph (16), such term does not include—

(A) any such payments with respect to care or services for any individual who is an inmate of a public institution (except as a patient in a medical institution); or

(B) any such payments with respect to care or services for any individual who has not attained 65 years of age and who is a patient in an institution for mental diseases.

For purposes of clause (vi) of the preceding sentence, a person shall be considered essential to another individual if such person is the spouse of and is living with such individual, the needs of such person are taken into account in determining the amount of aid or assistance furnished to such individual (under a State plan approved under title I, X, XIV, or XVI), and such person is determined, under such a State plan, to be essential to the well-being of such individual. The payment described in the first sentence may include expenditures for medicare cost-sharing and for premiums under part B of title XVIII for individuals who are eligible for medical assistance under the plan and (A) are receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A of title IV, or with respect to whom supplemental security income benefits are being paid under title XVI, or (B) with respect to whom there is being paid a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in section 1902(a)(10)(A), and, except in the case of individuals 65 years of age or older and disabled individuals entitled to health insurance benefits under title XVIII who are not enrolled under part B of title XVIII, other insurance premiums for medical or any other type of remedial care or the cost thereof. No service (including counseling) shall be excluded from the definition

of “medical assistance” solely because it is provided as a treatment service for alcoholism or drug dependency.

* * * * *

TREATMENT OF INCOME AND RESOURCES FOR CERTAIN INSTITUTIONALIZED SPOUSES

SEC. 1924. (a) SPECIAL TREATMENT FOR INSTITUTIONALIZED SPOUSES.—

(1) * * *

* * * * *

(5) APPLICATION TO INDIVIDUALS RECEIVING SERVICES [FROM ORGANIZATIONS RECEIVING CERTAIN WAIVERS] UNDER PACE PROGRAMS.—This section applies to individuals receiving institutional or noninstitutional services [from any organization receiving a frail elderly demonstration project waiver under section 9412(b) of the Omnibus Budget Reconciliation Act of 1986 or a waiver under section 603(c) of the Social Security Amendments of 1983.] under a PACE demonstration waiver program (as defined in subsection (a)(7) of section 1894) or under a PACE program under section 1932.

* * * * *

SEC. 1932. PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE).

(a) OPTION.—

(1) IN GENERAL.—A State may elect to provide medical assistance under this section with respect to PACE program services to PACE program eligible individuals who are eligible for medical assistance under the State plan and who are enrolled in a PACE program under a PACE program agreement. Such individuals need not be eligible for benefits under part A, or enrolled under part B, of title XVIII to be eligible to enroll under this section.

(2) BENEFITS THROUGH ENROLLMENT IN PACE PROGRAM.—In the case of an individual enrolled with a PACE program pursuant to such an election—

(A) the individual shall receive benefits under the plan solely through such program, and

(B) the PACE provider shall receive payment in accordance with the PACE program agreement for provision of such benefits.

(3) APPLICATION OF DEFINITIONS.—The definitions of terms under section 1894(a) shall apply under this section in the same manner as they apply under section 1894.

(b) APPLICATION OF MEDICARE TERMS AND CONDITIONS.—Except as provided in this section, the terms and conditions for the operation and participation of PACE program eligible individuals in PACE programs offered by PACE providers under PACE program agreements under section 1894 shall apply for purposes of this section.

(c) ADJUSTMENT IN PAYMENT AMOUNTS.—In the case of individuals enrolled in a PACE program under this section, the amount of payment under this section shall not be the amount calculated

under section 1894(d), but shall be an amount, specified under the PACE agreement, which is less than the amount that would otherwise have been made under the State plan if the individuals were not so enrolled. The payment under this section shall be in addition to any payment made under section 1894 for individuals who are enrolled in a PACE program under such section.

(d) WAIVERS OF REQUIREMENTS.—With respect to carrying out a PACE program under this section, the following requirements of this title (and regulations relating to such requirements) shall not apply:

(1) Section 1902(a)(1), relating to any requirement that PACE programs or PACE program services be provided in all areas of a State.

(2) Section 1902(a)(10), insofar as such section relates to comparability of services among different population groups.

(3) Sections 1902(a)(23) and 1915(b)(4), relating to freedom of choice of providers under a PACE program.

(4) Section 1903(m)(2)(A), insofar as it restricts a PACE provider from receiving prepaid capitation payments.

(e) POST-ELIGIBILITY TREATMENT OF INCOME.—A State may provide for post-eligibility treatment of income for individuals enrolled in PACE programs under this section in the same manner as a State treats post-eligibility income for individuals receiving services under a waiver under section 1915(c).

REFERENCES TO LAWS DIRECTLY AFFECTING MEDICAID PROGRAM

SEC. [1932.] 1933. (a) AUTHORITY OR REQUIREMENTS TO COVER ADDITIONAL INDIVIDUALS.—For provisions of law which make additional individuals eligible for medical assistance under this title, see the following:

(1) AFDC.—(A) * * *

* * * * *

INTERNAL REVENUE CODE OF 1986

Subtitle A—Income Taxes

* * * * *

CHAPTER 1—NORMAL TAXES AND SURTAXES

* * * * *

PART III—ITEMS SPECIFICALLY EXCLUDED FROM GROSS INCOME

Sec. 101. Certain death benefits.

* * * * *

[Sec. 138. Cross references to other Acts.]

Sec. 138. MedicarePlus MSA.

Sec. 139. Cross references to other Acts.

* * * * *

SEC. 138. MEDICAREPLUS MSA.

(a) *EXCLUSION.*—Gross income shall not include any payment to the MedicarePlus MSA of an individual by the Secretary of Health and Human Services under part C of title XVIII of the Social Security Act.

(b) *MEDICAREPLUS MSA.*—For purposes of this section, the term “MedicarePlus MSA” means a medical savings account (as defined in section 220(d))—

(1) which is designated as a MedicarePlus MSA,

(2) with respect to which no contribution may be made other than—

(A) a contribution made by the Secretary of Health and Human Services pursuant to part C of title XVIII of the Social Security Act, or

(B) a trustee-to-trustee transfer described in subsection (c)(4),

(3) the governing instrument of which provides that trustee-to-trustee transfers described in subsection (c)(4) may be made to and from such account, and

(4) which is established in connection with an MSA plan described in section 1859(b)(2) of the Social Security Act.

(c) *SPECIAL RULES FOR DISTRIBUTIONS.*—

(1) *DISTRIBUTIONS FOR QUALIFIED MEDICAL EXPENSES.*—In applying section 220 to a MedicarePlus MSA—

(A) qualified medical expenses shall not include amounts paid for medical care for any individual other than the account holder, and

(B) section 220(d)(2)(C) shall not apply.

(2) *PENALTY FOR DISTRIBUTIONS FROM MEDICAREPLUS MSA 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 MedicarePlus 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 such 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 MedicarePlus MSA plan covering the account holder as of January 1 of the calendar year in which the taxable year begins.

Section 220(f)(2) shall not apply to any payment or distribution from a MedicarePlus MSA.

(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 MedicarePlus MSAs 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.—Section 220(f)(2) and paragraph (2) of this subsection shall not apply to any payment or distribution from a MedicarePlus MSA to the Secretary of Health and Human Services of an erroneous contribution to such MSA and of the net income attributable to such contribution.

(4) TRUSTEE-TO-TRUSTEE TRANSFERS.—Section 220(f)(2) and paragraph (2) of this subsection shall not apply to any trustee-to-trustee transfer from a MedicarePlus MSA of an account holder to another MedicarePlus MSA of such account holder.

(d) SPECIAL RULES FOR TREATMENT OF ACCOUNT AFTER DEATH OF ACCOUNT HOLDER.—In applying section 220(f)(8)(A) to an account which was a MedicarePlus MSA of a decedent, the rules of section 220(f) shall apply in lieu of the rules of subsection (c) of this section with respect to the spouse as the account holder of such MedicarePlus MSA.

(e) REPORTS.—In the case of a MedicarePlus MSA, the report under section 220(h)—

(1) shall include the fair market value of the assets in such MedicarePlus MSA as of the close of each calendar year, and

(2) shall be furnished to the account holder—

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

(B) in such manner as the Secretary prescribes in such regulations.

(f) COORDINATION WITH LIMITATION ON NUMBER OF TAXPAYERS HAVING MEDICAL SAVINGS ACCOUNTS.—Subsection (i) of section 220 shall not apply to an individual with respect to a MedicarePlus MSA, and MedicarePlus MSA's shall not be taken into account in determining whether the numerical limitations under section 220(j) are exceeded.

SEC. [138.] 139. CROSS REFERENCES TO OTHER ACTS.

(a) * * *

* * * * *

PART VII—ADDITIONAL ITEMIZED DEDUCTIONS FOR INDIVIDUALS

* * * * *

SEC. 220. MEDICAL SAVINGS ACCOUNTS.

(a) * * *

(b) LIMITATIONS.—

(1) * * *

* * * * *

(7) *MEDICARE ELIGIBLE INDIVIDUALS.*—*The limitation under this subsection for any month with respect to an individual shall be zero for the first month such individual is entitled to benefits under title XVIII of the Social Security Act and for each month thereafter.*

* * * * *

Subchapter F—Exempt Organizations

* * * * *

PART I—GENERAL RULE

* * * * *

SEC. 501. EXEMPTION FROM TAX ON CORPORATIONS, CERTAIN TRUSTS, ETC.

(a) * * *

* * * * *

(o) *TREATMENT OF HOSPITALS PARTICIPATING IN PROVIDER-SPONSORED ORGANIZATIONS.*—*An organization shall not fail to be treated as organized and operated exclusively for a charitable purpose for purposes of subsection (c)(3) solely because a hospital which is owned and operated by such organization participates in a provider-sponsored organization (as defined in section 1853(e) of the Social Security Act), whether or not the provider-sponsored organization is exempt from tax. For purposes of subsection (c)(3), any person with a material financial interest in such a provider-sponsored organization shall be treated as a private shareholder or individual with respect to the hospital.*

[(o)] (p) **CROSS REFERENCE.**—

For nonexemption of Communist-controlled organizations, see section 11(b) of the Internal Security Act of 1950 (64 Stat. 997; 50 U.S.C. 790(b)).

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Subtitle D—Miscellaneous Excise Taxes

* * * * *

CHAPTER 43—QUALIFIED PENSIONS, ETC., PLANS

* * * * *

SEC. 4973. TAX ON EXCESS CONTRIBUTIONS TO INDIVIDUAL RETIREMENT ACCOUNTS, MEDICAL SAVINGS ACCOUNTS, CERTAIN SECTION 403(B) CONTRACTS, AND CERTAIN INDIVIDUAL RETIREMENT ANNUITIES.

(a) * * *

* * * * *

(d) EXCESS CONTRIBUTIONS TO MEDICAL SAVINGS ACCOUNTS.—
For purposes of this section, in the case of medical savings accounts
(within the meaning of section 220(d)), the term “excess contribu-
tions” means the sum of—

(1) * * *

* * * * *

For purposes of this subsection, any contribution which is distrib-
uted out of the medical savings account in a distribution to which
section 220(f)(3) or section 138(c)(3) applies shall be treated as an
amount not contributed.

Subtitle F—Procedure and Administration

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CHAPTER 61—INFORMATION AND RETURNS

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Subchapter B—Miscellaneous Provisions

* * * * *

SEC. 6103. CONFIDENTIALITY AND DISCLOSURE OF RETURNS AND RE- TURN INFORMATION.

(a) * * *

* * * * *

(1) DISCLOSURE OF RETURNS AND RETURN INFORMATION FOR PUR-
POSES OTHER THAN TAX ADMINISTRATION.—

(1) * * *

* * * * *

(12) DISCLOSURE OF CERTAIN TAXPAYER IDENTITY INFORMA-
TION FOR VERIFICATION OF EMPLOYMENT STATUS OF MEDICARE
BENEFICIARY AND SPOUSE OF MEDICARE BENEFICIARY.—

(A) * * *

* * * * *

[(F) TERMINATION.—Subparagraphs (A) and (B) shall not
apply to—

[(i) any request made after September 30, 1998, and

[(ii) any request made before such date for informa-
tion relating to—

[(I) 1997 or thereafter in the case of subpara-
graph (A), or

[(II) 1998 or thereafter in the case of subpara-
graph (B).]

* * * * *



**SECTION 9412 OF THE OMNIBUS BUDGET
RECONCILIATION ACT OF 1986**

**SEC. 9412. WAIVER AUTHORITY FOR CHRONICALLY MENTALLY ILL
AND FRAIL ELDERLY.**

(a) * * *

[(b) FRAIL ELDERLY DEMONSTRATION PROJECT WAIVERS.—

[(1) The Secretary of Health and Human Services shall grant waivers of certain requirements of titles XVIII and XIX of the Social Security Act to not more than 10 public or non-profit private community-based organizations to enable such organizations to provide comprehensive health care services on a capitated basis to frail elderly patients at risk of institutionalization.

[(2)(A) Except as provided in subparagraph (B), the terms and conditions of a waiver granted pursuant to this subsection shall be substantially the same as the terms and conditions of the On Lok waiver (referred to in section 603(c) of the Social Security Amendments of 1983 and extended by section 9220 of the Consolidated Omnibus Budget Reconciliation Act of 1985), including permitting the organization to assume progressively (over the initial 3-year period of the waiver) the full financial risk.

[(B) In order to receive a waiver under this subsection, an organization must participate in an organized initiative to replicate the findings of the On Lok long-term care demonstration project (described in section 603(c)(1) of the Social Security Amendments of 1983).

[(C) Subject to subparagraph (B), any waiver granted pursuant to this subsection shall be for an initial period of 3 years. The Secretary may extend such waiver beyond such initial period for so long as the Secretary finds that the organization complies with the terms and conditions described in subparagraphs (A) and (B).]

**SECTION 603 OF THE SOCIAL SECURITY AMENDMENTS
OF 1983**

REPORTS, EXPERIMENTS, AND DEMONSTRATION PROJECTS

SEC. 603. (a) * * *

* * * * *

[(c) The Secretary shall approve, with appropriate terms and conditions as defined by the Secretary, within 30 days after the date of enactment of this Act—

[(1) the risk-sharing application of On Lok Senior Health Services (according to terms and conditions as specified by the Secretary), dated July 2, 1982, for waivers, pursuant to section 222 of the Social Security Amendments of 1972 and section 402(a) of the Social Security Amendments of 1967, of certain requirements of title XVIII of the Social Security Act over a period of 36 months in order to carry out a long-term care demonstration project, and

【(2) the application of the Department of Health Services, State of California, dated November 1, 1982, pursuant to section 1115 of the Social Security Act, for the waiver of certain requirements of title XIX of such Act over a period of 36 months in order to carry out a demonstration project for capitated reimbursement for comprehensive long-term care services involving On Lok Senior Health Services.】

* * * * *

**THE CONSOLIDATED OMNIBUS BUDGET
RECONCILIATION ACT OF 1985**

* * * * *

**TITLE IX—MEDICARE, MEDICAID, AND
MATERNAL AND CHILD HEALTH PRO-
GRAMS**

* * * * *

**PART 2—Provisions Relating to Parts A and B of
Medicare**

* * * * *

Subpart B—Other Provisions

* * * * *

**SEC. 9215. EXTENSION OF CERTAIN MEDICARE MUNICIPAL HEALTH
SERVICES DEMONSTRATION PROJECTS.**

(a) The Secretary of Health and Human Services shall extend through December 31, 1997, approval of four municipal health services demonstration projects (located in Baltimore, Cincinnati, Milwaukee, and San Jose) authorized under section 402(a) of the Social Security Amendments of 1967. The Secretary shall submit a report to Congress on the waiver program with respect to the quality of health care, beneficiary costs, costs to the medicaid program and other payers, access to care, outcomes, beneficiary satisfaction, utilization differences among the different populations served by the projects, and such other factors as may be appropriate. *Subject to subsection (c), the Secretary may further extend such demonstration projects through December 31, 2000, but only with respect to individuals enrolled with such projects before January 1, 1998.*

(b) *The Secretary shall work with each such demonstration project to develop a plan, to be submitted to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate by March 31, 1998, for the orderly transition of demonstration projects and the project enrollees to a non-demonstration project health care delivery system, such as through integration with private or public health plan, including a medicaid managed care or MedicarePlus plan.*

(c) A demonstration project under subsection (a) which does not develop and submit a transition plan under subsection (b) by March 31, 1998, or, if later, 6 months after the date of the enactment of this Act, shall be discontinued as of December 31, 1998. The Secretary shall provide appropriate technical assistance to assist in the transition so that disruption of medical services to project enrollees may be minimized.

* * * * *

[SEC. 9220. EXTENSION OF ON LOK WAIVER.

[(a) CONTINUED APPROVAL.—

[(1) MEDICARE WAIVERS.—Notwithstanding any limitations contained in section 222 of the Social Security Amendments of 1972 and section 402(a) of the Social Security Amendments of 1967, the Secretary of Health and Human Services shall continue approval of the risk-sharing application (described in section 603(c)(1) of Public Law 98–21) for waivers of certain requirements of title XVIII of the Social Security Act after the end of the period described in that section.

[(2) MEDICAID WAIVERS.—Notwithstanding any limitations contained in section 1115 of the Social Security Act, the Secretary shall approve any application of the Department of Health Services, State of California, for a waiver of requirements of title XIX of such Act in order to continue carrying out the demonstration project referred to in section 603(c)(2) of Public Law 98–21 after the end of the period described in that section.

[(b) TERMS, CONDITIONS, AND PERIOD OF APPROVAL.—The Secretary’s approval of an application (or renewal of an application) under this section—

[(1) shall be on the same terms and conditions as applied with respect to the corresponding application under section 603(c) of Public Law 98–21 as of July 1, 1985, except that requirements relating to collection and evaluation of information for demonstration purposes (and not for operational purposes) shall not apply; and

[(2) shall remain in effect until such time as the Secretary finds that the applicant no longer complies with the terms and conditions described in paragraph (1).]

* * * * *

SECTION 4018 OF THE OMNIBUS BUDGET RECONCILIATION ACT OF 1987

SEC. 4018. SPECIAL RULES.

(a) * * *

(b) **EXTENSION OF WAIVERS FOR SOCIAL HEALTH MAINTENANCE ORGANIZATIONS.—**

(1) The Secretary of Health and Human Services shall extend without interruption, through December 31, **[1997] 2000**, the approval of waivers granted under subsection (a) of section 2355 of the Deficit Reduction Act of 1984 for the demonstration project described in subsection (b) of that section, subject to the

terms and conditions (other than duration of the project) established under that section (as amended by paragraph (2) of this subsection).

(2) * * *

* * * * *

(4) The Secretary of Health and Human Services shall submit a second interim report to the Congress on the project referred to in paragraph (1) not later than March 31, 1993, and shall submit a final report on the demonstration projects conducted under section 2355 of the Deficit Reduction Act of 1984 not later than March 31, [1998] 2001.

* * * * *

THE OMNIBUS BUDGET RECONCILIATION ACT OF 1993

* * * * *

TITLE XIII—REVENUE, HEALTH CARE, HUMAN RESOURCES, INCOME SECURITY, CUSTOMS AND TRADE, FOOD STAMP PROGRAM, AND TIMBER SALE PROVISIONS

* * * * *

CHAPTER 2—HEALTH CARE, HUMAN RESOURCES, INCOME SECURITY, AND CUSTOMS AND TRADE PROVISIONS

Subchapter A—Medicare

* * * * *

PART I—PROVISIONS RELATING TO PART A

SEC. 13501. PAYMENTS FOR PPS HOSPITALS.

(a) * * *

* * * * *

(e) EXTENSION FOR MEDICARE-DEPENDENT, SMALL RURAL HOSPITALS.—

(1) * * *

(2) PERMITTING HOSPITALS TO DECLINE RECLASSIFICATION.—If any hospital fails to qualify as a medicare-dependent, small rural hospital under section 1886(d)(5)(G)(i) of the Social Security Act as a result of a decision by the Medicare Geographic Classification Review Board under section 1886(d)(10) of such Act to reclassify the hospital as being located in an urban area for fiscal year 1993 [or fiscal year 1994] , *fiscal year 1994, fiscal year 1998, fiscal year 1999, or fiscal year 2000*, the Secretary of Health and Human Services shall—

(A) * * *

* * * * *

PART III—PROVISIONS RELATING TO PARTS A AND B

* * * * *

SEC. 13567. EXTENSION OF SOCIAL HEALTH MAINTENANCE ORGANIZATION DEMONSTRATIONS.

(a) * * *

* * * * *

(c) **EXPANSION OF NUMBER OF MEMBERS PER SITE.**—The Secretary of Health and Human Services may not impose a limit of less than **[12,000] 24,000** on the number of individuals that may participate in a project conducted under section 2355 of the Deficit Reduction Act of 1984.

* * * * *

SECTION 6011 OF THE OMNIBUS BUDGET RECONCILIATION ACT OF 1989

SEC. 6011. PASS THROUGH PAYMENT FOR HEMOPHILIA INPATIENTS.

(a) * * *

* * * * *

(d) **EFFECTIVE DATE.**—The amendments made by subsection (a) shall apply with respect to items furnished 6 months after the date of enactment of this Act **[and shall expire September 30, 1994].**

SOCIAL SECURITY ACT

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TITLE XI—GENERAL PROVISIONS, PEER REVIEW, AND ADMINISTRATIVE SIMPLIFICATION

PART A—GENERAL PROVISIONS

DEFINITIONS

SEC. 1101. (a) When used in this Act—

(1) The term “State”, except where otherwise provided, includes the District of Columbia and the Commonwealth of Puerto Rico, and when used in titles IV, V, VII, XI, **[and XIX] XIX, and XXI** includes the Virgin Islands and Guam. Such term when used in titles III, IX, and XII also includes the Virgin Islands. Such term when used in title V and in part B of this title also includes American Samoa, the Northern Mariana Islands, and the Trust Territory of the Pacific Islands. Such term when used in **[title XIX] titles XIX and XXI** also includes the Northern Mariana Islands and American Samoa. In the case of Puerto Rico, the Virgin Islands, and Guam, titles I, X, and XIV, and title XVI (as in effect without regard to the amendment made by section 301 of the Social Security Amend-

ments of 1972) shall continue to apply, and the term “State” when used in such titles (but not in title XVI as in effect pursuant to such amendment after December 31, 1973) includes Puerto Rico, the Virgin Islands, and Guam. Such term when used in title XX also includes the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands. Such term when used in title IV also includes American Samoa.

* * * * *

TITLE XIX—GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

* * * * *

STATE PLANS FOR MEDICAL ASSISTANCE

SEC. 1902. (a) A State plan for medical assistance must—

(1) * * *

* * * * *

(47) at the option of the State, provide for making ambulatory prenatal care available to pregnant women during a presumptive eligibility period in accordance with section 1920 and provide for making medical assistance for items and services described in subsection (a) of section 1920A available to children during a presumptive eligibility period in accordance with such section;

* * * * *

PAYMENT TO STATES

SEC. 1903. (a) * * *

* * * * *

(u)(1)(A) * * *

* * * * *

(D)(i) * * *

* * * * *

(v) In determining the amount of erroneous excess payments, there shall not be included any erroneous payments made for ambulatory prenatal care provided during a presumptive eligibility period (as defined in section 1920(b)(1)) or for items and services described in subsection (a) of section 1920A provided to a child during a presumptive eligibility period under such section.

* * * * *

DEFINITIONS

SEC. 1905. For purposes of this title—

(a) * * *

(b) The term “Federal medical assistance percentage” for any State shall be 100 per centum less the State percentage; and the State percentage shall be that percentage which bears the same ratio to 45 per centum as the square of the per capita income of such State bears to the square of the per capita income of the con-

tinental United States (including Alaska) and Hawaii; except that (1) the Federal medical assistance percentage shall in no case be less than 50 per centum or more than 83 per centum, and (2) the Federal medical assistance percentage for Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa shall be 50 per centum. The Federal medical assistance percentage for any State shall be determined and promulgated in accordance with the provisions of section 1101(a)(8)(B). Notwithstanding the first sentence of this section, the Federal medical assistance percentage shall be 100 per centum with respect to amounts expended as medical assistance for services which are received through an Indian Health Service facility whether operated by the Indian Health Service or by an Indian tribe or tribal organization (as defined in section 4 of the Indian Health Care Improvement Act). *Notwithstanding the first sentence of this subsection, in the case of a State plan that meets the condition described in subsection (t)(1), with respect to expenditures for medical assistance for optional targeted low-income children described in subsection (t)(2), the Federal medical assistance percentage is equal to the enhanced medical assistance percentage described in subsection (t)(3).*

* * * * *

(t)(1) The conditions described in this paragraph for a State plan are as follows:

(A) The plan is not applying income and resource standards and methodologies for the purpose of determining eligibility of individuals under section 1902(l) that are more restrictive than those applied as of June 1, 1997, for the purpose of determining eligibility of individuals under such section.

(B) The plan provides for such reporting of information about expenditures and payments attributable to the operation of this subsection as the Secretary deems necessary in order to carry out sections 2103(d) and 2104(b)(2).

(C) The amount of the increased payments under section 1903(a) resulting from the application of this subsection does not exceed the total amount of any allotment not otherwise expended by the State under section 2103 for the period involved.

(2) For purposes of subsection (b), the term 'optional targeted low-income child' means a targeted low-income child described in section 2108(b)(1) who would not qualify for medical assistance under the State plan under this title based on such plan as in effect on June 1, 1997 (taking into account the process of individuals aging into eligibility under section 1902(l)(2)(D)).

(3) The enhanced medical assistance percentage described in this paragraph for a State is equal to the Federal medical assistance percentage (as defined in the first sentence of subsection (b)) for the State increased by a number of percentage points equal to 30 per cent of the number of percentage points by which (A) such Federal medical assistance percentage for the State, is less than (B) 100 per cent.

(4) Notwithstanding any other provision of this title, a State plan under this title may impose a limit on the number of optional targeted low-income children described in paragraph (2). The previous

sentence shall not be construed as applying to any child to whom the State is required to provide medical assistance under this title.

* * * * *

PRESUMPTIVE ELIGIBILITY FOR CHILDREN

SEC. 1920A. (a) A State plan approved under section 1902 may provide for making medical assistance with respect to health care items and services covered under the State plan available to a child during a presumptive eligibility period.

(3) In the case of a child who is determined by a qualified entity to be presumptively eligible for medical assistance under a State plan, the parent, guardian, or other person shall make application on behalf of the child for medical assistance under such plan by not later than the last day of the month following the month during which the determination is made, which application may be the application used for the receipt of medical assistance by individuals described in section 1902(l)(1).

(d) Notwithstanding any other provision of this title, medical assistance for items and services described in subsection (a) that—

(1) are furnished to a child—

(A) during a presumptive eligibility period,

(B) by a entity that is eligible for payments under the State plan; and

(2) are included in the care and services covered by a State plan;

shall be treated as medical assistance provided by such plan for purposes of section 1903.

* * * * *

TITLE XXI—CHILD HEALTH ASSISTANCE PROGRAM

SEC. 2101. PURPOSE; STATE CHILD HEALTH PLANS.

(a) PURPOSE.—The purpose of this title is to provide funds to States to enable them to implement plans to initiate and expand the provision of child health care assistance to uninsured, low-income children in an effective and efficient manner that is coordinated with other sources of coverage for children. Such assistance may be provided for obtaining creditable health coverage through methods specified in the plan, which may include any or all of the following:

(1) Providing benefits under the State’s medicaid plan under title XIX.

(2) Obtaining coverage under group health plans or group or individual health insurance coverage.

(3) Direct purchase of services from providers.

(4) Other methods specified under the plan.

(b) STATE CHILD HEALTH PLAN REQUIRED.—A State is not eligible for payment under section 2104 unless the State has submitted to the Secretary under section 2105 a plan that—

(1) sets forth how the State intends to use the funds provided under this title to provide child health assistance to needy children consistent with the provisions of this title, and

(2) is approved under section 2105.

(c) *STATE ENTITLEMENT.*—This title constitutes budget authority in advance of appropriations Acts and represents the obligation of the Federal Government to provide for the payment to States of amounts provided under section 2104.

(d) *EFFECTIVE DATE.*—No State is eligible for payments under section 2104 for any calendar quarter beginning before October 1, 1997.

SEC. 2102. CONTENTS OF STATE CHILD HEALTH PLAN.

(a) *GENERAL BACKGROUND AND DESCRIPTION.*—A State child health plan shall include a description, consistent with the requirements of this title, of—

(1) the extent to which, and manner in which, children in the State, including targeted low-income children and other classes of children classified by income and other relevant factors, currently have creditable health coverage (as defined in section 2108(c)(2));

(2) current State efforts to provide or obtain creditable health coverage for uncovered children, including the steps the State is taking to identify and enroll all uncovered children who are eligible to participate in public health insurance programs and health insurance programs that involve public-private partnerships;

(3) how the plan is designed to be coordinated with such efforts to increase coverage of children under creditable health coverage; and

(4) how the plan will comply with subsection (c)(5).

(b) *GENERAL DESCRIPTION OF ELIGIBILITY STANDARDS AND METHODOLOGY.*—

(1) *ELIGIBILITY STANDARDS.*—

(A) *IN GENERAL.*—The plan shall include a description of the standards used to determine the eligibility of targeted low-income children for child health assistance under the plan. Such standards may include (to the extent consistent with this title) those relating to the geographic areas to be served by the plan, age, income and resources (including any standards relating to spenddowns and disposition of resources), residency, disability status, immigration status, access to or coverage under other health coverage, and duration of eligibility. Such standards may not discriminate on the basis of diagnosis.

(B) *LIMITATIONS ON ELIGIBILITY STANDARDS.*—Such eligibility standards—

(i) shall, within any defined group of covered targeted low-income children, not cover such children with higher family income without covering children with a lower family income, and

(ii) may not deny eligibility based on a child having a preexisting medical condition.

(2) *METHODOLOGY.*—The plan shall include a description of methods of establishing and continuing eligibility and enrollment, including a methodology for computing family income that is consistent with the methodology used under section 1902(l)(3)(E).

(3) *ELIGIBILITY SCREENING; COORDINATION WITH OTHER HEALTH COVERAGE PROGRAMS.*—The plan shall include a description of procedures to be used to ensure—

(A) through both intake and followup screening, that only targeted low-income children are furnished child health assistance under the State child health plan;

(B) that children found through the screening to be eligible for medical assistance under the State medicaid plan under title XIX are enrolled for such assistance under such plan;

(C) that the insurance provided under the State child health plan does not substitute for coverage under group health plans; and

(D) coordination with other public and private programs providing creditable coverage for low-income children.

(4) *NONENTITLEMENT.*—Nothing in this title shall be construed as providing an individual with an entitlement to child health assistance under a State child health plan.

(c) *DESCRIPTION OF ASSISTANCE.*—

(1) *IN GENERAL.*—A State child health plan shall include a description of the child health assistance provided under the plan for targeted low-income children. The child health assistance provided to a targeted low-income child under the plan in the form described in paragraph (1) or (2) of section 2101(a) shall include benefits (in an amount, duration, and scope specified under the plan) for at least the following categories of services:

(A) Inpatient and outpatient hospital services.

(B) Physicians' surgical and medical services.

(C) Laboratory and x-ray services.

(D) Well-baby and well-child care, including age-appropriate immunizations.

The previous sentence shall not apply to coverage under a group health plan if the benefits under such coverage for individuals under this title are no less than the benefits for other individuals similarly covered under the plan.

(2) *ITEMS.*—The description shall include the following:

(A) *COST SHARING.*—Subject to paragraph (3), the amount (if any) of premiums, deductibles, coinsurance, and other cost sharing imposed.

(B) *DELIVERY METHOD.*—The State's approach to delivery of child health assistance, including a general description of—

(i) the use (or intended use) of different delivery methods, which may include the delivery methods used under the medicaid plan under title XIX, fee-for-service, managed care arrangements (such as capitated health care plans, case management, and case coordination), direct provision of health care services (such as through community health centers and disproportionate share hospitals), vouchers, and other delivery methods; and

(ii) utilization control systems.

(3) *LIMITATIONS ON COST SHARING.*—

(A) *NO COST SHARING ON PREVENTIVE BENEFITS.*—The plan may not impose deductibles, coinsurance, or similar cost sharing with respect to benefits for preventive services.

(B) *SLIDING SCALE.*—To the extent practicable, any premiums imposed under the plan shall be imposed on a sliding scale related to income and the plan may only vary premiums, deductibles, coinsurance, and other cost sharing based on the family income of targeted low-income children only in a manner that does not favor children from families with higher income over children from families with lower income.

(4) *RESTRICTION ON APPLICATION OF PREEXISTING CONDITION EXCLUSIONS.*—

(A) *IN GENERAL.*—Subject to subparagraph (B), the State child health plan shall not permit the imposition of any preexisting condition exclusion for covered benefits under the plan.

(B) *GROUP HEALTH PLANS AND GROUP HEALTH INSURANCE COVERAGE.*—If the State child health plan provides for benefits through payment for, or a contract with, a group health plan or group health insurance coverage, the plan may permit the imposition of a preexisting condition exclusion but only insofar as it is permitted under the applicable provisions of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 and title XXVII of the Public Health Service Act.

(5) *SPECIAL PROTECTION FOR CHILDREN WITH CHRONIC HEALTH CONDITIONS AND SPECIAL HEALTH CARE NEEDS.*—In the case of a child who has a chronic condition, life-threatening condition, or combination of conditions that warrants medical specialty care and who is eligible for benefits under the plan with respect to such care, the State child health plan shall assure access to such care, including the use of a medical specialist as a primary care provider.

(6) *SECONDARY PAYMENT.*—Nothing in this section shall be construed as preventing a State from denying benefits to an individual to the extent such benefits are available to the individual under another public or private health care insurance program.

(7) *TREATMENT OF CASH PAYMENTS.*—Payments in the form of cash or vouchers provided as child health or other assistance under the State child health plan to parents, guardians or other caretakers of a targeted low-income child are not considered income for purpose of eligibility for, or benefits provided under, any means-tested Federal or Federally-assisted program.

(d) *OUTREACH AND COORDINATION.*—A State child health plan shall include a description of the procedures to be used by the State to accomplish the following:

(1) *OUTREACH.*—Outreach to families of children likely to be eligible for child health assistance under the plan or under other public or private health coverage programs to inform these families of the availability of, and to assist them in enrolling their children in, such a program.

(2) *COORDINATION WITH OTHER HEALTH INSURANCE PROGRAMS.*—Coordination of the administration of the State program under this subtitle with other public and private health insurance programs.

SEC. 2103. ALLOTMENTS.

(a) *TOTAL ALLOTMENT.*—The total allotment that is available under this title for each fiscal year, beginning with fiscal year 1998, is \$2,880,000,000.

(b) *ALLOTMENTS TO 50 STATES AND DISTRICT OF COLUMBIA.*—

(1) *IN GENERAL.*—Subject to paragraphs (4) and (5), of the total allotment available under subsection (a) for a fiscal year, reduced by the amount of allotments made under subsection (c) for the fiscal year, the Secretary shall allot to each State (other than a State described in such subsection) with a State child health plan approved under this title the same proportion as the ratio of—

(A) the product of (i) the number of uncovered low-income children for the fiscal year in the State (as determined under paragraph (2)) and (ii) the State cost factor for that State (established under paragraph (3)); to

(B) the sum of the products computed under subparagraph (A).

(2) *NUMBER OF UNCOVERED LOW-INCOME CHILDREN.*—For the purposes of paragraph (1)(A)(i), the number of uncovered low-income children for a fiscal year in a State is equal to the arithmetic average of the number of low-income children (as defined in section 2108(c)(4)) with no health insurance coverage, as reported and defined in the three most recent March supplements to the Current Population Survey of the Bureau of the Census before the beginning of the fiscal year.

(3) *ADJUSTMENT FOR GEOGRAPHIC VARIATIONS IN HEALTH COSTS.*—

(A) *IN GENERAL.*—For purposes of paragraph (1)(A)(ii), the “State cost factor” for a State for a fiscal year equal to the sum of—

(i) 0.15, and

(ii) 0.85 multiplied by the ratio of—

(I) the annual average wages per employee for the State for such year (as determined under subparagraph (B)), to

(II) the annual average wages per employee for the 50 States and the District of Columbia.

(B) *ANNUAL AVERAGE WAGES PER EMPLOYEE.*—For purposes of subparagraph (A), the “annual average wages per employee” for a State, or for all the States, for a fiscal year is equal to the average of the annual wages per employee for the State or for the 50 States and the District of Columbia for employees in the health services industry (SIC code 8000), as reported by the Bureau of Labor Statistics of the Department of Labor for each of the most recent 3 years before the beginning of the fiscal year involved.

(4) *FLOOR FOR STATES.*—Subject to paragraph (5), in no case shall the amount of the allotment under this subsection for one of the 50 States or the District of Columbia for a year be less

than \$2,000,000. To the extent that the application of the previous sentence results in an increase in the allotment to a State above the amount otherwise provided, the allotments for the other States and the District of Columbia under this subsection shall be decreased in a pro rata manner (but not below \$2,000,000) so that the total of such allotments in a fiscal year does not exceed the amount otherwise provided for allotment under paragraph (1) for that fiscal year.

(5) *OFFSET FOR EXPENDITURES UNDER MEDICAID PRESUMPTIVE ELIGIBILITY.*—The amount of the allotment otherwise provided to a State under this subsection for a fiscal year shall be reduced by the amount of the payments made to the State under section 1903(a) for calendar quarters during such fiscal year that are attributable to provision of medical assistance to a child during a presumptive eligibility period under section 1920A.

(c) *ALLOTMENTS TO TERRITORIES.*—

(1) *IN GENERAL.*—Subject to paragraph (3), of the total allotment under subsection (a) for a fiscal year, the Secretary shall allot 0.5 percent among each of the commonwealths and territories described in paragraph (4) in the same proportion as the percentage specified in paragraph (2) for such commonwealth or territory bears to the sum of such percentages for all such commonwealths or territories so described.

(2) *PERCENTAGE.*—The percentage specified in this paragraph for—

- (A) Puerto Rico is 91.6 percent,
- (B) Guam is 3.5 percent,
- (C) Virgin Islands is 2.6 percent,
- (D) American Samoa is 1.2 percent, and
- (E) the Northern Mariana Islands is 1.1 percent.

(3) *FLOOR.*—In no case shall the amount of the allotment health plan that meets the applicable requirements of this title.

(2) *APPROVAL.*—Except as the Secretary may provide under subsection (e), a State plan submitted under paragraph (1)—

- (A) shall be approved for purposes of this title, and
- (B) shall be effective beginning with a calendar quarter that is specified in the plan, but in no case earlier than the first calendar quarter that begins at least 60 days after the date the plan is submitted.

(b) *PLAN AMENDMENTS.*—

(1) *IN GENERAL.*—A State may amend, in whole or in part, its State child health plan at any time through transmittal of a plan amendment.

(2) *APPROVAL.*—except as the secretary may provide under subsection (e), an amendment to a state plan submitted under paragraph (1)—

- (A) shall be approved for purposes of this title, and
- (B) shall be effective as provided in paragraph (3).

(3) *EFFECTIVE DATES FOR AMENDMENTS.*—

(A) *IN GENERAL.*—Subject to the succeeding provisions of this paragraph, an amendment to a State plan shall take effect on one or more effective dates specified in the amendment.

(B) AMENDMENTS RELATING TO ELIGIBILITY OR BENEFITS.—

(i) **NOTICE REQUIREMENT.**—Any plan amendment that eliminates or restricts eligibility or benefits under the plan may not take effect unless the State certifies that it has provided prior or contemporaneous public notice of the change, in a form and manner provided under applicable State law.

(ii) **TIMELY TRANSMITTAL.**—Any plan amendment that eliminates or restricts eligibility or benefits under the plan shall not be effective for longer than a 60-day period unless the amendment has been transmitted to the Secretary before the end of such period.

(C) **OTHER AMENDMENTS.**—Any plan amendment that is not described in subparagraph (C) becomes effective in a State fiscal year may not remain in effect after the end of such fiscal year (or, if later, the end of the 90-day period on which it becomes effective) unless the amendment has been transmitted to the Secretary.

(c) DISAPPROVAL OF PLANS AND PLAN AMENDMENTS.—

(1) **PROMPT REVIEW OF PLAN SUBMITTALS.**—The Secretary shall promptly review State plans and plan amendments submitted under this section to determine if they substantially comply with the requirements of this title.

(2) **90-DAY APPROVAL DEADLINES.**—A State plan or plan amendment is considered approved unless the Secretary notifies the State in writing, within 90 days after receipt of the plan or amendment, that the plan or amendment is disapproved (and the reasons for disapproval) or that specified additional information is needed.

(3) **CORRECTION.**—In the case of a disapproval of a plan or plan amendment, the Secretary shall provide a State with a reasonable opportunity for correction before taking financial sanctions against the State on the basis of such disapproval.

(d) PROGRAM OPERATION.—

(1) **IN GENERAL.**—The State shall conduct the program in accordance with the plan (and any amendments) approved under subsection (c) and with the requirements of this title.

(2) **VIOLATIONS.**—The Secretary shall establish a process for enforcing requirements under this title. Such process shall provide for the withholding of funds in the case of substantial noncompliance with such requirements. In the case of an enforcement action against a State under this paragraph, the Secretary shall provide a State with a reasonable opportunity for correction before taking financial sanctions against the State on the basis of such an action.

(e) **CONTINUED APPROVAL.**—An approved State child health plan shall continue in effect unless and until the State amends the plan under subsection (b) or the Secretary finds substantial noncompliance of the plan with the requirements of this title under section subsection (d)(2).

SEC. 2106. STRATEGIC OBJECTIVES AND PERFORMANCE GOALS; PLAN ADMINISTRATION.**(a) STRATEGIC OBJECTIVES AND PERFORMANCE GOALS.—**

(1) *DESCRIPTION.*—A State child health plan shall include a description of—

- (A) the strategic objectives,
- (B) the performance goals, and
- (C) the performance measures,

the State has established for providing child health assistance to targeted low-income children under the plan and otherwise for maximizing health coverage for other low-income children and children generally in the State.

(2) *STRATEGIC OBJECTIVES.*—Such plan shall identify specific strategic objectives relating to increasing the extent of creditable health coverage among targeted low-income children and other low-income children.

(3) *PERFORMANCE GOALS.*—Such plan shall specify one or more performance goals for each such strategic objective so identified.

(4) *PERFORMANCE MEASURES.*—Such plan shall describe how performance under the plan will be—

- (A) measured through objective, independently verifiable means, and
- (B) compared against performance goals, in order to determine the State's performance under this title.

(b) *RECORDS, REPORTS, AUDITS, AND EVALUATION.*—

(1) *DATA COLLECTION, RECORDS, AND REPORTS.*—A State child health plan shall include an assurance that the State will collect the data, maintain the records, and furnish the reports to the Secretary, at the times and in the standardized format the Secretary may require in order to enable the Secretary to monitor State program administration and compliance and to evaluate and compare the effectiveness of State plans under this title.

(2) *STATE ASSESSMENT AND STUDY.*—A State child health plan shall include a description of the State's plan for the annual assessments and reports under section 2107(a) and the evaluation required by section 2107(b).

(3) *AUDITS.*—A State child health plan shall include an assurance that the State will afford the Secretary access to any records or information relating to the plan for the purposes of review or audit.

(c) *PROGRAM DEVELOPMENT PROCESS.*—A State child health plan shall include a description of the process used to involve the public in the design and implementation of the plan and the method for ensuring ongoing public involvement.

(d) *PROGRAM BUDGET.*—A State child health plan shall include a description of the budget for the plan. The description shall be updated periodically as necessary and shall include details on the planned use of funds and the sources of the non-Federal share of plan expenditures, including any requirements for cost sharing by beneficiaries.

(e) *APPLICATION OF CERTAIN GENERAL PROVISIONS.*—The following sections in part A of title XI shall apply to States under this title in the same manner as they applied to a State under title XIX:

- (1) Section 1101(a)(1) (relating to definition of State).

(2) Section 1116 (relating to administrative and judicial review), but only insofar as consistent with the provisions of part B.

(3) Section 1124 (relating to disclosure of ownership and related information).

(4) Section 1126 (relating to disclosure of information about certain convicted individuals).

(5) Section 1128B(d) (relating to criminal penalties for certain additional charges).

(6) Section 1132 (relating to periods within which claims must be filed).

SEC. 2107. ANNUAL REPORTS; EVALUATIONS.

(a) **ANNUAL REPORT.**—The State shall—

(1) assess the operation of the State plan under this title in each fiscal year, including the progress made in reducing the number of uncovered low-income children; and

(2) report to the Secretary, by January 1 following the end of the fiscal year, on the result of the assessment.

(b) **STATE EVALUATIONS.**—

(1) **IN GENERAL.**—By March 31, 2000, each State that has a State child health plan shall submit to the Secretary an evaluation that includes each of the following:

(A) An assessment of the effectiveness of the State plan in increasing the number of children with creditable health coverage.;

(B) A description and analysis of the effectiveness of elements of the State plan, including—

(i) the characteristics of the children and families assisted under the State plan including age of the children, family income, and the assisted child's access to or coverage by other health insurance prior to the State plan and after eligibility for the State plan ends,

(ii) the quality of health coverage provided including the types of benefits provided,

(iii) the amount and level (payment of part or all of the premium) of assistance provided by the State,

(iv) the service area of the State plan,

(v) the time limits for coverage of a child under the State plan,

(vi) the State's choice of health insurance plans and other methods used for providing child health assistance, and

(vii) the sources of non-Federal funding used in the State plan;

(C) an assessment of the effectiveness of other public and private programs in the State in increasing the availability of affordable quality individual and family health insurance for children;

(D) a review and assessment of State activities to coordinate the plan under this title with other public and private programs providing health care and health care financing, including Medicaid and maternal and child health services;

(E) an analysis of changes and trends in the State that affect the provision of accessible, affordable, quality health insurance and health care to children;

(F) a description of any plans the State has for improving the availability of health insurance and health care for children;

(G) recommendations for improving the program under this title; and

(H) any other matters the State and the Secretary consider appropriate.

(2) *REPORT OF THE SECRETARY.*—The Secretary shall submit to the Congress and make available to the public by December 31, 2000, a report based on the evaluations submitted by States under paragraph (1), containing any conclusions and recommendations the Secretary considers appropriate.

SEC. 2108. DEFINITIONS.

(a) *CHILD HEALTH ASSISTANCE.*—For purposes of this title, the term “child health assistance” means payment of part or all of the cost of any of the following, or assistance in the purchase, in whole or in part, of health benefit coverage that includes any of the following, for targeted low-income children (as defined in subsection (b)) as specified under the State plan:

(1) Inpatient hospital services.

(2) Outpatient hospital services.

(3) Physician services.

(4) Surgical services.

(5) Clinic services (including health center services) and other ambulatory health care services.

(6) Prescription drugs and biologicals and the administration of such drugs and biologicals, only if such drugs and biologicals are not furnished for the purpose of causing, or assisting in causing, the death, suicide, euthanasia, or mercy killing of a person.

(7) Over-the-counter medications.

(8) Laboratory and radiological services.

(9) Prenatal care and pre-pregnancy family planning services and supplies.

(10) Inpatient mental health services, including services furnished in a State-operated mental hospital and including residential or other 24-hour therapeutically planned structured services.

(11) Outpatient mental health services, including services furnished in a State-operated mental hospital and including community-based services.

(12) Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices).

(13) Disposable medical supplies.

(14) Home and community-based health care services and related supportive services (such as home health nursing services, home health aide services, personal care, assistance with activities of daily living, chore services, day care services, respite care services, training for family members, and minor modifications to the home).

(15) *Nursing care services (such as nurse practitioner services, nurse midwife services, advanced practice nurse services, private duty nursing care, pediatric nurse services, and respiratory care services) in a home, school, or other setting.*

(16) *Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest.*

(17) *Dental services.*

(18) *Inpatient substance abuse treatment services and residential substance abuse treatment services.*

(19) *Outpatient substance abuse treatment services.*

(20) *Case management services.*

(21) *Care coordination services.*

(22) *Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders.*

(23) *Hospice care.*

(24) *Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services (whether in a facility, home, school, or other setting) if recognized by State law and only if the service is—*

(A) *prescribed by or furnished by a physician or other licensed or registered practitioner within the scope of practice as defined by State law,*

(B) *performed under the general supervision or at the direction of a physician, or*

(C) *furnished by a health care facility that is operated by a State or local government or is licensed under State law and operating within the scope of the license.*

(25) *Premiums for private health care insurance coverage.*

(26) *Medical transportation.*

(27) *Enabling services (such as transportation, translation, and outreach services) only if designed to increase the accessibility of primary and preventive health care services for eligible low-income individuals.*

(28) *Any other health care services or items specified by the Secretary and not excluded under this section.*

(b) **TARGETED LOW-INCOME CHILD DEFINED.**—*For purposes of this title—*

(1) **IN GENERAL.**—*The term “targeted low-income child” means a child—*

(A) *who has been determined eligible by the State for child health assistance under the State plan;*

(B) *whose family income (as determined under the State child health plan)—*

(i) *exceeds the medicaid applicable income level (as defined in paragraph (2) and expressed as a percentage of the poverty line), but*

(ii) *but does not exceed an income level that is 75 percentage points higher (as so expressed) than the medicaid applicable income level, or, if higher, 133 percent of the poverty line for a family of the size involved; and*

(C) *who is not found to be eligible for medical assistance under title XIX or covered under a group health plan or*

under health insurance coverage (as such terms are defined in section 2791 of the Public Health Service Act). Such term does not include a child who is an inmate of a public institution.

(2) **MEDICAID APPLICABLE INCOME LEVEL.**—*The term “medicaid applicable income level” means, with respect to a child, the effective income level (expressed as a percent of the poverty line) that has been specified under the State plan under title XIX (including under a waiver authorized by the Secretary or under section 1902(r)(2)), as of June 1, 1997, for the child to be eligible for medical assistance under section 1902(l)(2) for the age of such child. In applying the previous sentence in the case of a child described in section 1902(l)(2)(D), such level shall be applied taking into account the expanded coverage effected among such children under such section with the passage of time.*

(c) **ADDITIONAL DEFINITIONS.**—*For purposes of this title:*

(1) **CHILD.**—*The term “child” means an individual under 19 years of age.*

(2) **CREDITABLE HEALTH COVERAGE.**—*The term “creditable health coverage” has the meaning given the term “creditable coverage” under section 2701(c) of the Public Health Service Act (42 U.S.C. 300gg(c)) and includes coverage (including the direct provision of services) provided to a targeted low-income child under this title.*

(3) **GROUP HEALTH PLAN; HEALTH INSURANCE COVERAGE; ETC.**—*The terms “group health plan”, “group health insurance coverage”, and “health insurance coverage” have the meanings given such terms in section 2191 of the Public Health Service Act.*

(4) **LOW-INCOME.**—*The term “low-income child” means a child whose family income is below 200 percent of the poverty line for a family of the size involved.*

(5) **POVERTY LINE DEFINED.**—*The term “poverty line” has the meaning given such term in section 673(2) of the Community Services Block Grant Act (42 U.S.C. 9902(2)), including any revision required by such section.*

(6) **PREEXISTING CONDITION EXCLUSION.**—*The term “preexisting condition exclusion” has the meaning given such term in section 2701(b)(1)(A) of the Public Health Service Act (42 U.S.C. 300gg(b)(1)(A)).*

(7) **STATE CHILD HEALTH PLAN; PLAN.**—*Unless the context otherwise requires, the terms “State child health plan” and “plan” mean a State child health plan approved under section 2105.*

(8) **UNCOVERED CHILD.**—*The term “uncovered child” means a child that does not have creditable health coverage.*

SOCIAL SECURITY ACT

* * * * *

TITLE XI—GENERAL PROVISIONS, PEER REVIEW, AND ADMINISTRATIVE SIMPLIFICATION

* * * * *

SEC. 1115. (a) * * *

* * * * *

(e)(1) The provisions of this subsection shall apply to the extension of State-wide comprehensive demonstration project (in this subsection referred to as "waiver project") for which a waiver of compliance with requirements of title XIX is granted under subsection (a).

(2) Not earlier than 1 year before the date the waiver under subsection (a) with respect to a waiver project would otherwise expire, the chief executive officer of the State which is operating the project may submit to the Secretary a written request for an extension, of up to 3 years, of the project.

(3) If the Secretary fails to respond to the request within 6 months after the date it is submitted, the request is deemed to have been granted.

(4) If such a request is granted, the deadline for submittal of a final report under the waiver project is deemed to have been extended until the date that is 1 year after the date the waivers under subsection (a) with respect to the project would otherwise have expired.

(5) The Secretary shall release an evaluation of each such project not later than 1 year after the date of receipt of the final report.

(6) Subject to paragraphs (4) and (7), the extension of a waiver project under this subsection shall be on the same terms and conditions (including applicable terms and conditions relating to quality and access of services, budget neutrality, data and reporting requirements, and special population protections) that applied to the project before its extension under this subsection.

(7) If an original condition of approval of a waiver project was that Federal expenditures under the project not exceed the Federal expenditures that would otherwise have been made, the Secretary shall take such steps as may be necessary to assure that, in the extension of the project under this subsection, such condition continues to be met. In applying the previous sentence, the Secretary shall take into account the Secretary's best estimate of rates of change in expenditures at the time of the extension.

* * * * *

CRIMINAL PENALTIES FOR ACTS INVOLVING FEDERAL HEALTH CARE PROGRAMS

SEC. 1128B. (a) Whoever—

(1) * * *

* * * * *

[(6) knowingly and willfully disposes of assets (including by any transfer in trust) in order for an individual to become eligible for medical assistance under a State plan under title XIX, if disposing of the assets results in the imposition of a period of ineligibility for such assistance under section 1917(c),]

(6) for a fee knowingly and willfully counsels or assists an individual to dispose of assets (including by any transfer in trust) in order for the individual to become eligible for medical assistance under a State plan under title XIX, if disposing of the as-

sets results in the imposition of a period of ineligibility for such assistance under section 1917(c),
 shall (i) in the case of such a statement, representation, concealment, failure, or conversion by any person in connection with the furnishing (by that person) of items or services for which payment is or may be made under the program, be guilty of a felony and upon conviction thereof fined not more than \$25,000 or imprisoned for not more than five years or both, or (ii) in the case of such a statement, representation, concealment, ~~failure, or conversion by any other person~~ *failure, conversion, or provision of counsel or assistance by any other person*, be guilty of a misdemeanor and upon conviction thereof fined not more than \$10,000 or imprisoned for not more than one year, or both. In addition, in any case where an individual who is otherwise eligible for assistance under a Federal health care program is convicted of an offense under the preceding provisions of this subsection, the administrator of such program may at its option (notwithstanding any other provision of such program) limit, restrict, or suspend the eligibility of that individual for such period (not exceeding one year) as it deems appropriate; but the imposition of a limitation, restriction, or suspension with respect to the eligibility of any individual under this sentence shall not affect the eligibility of any other person for assistance under the plan, regardless of the relationship between that individual and such other person.

* * * * *

TITLE XVIII—HEALTH INSURANCE FOR THE AGED AND DISABLED

* * * * *

PAYMENTS TO, AND COVERAGE OF BENEFITS UNDER, PROGRAMS OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)

SEC. 1894. (a) RECEIPT OF BENEFITS THROUGH ENROLLMENT IN PACE PROGRAM; DEFINITIONS FOR PACE PROGRAM RELATED TERMS.—

(1) BENEFITS THROUGH ENROLLMENT IN A PACE PROGRAM.—
In accordance with this section, in the case of an individual who is entitled to benefits under part A or enrolled under part B and who is a PACE program eligible individual with respect to a PACE program offered by a PACE provider under a PACE program agreement—

(A) *the individual may enroll in the program under this section; and*

(B) *so long as the individual is so enrolled and in accordance with regulations—*

(i) *the individual shall receive benefits under this title solely through such program, and*

(ii) *the PACE provider is entitled to payment under and in accordance with this section and such agreement for provision of such benefits.*

(2) APPLICATION OF DEFINITIONS.—*The definitions of terms under section 1932(a) shall apply under this section in the same manner as they apply under section 1932.*

(b) *APPLICATION OF MEDICAID TERMS AND CONDITIONS.*—Except as provided in this section, the terms and conditions for the operation and participation of PACE program eligible individuals in PACE programs offered by PACE providers under PACE program agreements under section 1932 shall apply for purposes of this section.

(c) *PAYMENT.*—

(1) *ADJUSTMENT IN PAYMENT AMOUNTS.*—In the case of individuals enrolled in a PACE program under this section, the amount of payment under this section shall not be the amount calculated under section 1932(d)(2), but shall be an amount, specified under the PACE agreement, based upon payment rates established for purposes of payment under section 1854 (or, for periods before January 1, 1999, for purposes of risk-sharing contracts under section 1876) and shall be adjusted to take into account the comparative frailty of PACE enrollees and such other factors as the Secretary determines to be appropriate. Such amount under such an agreement shall be computed in a manner so that the total payment level for all PACE program eligible individuals enrolled under a program is less than the projected payment under this title for a comparable population not enrolled under a PACE program.

(2) *FORM.*—The Secretary shall make prospective monthly payments of a capitation amount for each PACE program eligible individual enrolled under this section in the same manner and from the same sources as payments are made to a MedicarePlus organization under section 1854 (or, for periods beginning before January 1, 1999, to an eligible organization under a risk-sharing contract under section 1876). Such payments shall be subject to adjustment in the manner described in section 1854(a)(2) or section 1876(a)(1)(E), as the case may be.

(d) *WAIVERS OF REQUIREMENTS.*—With respect to carrying out a PACE program under this section, the following requirements of this title (and regulations relating to such requirements) are waived and shall not apply:

(1) Section 1812, insofar as it limits coverage of institutional services.

(2) Sections 1813, 1814, 1833, and 1886, insofar as such sections relate to rules for payment for benefits.

(3) Sections 1814(a)(2)(B), 1814(a)(2)(C), and 1835(a)(2)(A), insofar as they limit coverage of extended care services or home health services.

(4) Section 1861(i), insofar as it imposes a 3-day prior hospitalization requirement for coverage of extended care services.

(5) Sections 1862(a)(1) and 1862(a)(9), insofar as they may prevent payment for PACE program services to individuals enrolled under PACE programs.

* * * * *

TITLE XIX—GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

* * * * *

STATE PLANS FOR MEDICAL ASSISTANCE

SEC. 1902. (a) A State plan for medical assistance must—

(1) * * *

* * * * *

(10) provide—

(A) * * *

* * * * *

(C) that if medical assistance is included for any group of individuals described in section 1905(a) who are not described in subparagraph (A) or (E), then—

(i) * * *

* * * * *

(iv) if such medical assistance includes services in institutions for mental diseases or in an intermediate care facility for the mentally retarded (or both) for any such group, it also must include for all groups covered at least the care and services listed in paragraphs (1) through (5) and (17) of section 1905(a) or the care and services listed in any 7 of the paragraphs numbered (1) through ~~[(24)]~~ (27) of such section;

* * * * *

(E)(i) for making medical assistance available for medicare cost-sharing (as defined in section 1905(p)(3)) for qualified medicare beneficiaries described in section 1905(p)(1);

(ii) for making medical assistance available for payment of medicare cost-sharing described in section 1905(p)(3)(A)(i) for qualified disabled and working individuals described in section 1905(s); **[and]**

* * * * *

(iv) subject to section 1905(p)(4), for making medical assistance available for the portion of medicare cost sharing described in section 1905(p)(3)(A)(ii), that is attributable to the application under section 1839(a)(5) of section 1833(d)(2) for individuals who would be described in clause (iii) but for the fact that their income exceeds 120 percent, but is less than 175 percent, of the official poverty line (referred to in section 1905(p)(2)) for a family of the size involved;

* * * * *

(13) provide—

[(A) for payment (except where the State agency is subject to an order under section 1914) of the hospital services, nursing facility services, and services in an intermediate care facility for the mentally retarded provided under the plan through the use of rates (determined in accordance with methods and standards developed by the State which, in the case of nursing facilities, take into account the costs (including the costs of services required to attain or maintain the highest practicable physical, mental, and

psychosocial well-being of each resident eligible for benefits under this title) of complying with subsections (b) (other than paragraph (3)(F) thereof), (c), and (d) of section 1919 and provide (in the case of a nursing facility with a waiver under section 1919(b)(4)(C)(ii)) for an appropriate reduction to take into account the lower costs (if any) of the facility for nursing care, and which, in the case of hospitals, take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs and provide, in the case of hospital patients receiving services at an inappropriate level of care (under conditions similar to those described in section 1861(v)(1)(G)), for lower reimbursement rates reflecting the level of care actually received (in a manner consistent with section 1861(v)(1)(G)) which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards and to assure that individuals eligible for medical assistance have reasonable access (taking into account geographic location and reasonable travel time) to inpatient hospital services of adequate quality; and such State makes further assurances, satisfactory to the Secretary, for the filing of uniform cost reports by each hospital, nursing facility, and intermediate care facility for the mentally retarded and periodic audits by the State of such reports;

[(B) that the State shall provide assurances satisfactory to the Secretary that the payment methodology utilized by the State for payments to hospitals can reasonably be expected not to increase such payments, solely as a result of a change of ownership, in excess of the increase which would result from the application of section 1861(v)(1)(O);

[(C) that the State shall provide assurances satisfactory to the Secretary that the valuation of capital assets, for purposes of determining payment rates for nursing facilities and for intermediate care facilities for the mentally retarded, will not be increased (as measured from the date of acquisition by the seller to the date of the change of ownership), solely as a result of a change of ownership, by more than the lesser of—

[(i) one-half of the percentage increase (as measured over the same period of time, or, if necessary, as extrapolated retrospectively by the Secretary) in the Dodge Construction Systems Costs for Nursing Homes, applied in the aggregate with respect to those facilities which have undergone a change of ownership during the fiscal year, or

[(ii) one-half of the percentage increase (as measured over the same period of time) in the Consumer Price Index for All Urban Consumers (United States city average);]

(A) for a public process for determination of rates of payment under the plan for hospital services, nursing facility services, and services of intermediate care facilities for the mentally retarded under which—

(i) proposed rates are published, and providers, beneficiaries and their representatives, and other concerned State residents are given a reasonable opportunity for review and comment on the proposed rates;

(ii) final rates are published, together with justifications, and

(iii) in the case of hospitals, take into account (in a manner consistent with section 1923) the situation of hospitals which serve a disproportionate number of low income patients with special needs;

(B) that the State shall provide assurances satisfactory to the Secretary that the average level of payments under the plan for nursing facility services (as determined on an aggregate per resident-day basis) and the level of payments under the plan for inpatient hospital services (as determined on an aggregate hospital payment basis) furnished during the 18-month period beginning October 1, 1997, is not less than the average level of payments that would be made under the plan during such 18-month period for such respective services (determined on such basis) based on rates or payment basis in effect as of May 1, 1997;

(D) for payment for hospice care in amounts no lower than the amounts, using the same methodology, used under part A of title XVIII and for payment of amounts under section 1905(o)(3); except that in the case of hospice care which is furnished to an individual who is a resident of a nursing facility or intermediate care facility for the mentally retarded, and who would be eligible under the plan for nursing facility services or services in an intermediate care facility for the mentally retarded if he had not elected to receive hospice care, there shall be paid an additional amount, to take into account the room and board furnished by the facility, equal to at least 95 percent of the rate that would have been paid by the State under the plan for facility services in that facility for that individual; and

(E)¹ (i) for payment for services described in clause (B) or (C) of section 1905(a)(2) under the plan, of 100 percent (or 95 percent for services furnished during fiscal year 2000, 90 percent for service furnished during fiscal year 2001, and 85 percent for services furnished during fiscal year 2002) of costs which are reasonable and related to the cost of furnishing such services or based on such other tests of reasonableness, as the Secretary prescribes in regulations under section 1833(a)(3), or, in the case of services to which those regulations do not apply, on the same methodology used under section 1833(a)(3) and (ii) in carrying

¹ Effective for services furnished on or after October 1, 2002, subparagraph (E) of section 1902(a)(13) is repealed.

out clause (i) in the case of services furnished by a federally qualified health center or a rural health clinic pursuant to a contract between the center and a health maintenance organization under section 1903(m), for payment by the State of a supplemental payment equal to the amount (if any) by which the amount determined under clause (i) exceeds the amount of the payments provided under such contract;
[and]

[(F) for payment for home and community care (as defined in section 1929(a) and provided under such section) through rates which are reasonable and adequate to meet the costs of providing care, efficiently and economically, in conformity with applicable State and Federal laws, regulations, and quality and safety standards;]

* * * * *

(25) provide—

(A) that the State or local agency administering such plan will take all reasonable measures to ascertain the legal liability of third parties (including health insurers, group health plans (as defined in section 607(1) of the Employee Retirement Income Security Act of 1974), service benefit plans, and health maintenance organizations) to pay for care and services available under the plan, including—

(i) the collection of sufficient information (as specified by the Secretary in regulations) to enable the State to pursue claims against such third parties, with such information being collected at the time of any determination or redetermination of eligibility for medical assistance, and

(ii) the submission to the Secretary of a plan (subject to approval by the Secretary) for pursuing claims against such third parties, which plan shall **[—]** *be integrated with, and be monitored as a part of the Secretary's review of, the State's mechanized claims processing and information retrieval system under section 1903(r);*

[(I) be integrated with, and be monitored as a part of the Secretary's review of, the State's mechanized claims processing and information retrieval system under section 1903(r), and]

[(II) be subject to the provisions of section 1903(r)(4) relating to reductions in Federal payments for failure to meet conditions of approval, but shall not be subject to any other financial penalty as a result of any other monitoring, quality control, or auditing requirements;]

* * * * *

[(G) that the State plan shall meet the requirements of section 1906 (relating to enrollment of individuals under group health plans in certain cases);]

[(H)] (G) that the State prohibits any health insurer (including a group health plan, as defined in section 607(1)

of the Employee Retirement Income Security Act of 1974, a service benefit plan, and a health maintenance organization), in enrolling an individual or in making any payments for benefits to the individual or on the individual's behalf, from taking into account that the individual is eligible for or is provided medical assistance under a plan under this title for such State, or any other State; and

[(I)] (H) that to the extent that payment has been made under the State plan for medical assistance in any case where a third party has a legal liability to make payment for such assistance, the State has in effect laws under which, to the extent that payment has been made under the State plan for medical assistance for health care items or services furnished to an individual, the State is considered to have acquired the rights of such individual to payment by any other party for such health care items or services;

(26) if the State plan includes medical assistance for inpatient mental hospital services, [provide—

[(A) with respect to each patient] *provide, with respect to each patient* receiving such services, for a regular program of medical review (including medical evaluation) of his need for such services, and for a written plan of care;

[(B) for periodic inspections to be made in all mental institutions within the State by one or more medical review teams (composed of physicians and other appropriate health and social service personnel) of the care being provided to each person receiving medical assistance, including (i) the adequacy of the services available to meet his current health needs and promote his maximum physical well-being, (ii) the necessity and desirability of his continued placement in the institution, and (iii) the feasibility of meeting his health care needs through alternative institutional or noninstitutional services; and

[(C) for full reports to the State agency by each medical review team of the findings of each inspection under subparagraph (B), together with any recommendations;]

* * * * *

(31) with respect to services in an intermediate care facility for the mentally retarded (where the State plan includes medical assistance for such services) [provide—

[(A) with respect to each patient] *provide, with respect to each patient* receiving such services, for a written plan of care, prior to admission to or authorization of benefits in such facility, in accordance with regulations of the Secretary, and for a regular program of independent professional review (including medical evaluation) which shall periodically review his need for such services;

[(B) with respect to each intermediate care facility for the mentally retarded within the State, for periodic onsite inspections of the care being provided to each person receiving medical assistance, by one or more independent professional review teams (composed of a physician or registered nurse and other appropriate health and social serv-

ice personnel), including with respect to each such person (i) the adequacy of the services available to meet his current health needs and promote his maximum physical well-being, (ii) the necessity and desirability of his continued placement in the facility, and (iii) the feasibility of meeting his health care needs through alternative institutional or noninstitutional services; and

【(C) for full reports to the State agency by each independent professional review team of the findings of each inspection under subparagraph (B), together with any recommendations;】

* * * * *

(62) provide for a program for the distribution of pediatric vaccines to program-registered providers for the immunization of vaccine-eligible children in accordance with section 1928; **【and】**

(63) provide for administration and determinations of eligibility with respect to individuals who are (or seek to be) eligible for medical assistance based on the application of section 1931**【.】**; and

(64) provide, with respect to all contracts described in section 1903(m)(2)(A) with an organization or provider, that—

(A) *the State agency develops and implements a quality assessment and improvement strategy, consistent with standards that the Secretary shall establish, in consultation with the States, and monitor and that do not preempt the application of stricter State standards, which includes—*

(i) *standards for access to care so that covered services are available within reasonable timeframes and in a manner that ensures continuity of care and adequate primary care and, where applicable, specialized services capacity, including pediatric specialized services for special needs children (as defined in section 1915(i)); and*

(ii) *procedures for monitoring and evaluating the quality and appropriateness of care and services to beneficiaries that reflect the full spectrum of populations enrolled under the contract and that include—*

(I) *requirements for provision of quality assurance data to the State using the data and information set that the Secretary shall specify with respect to entities contracting under section 1876 or alternative data requirements approved by the Secretary;*

(II) *regular and periodic examination of the scope and content of the quality improvement strategy; and*

(III) *other aspects of care and service directly related to the improvement of quality of care (including grievance procedures and marketing and information standards); and*

(B) that adequate provision is made, consistent with standards that the Secretary shall specify and monitor, with respect to financial reporting under the contracts.

* * * * *
(e)(1) * * *

* * * * *
(12) At the option of the State, the plan may provide that an individual who is under an age specified by the State (not to exceed 19 years of age) and who is determined to be eligible for benefits under a State plan approved under this title under subsection (a)(10)(A) shall remain eligible for those benefits until the earlier of—

- (A) the end of a period (not to exceed 12 months) following the determination; or*
- (B) the time that the individual exceeds that age.*

* * * * *
(i)(1) In addition to any other authority under State law, where a State determines that a intermediate care facility for the mentally retarded which is certified for participation under its plan no longer substantially meets the requirements for such a facility under this title and further determines that the facility's deficiencies—

(A) immediately jeopardize the health and safety of its patients, the State shall provide for the termination of the facility's certification for participation under the plan and may provide, or

(B) do not immediately jeopardize the health and safety of its patients, the State may, in lieu of providing for terminating the facility's certification for participation under the plan, **provide** *establish alternative remedies if the State demonstrates to the Secretary's satisfaction that the alternative remedies are effective in deterring noncompliance and correcting deficiencies, and may provide*

that no payment will be made under the State plan with respect to any individual admitted to such facility after a date specified by the State.

* * * * *
(j) Notwithstanding any other requirement of this title, the Secretary may waive or modify any requirement of this title with respect to the medical assistance program in American Samoa and the Northern Mariana Islands, other than a waiver of the Federal medical assistance percentage, the limitation in section 1108(f), or the requirement that payment may be made for medical assistance only with respect to amounts expended by American Samoa or the Northern Mariana Islands for care and services described in paragraphs (1) through **[(25)] (28)** of section 1905(a).

* * * * *
(l)(1) Individuals described in this paragraph are—
(A) * * *

* * * * *

(D) children born after September 30, 1983 (or, at the option of a State, after any earlier date), who have attained 6 years of age but have not attained 19 years of age, who are not described in any of subclauses (I) through (III) of subsection (a)(10)(A)(i) and whose family income does not exceed the income level established by the State under paragraph (2) for a family size equal to the size of the family, including the woman, infant, or child.

* * * * *

(aa)(1) Notwithstanding any other provision of law, no provision of law shall be construed as preventing any State from allowing determinations of eligibility to receive medical assistance under this title to be made by an entity that is not a State or local government, or by an individual who is not an employee of a State or local government, which meets such qualifications as the State determines. For purposes of any Federal law, such determinations shall be considered to be made by the State and by a State agency.

(2) Nothing in this subsection shall be construed as affecting—

(A) the conditions for eligibility for benefits (including any conditions relating to income or resources);

(B) the rights to challenge determinations regarding eligibility or rights to benefits; and

(C) determinations regarding quality control or error rates.

PAYMENT TO STATES

SEC. 1903. (a) * * *
(b)(1) * * *

* * * * *

(4) Notwithstanding the preceding provisions of this section, the amount determined under subsection (a)(1) for any State shall be decreased in a quarter by the amount of any health care related taxes (described in section 1902(w)(3)(A)) that are imposed on a hospital described in subsection (w)(3)(F) in that quarter.

(5) Amounts expended by a State for the use an enrollment broker in marketing health maintenance organizations and other managed care entities to eligible individuals under this title shall be considered, for purposes of subsection (a)(7), to be necessary for the proper and efficient administration of the State plan but only if the following conditions are met with respect to the broker:

(A) The broker is independent of any such entity and of any health care providers (whether or not any such provider participates in the State plan under this title) that provide coverage of services in the same State in which the broker is conducting enrollment activities.

(B) No person who is an owner, employee, consultant, or has a contract with the broker either has any direct or indirect financial interest with such an entity or health care provider or has been excluded from participation in the program under this title or title XVIII or debarred by any Federal agency, or subject to a civil money penalty under this Act.

* * * * *

(f)(1) * * *

* * * * *

(4) The limitations on payment imposed by the preceding provisions of this subsection shall not apply with respect to any amount expended by a State as medical assistance for any individual described in section 1902(a)(10)(A)(i)(III), 1902(a)(10)(A)(i)(IV), 1902(a)(10)(A)(i)(V), 1902(a)(10)(A)(i)(VI), 1902(a)(10)(A)(i)(VII), 1902(a)(10)(A)(ii)(IX), 1902(a)(10)(A)(ii)(X), or 1905(p)(1) or for any individual—

(A) * * *

* * * * *

(C) with respect to whom there is being paid, or who is eligible, or would be eligible if he were not in a medical institution, to have paid with respect to him, a State supplementary payment and is eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in section 1902(a)(10)(A), or who is a PACE program eligible individual enrolled in a PACE program under section 1932, but only if the income of such individual (as determined under section 1612, but without regard to subsection (b) thereof) does not exceed 300 percent of the supplemental security income benefit rate established by section 1611(b)(1),

at the time of the provision of the medical assistance giving rise to such expenditure.

* * * * *

(i) Payment under the preceding provisions of this section shall not be made—

(1) * * *

* * * * *

[(12) with respect to any amount expended for physicians' services furnished by a physician on or after January 1, 1992, to—

[(A) a child under 21 years of age, unless the physician—

[(i) is certified in family practice or pediatrics by the medical specialty board recognized by the American Board of Medical Specialties for family practice or pediatrics or is certified in family practice or pediatrics by the medical specialty board recognized by the American Osteopathic Association,

[(ii) is employed by, or affiliated with, a Federally-qualified health center (as defined in section 1905(l)(2)(B)),

[(iii) holds admitting privileges at a hospital participating in a State plan approved under this title,

[(iv) is a member of the National Health Service Corps,

[(v) documents a current, formal, consultation and referral arrangement with a pediatrician or family practitioner who has the certification described in

clause (i) for purposes of specialized treatment and admission to a hospital,

[(vi) delivers such services in the emergency department of a hospital participating in the State plan approved under this title, or

[(vii) has been certified by the Secretary (or certified by the State in accordance with policies of the Secretary) as qualified to provide physicians' services to a child under 21 years of age; or

[(B) to a pregnant woman (or during the 60 day period beginning on the date of termination of the pregnancy) unless the physician—

[(i) is certified in family practice or obstetrics by the medical specialty board recognized by the American Board of Medical Specialties for family practice or obstetrics or is certified in family practice or obstetrics by the medical specialty board recognized by the American Osteopathic Association,

[(ii) is employed by, or affiliated with, a Federally-qualified health center (as defined in section 1905(l)(2)(B)),

[(iii) holds admitting privileges at a hospital participating in a State plan approved under this title,

[(iv) is a member of the National Health Service Corps,

[(v) documents a current, formal, consultation and referral arrangement with an obstetrician or family practitioner who has the certification described in clause (i) for purposes of specialized treatment and admission to a hospital,

[(vi) delivers such services in the emergency department of a hospital participating in the State plan approved under this title, or

[(vii) has been certified by the Secretary (or certified by the State in accordance with policies of the Secretary) as qualified to provide physicians' services to pregnant women; or]

* * * * *

(m)(1)(A) The term "health maintenance organization" means a public or private organization, organized under the laws of any State, which meets the requirement of section 1902(w) is a qualified health maintenance organization (as defined in section 1310(d) of the Public Health Service Act) or which meets the requirement of section 1902(a) and—

(i) * * *

(ii) has made adequate provision against the risk of insolvency, which provision is satisfactory to the State, *meets the requirements of subparagraph (C)(i) (if applicable)*, and which assures that individuals eligible for benefits under this title are in no case held liable for debts of the organization in case of the organization's insolvency.

* * * * *

(C)(i) *Subject to clause (ii), a provision meets the requirements of this subparagraph for an organization if the organization meets solvency standards established by the State for private health maintenance organizations or is licensed or certified by the State as a risk-bearing entity.*

(ii) *Clause (i) shall not apply to an organization if—*

(I) the organization is not responsible for the provision (directly or through arrangements with providers of services) of inpatient hospital services and physicians' services;

(II) the organization is a public entity;

(III) the solvency of the organization is guaranteed by the State; or

(IV) the organization is (or is controlled by) one or more federally-qualified health centers and meets solvency standards established by the State for such an organization.

For purposes of subclause (IV), the term "control" means the possession, whether direct or indirect, of the power to direct or cause the direction of the management and policies of the organization through membership, board representation, or an ownership interest equal to or greater than 50.1 percent.

(2)(A) Except as provided in subparagraphs (B), (C), and (G), no payment shall be made under this title to a State with respect to expenditures incurred by it for payment (determined under a prepaid capitation basis or under any other risk basis) for services provided by any entity (including a health insuring organization) which is responsible for the provision (directly or through arrangements with providers of services) of inpatient hospital services and any other service described in paragraph (2), (3), (4), (5), or (7) of section 1905(a) or for the provision of any three or more of the services described in such paragraphs unless—

(i) the Secretary has determined that the entity is a health maintenance organization as defined in paragraph (1);

[(ii) less than 75 percent of the membership of the entity which is enrolled on a prepaid basis consists of individuals who (I) are insured for benefits under part B of title XVIII or for benefits under both parts A and B of such title, or (II) are eligible to receive benefits under this title;]

(iii) such services are provided for the benefit of individuals eligible for benefits under this title in accordance with a contract between the State and the entity under which prepaid payments to the entity are made on an actuarially sound basis and under which the Secretary must provide prior approval for contracts providing for expenditures in excess of **[\$100,000]** *\$1,000,000 for 1998 and, for a subsequent year, the amount established under this clause for the previous year increased by the percentage increase in the consumer price index for all urban consumers over the previous year;*

* * * * *

(vi) such contract **[(I) except as provided under subparagraph (F),]** permits individuals who have elected under the plan to enroll with the entity for provision of such benefits to terminate such enrollment **[without cause as of the beginning of the first calendar month following a full calendar month after the request is made for such termination, and (II) pro-**

vides for notification of each such individual, at the time of the individual's enrollment, of such right to terminate such enrollment;】 *in accordance with the provisions of subparagraph (F)*;

(vii) such contract provides that, in the case of medically necessary services which were provided (I) to an individual enrolled with the entity under the contract and entitled to benefits with respect to such services under the State's plan and (II) other than through the organization because the services were immediately required due to an unforeseen illness, injury, or condition, either the entity or the State provides for reimbursement with respect to those services,

(viii) such contract provides for disclosure of information in accordance with section 1124 and paragraph (4) of this subsection *and compliance with the requirements of paragraphs (10) and (11)*;

【(ix) such contract provides, in the case of an entity that has entered into a contract for the provision of services of such center with a federally qualified health center, that (I) rates of prepayment from the State are adjusted to reflect fully the rates of payment specified in section 1902(a)(13)(E), and (II) at the election of such center payments made by the entity to such a center for services described in 1905(a)(2)(C) are made at the rates of payment specified in section 1902(a)(13)(E);】

(ix)¹ *such contract provides, in the case of an entity that has entered into a contract for the provision of services with a federally qualified health center or a rural health clinic, that the entity shall provide payment that is not less than the level and amount of payment which the entity would make for the services if the services were furnished by a provider which is not a federally qualified health center or a rural health clinic;*

(x) any physician incentive plan that it operates meets the requirements described in section 1876(i)(8); 【and】

(xi) such contract provides for maintenance of sufficient patient encounter data to identify the physician who delivers services to patients【.】;

(xii) *such contract provides for—*

(I) *submitting to the State agency such information as may be necessary to monitor the care delivered to members,*

(II) *maintenance of an internal quality assurance program consistent with section 1902(a)(64)(A), and meeting standards that the Secretary shall establish in regulations;*

(III) *providing effective procedures for hearing and resolving grievances between the entity and members enrolled with the organization under this subsection;*

(xiii) *the State has in effect conflict-of-interest safeguards with respect to officers and employees of the State with responsibilities relating to contracts with such organizations and to any default enrollment process that are at least as effective as the Federal safeguards provided under section 27 of the Office of Federal Procurement Policy Act (41 U.S.C. 423), against con-*

¹Effective for services furnished on or after October 1, 2002, clause (ix) of section 1903(m)(2)(A) (42 U.S.C. 1396b(m)(2)(A)) is repealed.

flicts of interest that apply with respect to Federal procurement officials with comparable responsibilities with respect to such contracts;

(xiv) such contract provides for compliance of the organization with the grievance and appeals requirements described in paragraph (3); and

(xv) the organization complies with the requirements of paragraph (12).

* * * * *

[(C) Subparagraph (A)(ii) shall not apply with respect to payments under this title to a State with respect to expenditures incurred by it for payment for services by an entity during the three-year period beginning on the date of enactment of this subsection or beginning on the date the entity qualifies as a health maintenance organization (as determined by the Secretary), whichever occurs later, but only if the entity demonstrates to the satisfaction of the Secretary by the submission of plans for each year of such three-year period that it is making continuous efforts and progress toward achieving compliance with subparagraph (A)(ii).

[(D) In the case of a health maintenance organization that is a public entity, the Secretary may modify or waive the requirement described in subparagraph (A)(ii) but only if the Secretary determines that the organization has taken and is taking reasonable efforts to enroll individuals who are not entitled to benefits under the State plan approved under this title or under title XVIII.

[(E) In the case of a health maintenance organization that—

[(i) is a nonprofit organization with at least 25,000 members,

[(ii) is and has been a qualified health maintenance organization (as defined in section 1310(d) of the Public Health Service Act) for a period of at least four years,

[(iii) provides basic health services through members of the staff of the organization,

[(iv) is located in an area designated as medically underserved under section 1302(7) of the Public Health Service Act, and

[(v) previously received a waiver of the requirement described in subparagraph (A)(ii) under section 1115,

the Secretary may modify or waive the requirement described in subparagraph (A)(ii) but only if the Secretary determines that special circumstances warrant such modification or waiver and that the organization has taken and is taking reasonable efforts to enroll individuals who are not entitled to benefits under the State plan approved under this title or under title XVIII.]

(F) [In the case of—

[(i) a contract with an entity described in subparagraph (E) or (G), with a qualified health maintenance organization (as defined in section 1310(d) of the Public Health Service Act) which meets the requirement of subparagraph (A)(ii), or with an eligible organization with a contract under section 1876 which meets the requirement of subparagraph (A)(ii), or

[(ii) a program pursuant to an undertaking described in paragraph (6) in which at least 25 percent of the membership enrolled on a prepaid basis are individuals who (I) are not insured for benefits under part B of title XVIII or eligible for

benefits under this title, and (II) (in the case of such individuals whose prepayments are made in whole or in part by any government entity) had the opportunity at the time of enrollment in the program to elect other coverage of health care costs that would have been paid in whole or in part by any governmental entity,

a State plan] A *State plan* may restrict the period in which requests for termination of enrollment without cause under subparagraph [(A)(vi)(I)] (A)(vi) are permitted to the first month of each period of enrollment, each such period of enrollment not to exceed six months in duration, but only if the State provides notification, at least twice per year, to individuals enrolled with such entity or organization of the right to terminate such enrollment and the restriction on the exercise of this right. Such restriction shall not apply to requests for termination of enrollment for cause.

(G) In the case of an entity which is receiving (and has received during the previous two years) a grant of at least \$100,000 under section 329(d)(1)(A) or 330(d)(1) of the Public Health Service Act or is receiving (and has received during the previous two years) at least \$100,000 (by grant, subgrant, or subcontract) under the Appalachian Regional Development Act of 1965, [clauses (i) and (ii)] clause (i) of subparagraph (A) shall not apply.

* * * * *

(3)(A) *An eligible organization must provide a meaningful and expedited procedure, which includes notice and hearing requirements, for resolving grievances between the organization (including any entity or individual through which the organization provides health care services) and members enrolled with the organization under this subsection. Under the procedure any member enrolled with the organization may at any time file orally or in writing a complaint to resolve grievances between the member and the organization before a board of appeals established under subparagraph (C).*

(B)(i) *The organization must provide, in a timely manner, such an enrollee a notice of any denial of services in-network or denial of payment for out-of-network care or notice of termination or reduction of services.*

(ii) *Such notice shall include the following:*

(I) *A clear statement of the reason for the denial.*

(II) *An explanation of the complaint process under subparagraph (C) which is available to the enrollee upon request.*

(III) *An explanation of all other appeal rights available to all enrollees.*

(IV) *A description of how to obtain supporting evidence for this hearing, including the patient's medical records from the organization, as well as supporting affidavits from the attending health care providers.*

(C)(i) *Each eligible organization shall establish a board of appeals to hear and make determinations on complaints by enrollees under this subsection concerning denials of coverage or payment for services (whether in-network or out-of-network) and the medical necessity and appropriateness of covered items and services.*

(ii) *A board of appeals of an eligible organization shall consist of—*

- (I) representatives of the organization, including physicians, nonphysicians, administrators, and enrollees;
- (II) consumers who are not enrollees; and
- (III) providers with expertise in the field of medicine which necessitates treatment.

(iii) A board of appeals shall hear and resolve complaints within 30 days after the date the complaint is filed with the board.

(D) Nothing in this paragraph may be construed to replace or supersede any appeals mechanism otherwise provided for an individual entitled to benefits under this title.

* * * * *

(7) *DEEMED COMPLIANCE.*—

(A) *MEDICARE ORGANIZATIONS.*—At the option of a State, the requirements of the previous provisions of this subsection shall not apply with respect to a health maintenance organization if the organization is an eligible organization with a contract in effect under section 1876 or a MedicarePlus organization with a contract in effect under C of title XVIII.

(B) *PRIVATE ACCREDITATION.*—

(i) *IN GENERAL.*—At the option of a State, such requirements shall not apply with respect to a health maintenance organization if—

(I) the organization is accredited by an organization meeting the requirements described in subparagraph (C); and

(II) the standards and process under which the organization is accredited meet such requirements as are established under clause (ii), without regard to whether or not the time requirement of such clause is satisfied.

(ii) *STANDARDS AND PROCESS.*—Not later than 180 days after the date of the enactment of this paragraph, the Secretary shall specify requirements for the standards and process under which a health maintenance organization is accredited by an organization meeting the requirements of subparagraph (C).

(C) *ACCREDITING ORGANIZATION.*—An accrediting organization meets the requirements of this subparagraph if the organization—

(i) is a private, nonprofit organization;

(ii) exists for the primary purpose of accrediting managed care organizations or health care providers; and

(iii) is independent of health care providers or associations of health care providers.

(8)(A)(i) Each contract with a health maintenance organization under this subsection shall require the organization—

(I) to provide coverage for emergency services (as defined in subparagraph (B)) without regard to prior authorization or the emergency care provider's contractual relationship with the organization, and

(II) to comply with guidelines established under section 1852(d)(2) (respecting coordination of post-stabilization care) in the same manner as such guidelines apply to MedicarePlus plans offered under part C of title XVIII.

(B) In subparagraph (A)(i)(I), the term “emergency services” means, with respect to an individual enrolled with an organization, covered inpatient and outpatient services that—

- (i) are furnished by a provider that is qualified to furnish such services under this title, and
- (ii) are needed to evaluate or stabilize an emergency medical condition (as defined in subparagraph (C)).

(C) In subparagraph (B)(ii), the term “emergency medical condition” means a medical condition manifesting itself by acute symptoms of sufficient severity such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in—

- (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
- (ii) serious impairment to bodily functions, or
- (iii) serious dysfunction of any bodily organ or part.

(9)(A) Subject to subparagraphs (B) and (C), under a contract under this subsection a health maintenance organization (in relation to an individual enrolled under the contract) shall not prohibit or otherwise restrict a covered health care professional (as defined in subparagraph (D)) from advising such an individual who is a patient of the professional about the health status of the individual or medical care or treatment for the individual’s condition or disease, regardless of whether benefits for such care or treatment are provided under the plan, if the professional is acting within the lawful scope of practice.

(B) Subparagraph (A) shall not be construed as requiring a health maintenance organization to provide, reimburse for, or provide coverage of a counseling or referral service if the organization—

- (i) objects to the provision of such service on moral or religious grounds; and
- (ii) in the manner and through the written instrumentalities such organization deems appropriate, makes available information on its policies regarding such service to prospective enrollees before or during enrollment and to enrollees within 90 days after the date that the organization or plan adopts a change in policy regarding such a counseling or referral service.

(C) Nothing in subparagraph (B) shall be construed to affect disclosure requirements under State law or under the Employee Retirement Income Security Act of 1974.

(D) For purposes of this paragraph, the term “health care professional” means a physician (as defined in section 1861(r)) or other health care professional if coverage for the professional’s services is provided under the contract under this subsection for the services of the professional. Such term includes a podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist and therapy assistant, speech-language pathologist, audiologist, registered or licensed practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified nurse-midwife), licensed certified social worker, registered respiratory therapist, and certified respiratory therapy technician.

(10)(A)(i) A health maintenance organization with respect to activities under this subsection may not distribute directly or through any agent or independent contractor marketing materials within any State—

(I) without the prior approval of the State; and

(II) that contain false or materially misleading information.

(ii) In the process of reviewing and approving such materials, the State shall provide for consultation with a medical care advisory committee.

(iii) The State may not enter into or renew a contract with a health maintenance organization for the provision of services to individuals enrolled under the State plan under this title if the State determines that the entity distributed directly or through any agent or independent contractor marketing materials in violation of clause (i)(II).

(B) A health maintenance organization shall distribute marketing materials to the entire service area of such organization.

(C) A health maintenance organization, or any agency of such organization, may not seek to influence an individual's enrollment with the organization in conjunction with the sale of any other insurance.

(D) Each health maintenance organization shall comply with such procedures and conditions as the Secretary prescribes in order to ensure that, before an individual is enrolled with the organization under this title, the individual is provided accurate oral and written and sufficient information to make an informed decision whether or not to enroll.

(E) Each health maintenance organization shall not, directly or indirectly, conduct door-to-door, telephonic, or other 'cold call' marketing of enrollment under this title.

(11)(A) A health maintenance organization may not knowingly—

(i) have a person described in subparagraph (C) as a director, officer, partner, or person with beneficial ownership of more than 5 percent of the organization equity; or

(ii) have an employment, consulting, or other agreement with a person described in such subparagraph for the provision of items and services that are significant and material to the organization's obligations under its contract with the State.

(B) If a State finds that a health maintenance organization is not in compliance with clause (i) or (ii) of subparagraph (A), the State—

(i) shall notify the Secretary of such noncompliance;

(ii) may continue an existing agreement with the organization unless the Secretary (in consultation with the Inspector General of the Department of Health and Human Services) directs otherwise; and

(iii) may not renew or otherwise extend the duration of an existing agreement with the organization unless the Secretary (in consultation with the Inspector General of the Department of Health and Human Services) provides to the State and to the Congress a written statement describing compelling reasons that exist for renewing or extending the agreement.

(C) A person is described in this subparagraph if such person—

(i) is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal acquisition

regulation or from participating in nonprocurement activities under regulations issued pursuant to Executive Order 12549; or
 (ii) is an affiliate (within the meaning of the Federal acquisition regulation) of a person described in clause (i).

(12)(A) If a health maintenance organization, under a contract under this subsection, requires or provides for an enrollee to designate a participating primary care provider—

(i) the organization shall permit a female enrollee to designate an obstetrician-gynecologist who has agreed to be designated as such, as the enrollee's primary care provider; and

(ii) if such an enrollee has not designated such a provider as a primary care provider, the organization—

(I) may not require prior authorization by the enrollee's primary care provider or otherwise for coverage of obstetric and gynecologic care provided by a participating obstetrician-gynecologist, or a participating health care professional practicing in collaboration with the obstetrician-gynecologist and in accordance with State law, to the extent such care is otherwise covered, and

(II) shall treat the ordering of other gynecologic care by such a participating physician as the prior authorization of the primary care provider with respect to such care under the contract.

(B) Nothing in subparagraph (A)(ii)(II) shall waive any requirements of coverage relating to medical necessity or appropriateness with respect to coverage of gynecologic care so ordered.

* * * * *

[(r)(1)(A) In order to receive payments under paragraphs (2)(A) and (7) of subsection (a) without being subject to per centum reductions set forth in subparagraph (C) of this paragraph, a State must provide that mechanized claims processing and information retrieval systems of the type described in subsection (a)(3)(B) and detailed in an advance planning document approved by the Secretary are operational on or before the deadline established under subparagraph (B).

[(B) The deadline for operation of such systems for a State is September 30, 1985.

[(C) If a State fails to meet the deadline established under subparagraph (B), the per centums specified in paragraphs (2)(A) and (7) of subsection (a) with respect to that State shall each be reduced by 5 percentage points for the first two quarters beginning on or after such deadline, and shall be further reduced by an additional 5 percentage points after each period consisting of two quarters during which the Secretary determines the State fails to meet the requirements of subparagraph (A); except that—

[(i) neither such per centum may be reduced by more than 25 percentage points by reason of this paragraph; and

[(ii) no reduction shall be made under this paragraph for any quarter following the quarter during which such State meets the requirements of subparagraph (A).

[(2)(A) In order to receive payments under paragraphs (2)(A) and (7) of subsection (a) without being subject to the per centum reductions set forth in subparagraph (C) of this paragraph, a State must have its mechanized claims processing and information retrieval

systems, of the type required to be operational under paragraph (1), initially approved by the Secretary in accordance with paragraph (5)(A) on or before the deadline established under subparagraph (B).

[(B) The deadline for approval of such systems for a State is the last day of the fourth quarter that begins after the date on which the Secretary determines that such systems became operational as required under paragraph (1).

[(C) If a State fails to meet the deadline established under subparagraph (B), the per centums specified in paragraphs (2)(A) and (7) of subsection (a) with respect to that State shall each be reduced by 5 percentage points for the first two quarters beginning after such deadline, and shall be further reduced by an additional 5 percentage points at the end of each period consisting of two quarters during which the State fails to meet the requirements of subparagraph (A); except that—

[(i) neither such per centum may be reduced by more than 25 percentage points by reason of this paragraph, and

[(ii) no reduction shall be made under this paragraph for any quarter following the quarter during which such State's systems are approved by the Secretary as provided in subparagraph (A).

[(D) Any State's systems which are approved by the Secretary for purposes of subsection (a)(3)(B) on or before the date of the enactment of this subsection shall be deemed to be initially approved for purposes of this subsection.

[(3)(A) When a State's systems are initially approved, the 75 per centum Federal matching provided in subsection (a)(3)(B) shall become effective with respect to such systems, retroactive to the first quarter beginning after the date on which such systems became operational as required under paragraph (1), except as provided in subparagraph (B).

[(B) In the case of any State which was subject to a per centum reduction under paragraph (2), the per centum specified in subsection (a)(3)(B) shall be reduced by 5 percentage points for the first two quarters beginning after the deadline established under paragraph (2)(B), and shall be further reduced by an additional 5 percentage points at the end of each period consisting of two quarters beginning after such deadline and before the date on which such systems are initially approved, except that no reduction shall be made under this paragraph for any quarter following the quarter during which the State's systems are initially approved by the Secretary.

[(4)(A) The Secretary shall review all approved systems not less often than once every three years, and shall reapprove or disapprove any such systems. Systems which fail to meet the current performance standards, system requirements, and any other conditions for approval developed by the Secretary under paragraph (6) shall be disapproved. Any State having systems which are so disapproved shall be subject to a per centum reduction under subparagraph (B). The Secretary shall make the determination of reapproval or disapproval and so notify the States not later than the end of the first quarter following the review period. Reviews may, at the Secretary's discretion, constitute reviews of the entire sys-

tem or of only those standards, systems requirements, and other conditions which have demonstrated weakness in previous reviews.

[(B) If the Secretary disapproves a State's systems under subparagraph (A), the Secretary shall, with respect to such State for quarters beginning after the determination of disapproval and before the first quarter beginning after such systems are reapproved, reduce the per centum specified in subsection (a)(3)(B) to a per centum of not less than 50 per centum and not more than 70 per centum as the Secretary determines to be appropriate and commensurate with the nature of noncompliance by such State; except that such per centum may not be reduced by more than 10 percentage points in any 4-quarter period by reason of this subparagraph. No State shall be subject to a per centum reduction under this paragraph (i) before the fifth quarter beginning after such State's systems were initially approved, or (ii) on the basis of a review conducted before October 1, 1981.

[(C) The Secretary may retroactively waive a per centum reduction imposed under subparagraph (B), if the Secretary determines that the State's systems meet all current performance standards and other requirements for reapproval and that such action would improve the administration of the State's plan under this title, except that no such waiver may extend beyond the four quarters immediately prior to the quarter in which the State's systems are reapproved.

[(5)(A) In order to be initially approved by the Secretary, mechanized claims processing and information retrieval systems must be of the type described in subsection (a)(3)(B) and must meet the following requirements:]

(r)(1) In order to receive payments under subsection (a) for use of automated data systems in administration of the State plan under this title, a State must have in operation mechanized claims processing and information retrieval systems that meet the requirements of this subsection and that the Secretary has found—

(A) is adequate to provide efficient, economical, and effective administration of such State plan;

(B) is compatible with the claims processing and information retrieval systems used in the administration of title XVIII, and for this purpose—

(i) has a uniform identification coding system for providers, other payees, and beneficiaries under this title or title XVIII;

(ii) provides liaison between States and carriers and intermediaries with agreements under title XVIII to facilitate timely exchange of appropriate data; and

(iii) provides for exchange of data between the States and the Secretary with respect to persons sanctioned under this title or title XVIII;

(C) is capable of providing accurate and timely data;

(D) is complying with the applicable provisions of part C of title XI;

(E) is designed to receive provider claims in standard formats to the extent specified by the Secretary; and

(F) effective for claims filed on or after January 1, 1999, provides for electronic transmission of claims data in the format

specified by the Secretary and consistent with the Medicaid Statistical Information System (MSIS) (including detailed individual enrollee encounter data and other information that the Secretary may find necessary).

(2) *In order to meet the requirements of this paragraph, mechanized claims processing and information retrieval systems must meet the following requirements:*

[(i)] (A) The systems must be capable of developing provider, physician, and patient profiles which are sufficient to provide specific information as to the use of covered types of services and items, including prescribed drugs.

[(ii)] (B) The State must provide that information on probable fraud or abuse which is obtained from, or developed by, the systems, is made available to the State's medicaid fraud control unit (if any) certified under subsection (q) of this section.

[(iii)] (C) The systems must meet all performance standards and other requirements for initial approval developed by the Secretary [under paragraph (6)].

[(B) In order to be reapproved by the Secretary, mechanized claims processing and information retrieval systems must meet the requirements of subparagraphs (A)(i) and (A)(ii) and performance standards and other requirements for reapproval developed by the Secretary under paragraph (6).]

[(6) The Secretary, with respect to State systems, shall—

[(A) develop performance standards, system requirements, and other conditions for approval for use in initially approving such State systems, and shall further develop written approval procedures for conducting reviews for initial approval, including specific criteria for assessing systems in operation to insure that all such performance standards and other requirements are met;

[(B) by not later than October 1, 1980, develop an initial set of performance standards, system requirements, and other conditions for reapproval for use in reapproving or disapproving State systems, and shall further develop written reapproval procedures for conducting reviews for reapproval, including specific criteria for reassessing systems operations over a period of at least six months during each fiscal year to insure that all such performance standards and other requirements are met on a continuous basis;

[(C) provide that reviews for reapproval, conducted before October 1, 1981, shall be for the purpose of developing a systems performance data base and assisting States to improve their systems, and that no per centum reduction shall be made under paragraph (4) on the basis of such a review;

[(D) insure that review procedures, performance standards, and other requirements developed under subparagraph (B) are sufficiently flexible to allow for differing administrative needs among the States, and that such procedures, standards, and requirements are of a nature which will permit their use by the States for self-evaluation;

[(E) notify all States of proposed procedures, standards, and other requirements at least one quarter prior to the fiscal year

in which such procedures, standards, and other requirements will be used for conducting reviews for reapproval;

[(F) periodically update the systems performance standards, system requirements, review criteria, objectives, regulations, and guides as the Secretary shall from time to time deem appropriate;

[(G) provide technical assistance to States in the development and improvement of the systems so as to continually improve the capacity of such systems to effectively detect cases of fraud or abuse;

[(H) for the purpose of insuring compatibility between the State systems and the systems utilized in the administration of title XVIII—

[(i) develop a uniform identification coding system (to the extent feasible) for providers, other persons receiving payments under the State plans (approved under this title) or under title XVIII, and beneficiaries of medical services under such plans or title;

[(ii) provide liaison between States and carriers and intermediaries having agreements under title XVIII to facilitate timely exchange of appropriate data; and

[(iii) improve the exchange of data between the States and the Secretary with respect to providers and other persons who have been terminated, suspended, or otherwise sanctioned under a State plan (approved under this title) or under title XVIII;

[(I) develop and disseminate clear definitions of those types of reasonable costs relating to State systems which are reimbursable under the provisions of subsection (a)(3) of this section; and

[(J) develop and disseminate performance standards for assessing the State's third party collection efforts in accordance with section 1902(a)(25)(A)(ii).

[(7)(A) The Secretary shall waive the provisions of this subsection with respect to initial operation and approval of mechanized claims processing and information retrieval systems with respect to any State which—

[(i) had a 1976 population (as reported by the Bureau of the Census) of less than 1,000,000 and which made total expenditures (including Federal reimbursement) for which Federal financial participation is authorized under this title of less than \$100,000,000 in fiscal year 1976 (as reported by such State for such year), or

[(ii) is a Commonwealth, or territory or possession, of the United States,

if such State reasonably demonstrates, and the Secretary does not formally disagree, that the application of such provisions would not significantly improve the efficiency of the administration of such State's plan under this title.

[(B) If the Secretary determines that the application of the provisions described in subparagraph (A) to a State would significantly improve the efficiency of the administration of the State's plan under this title, the Secretary may withdraw the State's waiver under subparagraph (A) and, in such case, the Secretary shall im-

pose a timetable for such State with respect to compliance with the provisions of this subsection and the imposition of per centum reductions. Such timetable shall be comparable to the timetable established under this subsection as to the amount of time allowed such State to comply and the timing of per centum reductions.

[(8)(A) The per centum reductions provided for under this subsection shall not apply to a State for any quarter with respect to which the Secretary determines that such State is unable to comply with the relevant requirements of this subsection—

[(i) for good cause (but such a waiver may not be for a period in excess of 2 quarters), or

[(ii) due to circumstances beyond the control of such State.

[(B) If the Secretary determines under subparagraph (A) that such a reduction will not apply to a State, the Secretary shall report to the Congress on the basis for each such determination and on the modification of all time limitations and deadlines as described in subparagraph (C).

[(C) For purposes of determining all time limitations and deadlines imposed under this subsection, any time period during which a State was found under subparagraph (A)(ii) to be unable to comply with requirements of this subsection due to circumstances beyond its control shall not be taken into account, and the Secretary shall modify all such time limitations and deadlines with respect to such State accordingly.]

* * * * *

(w)(1) * * *

* * * * *

(3)(A) * * *

(B) In this subsection, the term “broad-based health care related tax” means a health care related tax which is imposed with respect to a class of health care items or services (as described in paragraph (7)(A)) or with respect to providers of such items or services and which, except as provided in subparagraphs (D) [and (E)] (E), and (F)—

(i) * * *

* * * * *

(F) In no case shall a tax not qualify as a broad-based health care related tax under this paragraph because it does not apply to a hospital that is exempt from taxation under section 501(c)(3) of the Internal Revenue Code of 1986 and that does not accept payment under the State plan under this title or under title XVIII.

* * * * *

DEFINITIONS

SEC. 1905. For purposes of this title—

(a) The term “medical assistance” means payment of part or all of the cost of the following care and services (if provided in or after the third month before the month in which the recipient makes application for assistance or, in the case of medicare cost-sharing with respect to a qualified medicare beneficiary described in subsection (p)(1), if provided after the month in which the individual becomes such a beneficiary) for individuals, and, with respect to physicians’

or dentists' services, at the option of the State, to individuals (other than individuals with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in section 1902(a)(10)(A)) not receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A of title IV, and with respect to whom supplemental security income benefits are not being paid under title XVI, who are—

(i) under the age of 21, or, at the option of the State, under the age of 20, 19, or 18 as the State may choose,

* * * * *

but whose income and resources are insufficient to meet all of such cost—

(1) * * *

* * * * *

(22) *services furnished by a physician assistant (as defined in section 1861(aa)(5)) which the assistant is legally authorized to perform under State law and with the supervision of a physician;*

[(22)] (23) home and community care (to the extent allowed and as defined in section 1929) for functionally disabled elderly individuals;

[(23)] (24) community supported living arrangements services (to the extent allowed and as defined in section 1930);

[(24)] (25) personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are (A) authorized for the individual by a physician in accordance with a plan of treatment or (at the option of the State) otherwise authorized for the individual in accordance with a service plan approved by the State, (B) provided by an individual who is qualified to provide such services and who is not a member of the individual's family, and (C) furnished in a home or other location; [and]

(26) *primary care case management services (as defined in subsection (t));*

(27) *services furnished under a PACE program under section 1932 to PACE program eligible individuals enrolled under the program under such section; and*

[(25)] (28) any other medical care, and any other type of remedial care recognized under State law, specified by the Secretary[.],

except as otherwise provided in paragraph (16), such term does not include—

(A) * * *

* * * * *

(b) The term "Federal medical assistance percentage" for any State shall be 100 per centum less the State percentage; and the State percentage shall be that percentage which bears the same

ratio to 45 per centum as the square of the per capita income of such State bears to the square of the per capita income of the continental United States (including Alaska) and Hawaii; except that (1) the Federal medical assistance percentage shall in no case be less than 50 per centum or more than 83 per centum, and (2) the Federal medical assistance percentage for Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa shall be 50 per centum. The Federal medical assistance percentage for any State shall be determined and promulgated in accordance with the provisions of section 1101(a)(8)(B). Notwithstanding the first sentence of this section, the Federal medical assistance percentage shall be 100 per centum with respect to amounts expended as medical assistance for services which are received through an Indian Health Service facility whether operated by the Indian Health Service or by an Indian tribe or tribal organization (as defined in section 4 of the Indian Health Care Improvement Act) *and with respect to amounts expended for medical assistance described in section 1902(a)(10)(E)(iv) for individuals described in such section.*

* * * * *

(1)(1) * * *

(2)(A) * * *

(B) The term “Federally-qualified health center” means a entity which—

(i) * * *

* * * * *

(iii) based on the recommendation of the Health Resources and Services Administration within the Public Health Service, is determined by the Secretary to meet the requirements for receiving such a grant *and is not other than an entity that is owned, controlled, or operated by another provider, or*

* * * * *

(t)(1) *The term “primary care case management services” means case-management related services (including coordination and monitoring of health care services) provided by a primary care case manager under a primary care case management contract.*

(2)(A) *The term “primary care case manager” means, with respect to a primary care case management contract, a provider described in subparagraph (B).*

(B) *A provider described in this subparagraph is a provider that provides primary care case management services under contract and is—*

(i) *a physician, a physician group practice, or an entity employing or having other arrangements with physicians; or*

(ii) *at State option—*

(I) *a nurse practitioner (as described in section 1905(a)(21));*

(II) *a certified nurse-midwife (as defined in section 1861(gg)); or*

(III) *a physician assistant (as defined in section 1861(aa)(5)).*

(3) The term “primary care case management contract” means a contract with a State agency under which a primary care case manager undertakes to locate, coordinate and monitor covered primary care (and such other covered services as may be specified under the contract) to all individuals enrolled with the primary care case manager, and which provides for—

(A) reasonable and adequate hours of operation, including 24-hour availability of information, referral, and treatment with respect to medical emergencies;

(B) restriction of enrollment to individuals residing sufficiently near a service delivery site of the entity to be able to reach that site within a reasonable time using available and affordable modes of transportation;

(C) employment of, or contracts or other arrangements with, sufficient numbers of physicians and other appropriate health care professionals to ensure that services under the contract can be furnished to enrollees promptly and without compromise to quality of care;

(D) a prohibition on discrimination on the basis of health status or requirements for health services in enrollment, disenrollment, or reenrollment of individuals eligible for medical assistance under this title;

(E) a right for an enrollee to terminate enrollment without cause during the first month of each enrollment period, which period shall not exceed six months in duration, and to terminate enrollment at any time for cause; and

(F) if payment is made to the organization on a prepaid capitated or other risk basis, compliance with the requirements of section 1903(m)(2)(A)(xii) in the same manner such requirements apply to a health maintenance organization under section 1903(m)(2)(A).

(4) For purposes of this subsection, the term “primary care” includes all health care services customarily provided in accordance with State licensure and certification laws and regulations, and all laboratory services customarily provided by or through, a general practitioner, family medicine physician, internal medicine physician, obstetrician/gynecologist, or pediatrician.

* * * * *

ENROLLMENT OF INDIVIDUALS UNDER GROUP HEALTH PLANS

SEC. 1906. (a) [For purposes of section 1902(a)(25)(G) and subject to subsection (d), each] *Each State plan—*

(1) [shall] *may* implement guidelines established by the Secretary, consistent with subsection (b), to identify those cases in which enrollment of an individual otherwise entitled to medical assistance under this title in a group health plan (in which the individual is otherwise eligible to be enrolled) is cost-effective (as defined in subsection (e)(2));

(2) [shall] *may* require, in case of an individual so identified and as a condition of the individual being or remaining eligible for medical assistance under this title and subject to subsection (b)(2), notwithstanding any other provision of this title, that

the individual (or in the case of a child, the child's parent) apply for enrollment in the group health plan; and

* * * * *

[(d)(1) In the case of any State which is providing medical assistance to its residents under a waiver granted under section 1115, the Secretary shall require the State to meet the requirements of this section in the same manner as the State would be required to meet such requirement if the State had in effect a plan approved under this title.

[(2) This section, and section 1902(a)(25)(G), shall only apply to a State that is one of the 50 States or the District of Columbia.]

* * * * *

PROVISIONS RESPECTING INAPPLICABILITY AND WAIVER OF CERTAIN REQUIREMENTS OF THIS TITLE

SEC. 1915. (a) A State shall not be deemed to be out of compliance with the requirements of paragraphs (1), (10), or (23) of section 1902(a) solely by reason of the fact that the State (or any political subdivision thereof)—

(1) has entered into—

(A) a contract with an organization which has agreed to provide care and services in addition to those offered under the State plan to individuals eligible for medical assistance who reside in the geographic area served by such organization and who elect to obtain such care and services from such organization, or by reason of the fact that the plan provides for payment for rural health clinic services only if those services are provided by a rural health clinic; or

(B) arrangements through a competitive bidding process or otherwise for the purchase of laboratory services referred to in section 1905(a)(3) or medical devices if the Secretary has found that—

(i) adequate services or devices will be available under such arrangements, and

(ii) any such laboratory services will be provided only through laboratories—

(I) which meet the applicable requirements of section 1861(e)(9) or paragraphs (15) and (16) of section 1861(s), and such additional requirements as the Secretary may require, and

(II) no more than 75 percent of whose charges for such services are for services provided to individuals who are entitled to benefits under this title or under part A or part B of title XVIII; [or]

(2) restricts for a reasonable period of time the provider or providers from which an individual (eligible for medical assistance for items or services under the State plan) can receive such items or services, if—

(A) the State has found, after notice and opportunity for a hearing (in accordance with procedures established by the State), that the individual has utilized such items or services at a frequency or amount not medically necessary

(as determined in accordance with utilization guidelines established by the State), and

(B) under such restriction, individuals eligible for medical assistance for such services have reasonable access (taking into account geographic location and reasonable travel time) to such services of adequate quality[.]; or

(3) *requires individuals, other than special needs children (as defined in subsection (i)), eligible for medical assistance for items or services under the State plan to enroll with an entity that provides or arranges for services for enrollees under a contract pursuant to section 1903(m), or with a primary care case manager (as defined in section 1905(t)(2)) (or restricts the number of provider agreements with those entities under the State plan, consistent with quality of care), if—*

(A) *the State permits an individual to choose the manager or managed care entity from among the managed care organizations and primary care case providers who meet the requirements of this title;*

(B)(i) *individuals are permitted to choose between at least 2 of those entities, or 2 of the managers, or an entity and a manager, each of which has sufficient capacity to provide services to enrollees; or*

(ii) *with respect to a rural area—*

(I) *individuals who are required to enroll with a single entity are afforded the option to obtain covered services by an alternative provider; and*

(II) *an individual who is offered no alternative to a single entity or manager is given a choice between at least two providers within the entity or through the manager;*

(C) *no individual who is an Indian (as defined in section 4 of the Indian Health Care Improvement Act of 1976) is required to enroll in any entity that is not one of the following (and only if such entity is participating under the plan): the Indian Health Service, an Indian health program operated by an Indian tribe or tribal organization pursuant to a contract, grant, cooperative agreement, or compact with the Indian Health Service pursuant to the Indian Self-Determination Act (25 U.S.C. 450 et seq.), or an urban Indian health program operated by an urban Indian organization pursuant to a grant or contract with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.);*

(D) *the State restricts those individuals from changing their enrollment without cause for periods no longer than six months (and permits enrollees to change enrollment for cause at any time);*

(E) *the restrictions do not apply to providers of family planning services (as defined in section 1905(a)(4)(C)) and are not conditions for payment of medicare cost sharing pursuant to section 1905(p)(3); and*

(F) *prior to establishing an enrollment requirement under this paragraph, the State agency provides for public notice*

and comment pursuant to requirements established by the Secretary.

* * * * *
(c)(1) * * *
* * * * *

(5) For purposes of paragraph (4)(B), the term “habilitation services” [with respect to individuals who receive such services after discharge from a nursing facility or intermediate care facility for the mentally retarded]—

(A) * * *

* * * * *
(i) For purposes of subsection (a)(3), the term “special needs child” means an individual under 19 years of age who—

- (1) is eligible for supplemental security income under title XVI,
- (2) is described in section 501(a)(1)(D),
- (3) is described in section 1902(e)(3), or
- (4) is in foster care or otherwise in an out-of-home placement.

USE OF ENROLLMENT FEES, PREMIUMS, DEDUCTIONS, COST SHARING, AND SIMILAR CHARGES

SEC. 1916. (a) The State plan shall provide that in the case of individuals described in subparagraph (A) or (E)(i) of section 1902(a)(10) who are eligible under the plan—

- (1) no enrollment fee, premium, or similar charge will be imposed under the plan (except for a premium imposed under subsection (c));
- (2) no deduction, cost sharing or similar charge will be imposed under the plan with respect to—

(A) * * *

* * * * *
(D) emergency services (as defined by the Secretary), family planning services and supplies described in section 1905(a)(4)(C), or (at the option of the State) services furnished to such an individual by a health maintenance organization (as defined in section 1903(m)) in which he is enrolled, or

* * * * *

REQUIREMENTS FOR NURSING FACILITIES

SEC. 1919. (a) * * *

* * * * *

(h) ENFORCEMENT PROCESS.—

(1) * * *

* * * * *

(3) SECRETARIAL AUTHORITY.—

(A) * * *

* * * * *

(D) CONTINUATION OF PAYMENTS PENDING REMEDIATION.—The Secretary may continue payments, over a period of not longer than 6 months after the effective date of the findings, under this title with respect to a nursing facility not in compliance with a requirement of subsection (b), (c), or (d), if—

(i) the State survey agency finds that it is more appropriate to take alternative action to assure compliance of the facility with the requirements than to terminate the certification of the facility, *and*

(ii) the State has submitted a plan and timetable for corrective action to the Secretary for approval and the Secretary approves the plan of corrective action **and**.

[(iii) the State agrees to repay to the Federal Government payments received under this subparagraph if the corrective action is not taken in accordance with the approved plan and timetable.]

The Secretary shall establish guidelines for approval of corrective actions requested by States under this subparagraph.

* * * * *

ADJUSTMENT IN PAYMENT FOR INPATIENT HOSPITAL SERVICES
FURNISHED BY DISPROPORTIONATE SHARE HOSPITALS

SEC. 1923. (a) IMPLEMENTATION OF REQUIREMENT.—

(1) A State plan under this title shall not be considered to meet the requirement of section 1902(a)(13)(A) (insofar as it requires payments to hospitals to take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs), as of July 1, 1988, unless the State has submitted to the Secretary, by not later than such date, an amendment to such plan that—

(A) specifically defines the hospitals so described (and includes in such definition any disproportionate share hospital described in subsection (b)(1) which meets the requirements of subsection (d)), **and**

(B) provides, effective for inpatient hospital services provided not later than July 1, 1988, for an appropriate increase in the rate or amount of payment for such services provided by such hospitals, consistent with subsection (c) **and**

(C) *provides that payment adjustments under the plan under this section for services furnished by a hospital on or after October 1, 1997, for individuals entitled to benefits under the plan, and enrolled with an entity described in section 1903(m), under a primary care case management system (described in section 1905(t)), or other managed care plan—*

(i) are made directly to the hospital by the State, and

(ii) are not used as part of, and are disregarded in determining the amount of, prepaid capitation paid under the State plan with respect to those services.

* * * * *

(f) DENIAL OF FEDERAL FINANCIAL PARTICIPATION FOR PAYMENTS IN EXCESS OF CERTAIN LIMITS.—

(1) * * *

(2) DETERMINATION OF STATE DSH ALLOTMENTS.—

(A) IN GENERAL.—Subject to subparagraph (B) and paragraph (5), the State DSH allotment for a fiscal year is equal to the State DSH allotment for the previous fiscal year (or, for fiscal year 1993, the State base allotment as defined in paragraph (4)(C)), increased by—

(i) * * *

* * * * *

(5) ADJUSTMENTS IN DSH ALLOTMENTS.—

(A) ALLOTMENT FROZEN FOR STATES WITH VERY LOW DSH EXPENDITURES.—In the case of a State for which its State 1995 DSH spending did not exceed 1 percent of the total amount expenditures made under the State plan under this title for medical assistance during fiscal year 1995 (as reported by the State no later than January 1, 1997, on HCFA Form 64), the DSH allotment for each of fiscal years 1998 through 2002 is equal to its State 1995 DSH spending.

(B) FULL REDUCTION FOR HIGH DSH STATES.—In the case of a State which was classified under this subsection as a high DSH State for fiscal year 1997, the DSH allotment for each of fiscal years 1998 through 2002 is equal to the State 1995 DSH spending reduced by the full reduction percentage (described in subparagraph (D)) for the fiscal year involved.

(C) HALF-REDUCTION FOR OTHER STATES.—In the case of a State not described in subparagraph (A) or (B), the DSH allotment for each of fiscal years 1998 through 2002 is equal to the State 1995 DSH spending reduced by 1/2 of the full reduction percentage for the fiscal year involved.

(D) FULL REDUCTION PERCENTAGE.—For purposes of this paragraph, the “full reduction percentage” for—

- (i) fiscal year 1998 is 2 percent,
- (ii) fiscal year 1999 is 5 percent,
- (iii) fiscal year 2000 is 20 percent,
- (iv) fiscal year 2001 is 30 percent, and
- (v) fiscal year 2002 is 40 percent.

(E) DEFINITIONS.— In this paragraph:

(i) STATE.—The term “State” means the 50 States and the District of Columbia.

(ii) STATE 1995 DSH SPENDING.—The term “State 1995 DSH spending” means, with respect to a State, the total amount of payment adjustments made under subsection (c) under the State plan during fiscal year

1995 as reported by the State no later than January 1, 1997, on HCFA Form 64.

* * * * *

TREATMENT OF INCOME AND RESOURCES FOR CERTAIN INSTITUTIONALIZED SPOUSES

SEC. 1924. (a) SPECIAL TREATMENT FOR INSTITUTIONALIZED SPOUSES.—

(1) * * *

* * * * *

(5) APPLICATION TO INDIVIDUALS RECEIVING SERVICES [FROM ORGANIZATIONS RECEIVING CERTAIN WAIVERS] UNDER PACE PROGRAMS.—This section applies to individuals receiving institutional or noninstitutional services [from any organization receiving a frail elderly demonstration project waiver under section 9412(b) of the Omnibus Budget Reconciliation Act of 1986 or a waiver under section 603(c) of the Social Security Amendments of 1983.] under a PACE demonstration waiver program (as defined in subsection (a)(7) of section 1932) or under a PACE program under section 1894.

* * * * *

PAYMENT FOR COVERED OUTPATIENT DRUGS

SEC. 1927. (a) * * *

* * * * *

(g) DRUG USE REVIEW.—

(1) IN GENERAL.—

(A) * * *

(B) The program shall assess data on drug use against predetermined standards, consistent with the following:

(i) compendia which shall consist of the following:

(I) American Hospital Formulary Service Drug Information;

(II) United States Pharmacopeia-Drug Information; [and]

(III) the DRUGDEX Information System; and

[(III)] (IV) American Medical Association Drug Evaluations; and

(ii) the peer-reviewed medical literature.

* * * * *

PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)

SEC. 1932. (a) OPTION.—

(1) IN GENERAL.—A State may elect to provide medical assistance under this section with respect to PACE program services to PACE program eligible individuals who are eligible for medical assistance under the State plan and who are enrolled in a PACE program under a PACE program agreement. Such individuals need not be eligible for benefits under part A, or enrolled under part B, of title XVIII to be eligible to enroll under

this section. In the case of an individual enrolled with a PACE program pursuant to such an election—

(A) the individual shall receive benefits under the plan solely through such program, and

(B) the PACE provider shall receive payment in accordance with the PACE program agreement for provision of such benefits.

A State may limit through its PACE program agreement the number of individuals who may be enrolled in a PACE program under the State plan.

(2) PACE PROGRAM DEFINED.—For purposes of this section and section 1894, the term “PACE program” means a program of all-inclusive care for the elderly that meets the following requirements:

(A) OPERATION.—The entity operating the program is a PACE provider (as defined in paragraph (3)).

(B) COMPREHENSIVE BENEFITS.—The program provides comprehensive health care services to PACE program eligible individuals in accordance with the PACE program agreement and regulations under this section.

(C) TRANSITION.—In the case of an individual who is enrolled under the program under this section and whose enrollment ceases for any reason (including the individual no longer qualifies as a PACE program eligible individual, the termination of a PACE program agreement, or otherwise), the program provides assistance to the individual in obtaining necessary transitional care through appropriate referrals and making the individual’s medical records available to new providers.

(3) PACE PROVIDER DEFINED.—

(A) IN GENERAL.—For purposes of this section, the term “PACE provider” means an entity that—

(i) subject to subparagraph (B), is (or is a distinct part of) a public entity or a private, nonprofit entity organized for charitable purposes under section 501(c)(3) of the Internal Revenue Code of 1986, and

(ii) has entered into a PACE program agreement with respect to its operation of a PACE program.

(B) TREATMENT OF PRIVATE, FOR-PROFIT PROVIDERS.—Clause (i) of subparagraph (A) shall not apply—

(i) to entities subject to a demonstration project waiver under subsection (h); and

(ii) after the date the report under section 4014(b) of the Balanced Budget Act of 1997 is submitted, unless the Secretary determines that any of the findings described in subparagraph (A), (B), (C) or (D) of paragraph (2) of such section are true.

(4) PACE PROGRAM AGREEMENT DEFINED.—For purposes of this section, the term “PACE program agreement” means, with respect to a PACE provider, an agreement, consistent with this section, section 1894 (if applicable), and regulations promulgated to carry out such sections, between the PACE provider, the Secretary, and a State administering agency for the operation of a PACE program by the provider under such sections.

(5) *PACE PROGRAM ELIGIBLE INDIVIDUAL DEFINED.*—For purposes of this section, the term “PACE program eligible individual” means, with respect to a PACE program, an individual who—

(A) is 55 years of age or older;

(B) subject to subsection (c)(4), is determined under subsection (c) to require the level of care required under the State medicaid plan for coverage of nursing facility services;

(C) resides in the service area of the PACE program; and

(D) meets such other eligibility conditions as may be imposed under the PACE program agreement for the program under subsection (e)(2)(A)(ii).

(6) *PACE PROTOCOL.*—For purposes of this section, the term “PACE protocol” means the Protocol for the Program of All-inclusive Care for the Elderly (PACE), as published by On Lok, Inc., as of April 14, 1995.

(7) *PACE DEMONSTRATION WAIVER PROGRAM DEFINED.*—For purposes of this section, the term “PACE demonstration waiver program” means a demonstration program under either of the following sections (as in effect before the date of their repeal):

(A) Section 603(c) of the Social Security Amendments of 1983 (Public Law 98–21), as extended by section 9220 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99–272).

(B) Section 9412(b) of the Omnibus Budget Reconciliation Act of 1986 (Public Law 99–509).

(8) *STATE ADMINISTERING AGENCY DEFINED.*—For purposes of this section, the term “State administering agency” means, with respect to the operation of a PACE program in a State, the agency of that State (which may be the single agency responsible for administration of the State plan under this title in the State) responsible for administering PACE program agreements under this section and section 1894 in the State.

(9) *TRIAL PERIOD DEFINED.*—

(A) *IN GENERAL.*—For purposes of this section, the term “trial period” means, with respect to a PACE program operated by a PACE provider under a PACE program agreement, the first 3 contract years under such agreement with respect to such program.

(B) *TREATMENT OF ENTITIES PREVIOUSLY OPERATING PACE DEMONSTRATION WAIVER PROGRAMS.*—Each contract year (including a year occurring before the effective date of this section) during which an entity has operated a PACE demonstration waiver program shall be counted under subparagraph (A) as a contract year during which the entity operated a PACE program as a PACE provider under a PACE program agreement.

(10) *REGULATIONS.*—For purposes of this section, the term “regulations” refers to interim final or final regulations promulgated under subsection (f) to carry out this section and section 1894.

(b) *SCOPE OF BENEFITS; BENEFICIARY SAFEGUARDS.*—

(1) *IN GENERAL.*—Under a PACE program agreement, a PACE provider shall—

(A) provide to PACE program eligible individuals, regardless of source of payment and directly or under contracts with other entities, at a minimum—

(i) all items and services covered under title XVIII (for individuals enrolled under section 1894) and all items and services covered under this title, but without any limitation or condition as to amount, duration, or scope and without application of deductibles, copayments, coinsurance, or other cost-sharing that would otherwise apply under such title or this title, respectively; and

(ii) all additional items and services specified in regulations, based upon those required under the PACE protocol;

(B) provide such enrollees access to necessary covered items and services 24 hours per day, every day of the year;

(C) provide services to such enrollees through a comprehensive, multidisciplinary health and social services delivery system which integrates acute and long-term care services pursuant to regulations; and

(D) specify the covered items and services that will not be provided directly by the entity, and to arrange for delivery of those items and services through contracts meeting the requirements of regulations.

(2) *QUALITY ASSURANCE; PATIENT SAFEGUARDS.*—The PACE program agreement shall require the PACE provider to have in effect at a minimum—

(A) a written plan of quality assurance and improvement, and procedures implementing such plan, in accordance with regulations, and

(B) written safeguards of the rights of enrolled participants (including a patient bill of rights and procedures for grievances and appeals) in accordance with regulations and with other requirements of this title and Federal and State law designed for the protection of patients.

(c) *ELIGIBILITY DETERMINATIONS.*—

(1) *IN GENERAL.*—The determination of whether an individual is a PACE program eligible individual—

(A) shall be made under and in accordance with the PACE program agreement, and

(B) who is entitled to medical assistance under this title, shall be made (or who is not so entitled, may be made) by the State administering agency.

(2) *CONDITION.*—An individual is not a PACE program eligible individual (with respect to payment under this section) unless the individual's health status has been determined, in accordance with regulations, to be comparable to the health status of individuals who have participated in the PACE demonstration waiver programs. Such determination shall be based upon information on health status and related indicators (such as medical diagnoses and measures of activities of daily living, instrumental activities of daily living, and cognitive impairment)

that are part of a uniform minimum data set collected by PACE providers on potential eligible individuals.

(3) ANNUAL ELIGIBILITY RECERTIFICATIONS.—

(A) *IN GENERAL.*—Subject to subparagraph (B), the determination described in subsection (a)(5)(B) for an individual shall be reevaluated at least once a year.

(B) *EXCEPTION.*—The requirement of annual reevaluation under subparagraph (A) may be waived during a period in accordance with regulations in those cases where the State administering agency determines that there is no reasonable expectation of improvement or significant change in an individual's condition during the period because of the advanced age, severity of the advanced age, severity of chronic condition, or degree of impairment of functional capacity of the individual involved.

(4) *CONTINUATION OF ELIGIBILITY.*—An individual who is a PACE program eligible individual may be deemed to continue to be such an individual notwithstanding a determination that the individual no longer meets the requirement of subsection (a)(5)(B) if, in accordance with regulations, in the absence of continued coverage under a PACE program the individual reasonably would be expected to meet such requirement within the succeeding 6-month period.

(5) *ENROLLMENT; DISENROLLMENT.*—The enrollment and disenrollment of PACE program eligible individuals in a PACE program shall be pursuant to regulations and the PACE program agreement and shall permit enrollees to voluntarily disenroll without cause at any time.

(d) PAYMENTS TO PACE PROVIDERS ON A CAPITATED BASIS.—

(1) *IN GENERAL.*—In the case of a PACE provider with a PACE program agreement under this section, except as provided in this subsection or by regulations, the State shall make prospective monthly payments of a capitation amount for each PACE program eligible individual enrolled under the agreement under this section.

(2) *CAPITATION AMOUNT.*—The capitation amount to be applied under this subsection for a provider for a contract year shall be an amount specified in the PACE program agreement for the year. Such amount shall be an amount, specified under the PACE agreement, which is less than the amount that would otherwise have been made under the State plan if the individuals were not so enrolled and shall be adjusted to take into account the comparative frailty of PACE enrollees and such other factors as the Secretary determines to be appropriate. The payment under this section shall be in addition to any payment made under section 1894 for individuals who are enrolled in a PACE program under such section.

(e) PACE PROGRAM AGREEMENT.—

(1) *REQUIREMENT.*—

(A) *IN GENERAL.*—The Secretary, in close cooperation with the State administering agency, shall establish procedures for entering into, extending, and terminating PACE program agreements for the operation of PACE programs

by entities that meet the requirements for a PACE provider under this section, section 1894, and regulations.

(B) NUMERICAL LIMITATION.—

(i) IN GENERAL.—The Secretary shall not permit the number of PACE providers with which agreements are in effect under this section or under section 9412(b) of the Omnibus Budget Reconciliation Act of 1986 to exceed—

(I) 40 as of the date of the enactment of this section, or

(II) as of each succeeding anniversary of such date, the numerical limitation under this subparagraph for the preceding year plus 20.

Subclause (II) shall apply without regard to the actual number of agreements in effect as of a previous anniversary date.

(ii) TREATMENT OF CERTAIN PRIVATE, FOR-PROFIT PROVIDERS.—The numerical limitation in clause (i) shall not apply to a PACE provider that—

(I) is operating under a demonstration project waiver under subsection (h), or

(II) was operating under such a waiver and subsequently qualifies for PACE provider status pursuant to subsection (a)(3)(B)(ii).

(2) SERVICE AREA AND ELIGIBILITY.—

(A) IN GENERAL.—A PACE program agreement for a PACE program—

(i) shall designate the service area of the program;

(ii) may provide additional requirements for individuals to qualify as PACE program eligible individuals with respect to the program;

(iii) shall be effective for a contract year, but may be extended for additional contract years in the absence of a notice by a party to terminate and is subject to termination by the Secretary and the State administering agency at any time for cause (as provided under the agreement);

(iv) shall require a PACE provider to meet all applicable State and local laws and requirements; and

(v) shall have such additional terms and conditions as the parties may agree to consistent with this section and regulations.

(B) SERVICE AREA OVERLAP.—In designating a service area under a PACE program agreement under subparagraph (A)(i), the Secretary (in consultation with the State administering agency) may exclude from designation an area that is already covered under another PACE program agreement, in order to avoid unnecessary duplication of services and avoid impairing the financial and service viability of an existing program.

(3) DATA COLLECTION.—

(A) IN GENERAL.—Under a PACE program agreement, the PACE provider shall—

(i) collect data,

(ii) maintain, and afford the Secretary and the State administering agency access to, the records relating to the program, including pertinent financial, medical, and personnel records, and

(iii) make to the Secretary and the State administering agency reports that the Secretary finds (in consultation with State administering agencies) necessary to monitor the operation, cost, and effectiveness of the PACE program under this title and title XVIII.

(B) *REQUIREMENTS DURING TRIAL PERIOD.*—During the first three years of operation of a PACE program (either under this section or under a PACE demonstration waiver program), the PACE provider shall provide such additional data as the Secretary specifies in regulations in order to perform the oversight required under paragraph (4)(A).

(4) *OVERSIGHT.*—

(A) *ANNUAL, CLOSE OVERSIGHT DURING TRIAL PERIOD.*—During the trial period (as defined in subsection (a)(9)) with respect to a PACE program operated by a PACE provider, the Secretary (in cooperation with the State administering agency) shall conduct a comprehensive annual review of the operation of the PACE program by the provider in order to assure compliance with the requirements of this section and regulations. Such a review shall include—

- (i) an on-site visit to the program site;
- (ii) comprehensive assessment of a provider's fiscal soundness;
- (iii) comprehensive assessment of the provider's capacity to provide all PACE services to all enrolled participants;
- (iv) detailed analysis of the entity's substantial compliance with all significant requirements of this section and regulations; and
- (v) any other elements the Secretary or State agency considers necessary or appropriate.

(B) *CONTINUING OVERSIGHT.*—After the trial period, the Secretary (in cooperation with the State administering agency) shall continue to conduct such review of the operation of PACE providers and PACE programs as may be appropriate, taking into account the performance level of a provider and compliance of a provider with all significant requirements of this section and regulations.

(C) *DISCLOSURE.*—The results of reviews under this paragraph shall be reported promptly to the PACE provider, along with any recommendations for changes to the provider's program, and shall be made available to the public upon request.

(5) *TERMINATION OF PACE PROVIDER AGREEMENTS.*—

(A) *IN GENERAL.*—Under regulations—

- (i) the Secretary or a State administering agency may terminate a PACE program agreement for cause, and

(ii) a PACE provider may terminate such an agreement after appropriate notice to the Secretary, the State agency, and enrollees.

(B) CAUSES FOR TERMINATION.—In accordance with regulations establishing procedures for termination of PACE program agreements, the Secretary or a State administering agency may terminate a PACE program agreement with a PACE provider for, among other reasons, the fact that—

(i) the Secretary or State administering agency determines that—

(I) there are significant deficiencies in the quality of care provided to enrolled participants; or

(II) the provider has failed to comply substantially with conditions for a program or provider under this section or section 1894; and

(ii) the entity has failed to develop and successfully initiate, within 30 days of the date of the receipt of written notice of such a determination, and continue implementation of a plan to correct the deficiencies.

(C) TERMINATION AND TRANSITION PROCEDURES.—An entity whose PACE provider agreement is terminated under this paragraph shall implement the transition procedures required under subsection (a)(2)(C).

(6) SECRETARY'S OVERSIGHT; ENFORCEMENT AUTHORITY.—

(A) IN GENERAL.—Under regulations, if the Secretary determines (after consultation with the State administering agency) that a PACE provider is failing substantially to comply with the requirements of this section and regulations, the Secretary (and the State administering agency) may take any or all of the following actions:

(i) Condition the continuation of the PACE program agreement upon timely execution of a corrective action plan.

(ii) Withhold some or all further payments under the PACE program agreement under this section or section 1894 with respect to PACE program services furnished by such provider until the deficiencies have been corrected.

(iii) Terminate such agreement.

(B) APPLICATION OF INTERMEDIATE SANCTIONS.—Under regulations, the Secretary may provide for the application against a PACE provider of remedies described in section 1857(f)(2) (or, for periods before January 1, 1999, section 1876(i)(6)(B)) or 1903(m)(6)(B) in the case of violations by the provider of the type described in section 1857(f)(1) (or 1876(i)(6)(A) for such periods) or 1903(m)(6)(A), respectively (in relation to agreements, enrollees, and requirements under section 1894 or this section, respectively).

(7) PROCEDURES FOR TERMINATION OR IMPOSITION OF SANCTIONS.—Under regulations, the provisions of section 1857(g) (or for periods before January 1, 1999, section 1876(i)(9)) shall apply to termination and sanctions respecting a PACE program agreement and PACE provider under this subsection in the same manner as they apply to a termination and sanctions with

respect to a contract and a MedicarePlus organization under part C (or for such periods an eligible organization under section 1876).

(8) *TIMELY CONSIDERATION OF APPLICATIONS FOR PACE PROGRAM PROVIDER STATUS.*—In considering an application for PACE provider program status, the application shall be deemed approved unless the Secretary, within 90 days after the date of the submission of the application to the Secretary, either denies such request in writing or informs the applicant in writing with respect to any additional information that is needed in order to make a final determination with respect to the application. After the date the Secretary receives such additional information, the application shall be deemed approved unless the Secretary, within 90 days of such date, denies such request.

(f) *REGULATIONS.*—

(1) *IN GENERAL.*—The Secretary shall issue interim final or final regulations to carry out this section and section 1894.

(2) *USE OF PACE PROTOCOL.*—

(A) *IN GENERAL.*—In issuing such regulations, the Secretary shall, to the extent consistent with the provisions of this section, incorporate the requirements applied to PACE demonstration waiver programs under the PACE protocol.

(B) *FLEXIBILITY.*—The Secretary (in close consultation with State administering agencies) may modify or waive such provisions of the PACE protocol in order to provide for reasonable flexibility in adapting the PACE service delivery model to the needs of particular organizations (such as those in rural areas or those that may determine it appropriate to use non-staff physicians accordingly to State licensing law requirements) under this section and section 1932 where such flexibility is not inconsistent with and would not impair the essential elements, objectives, and requirements of this section, including—

(i) the focus on frail elderly qualifying individuals who require the level of care provided in a nursing facility;

(ii) the delivery of comprehensive, integrated acute and long-term care services;

(iii) the interdisciplinary team approach to care management and service delivery;

(iv) capitated, integrated financing that allows the provider to pool payments received from public and private programs and individuals; and

(v) the assumption by the provider over time of full financial risk.

(3) *APPLICATION OF CERTAIN ADDITIONAL BENEFICIARY AND PROGRAM PROTECTIONS.*—

(A) *IN GENERAL.*—In issuing such regulations and subject to subparagraph (B), the Secretary may apply with respect to PACE programs, providers, and agreements such requirements of part C of title XVIII (or, for periods before January 1, 1999, section 1876) and section 1903(m) relating to protection of beneficiaries and program integrity as would apply to MedicarePlus organizations under such

part C (or for such periods eligible organizations under risk-sharing contracts under section 1876) and to health maintenance organizations under prepaid capitation agreements under section 1903(m).

(B) *CONSIDERATIONS.*—In issuing such regulations, the Secretary shall—

(i) take into account the differences between populations served and benefits provided under this section and under part C of title XVIII (or, for periods before January 1, 1999, section 1876) and section 1903(m);

(ii) not include any requirement that conflicts with carrying out PACE programs under this section; and

(iii) not include any requirement restricting the proportion of enrollees who are eligible for benefits under this title or title XVIII.

(g) *WAIVERS OF REQUIREMENTS.*—With respect to carrying out a PACE program under this section, the following requirements of this title (and regulations relating to such requirements) shall not apply:

(1) Section 1902(a)(1), relating to any requirement that PACE programs or PACE program services be provided in all areas of a State.

(2) Section 1902(a)(10), insofar as such section relates to comparability of services among different population groups.

(3) Sections 1902(a)(23) and 1915(b)(4), relating to freedom of choice of providers under a PACE program.

(4) Section 1903(m)(2)(A), insofar as it restricts a PACE provider from receiving prepaid capitation payments.

(h) *DEMONSTRATION PROJECT FOR FOR-PROFIT ENTITIES.*—

(1) *IN GENERAL.*—In order to demonstrate the operation of a PACE program by a private, for-profit entity, the Secretary (in close consultation with State administering agencies) shall grant waivers from the requirement under subsection (a)(3) that a PACE provider may not be a for-profit, private entity.

(2) *SIMILAR TERMS AND CONDITIONS.*—

(A) *IN GENERAL.*—Except as provided under subparagraph (B), and paragraph (1), the terms and conditions for operation of a PACE program by a provider under this subsection shall be the same as those for PACE providers that are nonprofit, private organizations.

(B) *NUMERICAL LIMITATION.*—The number of programs for which waivers are granted under this subsection shall not exceed 10. Programs with waivers granted under this subsection shall not be counted against the numerical limitation specified in subsection (e)(1)(B).

(i) *POST-ELIGIBILITY TREATMENT OF INCOME.*—A State may provide for post-eligibility treatment of income for individuals enrolled in PACE programs under this section in the same manner as a State treats post-eligibility income for individuals receiving services under a waiver under section 1915(c).

(j) *MISCELLANEOUS PROVISIONS.*—

(1) *CONSTRUCTION.*—Nothing in this section or section 1894 shall be construed as preventing a PACE provider from entering into contracts with other governmental or nongovernmental

payers for the care of PACE program eligible individuals who are not eligible for benefits under part A, or enrolled under part B, of title XVIII or eligible for medical assistance under this title.

DETERMINATION OF HOSPITAL STAY

SEC. 1933. (a) IN GENERAL.—A Medicaid health plan shall cover the length of an inpatient hospital stay under this title as determined by the attending physician (or other attending health care provider to the extent permitted under State law) in consultation with the patient to be medically appropriate.

(b) CONSTRUCTION.—Nothing in this title shall be construed—

(1) as requiring the provision of inpatient coverage if the attending physician (or other attending health care provider to the extent permitted under State law) and patient determine that a shorter period of hospital stay is medically appropriate, or

(2) as affecting the application of deductibles and coinsurance.

REFERENCES TO LAWS DIRECTLY AFFECTING MEDICAID PROGRAM

SEC. [1931.] 1934. (a) AUTHORITY OR REQUIREMENTS TO COVER ADDITIONAL INDIVIDUALS.—For provisions of law which make additional individuals eligible for medical assistance under this title, see the following:

(1) AFDC.—(A) Section 402(a)(32) of this Act (relating to individuals who are deemed recipients of aid but for whom a payment is not made).

* * * * *

SECTION 9412 OF THE OMNIBUS BUDGET RECONCILIATION ACT OF 1986

SEC. 9412. WAIVER AUTHORITY FOR CHRONICALLY MENTALLY ILL AND FRAIL ELDERLY.

(a) * * *

[(b) FRAIL ELDERLY DEMONSTRATION PROJECT WAIVERS.—

[(1) The Secretary of Health and Human Services shall grant waivers of certain requirements of titles XVIII and XIX of the Social Security Act to not more than 10 public or non-profit private community-based organizations to enable such organizations to provide comprehensive health care services on a capitated basis to frail elderly patients at risk of institutionalization.

[(2)(A) Except as provided in subparagraph (B), the terms and conditions of a waiver granted pursuant to this subsection shall be substantially the same as the terms and conditions of the On Lok waiver (referred to in section 603(c) of the Social Security Amendments of 1983 and extended by section 9220 of the Consolidated Omnibus Budget Reconciliation Act of 1985), including permitting the organization to assume progressively (over the initial 3-year period of the waiver) the full financial risk.

[(B) In order to receive a waiver under this subsection, an organization must participate in an organized initiative to replicate the findings of the On Lok long-term care demonstration project (described in section 603(c)(1) of the Social Security Amendments of 1983).

[(C) Subject to subparagraph (B), any waiver granted pursuant to this subsection shall be for an initial period of 3 years. The Secretary may extend such waiver beyond such initial period for so long as the Secretary finds that the organization complies with the terms and conditions described in subparagraphs (A) and (B).]

SECTION 603 OF THE SOCIAL SECURITY AMENDMENTS OF 1983

REPORTS, EXPERIMENTS, AND DEMONSTRATION PROJECTS

SEC. 603. (a) * * *

* * * * *

[(c) The Secretary shall approve, with appropriate terms and conditions as defined by the Secretary, within 30 days after the date of enactment of this Act—

[(1) the risk-sharing application of On Lok Senior Health Services (according to terms and conditions as specified by the Secretary), dated July 2, 1982, for waivers, pursuant to section 222 of the Social Security Amendments of 1972 and section 402(a) of the Social Security Amendments of 1967, of certain requirements of title XVIII of the Social Security Act over a period of 36 months in order to carry out a long-term care demonstration project, and

[(2) the application of the Department of Health Services, State of California, dated November 1, 1982, pursuant to section 1115 of the Social Security Act, for the waiver of certain requirements of title XIX of such Act over a period of 36 months in order to carry out a demonstration project for capitated reimbursement for comprehensive long-term care services involving On Lok Senior Health Services.]

* * * * *

SECTION 9220 OF THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985

[SEC. 9220. EXTENSION OF ON LOK WAIVER.

[(a) CONTINUED APPROVAL.—

[(1) MEDICARE WAIVERS.—Notwithstanding any limitations contained in section 222 of the Social Security Amendments of 1972 and section 402(a) of the Social Security Amendments of 1967, the Secretary of Health and Human Services shall continue approval of the risk-sharing application (described in section 603(c)(1) of Public Law 98–21) for waivers of certain requirements of title XVIII of the Social Security Act after the end of the period described in that section.

[(2) MEDICAID WAIVERS.—Notwithstanding any limitations contained in section 1115 of the Social Security Act, the Secretary shall approve any application of the Department of Health Services, State of California, for a waiver of requirements of title XIX of such Act in order to continue carrying out the demonstration project referred to in section 603(c)(2) of Public Law 98–21 after the end of the period described in that section.

[(b) TERMS, CONDITIONS, AND PERIOD OF APPROVAL.—The Secretary’s approval of an application (or renewal of an application) under this section—

[(1) shall be on the same terms and conditions as applied with respect to the corresponding application under section 603(c) of Public Law 98–21 as of July 1, 1985, except that requirements relating to collection and evaluation of information for demonstration purposes (and not for operational purposes) shall not apply; and

[(2) shall remain in effect until such time as the Secretary finds that the applicant no longer complies with the terms and conditions described in paragraph (1).]

* * * * *

SECTION 6408 OF THE OMNIBUS BUDGET RECONCILIATION ACT OF 1989

SEC. 6408. OTHER MEDICAID PROVISIONS.

(a) INSTITUTIONS FOR MENTAL DISEASES.—

(1) * * *

* * * * *

(3) MORATORIUM ON TREATMENT OF CERTAIN FACILITIES.— Any determination by the Secretary that Kent Community Hospital Complex in Michigan or Saginaw Community Hospital in Michigan is an institution for mental diseases, for purposes of title XIX of the Social Security Act shall not take effect until December 31, [1995] 2002.

* * * * *

COMMITTEE ON EDUCATION AND THE WORKFORCE,
HOUSE OF REPRESENTATIVES,
Washington, DC, June 13, 1997.

Hon. JOHN R. KASICH,
*Chairman, Committee on the Budget, U.S. House of Representatives,
Washington, DC.*

Pursuant to the reconciliation directives contained in the Conference Report on House Concurrent Resolution 84, the budget resolution for fiscal year 1998, I am pleased to transmit reconciliation recommendations for programs within the jurisdiction of the Committee on Education and the Workforce. The recommendations contained in this formal transmission were approved by the Full Committee on Thursday, June 12, 1997 by a vote of 24 ayes to 20 noes. A copy of the legislation, and report, including the Committee Views together with Summary, Section by Section Analysis, Ramseyer and other items necessary to comply with House Rules are enclosed. Also enclosed are dissenting and minority views. Pursuant to your letter of May 30, 1997, the cost estimate will be forthcoming, but in no event later than Monday, June 16, 1997.

I hope these proposals will be of assistance to your committee in meeting the budget reconciliation targets. If you have questions or comments, please do not hesitate to call me.

Sincerely,

BILL GOODLING,
Chairman.

Enclosures.

COMMITTEE ON EDUCATION AND THE WORKFORCE

PURPOSE

The purpose of Title V is to report legislative changes that reflect the bipartisan budget agreement approved by the President and Congressional leadership in May 1997 and to comply with the instructions of the Committee on the Budget to make changes in law necessary to achieve the direct spending and deficit reduction targets contained in the fiscal year 1998 concurrent resolution on the budget.

SUBTITLE A

The purpose of Subtitle A is to comply with the Budget Agreement by providing grants to States and localities to assist them in helping long-term welfare recipients enter employment and independence; and to clarify the application of various employment laws to certain welfare-to-work activities; to ensure the protection of participants in welfare-to-work activities; and to provide States with reasonable flexibility to meet work requirements.

SUBTITLE B

The purpose of Subtitle B is to achieve savings from the student loan programs totaling \$1,763,000,000 over a five year period. The savings are to be achieved by reducing administrative expenses associated with the Federal Family Education Loan Program and the Federal Direct Student Loan Program. The Budget Agreement set forth three areas for potential savings. These three areas have been included in Subtitle B of the Committee bill and the Committee has complied with the Budget Resolution.

SUBTITLE C

The purpose of Subtitle C is to repeal the Smith Hughes Act which is a small, mandatory vocational education program thereby complying with the Budget Resolution and the Administration's FY98 budget request.

SUBTITLE D

The purpose of Subtitle D is to deliver further improvements in the availability, affordability, and accountability of health insurance coverage, building on the ERISA provisions included under the Health Insurance Portability and Accountability Act (HIPAA). The subtitle amends ERISA to include the provisions of The Expanded Portability and Health Insurance Coverage Act of 1997 (EPHIC). EPHIC makes key health insurance reforms which will expand coverage and stop insurance fraud: (1) it would give franchise networks, union collectively-bargained plans, bona-fide trade, business and professional associations (e.g. chambers of commerce, retailers, wholesalers, printers, agricultural workers, grocers, churches, etc.) the ability to form large ERISA group health plans, thereby gaining the economies-of-scale so as to fully-insure or self-insure the workers, spouses and children of America's small businesses, just as large and mid-sized businesses have been able to do for 23 years since the passage of ERISA; and (2) it will end the jurisdictional confusion that has led to the proliferation of insurance fraud perpetrated by "bogus unions" and other illegitimate operators by drawing bright lines regarding state and federal authority, by making legitimate association plans accountable and by adding new civil and criminal tools to end fraudulent schemes.

COMMITTEE ACTION

SUBTITLES A, B, AND C

On Thursday, June 12, 1997 the Committee, acting pursuant to the Conference Report on House Concurrent Resolution 84, considered its recommendations for the budget reconciliation. The Committee approved a Committee Print containing Subtitles A (Welfare to Work provisions), B (Higher Education Act provisions) and C (Smith Hughes repeal). The Committee favorably approved budget reconciliation recommendations in the Committee Print to be transmitted to the Committee on the Budget by a recorded vote of 24 ayes to 20 noes.

SUBTITLE D

The Subcommittee on Employer-Employee Relations held a legislative hearing on EPHIC on May 8, 1997. Testimony was received from: the Honorable James P. Moran (D-VA, 8th District); Jack Faris, President and CEO, National Federation of Independent Business; Mary Castro, Vice President, Employee Benefits, Independent Grocers Alliance, Inc., Chicago, IL; Cathy Hurwit, Deputy Director, Citizen Action; Kathleen Sebelius, Commissioner of Insurance, State of Kansas; Donald Dressler, President of Insurance Services, Western Growers Association, on behalf of The Association Healthcare Coalition, Newport Beach, CA; and Jeffrey H. Joseph, Vice President, Domestic Policy, U.S. Chamber of Commerce.

EPHIC was introduced by Representative Harris Fawell as H.R. 1515 on May 1, 1997. The bipartisan legislation has over 140 cosponsors. EPHIC was introduced in the Senate by Senator Tim Hutchinson on May 9, 1997 (S. 729).

On Wednesday, June 11, 1997, the Committee on Education and the Workforce discharged H.R. 1515 from subcommittee. On Thursday June 12, 1997, the Committee approved it, as amended, on a voice vote, and, by a vote of 24 ayes to 20 noes, ordered the bill favorably reported and incorporated into subtitle D of the reconciliation package transmitted to the Budget Committee and ordered reported the bill, amended, to the House of Representatives.

SUMMARY

SUBTITLE A

This proposal provides \$3 billion, over four years, to provide targeted Federal assistance to fund State welfare to work services, in accordance with the parameters of the Budget Resolution. Under the Committee proposal, the Secretary of Labor must distribute 93.5% of welfare to work funds by formula to States, based on each State's share of poverty and adults receiving assistance under the State's Temporary Assistance to Needy Family (TANF) program. In order to qualify for funds, a State must match additional federal funds on a \$1 (State) per \$2 (Federal) basis, and submit a plan to the Secretary describing how it will spend the funds and the formula for distribution of funds within the State. States must distribute at least 85% of their allotment to Service Delivery Areas (SDA) based on a within State formula devised by the State, which must be based primarily on poverty but may also include long term welfare dependency and unemployment. Any service delivery area which would be allotted less than \$100,000 under the State's formula will not receive funding; funds will revert to the State to be awarded to other areas or sub-areas within the SDA. Governors may use up to 15% of their State's allocation to fund projects designed to help long-term welfare recipients enter the workforce without regard to the within State allocation formula. Language in the bill also prohibits private industry councils from directly providing services with these funds.

Of the remaining 6.5% of the funds, 5% would be reserved for the Secretary of Labor to award a limited number of demonstration grants on a competitive basis to private industry councils or other

political subdivisions of a State. The purpose of these demonstration grants is to develop successful models for making placements of long-term welfare dependents into the workforce. In addition, any funds which were allocated by formula to the States but not obligated (because the State did not meet the match requirements or for any other reason) may be awarded through these competitive grants.

In addition, 1% of the funds are reserved for Indian tribes and .5% is reserved for an evaluation by the Secretary of HHS, who must develop an evaluation plan in consultation with the Secretaries of Labor and HUD.

Funds under this proposal may be spent only for job creation through public or private sector employment wage subsidies, on-the-job training, contracts with job placement companies or public job placement programs, job vouchers, and job retention or support services if such services are not otherwise available. Any entity receiving funds under either formula grants or demonstration grants must expend at least 90% of funds on participants who will become ineligible for TANF assistance within 12 months due to time limits; or have been on welfare for a total of at least 30 months; or who meet at least two of the following criteria: have not completed high school/GED and has low skills; require substance abuse treatment for employment; or have a poor work history.

As provided in the budget agreement, the funds available under this subtitle are a capped entitlement. The amount available for each year are \$725 million for fiscal year 1998, \$1.25 billion for fiscal year 1999, and \$1.0 billion for fiscal year 2000.

Protections for welfare-to-work participants

The Committee proposal includes several provisions that clarify the application of various employment laws and other protections to welfare-to-work participants including those who receive assistance from the new funding just described. The first amends the "anti-displacement" provisions in the Welfare Reform law by including provisions which were included in the Employment, Training and Literacy Enhancement Act of 1997, passed on May 16, 1997. These provisions reflect the Committee's intention of a single set of federal rules for the various federally-funded employment and workforce development programs.

Second, the Committee proposal specifies that federal or state health and safety standards that otherwise apply to employees of an employer also apply to non-employee participants in work activities in workplaces of that employer. In addition, the proposal specifies that employees must be covered by workers compensation on the same basis as other employees, in accordance with state law.

Third, the proposal adds a provision prohibiting discrimination on the basis of gender with regard to participants in work activities under the welfare law. The current welfare law expressly incorporates several general anti-discrimination statutes (race, national origin, age, disability). This provision adds further protections against discrimination on the basis of gender in the work activities.

Fourth, the proposal clarifies that welfare to work participants who are in employment positions must be paid at least the minimum wage. The proposal also clarifies that participants in work ex-

perience and community service with public agencies or non-profit organizations are not employees of those agencies or organizations. However, participants in these programs and in on-the-job training may not be required to participate for more hours in a month than their monthly welfare benefits divided by the federal minimum wage rate. For purposes of that calculation, the participant's monthly welfare benefits must include both cash assistance and food stamps and may also include the value of Medicaid, housing assistance, and child care assistance. Alternatively, a state may assign a participant to additional hours of other education and training activities in order to meet this requirement.

Other welfare provisions

Limitation of Educational Activities: The proposal includes a clarification that the combined number of individuals allowed to participate in vocational education and completion of high school is 20 percent of all those counted as meeting the work requirements under section 40 of TANF.

Pay-for-Performance Enforcement: Under the work requirements passed as part of welfare reform, States were required to reduce (pro rata) assistance for recipients refusing, without good cause, to work. However, no means of enforcing this provision was included with the initial provision. Under this proposal, the Secretary would be required to penalize any State failing to implement this provision at a rate of not less than one percent and not more than five percent of the State's family assistance grant.

SUBTITLE B

This legislation achieves savings from the student loan programs in accordance with the parameters of the Budget Agreement. It achieves a savings total of \$1,763,000,000 by returning funds held in reserve accounts by guaranty agencies, reducing the mandatory administrative funds authorized in Section 458 of Part D of the Higher Education Act and eliminating a loan processing fee authorized under Part D of the Higher Education Act. This legislation also clarifies guarantor retention rates for student loans in default which are subsequently consolidated and returned to good standing.

SUBTITLE C

This legislation repeals the Smith Hughes Act, a small mandatory vocational education program created in 1917 and appropriated to the States as part of the Vocational Education Basic State Grant program under the Carl D. Perkins Vocational Education and Applied Technology Act. Repeal of this Act complies with the Budget Resolution and the Administration's FY98 budget request.

SUBTITLE D

EPHIC expands coverage to small businesses by clarifying current law to allow employers, particularly small employers, to band together voluntarily in associations (such as Chambers of Commerce) to form association health plans. Under the bill, these

groups could fully insure and self-insure, gaining all of the advantages this entails including greater economies of scale and lower costs. The bill recognizes that the problem of the uninsured is one of small businesses unable to afford coverage for their workers: 80% of the 40 million uninsured are in families with at least one employed worker, the vast majority of whom are employed by small businesses.

Moreover, the legislation stops health insurance fraud perpetrated by “bogus unions” and other illegitimate operators by making legitimate plans accountable and providing new state and federal enforcement powers to put a stop to fraudulent schemes.—

COMMITTEE VIEWS

Members of the Committee on Education and the Workforce believe there is nothing more important to the future of this country than all Americans having the opportunity for high quality education and training that will provide them with the skills needed to compete in the Information Age economy. The Committee also recognizes the importance of a balanced budget in achieving this goal. Balancing the budget and reducing our \$5 trillion national debt will lower interest rates, create new jobs and produce a more stable future for our children. We believe the changes in this bill will take the first steps toward balancing our Federal budget and thereby helping every American—child, worker, student, family and entrepreneur—achieve their highest potential.

By using common sense solutions, this bill helps more people move from welfare into the workforce, protects student loan programs, and helps millions of uninsured workers provide health insurance coverage to their families.

SUBTITLE A

One of the most important and significant accomplishments of the 104th Congress was the enactment of comprehensive welfare reform, in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA). Welfare reform is already having a major impact in reducing welfare rolls and dependency.¹

¹ Wolf, Richard. “Welfare rolls show record decline” USA Today. June 10, 1997. Excerpt:

The number of people on welfare dropped a record 7% in the first six months under a federal law that limits aid and forces most recipients to work.

Federal figures through March 1997, obtained by USA Today, show the six-month rate of decline was the fastest during a three-year period in which welfare rolls have dropped by 22% from 14.4 million in March 1994 to 11.2 million in March 1997.

The unprecedented rate of decline is helping states make welfare reform work. Their federal block grants are based on caseloads from 1992–95, giving them more dollars from fewer clients. Under the law, cutting welfare rolls also reduces the number of people states must put to work without losing federal funds. As a result, most states are adding money to child care and other services needed to help in the transition from welfare to work.

The plummeting figures show no signs of abating:

The 7% drop in the six months after the law took effect last October was greater than a 6% drop in the previous six months, and more than twice the 3% decline during the same period a year ago.

All but three states saw caseloads drop in the first six months of the new law. Welfare rolls increased only in Alaska, Hawaii, and West Virginia.

Every month, welfare rolls shrink by 100,000 or more clients, about a 1% decline.

While the latest federal statistics are for March, states are reporting caseloads declines since then. Florida’s welfare rolls dropped 9% between March and June. Texas lost 28,000 welfare recipients in the past two months, a 5% drop. Ohio’s caseload fell below 500,000 in May for first time since the 1970s.

Clearly one of the major challengers to continuing the successful implementation of welfare reform is addressing the challenges facing those individuals who have been trapped in the web of welfare for long periods of time, often living in communities in which welfare dependence has become a common way of life. Addressing the needs of these individuals has been a priority commitment of the 105th Congress.

Under the budget agreement, this Committee, along with the Committee on Ways and Means, was instructed to develop implementing language to provide \$3 billion, over four years, to target welfare-to-work services toward long-term welfare recipients.

In developing this language, it was the top priority of this Committee to refrain from duplicating existing employment and training programs and delivery systems. Instead, the Committee seeks to ensure that these funds are integrated into existing employment and training systems at the State and local level. In doing so, the Committee is continuing its efforts to streamline and consolidate the multitude of Federal employment and training programs undertaken with the Employment, Training and Literacy Enhancement Act of 1997, (ETLEA) which passed the House on May 16, 1997 by an overwhelming majority.

In addition to program consolidation, ETLEA is based on three guiding principles—all of which relate directly to the proposed welfare-to-work grants. These include:

Individual Choice: The proposal provides individuals with choice in the selection of employment options by making job placement vouchers one of the allowable activities.

Quality training and employment for the 21st Century: The proposal ensures that the best providers of services, including those in the private sector, are able to compete to provide services and involving employers in the design and implementation of employment programs—to ensure they are relevant to the needs of those businesses providing jobs in the community. This is accomplished by directing welfare-to-work grants through Private Industry Councils (PICs), and upon final passage of ETLEA, through Workforce Development Boards, replacing PICs and providing greater leadership in the design and implementation of programs. In addition, these boards will be responsible for implementation of full-service employment centers at the local level which increase the ease of access to high quality employment services. It is the clear intent of the Committee that services provided under welfare-to-work funding be available through these integrated local systems.

Driving resources and authority to local communities: Under ETLEA a vast majority of available funds flow directly to the local level in order to provide services which best meet their unique needs. This same approach is taken with welfare-to-work funding, 95 percent of which will flow directly to States and localities by formula.

Welfare-to-work funding: Formula grants

In accordance with the Budget agreement, welfare-to-work funding is to be targeted toward long-term welfare recipients. Consistent with this agreement, this legislation targets funding to this

population in several ways. First, funding would be distributed to States by formula based equally on poverty and welfare caseload. The Committee recognizes that reliable data is not currently available with respect to State shares of long-term welfare recipients and intends for poverty and welfare caseload data to serve as a proxy for such measure.

Further targeting of funds occurs at the State and local levels, through a State-developed formulas which must be based at least half on the relative proportion of excess poverty within Service Delivery Areas (as established under the Job Training Partnership Act) across the State. In addition, States may factor in the relative proportion of long-term welfare recipients within Service Delivery Areas and the relative proportion of unemployed individuals within such areas. In developing this formula, States must use a collaborative process. This is consistent with ETLA, which establishes a formal collaborative process to carry out such functions as well as overall design of the State-wide employment and training delivery system. It is the intent of the Committee that this same collaborative process be designated to develop the within-State formula under this part. In the event a particular Service Delivery Area receives a grant less than \$100,000, the funds would go to the Governor, to be pooled with additional Governor-held funding, in order to directly fund more substantial projects to help long-term recipients into the workforce.

This formula structure provides that funds will be directed to those areas with a high proportion of long-term welfare recipients, while allowing states some flexibility in how to best utilize funds received under this part. In order to further ensure that long-term recipients be served within those areas, the legislation requires at least 90 percent of the locally driven funds be expended on recipients who have received assistance under TANF (or AFDC) for a minimum of 30 months; have multiple barriers to employment as determined by a combination of a lack of high school diploma or GED and low basic skills and require substance abuse treatment or have a poor work history; or will become ineligible for assistance under the State TANF programs within 12 months.

States eligible to receive funds

In order to receive federal funds from this funding, a State would be required to match each federal dollar received at a rate of \$1 of State funds for every \$2 received under these grants.

Administration of funds

As previously outlined, it is the intent of this Committee to ensure welfare-to-work funds be administered through existing State and local employment and training delivery structures. To encourage this to happen at the State level, the Governor is provided authority to designate a State agency to oversee and administer welfare-to-work grants. In effect, this provides the option for States to designate agencies which have responsibility over State employment and training programs—even if such agency does not administer the State's TANF grant. This is especially important in the several States which have established State Workforce Commissions charged with overseeing all employment and training funds.

At the local level, sole authority for spending these funds is provided to Private Industry Councils (and their successor Workforce Development Boards). In administering these funds, the Committee intends for local boards to receive the full participation and cooperation with local welfare agencies to ensure services are not being duplicated and that recipients are provided access to a seamless delivery system which does not hamper their efforts to move into employment.

Demonstration grants

The Committee recognizes the desire of the Administration to provide increased funding to the Secretary of Labor in order to provide direct grants to cities and other localities. In doing so, the Administration suggests that this would allow for increased research and evaluation on a far fewer number of localities having access to a greater amount of resources to implement welfare-to-work programs. While the Committee agrees on the need to evaluate promising approaches to serving long-term welfare recipients, it is our belief that this can best be done by distributing a far greater share of funds across all regions of the country—including both rural, suburban and metropolitan areas—and thus leverage far more local innovations. In addition, however, the bill reserves 5% of the funds (after set asides) for the Secretary of Labor to provide demonstration grants for projects which show the most promise in placing welfare recipients in long-term jobs. The Committee intends for the Secretary of Health and Human Services to work with the Secretary of Labor to evaluate such programs utilizing amounts made available from the welfare-to-work funding.

Allowable Activities

The Committee intends that welfare-to-work grants be expended consistent with “work-first” policies under the TANF block grant—as opposed to concentrating on education and training. Accordingly, activities are limited to job creation through public or private sector employment wage subsidies; contracts with job placement companies or public job placement programs; and job vouchers. However, the language does allow for the provision of on-the-job training, which has shown much promise at increasing the earnings of welfare recipients by combining training within a workplace setting. The Committee also recognizes the need to allow for limited job retention and support services, although the language specifically limits the provision of these services to the extent they are not otherwise available.

Education limitation

The Committee notes that in negotiating welfare reform last Congress, a provision was added to allow for up to 20 percent of all those who qualify as meeting the work participation standards to participate in vocational education or, with respect to single teenage heads of households without a high school diploma, attendance in high school. However, the provision as drafted, failed to clarify that the 20 percent limitation was with respect to those engaged in work as opposed to all those on welfare. Clearly, without this clarification, the work requirements would be greatly weak-

ened by effectively reducing the real number of welfare recipients required to work in real jobs.

The Committee stresses that this provision does not limit the ability for States to provide vocation education and high school to welfare recipients—but simply limits the number of such participants toward the work requirement. For example, in 1997, with the participation rate at 25 percent—three fourths of the remaining caseload could also participate in vocational education or high school. The Committee also notes the firm belief in the importance of completion of high school, which is why attendance in high school for teenage heads of households is a requirement for receipt of assistance under welfare reform.

Penalty for not implementing “pay-for-performance”

Under the work requirements passed as part of welfare reform, States were supposed to reduce (pro rata) assistance for recipients refusing, without good cause, to work. However, because no means of enforcement were included, many States have ignored it. Under this proposal, the Secretary would be required to penalize any State failing to implement this provision at a rate of not less than, but not more than, one percent of their family assistance grant.

Protections for welfare-to-work participants

Section 5002 of the Committee print amends section 407(f) of the Social Security Act with regard to 3 issues.

The first of those three issues is the prohibition on displacement of current employees. Section 407(f) as amended by the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) currently prohibits use of funds provided under the Act to employ or assign an individual to a position when another individual is laid off from the same or substantially equivalent job, or if the employer has terminated or otherwise reduced the workforce in order to fill the vacancy with a welfare recipient. The same section also requires that each State maintain a grievance procedure resolving complaints for alleged violations of this “no displacement” provision, and further states that State and local laws dealing with displacement which provide additional protections for employees are not preempted by this provision in federal law.

The amendatory language for section 407(f) on displacement is adapted from the Employment, Training and Literacy Enhancement Act of 1997. It mirrors the current language of section 407(f) with the following exceptions: (1) in addition to prohibiting the filling of a position from which an employee is on layoff or has been terminated, it also prohibits displacing a currently employed employee or impairing an existing contract or collective bargaining agreement; (2) in addition to requiring that each State maintain a grievance procedure, it also provides that such State grievance procedure must include an opportunity for a hearing and be completed within 60 days of the filing of the grievance. In addition, the provision allows the Secretary of Labor to investigate cases in which a decision has not been made within 60 days, and to hear appeals from State determinations; (3) The provision specifies and limits the remedies that are available for violations of this section. Those remedies are: suspension or termination of payments, prohibition of

future payments, reinstatement, lost wages, and other equitable relief. The Committee intends that the procedures and remedies provided are the exclusive remedy for violations of this section.

The second issue addressed by Section 5002 is the inclusion of specific language on health and safety standards for participants in work activities under TANF. Section 5002 specifies that federal and state health and safety standards that otherwise apply to employees would also apply to non-employee participants in work activities under TANF. For example, if an employer is otherwise covered by health and safety standards promulgated by the Occupational Safety and Health Administration (OSHA), then those standards apply equally to any non-employee participants at the employer's places of work. However, if an employer is not otherwise covered by OSHA standards (because it is a public employer in a non-State plan State or has no employees), then the federal standards do not apply. In short, this provision does not extend federal or state requirements to new employers, but assures that employers who are covered must apply the same protections to non-employee participants as are provided to employees to the extent they are engaged in covered activities.

Third, section 5002 assures that participants in work activities are assured protection against discrimination. Section 408(c) of TANF references the following general provisions of law which prohibit discrimination in programs funded by the federal government: the Age Discrimination Act of 1975; Section 504 of the Rehabilitation Act of 1973; the Americans with Disabilities Act of 1990; and Title VI of the Civil Rights Act of 1964. Section 5002 adds to that list of protections already provided for participants in work activities under TANF a prohibition on discrimination on the basis of gender. In addition, it provides that the grievance procedure described above be available to participants for violations of the above listed provisions on discrimination, including the prohibition on discrimination on the basis of gender. In addition, of course, participants in welfare to work activities under TANF, who are employees of public or private sector employers, are also covered by general employment laws, including Title VII of the Civil Rights Act of 1964, in the same manner and extent as any other employees, and participants in education activities may already be covered by Title IX of the Education Amendments of 1972.

Section 5004 adds a new subsection to section 407 of the Social Security Act. A principal reason for this section is to address the confusion caused by a recent U.S. Department of Labor handbook on the application of labor and employment laws to participants in work activities under TANF.

First, section 5004 states that participants in work activities under section 407(d) of the Social Security Act which are employment ("unsubsidized employment," "subsidized private sector employment," and "subsidized public sector employment") must be paid in accordance with either the federal or state minimum wage law, whichever is higher, as well as any other aspects of applicable law to employment in that State or locality. Thus, for example, a welfare recipient who is hired by a private sector employer, whether or not the employer receives a subsidy for wages paid to that

employee, is covered by laws applicable to other employees, including the federal or state minimum wage law, whichever is higher.

Second, following a provision that was included in the Employment, Training and Literacy Enhancement Act of 1997, Section 5004 specifies that TANF recipients who are employed in above-listed work activities should receive compensation equivalent to other employees of the same employer who are in the same positions and have the same training, experience and skills.

Third, section 5004 clarifies that recipients of assistance who are participating in “work experience” and “community service” through a public agency or nonprofit agency are not employees of that public agency or nonprofit organization. In including this provision and distinguishing “employment” from these “workfare” programs the Committee is clarifying the applicable law, not exempting persons heretofore covered from the labor and employment laws.

In this regard, it should be pointed out that the predecessor federal welfare law, the Family Support Act of 1988, passed by a Democratic Congress and signed by President Reagan included a “workfare” program, called Community Work Experience (CWEP). As is the case under section 5004, the Family Support Act distinguished employment from CWEP. Participants in CWEP were not considered employees, but were defined as participants who worked in exchange for their welfare benefits.

Distinguishing employment from workfare is also consistent with the law under the federal Fair Labor Standards Act. In *Johns v. Stewart* 57 F.3d 1544 (10th Cir., 1995), the issue was presented whether participants in a state workfare program in Utah were employees under the FLSA. The Court of Appeals distinguished workfare from employment, citing factors such as participants being assigned rather than being hired, and the fact that workfare participation was intended to be part of an effort towards employment and independence from welfare. Both of those factors certainly describe “work experience” and “community service” under TANF as well.

Finally, it should be stated that the reason that this clarification is necessary is due to the confusion created by the Department of Labor’s recent publication of a handbook entitled “How Workplace Laws Apply to Welfare Recipients.” After many months of quite public deliberation and political pressure, the Department of Labor’s “guidance” provides no guidance at all. Contrary to most press reports on DOL’s position, the handbook simply says, “Welfare recipients in ‘workfare’ arrangements, which require recipients to work in return for their welfare benefits, must be compensated at the minimum wage *if they are classified as ‘employees’ under the FLSA’s broad definition.*” (emphasis added) By stating their “guidance” in this way, DOL not only did not provide any real guidance, it in fact caused greater confusion for States trying to implement welfare reform, and suggested a broader-than-justified reach of federal employment laws. The language of section 5004 is intended to clarify the law as the Department of Labor could have but chose not to do.

Although section 5004 clarifies the law that participants in work experience and community service with non-profit organizations or

public agencies are not employees, it also provides assurance to these participants and those in the on-the-job training programs that they will receive welfare benefits at least equal to the federal minimum wage rate for each hour they participate in these activities. For purposes of this calculation, the participant's welfare benefit must include any cash assistance and food stamps received, and may, at state option, include the value of medicaid, child care, and housing assistance. In the alternative, section 5004 allows a State to count other education and training activities described in section 407(d) in order to meet the minimum hour requirements for participants in work experience, community service, and on-the-job training.

It should be noted that in most cases a welfare recipient's total welfare benefit, including cash assistance, food stamps, medicaid, child care and housing assistance far exceeds the minimum wage times the number of hours of work activity required by federal law. A Heritage Foundation review of cash welfare plus food stamps plus medicaid benefits found that the average total welfare benefit in all states divided by the minimum number of hours of work activity under TANF results in a recipient receiving over \$18 in welfare benefits for every hour required in a work activity to be counted under TANF.

The handbook on "How Workplace Laws Apply to Welfare Recipients" issued by the Department of Labor includes an addendum from the Department of Agriculture which states that in most cases, under present law, States may count the value of food stamps in calculating any minimum wage obligation for recipients in either a "workfare" or "work supplementation" (subsidy) program. The provision in the legislation is consistent with this interpretation of current law, and extends the consideration of benefits for those in "workfare" positions under the new welfare reform law. This provision assures that participants in work experience, community service, and on-the-job training receive at least the minimum wage rate for each hour of participation in these activities *and* reflects a recognition of the real value of welfare benefits beyond any cash assistance received under TANF.

It has been argued that by allowing States to count welfare benefits besides cash assistance received under TANF in this calculation, the provision somehow will encourage or even force States to reduce cash assistance to welfare recipients. This argument ignores the fact that States are allowed now to set the level and amount of cash assistance under TANF. Nothing in this legislation affects that in either direction. The provision simply allows States to maintain strong work requirements and reflects a realistic assessment of the value of non-cash welfare benefits.

A fundamental purpose of welfare reform is to promote self sufficiency by emphasizing the importance of participating in work activities as a bridge to independence. The PRWORA states a clear preference that most recipients be placed in private sector employment, but that welfare also be used when employment positions are not available. Those who oppose these provisions, and seek to extend the reach of labor laws that apply to employment to all workfare positions ignore the historical distinction between employment and workfare, and would make it more difficult for states to

implement workfare, and thereby undercut the work requirements of PRWORA.

SUBTITLE B

The Budget Agreement assumes three areas of savings from the student loan programs. The first area is the return of reserve funds currently held by guaranty agencies. These funds have been accumulating over the years as loan volume has increased, defaults have decreased and guaranty agencies have become more efficient in their operations. Under the Higher Education Act, these funds are the property of the Federal Government and held by the guaranty agencies in a fiduciary capacity. These funds are used by guaranty agencies for payment of insurance claims to lenders, collection activities, default prevention activities and other operating expenses.

As of September 30, 1996, the funds held by guaranty agencies in reserve accounts totaled \$2,004,857,000. The Budget Agreement assumes that \$1,000,000,000 of these funds will be returned to the Treasury in Fiscal Year 2002 and the Committee bill achieves this goal. In order to ensure that these funds will be available for return to the Treasury in 2002, the Committee requires each guaranty agency to make yearly transfers of funds to restricted accounts approved by the Secretary. Because the Committee is concerned with the continued viability of the Federal Family Education Loan Program, the Committee requires guaranty agencies with substantial reserve funds to return a larger share of funds than would be required using a straight proportional share. In addition, guaranty agencies with lower reserve ratios may delay their yearly fund transfers until Fiscal Year 1999 or in accordance with any other payment schedule approved by the Secretary.

The Committee bill also contains a provision, adopted as an amendment offered by Representative McKeon, which clarifies the amount guarantors may retain on the collection of consolidated defaulted student loans. Specifically, this amendment establishes the collection retention rate for guaranty agencies at 18.5% for student loans in default which are subsequently consolidated and returned to good standing. The effective date for this provision is July 1, 1997, except that, for guaranty agencies which have been retaining 18.5% since enactment of the Higher Education Amendments of 1992, this provision applies as of the effective date of those amendments.

Under the student loan provisions of the Higher Education Act, when a guarantor collects a loan which is in default, it may retain up to 27 percent of what it recovers in order to help pay collection costs. In 1992, when the Higher Education Act was last reauthorized, borrowers in default who made satisfactory payment arrangements were allowed by statute to consolidate their loans and return them to good standing. The purpose of this was two-fold. First, it gave students with defaulted loans a means of returning their loans to good standing and removing the default status from their record. Second, by giving borrowers an incentive to make satisfactory repayment arrangements, it helped the taxpayer recoup student loan dollars that would otherwise be lost.

This option has proven popular, and guarantors have worked with students in establishing satisfactory repayment plans that will allow students to have their loans returned to good standing. In working to collect these loans, guarantors treated them as they would any other defaulted loan, and retained 27 percent of collections as the law allowed. This has gone on for a number of years.

On July 1st of this year, a new regulation recently put forward by the Department will go into effect. It changes the amount that guarantors can retain when they collect a defaulted loan through consolidation from 27 percent to not more than 18.5 percent. The Committee is concerned that the Department has been retroactively imposing its views on this issue on guarantors in the student loan programs. The Department has been requiring guarantors in many cases to refund any collections above the 18.5 percent level, even though the actual regulation is not yet in effect, going back to when the consolidation option became available in 1992.

For the future, this provision resolves the current confusion and sets forth a clear and coherent policy for retention on the collection of these loans. This provision statutorily sets the retention rate at 18.5 percent, rather than allowing the Department of Education to arbitrarily set a lower retention rate through regulation or interpretation for future collections. The budget legislation requires guaranty agencies to relinquish control of \$1 billion which they use to pay operating expenses in order to help us balance the budget. Allowing a retroactive change in the retention rate for these loans simply creates further financial uncertainty for guaranty agencies as they work to adjust to the loss of operating funds required under this legislation.

The cost of this provision is minimal: under \$500,000, and according to the Congressional Budget Office, there are more than enough savings in the Committee legislation to cover this cost so it will not hinder our attempts at balancing the budget.

The Committee bill also saves \$604 million over five years by reducing the mandatory administrative funds authorized in Section 458 of Part D of the Higher Education Act. These funds pay a majority of the expenses of the Federal Direct Student Loan Program and a portion of the administrative expenses of the Federal Family Education Loan Program. Specifically, administrative cost allowances to guaranty agencies are paid from this fund. Until enactment of the Federal Direct Student Loan Program in 1993, guaranty agencies received an administrative cost allowance equal to 1% of the student loan volume on which they issued insurance. However, as part of the Administration's effort to transition to 100% direct lending, the 1% payment to guaranty agencies was repealed and the funding for administrative costs of guaranty agencies was shifted to the Section 458 account.

The Conferees to the Omnibus Budget Reconciliation Act of 1993 filed a Committee Report which addressed this issue of administrative costs as follows: "It is the understanding of the conferees that the Department of Education will pay on a timely basis to each guaranty agency an amount equivalent to that which they otherwise would have received under the administrative cost allowance provision terminated in this legislation. It is the intention of the conferees that funding for this payment will come from the admin-

istrative funds provided under section 458.” Since 1993, the Committee has had a concern that due to the lack of statutory instructions, the Department of Education will stop paying administrative cost allowances to guaranty agencies and use the funds for purposes of the Federal Direct Student Loan Program. As a result of this concern, the Appropriations Committee has set the administrative cost reimbursement to guaranty agencies for Fiscal Years 1996 and 1997 in the respective Appropriations Bills.

At the request of this Committee, the reimbursement was reduced to .85% in an effort to save money and reduce costs in the Federal Family Education Loan Program. This bill continues that policy by directing the Secretary to pay guaranty agencies from the existing Section 458 account .85% of the principal amount of loans on which insurance is issued, subject to a maximum spending of \$170 million in Fiscal Years 1998 and 1999, and \$150 million thereafter. The Section 458 account from which these funds are to be paid is an existing entitlement account for the administrative expenses of the Federal Direct Student Loan Program and the Federal Family Education Loan Program. This legislation simply designates a set portion of those mandatory funds strictly for payments to guaranty agencies. As such, it is limited to the funding levels already established in this bill and creates no additional budget costs to the Federal Government. At a time when we are requiring guaranty agencies to return \$1,000,000,000 to the Federal Treasury, the Committee believes it is imperative for the Secretary to pay guaranty agencies a certain level of reimbursement for their administrative costs in order to give financial stability to all the guaranty agencies.

The final provision of this bill provides for the elimination of a \$10 application processing fee to institutions which participate in the Direct Student Loan Program. This provision saves \$160 million over five years. Payment of this fee has been prohibited in the recent Appropriations bills.

SUBTITLE C

Since 1917, the Smith Hughes Act is a small, mandatory vocational education program which, while separately authorized, has been rolled into the Basic State Grant program under the Carl D. Perkins Vocational Education and Applied Technology Act. The Committee does not believe the Smith Hughes Act needs to continue as a separate program; however, the Committee recognizes that such funds should continue to be made available to the vocational education basic State grant program. By repealing the Smith Hughes Act, the Committee on Education and the Workforce has complied with the Budget Resolution and the Administration’s FY98 budget request.

SUBTITLE D

Background and need for legislation

This legislation addresses important health insurance reform issues in EPHIC, which are not new to this Committee and have been addressed in a bipartisan fashion in various legislation introduced in the past. The Committee has studied the need for such

health insurance reform measures extensively over the past several years. During the 104th Congress, the Committee held extensive oversight and legislative hearings on H.R. 995, the ERISA Targeted Health Insurance Reform Act of 1996 which formed the basis of the ERISA structure contained in the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191).²

During the 103rd Congress, the Full Committee and its subcommittees held 33 days of health care hearings throughout the United States. Several of these hearings focused on bipartisan legislation similar in scope to EPHIC. In addition, the Subcommittee on Labor-Management Relations held 11 days of markup and the Full Committee held 8 days of markup on H.R. 3600.³

In the 102nd Congress, hearings were held on bipartisan legislation which included provisions that would promote multiple employer pooling among small employers. EPHIC follows in the tradition of this bipartisan effort to promote pooling for small employers in the 102nd Congress. Today's efforts by the Committee build on what originated as a bipartisan concern over the number of uninsured and an endeavor to expand health insurance coverage to such employees and their families by reducing the cost of employer-sponsored health coverage.⁴

²The Subcommittee on Employer-Employee Relations held an oversight hearing, "Health Insurance Reform—The ERISA Title I Framework: A 20-Year Success Story," on February 14, 1995. Testimony was received from: Representative Pat Williams; Former Representative John Erlenborn; Frank Cummings, LeBoeuf, Lamb, Greene & MacRae; Randall Johnson, Director of Benefits Planning, Motorola, Inc.; Ralph Brennan, President, Mr. B.'s, Inc.; William Goodrich, President, United Agribusiness League; and Brian Atchinson, Vice President, National Association of Insurance Commissioners, Superintendent, Bureau of Insurance, State of Maine.

H.R. 995, The ERISA Targeted Health Insurance Reform Act, was introduced by Representative Harris Fawell on February 21, 1995. The bipartisan legislation has 50 cosponsors. H.R. 996, the Targeted Individual Health Insurance Reform Act, was introduced by Representative Fawell on the same date.

The Subcommittee on Employer-Employee Relations held a legislative hearing to discuss H.R. 995 and H.R. 996 on March 10, 1995. During this hearing insurance reform issues concerning group-to-group portability, limits on preexisting condition exclusions, and small employer pooling were addressed. Testimony was received from: Jack Faris, President National Federation of Independent Business; Jerry Jasinowski, President, National Association of Manufacturers; Sean Sullivan, President and CEO, National Business Coalition on Health; Timothy Flaherty, American Medical Association; Charles Masten, Inspector General, U.S. Department of Labor; Gerald McGeehan, Graphic Arts Benefits Corp.; Kala Ladenheim, Intergovernmental Health Policy Project, George Washington University; and Judith Waxman, Director of Government Affairs of Families, USA.

The subcommittee held a third hearing on March 28, 1995. During this hearing, the subcommittee continued its discussion on H.R. 995, H.R. 996, and targeted health insurance reform. Testimony was received from: Richard Leshner, President, U.S. Chamber of Commerce; Keith Richman, President, Medco Associates, Inc.; Jon Reiker, Vice President, Benefits, General Mills Restaurants, Inc.; Frank Cummings, LeBoeuf, Lamb, Greene & MacRae; and Lee Douglass, Insurance Commissioner of Arkansas, President, National Association of Insurance Commissioners.

On March 6, 1996, the Committee on Economic and Educational Opportunities discharged H.R. 995 from the Subcommittee on Employer-Employee Relations, approved H.R. 995, as amended, on a voice vote, and, by a vote of 24-18, ordered the bill favorably reported.

³During the 103rd Congress, the full Committee held seven days of oversight hearings on the President's health care reform proposal, health care reform alternatives, regional health alliances, and the Cooper (H.R. 3222) and Michel (H.R. 3080) bills. The Subcommittee on Labor-Management Relations held 21 days of hearings on the following topics: oversight on the Administration's health care reform proposal; oversight on the effect of health care reform on workers and retirees, providers, the underserved, urban, and low-income populations, and children's mental health; and oversight on the effect of ERISA preemption on state health care reform efforts. In addition, the Subcommittee on Labor Standards, Occupational Health and Safety held two oversight hearings on the Health Security Act (H.R. 3600), the Subcommittee on Human Resources held an oversight hearing on health care reform and the existing long-term care network, and the Subcommittee on Select Education and Civil Rights held three oversight hearings on health care reform and its impact on schools and individuals with disabilities.

⁴During the 102nd Congress, the full Committee held an oversight hearing on national health reform and the Subcommittee on Labor-Management Relations held six days of hearings on the

Continued

Expanding health insurance coverage through multiple employer pooling arrangements is not a new concept. In 1991, Rep. Petri introduced the first bill to accomplish the twin goals of providing solvency standards for legitimate self-insured association health plans and giving the states more clear authority to end abusive schemes run by “bogus unions” and other illegitimate operators. This basic concept received bipartisan support (H.R. 2773 was cosponsored by Reps. Goodling, Gunderson, Armey, Fawell, Ballenger, Molinari, Barrett, Boehner, Klug, Grandy, Sensenbrenner, Roukema, Oxley, Henry, Martinez, Gillmor, Ireland, Quillen, Barnard, Kleczka, Morella, Edwards, Schaefer, Lewis, Barton, and Cox). Similar provisions were included in both the Republican Leader’s bill (H.R. 3080, Rep. Michel) and the Bipartisan Health Care Reform Act of 1994 (H.R. 5228, Reps. Rowland, Cooper, Bilirakis, Grandy, McCurdy, Goss, Parker, Hastert, Stenholm, Thomas, Tanner, Boehlert, Deal, Castle, Lloyd, Houghton, Hefner, Klug, Long, Collins, Andrews, and Everett) introduced as alternatives to the Clinton Health Plan in the 103rd Congress.—

This Committee has spent years establishing the need for the key elements of EPHIC, available and affordable health insurance. It is well documented that the most important incremental reforms that can be delivered to the American people are to improve group to group portability, by limiting preexisting condition exclusions, and facilitating through ERISA voluntary pooling by small employers on either a self-insured or fully-insured basis. The HIPAA legislation (P.L. 104–191) added needed protections for American workers in the first two areas—but more needs to be done to increase availability and affordability of coverage through the latter. Expanded coverage will become a reality if the cost of coverage can be made more affordable. Today 80% of the 40 million uninsured are in families with at least one employed worker, the vast majority of whom are employed by small businesses. Small business experts testified that 20 million Americans who now lack coverage might gain it under the type of pooling allowed under EPHIC—all through responsible changes that will expand choice in the marketplace. This is the kind of reform that Americans have demanded and deserve.

The need to preempt state benefit mandates to restore national uniformity

The issue of federal preemption in employee benefits is not new to this Committee. Throughout past deliberations on employee benefits, both employer and employee representatives stressed the enormous problems that had been created by separate, varying, or conflicting state regulation of these benefits. Congressional concern over national uniformity produced the Employee Retirement Income Security Act (ERISA) in 1974. Employee health coverage under ERISA has flourished and the foundation for this expansive

following topics: Legislation relating to ERISA’s preemption of certain State laws (H.R. 1602 and H.R. 2782, Mr. Berman), oversight on health care access issues, oversight on access to affordable and adequate health care, oversight on small business health insurance problems, oversight on ERISA and cutbacks in health benefits, and the Multiple Employer Health Benefits Protection Act of 1991 (H.R. 2773, Mr. Petri), the Multiple Employer Self-Insurance Enforcement Act of 1992 (H.R. 4919, Mr. Hughes), and the Multiple Employer Welfare Arrangements Enforcement Improvements Act of 1992 (H.R. 5386, Mr. Petri).

coverage is ERISA's preemption of costly and conflicting state regulation. Without this preemption, employers and the collective bargaining process would be subject to a patchwork of differing state rules and regulations, including mandates on specific types and levels of benefit coverage.

Unfortunately, the proven benefits of preemption were eroded for many employers—particularly smaller employers—by the Supreme Court's ruling in *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724 (1985). In that decision, the court held that if an employer's health plan purchases a fully-insured product offered by an insurer regulated by the states, then such insurance regulation may include imposing requirements that specific benefits be included in the products sold to the plan. For those small employers who can afford health insurance for their employees, a fully insured plan is often their only available option. The net effect of the *Metropolitan Life* decision has been to subject these smaller employers to the burdens of costly state mandates, thereby making health insurance for their employees even less affordable than it is for larger employers who have increased purchasing power.

During Subcommittee hearings, the President of the National Federation of Independent Business testified, "Small business owners often pay approximately 30% more than larger companies for similar benefits . . . In addition, they often pay another 30% in premiums because of costly state mandates, . . . which prevent small business owners from shopping for only the basic care that they and their employees might need." The General Accounting Office reports that mandated benefits account for between 6 and 22 percent of all insurance claims, depending on the state (and the number of benefits it mandates) (GAO/HEHS 96-161). A study by the National Center for Policy Analysis (NCPA) shows that one in five small companies that are not offering health benefits would do so in an environment free of state-mandated benefits. Were these businesses to begin offering plans, 6.3 million Americans (full-time workers and their dependents) would gain access to employer-sponsored coverage. According to another NCPA study, one out of every four uninsured people has been priced out of the market by state mandated benefit laws.

The story—and success—of ERISA in expanding coverage proves beyond any doubt that the cornerstone of preemption has been critical to the growth and expansion of employer-provided health insurance. It also proves, the Supreme Court's ruling in *Metropolitan Life Insurance Co. v. Massachusetts* notwithstanding, that the preemption cornerstone needs to be extended to a larger class of employers, namely small businesses. In reporting EPHIC, the Committee has acted to build on the proven success of ERISA in this regard.

Why current ERISA law needs changes to clarify the status of association health plans under Federal and State law

Multiple employer plans are the most efficient means to deliver affordable health coverage to employees, particularly for smaller employers and employees who work in industries with high job mobility or above-average insurance risk. However, current law has not achieved the twin goals of preserving the self-insured multiple

employer plans of legitimate business and industry associations and of keeping “bogus unions” and fraudulent insurance schemes from attempting to use the ERISA preemption clause as a shield to the promotion of their abusive health insurance practices.

As described below, EPHIC meets these twin goals by enabling legitimate associations (including church plans, franchise networks, and certain large employer and collectively-bargained plans) to maintain or establish multiple employer plans by voluntarily seeking licensure in the few states permitting this or to seek federal certification which in effect invokes the “exemption” provision (sec. 514(b)(6)(B)) under the current ERISA statute (reserve, eligibility, and other standards must be met; such requirements may be enforced by states if they desire, or otherwise by the Department of Labor). Entities that do not have either a state or federal certification are fully subject to state law (states, as they choose, may force them to meet any insurance or multiple employer plan licensing requirements or to shut them down). All such entities must register with DOL and the states and are subject to the criminal penalties under ERISA for failure to do so (illegitimate entities will become criminal enterprises—the enforcement tool lacking today and hindering both federal and state enforcement efforts). In addition, the Department of Labor is given “cease and desist” authority to curtail the activities of any such illegitimate entities.

The DOL Inspector General testified that the above described enforcement provisions are necessary and important changes to ERISA and the key to stopping health insurance fraud.

The above described changes are necessary to clarify the extent of ERISA preemption of state law and the role of the states and the federal government in relation to multiple employer health entities (under current law these entities are termed “multiple employer welfare arrangements” or MEWAs). These entities may be either “self-insured” or “fully-insured.” Under EPHIC fully-insured multiple employer plans are encouraged by permitting such plans to base premiums on their group experience and by preempting certain state benefit mandates and so-called state “fictitious group” laws—thus allowing them to compete on the same basis as self-insured plans with respect to these important elements.

Under ERISA a MEWA is defined as a plan or other “non-plan” arrangement established to provide benefits (e.g., health benefits) to the employees of two or more employers. Under current law, the breadth of this definition sweeps in the following types of entities: (1) all collectively-bargained multiple employer plans (including Taft-Hartley jointly-trusteed multiple employer plans) unless the DOL “finds” them to be collectively-bargained (the Department has not made any such finding)—under the bill, a new statutory exemption is provided and the exemption safe-harbor is provided for certain plans failing the statutory rule; (2) large employer plans that include employees of entities outside the “control group” of the employer—many large employer plans and plans with franchisee participants are MEWAs—under the bill, a new statutory exemption is provided and an exemption safe-harbor is provided certain plans failing the statutory rule; (3) “church plans” currently exempt from ERISA may voluntarily seek certification under ERISA; (4) multiple employer entities, such as those maintained by legitimate

trade, industry and professional associations, which meet the definition under ERISA of an “employee benefit plan”—for which exemptions may be granted under the bill; and (5) other multiple employer welfare arrangements which do not meet the definition under ERISA of an “employee benefit plan”—under the bill such entities are not eligible for an exemption and are fully subject to state law.

In general, ERISA preempts state insurance and other laws “relating to an employee benefit plan”. As originally enacted, this broad preemption included multiple employer arrangements as long as they met the definition of an “employee benefit plan”. Any multiple employer entity that was not a plan did not have the benefit of ERISA preemption.

Because illegitimate schemes (which did not rise to the level of ERISA “employee benefit plans”) promoted by “bogus unions” and others were delaying and thwarting legitimate state enforcement efforts by claiming ERISA preemption (even though ineligible), ERISA was amended in 1983 in an attempt to clarify the ability of states to regulate the non-ERISA-plan entities as well as legitimate self-insured ERISA multiple employer plans (but the regulation by the states of the later was conditional, i.e., regulation is permitted only “to the extent not inconsistent with the provisions . . .” of ERISA Title I). This later clause was intended to encourage responsible regulation of legitimate ERISA plans, under specific state laws relating to these entities, but not to enable states to terminate legitimate ERISA plan entities solely because they were not “insurance companies”—the later concept is incorporated in ERISA section 514 as the so-called “deemer clause” prohibiting states from deeming ERISA plans to be in the business of insurance.

Unfortunately the 1983 amendment has not achieved its intended purpose. While a few states have enacted specific statutes regulating legitimate self-insured multiple employer plans, others have intervened in the operations of legitimate arrangements meeting the ERISA plan definition and forced the involuntary termination of such arrangements. These state actions have been selective in nature and do not follow any consistent basis either within a state or among states (actions may vary depending on the entity involved—the size of the employer, the industry, the presence of collective-bargaining, etc.). As reported by the Committee, EPHIC provides a consistent basis for regulating the continued operations of legitimate ERISA multiple employer plans and provides that such plans may instead continue to choose to operate under the state laws specifically regulating such entities.

Neither did the 1983 amendment achieve the objective of stemming the number of illegitimate enterprises that continue to bilk the public under arrangements that do not meet the ERISA definition of an “employee benefit plan”. Therefore, EPHIC makes it clear that entities that have not received either an exemption under ERISA or a state license or certification are fully subject to state law and to improved federal civil and criminal enforcement. As requested by the National Association of Insurance Commissioners (NAIC), the qualification of their authority over non-certified self-insured multiple employer entities is removed (i.e., the

clause requiring state authority to be “consistent with” ERISA Title I is repealed).

These clarifications of ERISA preemption relating to multiple employer arrangements will free substantial additional resources that have been spent to stop health insurance fraud and abuse. Moreover, the considerable state resources involved in stopping insurance fraud will be released for more productive purposes. Additional resources of the federal government can also be redirected more productively in administering the new law and helping expand more affordable health coverage.

For example, the DOL Pension and Welfare Benefit Administration’s (PWBA) Office of Civil Enforcement expends about 25% of all group health plan civil enforcement resources on problem entities and expends about 68% of all group health plan criminal enforcement resources on illegitimate MEWAs. The Office of the Solicitor of Labor expends about two-thirds of all group health plan enforcement on illegitimate MEWAs. In addition, the Office of the Inspector General has expended between 5–15% of all investigative resources (not just related to group health plans) on illegitimate MEWAs. For 1993, 1994, and 1995 combined, the PWBA has allocated about 43 employees and 33,400 hours on Clinton Health Insurance Reform efforts. With the passage of targeted health insurance reform, a large portion of these resources can be allocated to the administration of EPHIC.

For nearly three decades the American people have looked to Congress to improve health insurance accessibility, affordability, and accountability. Finally, in the 104th Congress, the first real strides towards more portable and accountable health care were taken. HIPAA’s major accomplishments included: (1) limiting exclusions for preexisting conditions; (2) ending “job lock” by making health coverage portable; (3) guaranteeing availability of health coverage for small employers; (4) prohibiting discrimination against employees and dependents based on health status; (5) guaranteeing renewability of health coverage to employers and individuals; and (6) helping individuals leaving or losing their job to maintain their health coverage. EPHIC builds on this base to address the next major hurdle—making insurance more available and affordable to millions of working Americans and their families.

EPHIC’s reforms are built upon the bedrock of private health coverage

EPHIC presents this Congress with perhaps its best opportunity since the passage of ERISA to expand access to affordable health insurance for the many American families who are currently uninsured.

In 1974, Congress enacted the Employee Retirement Income Security Act or, as it came to be known, ERISA. In doing so, Congress shaped and put into place the cornerstone of our country’s employee benefits law. More importantly, it laid the foundation upon which employers and negotiated multiemployer plans have been able to successfully provide benefits to workers and their families, including pensions, health and other benefits. EPHIC builds upon that success and seeks to expand health coverage to an even greater universe of employers and employees.

By utilizing the time-tested features contained in ERISA, the legislation builds upon the successes produced by private sector innovation and market competition. It is a well-targeted and workable framework within which incremental health insurance reform can be enacted this year.

As Representative John Erlenborn, an author of the original ERISA law and former member of the Committee, stated during hearings, "it is my belief that Title I of ERISA has, over the past twenty years, proven to be a success and . . . the judgments that led to ERISA's enactment, continuing to rely on a voluntary system devised by employers and employees with the addition of protections for participants, are as valid today as when we [then] made them." Mr. Frank Cummings, a drafter of an early version of ERISA, stated "this bill is the right step, at the right time, in the right direction." They made clear that the legislation addresses many problems faced by workers who are currently uninsured. Many other witnesses also testified on the benefits of using ERISA as the basis for expanding health insurance coverage.

For example, Mr. Jack Faris, President of the National Federation of Independent Business, testified that NFIB considers association health plans created by EPHIC crucial to allowing small business to afford to insure their workers—and deemed it the NFIB's top legislative priority in health care. The most important construct of EPHIC is giving small business a chance to purchase health insurance on the same terms as big business. According to Mr. Faris, EPHIC "successfully takes on the most vexing challenge when it comes to insurance reforms in the small group market: providing for portability, accessibility, renewability, and rate stability without causing a rate hike for those who already have coverage. Providing access on the one hand and holding prices down on the other is a difficult balance to find. We believe [EPHIC] addresses this matter in a responsible way."

Mr. Sean Sullivan, President and CEO of the National Business Coalition on Health, applauded the sponsors for seeking to allow the market to work for small employers the way we are making it work for larger businesses." Mr. Sullivan stated that if pooling provisions were to become law, roughly half of the uninsured, 20 million people, could possibly be covered.

This assertion was seconded by Jeffrey Joseph, Vice President of Domestic Policy for the U.S. Chamber of Commerce. Mr. Joseph testified that one-half of the 41 million uninsured Americans, including 64 percent of all uninsured children, could gain access to affordable coverage under this legislation.

Donald Dressler, President of Insurance Services, Western Growers Association, stressed that EPHIC would help enable the 85% of those that are working (or are in families where there is someone working) but do not have health insurance, to finally afford it. It would make the plans competitive by providing consistent benefits and protections nationwide and would prevent association health plans from being driven out of the market because of increasing state mandates and increasing inconsistency between the states (i.e., increased employer costs), as has happened in the past. Mr. Dressler concluded that the choice is not between consumer protec-

tions and non-consumer protections, but instead it is between insurance coverage or no insurance coverage.

Mary Castro, Vice President, Independent Grocers Alliance, Inc. (IGA), testified that EPHIC would help small employers gain access to affordable insurance and would promote association-sponsored plans like the IGA plan, by allowing the employers to join together and take advantage of “cost savings and administrative efficiencies currently enjoyed under ERISA by larger employees.” She also believes that EPHIC would resolve the current jurisdictional problems association health plans are experiencing and contains many uniform safeguards that will protect consumers.

Also, Mr. Jerry J. Jasinowski, President of the National Association of Manufacturers, said that he was pleased that an earlier version of EPHIC “relies on competition, rather than government.” Supportive of the principles on which EPHIC was designed, Mr. Jasinowski said the bill “does what needs to be done . . . It enables competition and market forces—by facilitating purchasing groups within the ERISA framework—to allow smaller employers to band together and improve access to affordable coverage.”

Dr. Timothy Flaherty, testifying on behalf of the American Medical Association’s Board of trustees, commended the vision of the version of EPHIC introduced in the 104th Congress. Under such legislation, Dr. Flaherty said “the world would begin to change for the better. Insurers would be encouraged to provide insurance. Businesses would be encouraged to focus more of their attention on business. And physicians would be freed up to focus more on providing quality medical services to their patients.” The AMA believes such a bill would “make health care markets more competitive and increase access without resorting to global budgets, price controls, government subsidies or creating a Canadian-style single payer system.”

The Honorable Charles C. Masten, Inspector General of the U.S. Department of Labor, commented on the enforcement aspects of EPHIC’s predecessor—which are found in EPHIC as well. Mr. Masten said that the legislation “offers the promise of decreasing the level of fraud in health care benefit plans.” “I believe that [it] will make it easier for the OIG and other enforcement agencies to detect and investigate fraudulent activities, by identifying and defining entities which have created problems under the current law, such as employee leasing arrangements, ‘associate’ union memberships, and non-existent unions,” he said. The Committee agrees with the Inspector General that the strong enforcement aspects of EPHIC are necessary and important elements which are needed to stop insurance fraud and to bring increased accountability to the health care system.

Committee testimony also included findings from a report entitled “Small Group Market Reforms: A Snapshot of States’ Experience.” These findings of the Intergovernmental Health Policy Project of The George Washington University, were based on a survey of officials in 12 states that were among the earliest to enact small group market reforms. The main conclusion was that these small group reforms are unlikely to improve significantly either the affordability or availability of insurance for those working for small firms. The Committee believes that this evidence, substantiated

with additional survey information provided the Committee from state insurance commissioners, suggests that the market and competition based reforms under the bill are necessary to empower small businesses to offer their employees more affordable coverage using the same techniques available to larger employers under ERISA.—

As important as it is to note what EPHIC does, the Committee wishes to draw Members attention to what it does not do. For instance, by using the ERISA foundation the reported bill will not force Americans to give up their current health insurance coverage, but will serve to increase their choice of coverage. It will not impose government mandates. It will not require any new federal spending or taxes. Importantly, the bill will not create a new government-run health care bureaucracy that imposes price controls, mandates, and other impediments to high quality health care.

Expansion of coverage through association health plans

The Expanded Portability and Health Insurance Coverage Act of 1997 will empower millions of workers and their families, particularly the many uninsured employees working for small businesses, to obtain more affordable health insurance. The bill will make health insurance more affordable—thus expanding coverage by lowering costs; more accessible—thus increasing choice by removing barriers; and more secure—thus improving portability and coverage after job loss.

The Employee Benefit Research Institute (EBRI) has reported that about 80 percent of the 40 million uninsured Americans live in families with an employed worker who is likely to work for a small employer or be self-employed. Over 80% of all uninsured children are in families with working parents. Clearly, the problem of the uninsured, both children and adults, is predominantly a problem of small businesses lacking access to affordable coverage. Sadly, the choice is too often between paying for a Cadillac health insurance package or having no health insurance whatsoever. Too many Americans are paying for benefits they do not need, and too many others cannot get even the most basic coverage.

Studies by KPGM Peat Marwick and Foster and Higgins report that in recent years, larger employers saw health costs decline. For example, recent increases of only .5% were no doubt due to the benefits of economies-of-scale larger employers enjoy—to structure plans to include managed care alternatives and to negotiate with providers for high quality health plans at lower costs. Conversely, the smallest employers experienced cost increases, for example up 6.5 percent in 1994. There is obviously a need to put equity into the system.

Cost increases and increased regulation have discouraged small employers from offering health insurance—as a result the percentage of uninsured working for businesses with less than 100 employees increased 12.5% in only two years, from 24% in 1993 to 27% in 1995.

The ERISA law has played an important role in driving down costs for medium and large employers and allowing virtual universal coverage for their employees. ERISA also allows employers and unions the option not only to insure but also to self-insure, giving

them the low cost, quality, and choice advantages of uniform health benefit plans for all of their employees.

Pooling smaller employers could also save them as much as 30 percent in overhead costs, thus enabling employers to cover more employees and provide more benefits. ERISA plans are the foundation of private health care coverage in America. According to the Self-Insurance Institute of America, ERISA plans cover over 115 million Americans of which more than 50 million people, including 60 percent of all workers and their dependents, are covered under plans that have self-insured coverage options.

Former Delaware Governor Pete du Pont said it best: "ERISA has worked—more people are insured than would be the case had it not been passed" (Washington Times, May 10, 1995).

Rather than create a new federal law, EPHIC builds on the current successful ERISA framework upon which plan sponsors have relied for over twenty years. The enactment of EPHIC would put the nation well on its way to closing the gap in coverage by offering millions of uninsured workers, their spouses and their children, the opportunity to access more affordable health coverage.

It would give associations of retailers, wholesalers, printers, agricultural employees, churches, franchise networks, etc. and organizations such as the Chamber of Commerce or National Federation of Independent Business (NFIB) the ability to form large regional or national groups that could fully-insure and self-insure, gaining all of the advantages that entails: economies-of-scale, bargaining power with providers, uniformity of plans, freedom from costly state-mandated benefit packages, and significantly lower overhead costs.

As Mr. Jack Faris, President of the National Federation of Independent Business testified, "Small business owners often pay approximately 30% more than larger companies for similar benefits because of higher administrative costs. In addition, they often pay another 30% in premiums because of costly state mandates for specific types of insurance coverage . . .". EPHIC would expand these advantages that larger employers have through ERISA to the small and medium-size employer marketplace.

Some mistakenly claim that expanding ERISA would empower the federal government over the states. Those who understand ERISA know better. Again, former Governor du Pont: "The real issue is regulation, not federalism. By maintaining ERISA intact, or even better, expanding it so smaller employers, by voluntarily banding together, can utilize ERISA, the federal government would ensure that employers have the freedom they need to establish affordable health insurance policies, and that more and more employees have health insurance." EPHIC would expand coverage through the private market and without new taxes or costly mandates.

Expansion of coverage through self-insured association health plans

As reported, the bill also builds on the ERISA cornerstone to empower employers, particularly smaller employers, to offer affordable coverage under association health plans that are self-insured. Expanding coverage to the uninsured truly is a winning proposition for all—employees (who would have coverage, perhaps for the first time), employers (who could afford to offer coverage), insurers (who

would experience less cost shifting from the uninsured), and state governments (who would have fewer uninsured within their borders and reduced uncompensated care costs).

Testifying on this approach, Mr. Sean Sullivan, President and CEO of the National Business Coalition on Health, an organization of employer coalitions whose members collectively provide health benefits to more than 35 million Americans, states: "Under the umbrella of ERISA, real health care reform already is taking place, driven by employers seeking better value from providers in the competitive marketplace. Your legislation would empower thousands of small businesses to join this movement that is reinventing the health care system for the 21st century."

EPHIC builds on what works, rather than on what does not. What works is the 1974 Employee Retirement Income Security Act (ERISA), the successful and time-tested, free-market oriented cornerstone of employee benefits. What works is using and improving the incentives and momentum of the market, seeking to expand real coverage to areas that the market is capable of reaching. What does not work is government micro-management of employee health plans.

ERISA has played an important role in driving down costs for medium and large employers, and allowing virtual "universal coverage" for the employees of medium and large U.S. employers. ERISA allows an employer to self-insure, permitting companies to offer uniform health benefit plans to all of their employees, no matter where they work or reside. Under ERISA, employers and employees are free to voluntarily work out benefit packages that fit the needs of workers and their pocketbooks.

Unfortunately, the smallest employers and the self-employed have not shared in the advantages of ERISA. EPHIC builds on ERISA to give smaller employers the same economies of scale and freedom to offer affordable coverage that larger employers enjoy. The bill clears the way for market forces to bring small employer costs down, while also carefully addressing the problems of insurance fraud and abuse.

Under current law hundreds of legitimate association self-insured multiple employer plans exist (e.g., nationwide plans for corner hardware and grocery stores, rural electric and telephone coops, etc.). However, federal standards do not exist to assure their solvency and only about a dozen states have enacted specific statutes to regulate them for solvency.

To remedy this situation, the bill provides that legitimate associations, franchise networks, church plans, certain collectively-bargained plans and company affiliates may choose to either remain subject to the few state multiple plan laws or to apply for certification which would have the same effect as an "exemption" pursuant to a provision under current ERISA law which has not been implemented by the Department of Labor.

As described in more detail below, this process will require self-insured multiple employer plans to meet solvency, fiduciary, and other necessary standards. This provision has been included in bipartisan legislation for over 5 years, including the bipartisan health care reform bill developed as an alternative to the Clinton health plan (H.R. 5228, 103rd Congress) and H.R. 995 in the 104th.

As the National Center for Policy Analysis and the Heritage Foundation have found in their analyses, ERISA-based employer pooling is free-market and pro-competition.

While some critics might express concern that the existence of self-insured multiple employer health plans could reduce the pool of small employers subject to state insurance laws, this is not the inevitable consequence of the pooling provisions under the bill.

Without any change in the law the number of self-insured employers exempt from state law under ERISA will increase, as past experience shows, even among the very smallest single employer plans. However, under the bill the health insurance industry is put in a more competitive position than today in comparison with self-insured plans. Insured plans can now compete on the same basis regarding nationally uniform benefits, pooling, and premium structure. With the expansion of health coverage the number of workers covered under fully-insured plans will increase, thus reversing the trend under current law. In addition, the small association health plans will look very much like their large-employer cousins (i.e., offering managed care, PPOs, and other cost effective insured options) which means that the insurance products offered under even self-insured plans would still be subject to state insurance regulation as the Supreme Court ruled in *Metropolitan v. Massachusetts*.

The legislation would also draw bright lines regarding state and federal authority regarding self-insured multiple employer plans which does not currently exist. Today the law is confusing regarding the responsibility of the states and the Department of Labor under ERISA. Only a handful of states have specific statutes applicable to legitimate multiple employer plans—and even in these states there are other multiple employer plans operating without the benefit of solvency regulation. The several hundreds of existing self-insured multiple plans, therefore, are not being subjected to state or federal solvency regulation (a condition the bill corrects).

Unfortunately, the illegitimate schemes which are perpetrated by bogus-unions and other fraudulent operators continue to proliferate despite the efforts of the Committee to correct the situation in 1983 (P.L. 97-473). Clearly the limited extent of state regulatory authority under current law has not been adequate to stem the problems that led to the 1983 change to ERISA. The fact is that the problems presented by illegitimate non-ERISA-plans are inter-state in nature and the National Association of Insurance Commissioners (NAIC) testified that changes to federal law are needed. In prepared testimony, the President of the NAIC stated that “states often engage in lengthy jurisdictional battles with [collectively bargained and staff arrangements] even before states can assert their regulatory authority. Consequently, under the current structure, many years can and often do pass before the courts ultimately determine that States can regulate a fraudulent MEWA.”

To address this problem, the bill gives states and the federal government more authority to put an end to health insurance fraud. Under the bill, states are given clear and unrestricted authority to put a stop to illegitimate entities—if an entity does not clearly show that they are either licensed by the state or have received an exemption under section 514 of ERISA, the state can shut it down. To the extent the entity flees a state’s border, the Department of

Labor is directed to assist the state to shut the entity down through new “cease and desist” authority under the bill. Under the bill, illegal entities become subject to criminal penalties if they try to hide their operations. This is why the Inspector General of the Department of Labor testified that the Department supports these provisions as “necessary and important” changes to ERISA. These provisions make the private health insurance system more truly accountable.

The fact is that, under the bill, legitimate association self-insured arrangements will be subject to greater solvency regulation than union-sponsored multiemployer plans and the self-insured single-employer plans of even the smallest employers.

Clarification of duty of the Secretary of Labor to implement provisions of current law providing for exemptions and solvency standards for association health plans

In general, the bill clarifies the conditions (solvency, etc.) under which association health plans providing medical care may apply for an exemption from certain state laws (states may enforce such conditions). The exemption process is contained under the current ERISA law. Also, the current ERISA law contains restrictions on the ability of states to fully regulate such entities.

Specifically, current law section 514(b)(6)(A)(ii) of ERISA provides that in the case of such a partly insured or fully self-insured arrangement, any law of any State which regulates insurance may apply only “to the extent not inconsistent with other parts of ERISA”. However, under section 514(b)(6)(B) the Department of Labor may issue an exemption from state law with respect to such self-insured arrangements (but has yet to issue a procedure or regulations to implement the exemption process as intended under amendments to ERISA enacted in 1983). The “to the extent not inconsistent” language was intended to encourage states to enact specific statutes regulating such entities without forcing them to become “insurance companies” which is a key concept under the so-called “deemer clause” in ERISA section 514 (i.e., that ERISA “employee benefit plans” shall not be deemed to be in the business of insurance).

Under a new part 8 of ERISA Title I, the bill clarifies that only certain legitimate association health plans (AHPs) and other arrangements (described below) are eligible for an exemption and thereby treated as ERISA employee welfare benefit plans. EPHIC enables legitimate associations (including church plans, franchise networks, and certain large employer and collectively-bargained plans) to maintain or establish multiple employer plans by voluntarily seeking licensure in the few states permitting this or to seek federal certification which in effect invokes the “exemption” provision (sec. 514(b)(6)(B)) under the current ERISA statute (reserve, eligibility, and other standards must be met; such requirements may be enforced by states if they desire, or otherwise by the Department of Labor). Entities that do not have either a state or federal certification are fully subject to state law (states, as they choose, may force them to meet any insurance or multiple employer plan licensing requirements or to shut them down). All such entities must register with DOL and the states and are subject to the

criminal penalties under ERISA for failure to do so (illegitimate entities will become criminal enterprises—the enforcement tool lacking today and hindering both federal and state enforcement efforts). In addition, the Department of Labor is given “cease and desist” authority to curtail the activities of any such illegitimate entities.

Part 8 sets forth criteria which an association health plan must meet to qualify for an exemption. The Secretary shall grant an exemption to an AHP only if: (1) a complete application has been filed; (2) the application demonstrates compliance with eligibility requirements described below; (3) the Secretary finds that the exemption is administratively feasible, not adverse to the interests of the individuals covered under it, and protective of the rights and benefits of the individuals covered under the arrangement; (4) certain reserve, surplus and indemnification requirements (as described below) are met; and (5) all other terms of the exemption are met (e.g. including financial, actuarial, reporting, participation, and other requirements which may be specified as a condition of the exemption).

Under the eligibility requirements for AHPs, an applicant must demonstrate that the arrangement’s sponsor has been in existence for a continuous period of at least 3 years and organized and maintained in good faith, with a constitution and bylaws, as a trade association, an industry association, a professional association, or a chamber of commerce (or similar business group) for purposes other than that of obtaining or providing medical care. Also, the applicant must demonstrate that the sponsor is established as a permanent entity and has the active support of its members.

In addition to the associations described above, certain other entities are eligible to seek an exemption as AHPs. These include: (1) franchise networks; (2) certain existing collectively bargained arrangements which fail to meet the statutory exemption criteria; (3) certain arrangements not meeting the statutory exemption criteria for single employer plans; and (4) certain church plans electing to seek an exemption.

The bill also requires that the arrangement be operated, pursuant to a trust agreement, by a “board of trustees” which has complete fiscal control and which is responsible for all operations of the arrangement. The board of trustees must develop rules of operation and financial control based on a three-year plan of operation which is adequate to carry out the terms of the arrangement and to meet all applicable requirements of the exemption and Title I of ERISA. The Board of Trustees must be the “named fiduciary” under ERISA, thus being liable for any breach of fiduciary duty under Part 4 of the law.

The Committee expects that the following requirements will have to be met by any entity which is certified as an AHP under the bill. In general, each AHP under which some or all benefits are not fully insured shall be required to establish and maintain reserves, recommended by the plan qualified actuary with respect to the self-insured portion of the plan, consisting of: (1) a reserve sufficient for unearned contributions; (2) a reserve sufficient for benefit liabilities which have been incurred, which have not been satisfied, and for which risk of loss has not yet been transferred, and for expected

administrative costs with respect to such benefit liabilities; and (3) a reserve for any other obligations of the arrangement.

The Committee expects that, in general, the plan will be required to maintain surplus in an amount equal to the greater of: (1) 25 percent of the amount of benefit liabilities expected to be incurred for the plan year and for which risk of loss has not been effectively transferred and 25 percent of the amount of expected administrative costs with respect to such benefit liabilities for the plan year; or (2) \$400,000 less the amount of reserves described in (2) above.

The Committee expects that in determining the amounts of reserves required in connection with any association health plan, the qualified actuary shall include a margin for error and other fluctuations taking into account the specific circumstances of such plan.

The Committee expects that an AHP will have to maintain in force aggregate excess/stop loss insurance with an attachment point not greater than 125% of expected claims.

The Committee also intends that AHPs operate in such a manner so as to preclude the chance that claims will be left unpaid upon plan termination. To obtain this result EPHIC requires each AHP that offers a self-insured option to maintain an effective means of indemnification for any obligations of the plan for which reserves are insufficient upon plan termination. As an ultimate backstop to the preceding, EPHIC provides for an assessment based guarantee fund which would be triggered only in the unlikely event that plan indemnification and other plan assets would prove insufficient.

The Committee also intends that the Secretary may provide such additional requirements relating to reserves and excess/stop loss coverage as the Secretary considers appropriate. Such requirements may be provided, by regulation or otherwise, with respect to any arrangement or any class of arrangements. It is anticipated that the Secretary may provide for adjustments to the levels of reserves otherwise required with respect to any arrangement or class of arrangements to take into account excess/stop loss coverage provided with respect to such plans.

The Committee also intends that the Secretary shall permit an association health plan to substitute, for all or part of the reserves required, such security, guarantee, hold-harmless arrangements, insurance, or other financial arrangement as the Secretary determines to be adequate to enable the plan to fully satisfy all benefit liabilities on a timely basis. Such an alternative must not be less protective than the basic provisions for which it is substituted.

The Committee also intends that the Secretary will provide by regulation, or otherwise, procedures for the quarterly reporting of financial and actuarial information by the board of trustees and the qualified actuary, in cases of any failure to meet the standards, in order to assure the financial responsibility of the plan. It is expected that notice requirements for voluntary termination and additional rules for mandatory termination, in cases in which this may be necessary, will also be promulgated.

In addition to the above reserve and other consumer protections, EPHIC has strict rules to prevent so-called "anti-selection." First, the organizations eligible to sponsor AHPs cannot be structured to select only "good risks" because: (1) sponsors cannot be organized

for the purpose of offering health insurance and must be in existence for at least 3 years for substantial purposes other than establishing an AHP before becoming an eligible sponsor of an AHP; (2) sponsors can only be legitimate business associations, church plans, multiemployer and collectively-bargained arrangements, and franchise networks not otherwise in the health insurance business; and (3) since an AHP must meet the definition of "group health plan" under ERISA and the Health Insurance Portability and Accountability Act (HIPAA), only *bona fide* associations of *employers* (not individuals) are eligible—this precludes typical so-called MEWAs consisting of unrelated employers from eligibility (in fact, increased state and federal enforcement is made applicable to such entities under EPHIC).

Secondly, because AHPs must be ERISA "group health plans", the preexisting condition, portability, nondiscrimination, special enrollment, and renewability provisions under ERISA as added by HIPAA are applicable to such plans in the same manner as for insurers. Thus AHPs cannot deny enrollment to *employees* because of a preexisting medical condition or any health status factor. In addition, since EPHIC requires that AHPs must offer coverage to all *employer* members of the association without regard to claims experience, health status of workers, or other conditions, employers with more costly employees cannot be excluded. In fact, AHPs must "actively market" coverage to all employers so as to preclude any selection against higher cost employers.

Moreover, once coverage is offered to employers under an AHP, the renewability requirements of HIPAA ensures continued coverage eligibility. Also AHPs cannot set their premiums in a manner so as to force a high claims cost employer to pay higher premiums than other similarly situated employers in the plan so as to force such an employer out of the plan and into the non-association insurance market.

Anti-selection against the individual insurance market is also precluded under the bill by prohibiting employers who participate in AHPs from excluding sick employees and purchasing coverage for such individuals in the individual market.

Rather than anti-selection in favor of "good risks", self-insured multiple employer plans serve today as a backstop to practices in the insurance industry which have denied higher-than-average risk industries the access to health insurance they have sought. For example, in testimony a California growers cooperative produced evidence of dozens of insurers who refused to underwrite health insurance coverage for the farm workers in their industry.

A study by Lewin-VHI, Inc. demonstrates that the self-insured population is not composed of "lower health insurance risks" than the population of employees covered under employer sponsored fully-insured health insurance policies. The anti-selection argument is a specious one to mask the real issue that ERISA self-insured plans are not subject to state premium taxes. However, if directed at EPHIC this argument would be a hollow one since AHPs must offer at least one option of fully-insured health insurance coverage which is subject to state premium taxes.

The bill empowers employers, particularly small employers, to use the same time-tested "self-insured" concept that numerous

states, counties, and cities use to secure health insurance coverage for their own employees. Approximately seven million employees are covered under public employee self-insured plans.

Under EPHIC the fully-insured market will again be competitive with ERISA self-insured single-employer plans, since employers and insurers will be able to fashion under AHPs the benefit packages employees desire and can afford on a nationally uniform basis (with certain exceptions state benefit mandates are preempted). The expanded coverage under voluntary AHPs will also prove useful to retaining and expanding the share of the health insurance market for insurers and HMOs.

The intent of EPHIC is to help get the uninsured employees and their families into some sort of health insurance plan—whether fully-insured or self-insured. This alone will help reduce the cost-shifting of the uncompensated care incurred by the uninsured which today increases the costs for those who are insured.

Conclusion

EPHIC will open up the health insurance market to the millions of American workers and their families who today do not have access to or cannot afford private health insurance. It does so by removing the structural barriers that prevent some employers from voluntarily providing health insurance to their employees, either on their own or as part of an association health plan.

The bill employs ERISA Title I to provide a twenty-first-Century model of freedom for employees and employers to negotiate benefits, and provide a competitive environment to let market forces help reduce health care costs, thus making health insurance coverage more available and affordable for the American worker.

The bill creates a competitive health care marketplace, removes barriers and conflicting regulations, provides important new protections and freedoms for workers in a more mobile society, and allows cost-saving innovations to be introduced into the marketplace.

It is long overdue that cost-conscious small employers be given the same opportunity to achieve the economies-of-scale and freedom from excessive government regulation that large employers already have. The problems of uninsured workers and their families can be strongly attacked by removing barriers and allowing small employers to pool together to voluntarily form ERISA multiple employer health plans.

EPHIC builds on what is already working and by letting the market roar, the increased health plan competition that results will mean improved access to more affordable coverage for millions of employees, particularly those working for small businesses who do not have health insurance.

In conclusion, the only way major strides in expanding access to health coverage for the uninsured can be achieved in a voluntary market is to make reforms that bring down the cost of providing health coverage to employers, particularly small employers. Health care reform that is effective in expanding access and based on free market principles is possible. It is in the grasp of this Congress in the form of EPHIC. The way to expand coverage is the free market approach that is already working for over 50 million Americans now covered by an ERISA plan. We urge our colleagues to keep it

working for those who already have coverage and expand the advantages of ERISA to those who do not by passing the provisions of EPHIC and taking an epic step toward reducing the number of uninsured Americans.

SECTION-BY-SECTION

SUBTITLE A

Section 5001. This Act may be cited as the “Welfare-To-Work Grants.”

Section 5001(a) amends section 403(a) of the Social Security Act as follows:

“403(a)(5)(A)(i) specifies the process for determining the level of funding entitled to each welfare-to-work State.

403(a)(5)(A)(ii) specifies criteria for which to determine whether a State shall be considered a welfare-to-work State.

403(a)(5)(A)(iii) specifies the calculation to be used in determining the allotments to welfare-to-work States.

403(a)(5)(A)(iv) defines the term ‘available amount’ for purposes of calculating allotments to welfare-to-work States.

403(a)(5)(A)(v) defines the State percentage for purposes of calculating allotments to welfare-to-work States.

403(a)(5)(A)(vi) specifies the process for the within State distribution of funds. Including the 85 percent which must be distributed by formula and the remainder which the Governor may distribute to projects to help long-term recipients of assistance into the workforce.

403(a)(5)(A)(vii) specifies the State agencies authorized to be designated to administer grants and provides Private Industry Councils sole authority to expend funds.

403(a)(5)(B)(i) authorizes the Secretary of Labor to make grants to eligible applicants for demonstration projects.

403(a)(5)(B)(ii) defines criteria for applicants eligible for receipt of demonstration projects.

403(a)(5)(B)(iii) sets forth criteria for the determination of grant amounts made available for individual demonstration projects.

403(a)(5)(B)(iv) specifies calculation to be used to determine the total amount available for demonstration grants.

403(a)(5)(C)(i) specifies allowable activities with respect to the use of funds under this paragraph.

403(a)(5)(C)(ii) specifies those beneficiaries targeted for receipt of services.

403(a)(5)(C)(iii) sets forth limitation of the applicability of “use of grant” provisions under the Temporary Assistance to Needy Families grant.

403(a)(5)(C)(iv) prohibits Private Industry Councils from providing direct services.

403(a)(5)(C)(vi) sets deadline for expenditure of funds.

403(a)(5)(D) defines criteria for use in determining the number of individuals with income less than poverty.

403(a)(5)(E) includes definitions for: private industry council; the Secretary; and Service Delivery Areas.

403(a)(5)(F) reserves funding for Indian tribes.

403(a)(5)(G) reserves funding for the Secretary to conduct evaluations.

403(a)(5)(H) specifies funding levels for each of the fiscal years 1998 through 2000.

403(a)(5)(I) sets limit as to the period of time for which grants may be made.”

Section 5001(b) amends section 1108(a) to exempt welfare-to-work grant amounts from limitation on total payments to Territories.

Section 5001(c) amends section 412(a) as follows:

“412(a)(3)(A) requires the Secretary to make welfare-to-work grants to each Indian tribe that is a welfare-to-work tribe.

412(a)(3)(B) defines criteria for Indian tribe to be considered a welfare-to-work tribe.

412(a)(3)(C) sets forth limitations on the use of funds provided to welfare-to-work tribes.

Section 5001(d) amends section 408(a)(7) to clarify that funds received by an individual from welfare-to-work grants are to be disregarded in the application of durational limits on assistance.

Section 5001(e) amends section 413 to require the Secretary to develop a plan on the evaluation of grants and to allow for the evaluation of the use of grants by grantees.

Section 5002 amends section 407(f) as follows:

“407(f)(1) specifies prohibitions with respect to the displacement or partial displacement of an employee by a participant in a work activity; prohibits impairment of contracts and includes additional prohibitions with respect to work activities.

407(f)(2) specifies health and safety standards applicable to participants engaged in a work activity.

407(f)(3) specifies non-discrimination provisions applicable to participants engaged in a work activity.

407(f)(4) specifies establishment of grievance procedure for certain complaints and includes provisions with respect to the investigation of such grievances and remedies for violations.”

Section 5003 amends section 407(c)(2)(D) to clarify the limitation on the number of persons who may be treated as engaged in work by reason of participation in educational activities.

Section 5004 amends section 407 as follows:

“407(j) specifies the compensation required on behalf of recipients participating in specified work activities.

407(k) specifies limitation on the number of hours per month that a recipient of assistance may be required to participate in on-the-job training and with a public agency or nonprofit organization.”

Section 5005 amends section 409(a) to include a penalty for failure of a State to reduce assistance for recipients refusing without good cause to work.

SUBTITLE B

Section 5101 adds a new subsection (h) to Section 422 of the Higher Education Act which sets forth the amount of \$1,000,000,000 to be recalled from cash reserve funds held by guaranty agencies by the Secretary and the method for ensuring that such funds are available in 2002 for return to the Treasury. This

section dictates the calculation to be used to determine the amount of reserves to be returned by each individual guaranty agency. It also requires the transfer of reserve funds to restricted accounts on an annual basis or in accordance with a payment schedule agreed to by the Secretary. The funds transferred to the restricted accounts may not be used by the guaranty agencies, but the earnings on such accounts may be used to pay operating expenses.

Section 5102 repeals the provision of the Higher Education Act authorizing the payment of direct loan origination fees to institutions of higher education.

Section 5103 reduces the available funds under Section 458 of Part D of the Higher Education Act to \$532 million in Fiscal Year 1998, \$610 million in Fiscal Year 1999, \$705 million in Fiscal Year 2000, \$750 million in Fiscal Year 2001 and \$750 in Fiscal Year 2002. In addition, guaranty agencies are to receive administrative cost allowances from these funds calculated on the basis of .85% of the total principal amount of loans upon which insurance is issued on or after the date of enactment of this legislation subject to a maximum expenditure of \$170 million for each of the Fiscal Years 1998 and 1999 and \$150 million thereafter.

Section 5104 extends the authorizing dates for the student loan programs.

Section 5105 clarifies the amount guarantors may retain on the collection of consolidated defaulted student loans. This section establishes the collection retention rate for guaranty agencies at 18.5% for student loans in default which are subsequently consolidated and returned to good standing. The effective date for this provision is July 1, 1997, except that, for guaranty agencies which have been retaining 18.5% since enactment of the Higher Education Amendments of 1992, this provision applies as of the effective date of those amendments.

SUBTITLE C

Section 5201 repeals the Smith Hughes Act.

SUBTITLE D

Section 5301. This Act may be cited as the "Expansion of Portability and Health Insurance Coverage Act of 1997" or EPHIC.

Section 5302 adds a new Part 8 (Rules Governing Regulation of Association Health Plans) to Title I of ERISA, as follows:

801 states that the term "association health plan" means a "group health plan" (which is defined in ERISA as added by the Health Insurance Portability and Accountability Act or HIPAA; under HIPAA such group health plans are subject to all of the portability, preexisting condition, nondiscrimination, special enrollment, renewability and other provisions of ERISA Part 7)—

(1) under which at least one option of fully-insured "health insurance coverage" offered by a health insurance issuer is made available to plan participants and beneficiaries, and

(2) whose sponsor of the plan meets the following conditions.

The sponsor of an Association Health Plan (AHP) must be organized and maintained in good faith, with a constitution and bylaws specifically stating its purpose and providing for at least annual meetings, as a trade association, an industry association (including a rural electric or rural telephone cooperative), a professional association, or a chamber of commerce (or similar business group, including a similar organization that operates on a cooperative basis within the meaning of section 1381 of the IRC), for substantial purposes other than that of obtaining or providing medical care. Also, the applicant must demonstrate that the sponsor is established as a permanent entity, has the active support of its members, and collects dues or payments (to maintain eligibility) from its members without conditioning such on the basis of the health status or claims experience of plan participants or beneficiaries or on the basis of the member's participation in a group health plan.

In addition to the associations described above, certain other entities are eligible to seek certification as AHPs. These include (1) franchise networks (section 803(c)), (2) multiemployer plans and certain existing collectively bargained arrangements which fail to meet the statutory exemption criteria (section 803(d)), and (3) certain arrangements not meeting the statutory exemption criteria for single employer plans (section 803(e)). Section 810 also makes eligible certain church plans voluntarily electing to come under the fiduciary, reporting, and actuarial standards contained in section 810.

802 establishes a procedure for the certification of Association Health Plans as prescribed by the Secretary of Labor. The Secretary shall grant certification only if such certification is administratively feasible, not adverse to the interests of the individuals covered under it, and protective of the rights and benefits of the individuals covered under the plan. In essence, this procedure has the same effect as requiring the Secretary to implement the authority under current law to issue exemptions for association health plans (see ERISA section 514(b)(6)(B)). A "class certification" procedure is established to speed the approval of plans which offer only fully-insured health insurance coverage.

An AHP that is certified must also meet the applicable requirements of Part 8 as described below.

803 establishes additional eligibility requirements for AHPs. Applicants must demonstrate that the arrangement's sponsor has been in existence for a continuous period of at least 3 years for substantial purposes other than providing coverage under a group health plan.

Subsection (b) also requires that the plan be operated, pursuant to a trust agreement, by a "board of trustees" which has complete fiscal control and which is responsible for all operations of the plan. The board of trustees must develop rules of operation and financial control based on a three-year plan of operation which is adequate to carry out the terms of the plan and to meet all applicable requirements of the certification and Title I of ERISA. The board of trustees must consist of individuals who are owners, officers, directors or employees of the employers who participate in the plan.

In addition to the associations described in section 801, certain other entities are made eligible to seek certification as AHPs.

These include (1) franchise networks (section 803(c)), (2) multiemployer plans and certain existing collectively bargained arrangements which fail to meet the statutory exemption criteria (section 803(d)), and (3) certain arrangements not meeting the statutory exemption criteria for single employer plans (section 803(e)). Section 810 also makes eligible certain church plans voluntarily electing certification.

804 prohibits discrimination against eligible employers and employees by requiring that all employers who are association members be eligible for participation under the terms of the plan, that benefit options be actively marketed to all eligible members, and that eligible individuals of such participating employers not be excluded from enrolling in the plan because of health status. Plans may include minimum participation, contribution, and size requirements to the extent they meet the nondiscrimination and other rules under sections 701, 702, and 703. Affiliated members of the plan sponsor may be offered coverage if they are affiliated at the time of certification or if they were previously uninsured for 12 months prior to being covered. The legislation will not affect the individual health insurance market adversely inasmuch as the bill requires that no participating employer may exclude an employee from enrollment under an AHP by purchasing an individual policy of health insurance coverage for such person based on their health status.

805 requires an association health plan to meet the following requirements: (1) its governing instruments must provide that the board of trustees serves as the named fiduciary and plan administrator, that the sponsor serves as plan sponsor, and that the reserve requirements of section 806 are met; (2) the contribution rates for any particular employer must be nondiscriminatory—they cannot vary only on the claims experience of the particular employer or on the type of business or industry in which the employer is engaged, regardless of how much such claims may be above or below average claims experience, (3) the plan has at least 1,000 participants and beneficiaries if the plan does not consist solely of fully-insured health insurance coverage, and (4) the plan meets such other requirements as may be set forth in regulations by the Secretary.

The rules also stipulate that association health plans must be allowed to design benefit options. Specifically, no provision of state law shall preclude an AHP or health insurance issuer from exercising its discretion in designing the items and services of medical care to be included as health insurance coverage under the plan, except to the extent that such law (1) prohibits a specific disease from such coverage, or (2) is not preempted under section 731(a)(1) with respect to the matters governed by section 711 (relating to maternal and newborn hospitalization) and section 712 (relating to mental health coverage).

In addition, no provision of law shall be construed to preclude an AHP or health insurance issuer from setting contribution rates based on the experience under the plan to the extent such rates are nondiscriminatory as described above.

806 requires AHPs offering benefit options that do not consist solely of fully-insured health insurance coverage to establish and

maintain reserves sufficient for unearned contributions, benefit liabilities incurred but not yet satisfied and for which risk of loss has not been transferred, expected administrative costs, any other obligations and a margin for error recommended by the plan's qualified actuary. Surplus must be maintained in an amount at least equal to the larger of 25% of expected incurred claims and expenses for the year or \$400,000 over the amount of reserves for incurred but unpaid claims. In addition, each plan must secure coverage from an insurer consisting of (1) aggregate stop-loss insurance with an attachment point not greater than 125% of expected gross claims, and (2) to prevent insolvency, indemnification for any claims which a plan is unable to satisfy by reason of a mandatory termination described under section 809(b). The Secretary may provide additional requirements relating to reserves and excess/stop loss insurance and may provide adjustments to the levels of reserves otherwise required to take into account the level of excess/stop loss insurance or other financial arrangements.

807 sets forth additional criteria which association health plans must meet to qualify for certification. The Secretary shall grant certification to a plan only if: (1) a complete application has been filed, accompanied by the filing fee of \$5,000; and (2) all other terms of the certification are met (including financial, actuarial, reporting, participation, and such other requirements as may be specified as a condition of the certification).

The application must include the following: (1) identifying information about the arrangement and the states in which it will operate; (2) evidence that ERISA's bonding requirements will be met; (3) copies of all plan documents and agreements with service providers; (4) a funding report indicating that the reserve requirements of 806 will be met, that contribution rates will be adequate to cover obligations, and that a qualified actuary (a member in good standing of the American Academy of Actuaries or an actuary meeting such other standards the Secretary considers adequate) has issued an opinion with respect to the arrangement's assets, liabilities, and projected costs; and (5) any other information prescribed by the Secretary. Certified association health plans must notify the Secretary of any material changes in this information at any time, must file annual reports with the Secretary, and must engage a qualified actuary.

808 requires that, except as provided in section 809, an AHP may terminate only if the board of trustees provides 60 days advance written notice to participants and beneficiaries and submits to the Secretary a plan providing for timely payment of all benefit obligations.

809 requires an AHP which offers benefit options which are not fully-insured to continue to meet the reserve requirements under section 806 even if its exemption is no longer in effect. The board of trustees of such an AHP must quarterly determine whether the reserve requirements of section 806 are being met and, if they are not, must, in consultation with the qualified actuary, develop a plan to ensure compliance and report such information to the Secretary. In any case where an AHP notifies the Secretary that it has failed to meet the reserve requirements and corrective action has not restored compliance, and the Secretary determines that there

is a reasonable expectation that the plan will continue to fail to meet the requirements applicable to such AHPs, the Secretary may direct the board to terminate the arrangement. Under subsection (c), the Secretary of Labor is directed to assess self-insured association health plans up to 2% of self-insured claims per year to pay any outstanding claims of an AHP in the unlikely event that, upon the termination of any such plan, the reserves, stop-loss and indemnification insurance and other plan assets are insufficient to pay all claims incurred at the time of termination. Such assessments would be temporarily held in a guarantee fund and immediately paid out to settle any claims.

810 permits church plans providing medical care to voluntarily elect to apply to the Department of Labor for certification. In order to receive an exemption from state insurance law, an electing church plan would be subject to the requirements of section 810 providing for compliance with fiduciary standards (exclusive purpose and prudence rules); claims procedures; annual certification by a qualified actuary that the plan maintains reserves, capital, insurance or other financial arrangements adequate to enable the plan to meet all of its financial obligations on a timely basis; and annual statements certifying plan compliance with the above.

811 defines the following terms: group health plan, medical care, health insurance coverage, health insurance issuer, health status-related factor, individual market, participating employer, qualified actuary, applicable state authority and affiliated member. The terms are consistent with those added to ERISA by the Health Insurance Portability and Accountability Act. In addition, the terms "employer" and "employee" include self-employed individuals and partners for purposes of the application of Part 8 and the provisions of Title I as applicable to association health plans.

Subsection (b). Conforming Amendments. This subsection contains (1) conforming changes to the definition of "plan sponsor" to include the sponsor of an AHP; (2) conforming changes to the Title I exception for church plans electing association health plan status; and (3) as described below, conforming changes to the section 514 preemption rules to reflect the policy changes under Part 8 with respect to association health plans. First, paragraph (6) of section 514(b) is made inapplicable with respect to any state law in the case of a certified AHP. Secondly, a new subsection 514(d) (current subsection (d) is redesignated as (e)) clarifies the ability of health insurance issuers to offer health insurance coverage under AHPs and clarifies the ability of any health insurance issuer to offer health insurance coverage of the same policy type as offered in connection with a particular AHP to eligible employers, regardless of whether such employers choose or do not choose to become members of the particular association. Health insurance coverage policy forms filed and approved in a particular state in connection with an insurer's offering under an association health plan are deemed to be approved in any other state in which such coverage is offered when the insurer provides a complete filing in the same form and manner to the authority in the other state. Also, this section removes the current restriction on state regulation of self-insured multiple employer welfare arrangements providing medical care (which do not elect to meet the certification requirements for

AHPs) under section 514(b)(6)(A)(ii) by eliminating the requirement that such state laws otherwise “be consistent with the provisions of ERISA Title I.” Section 514 is also amended to include a cross-reference to section 805(b) (relating to the ability of AHPs and health insurance issuers to design association health insurance options) and to section 805(a)(2)(B) (relating to the ability of AHPs and health insurance issuers to base contribution rates on the experience of such plans). Other than as described above, the preemptive provisions of section 514 continue to apply as under current law, including their application with respect to self-insured plans and direct contracting with providers under such plans. Financial agreements to provide medical care services under direct contracting arrangements between ERISA self-insured plans and providers of medical care do not constitute the business of insurance and are protected from state regulation under the general preemption rules of section 514 of ERISA, since ERISA self-insured plans retain the obligation to pay benefits in connection with such medical care and do not fully transfer the so-called insurance risk for a premium as is the case under “health insurance coverage” (as that term is defined in ERISA). Direct contracting with providers is a common practice using traditional fee-for-service arrangements. In recent years, the use of various forms of provider payments to create incentives to manage the cost and use of their services has taken hold and is rapidly becoming the predominant payment method under private ERISA group health plans as well as public plans. Examples of such payment methods include: fixed per diem payments that cover all inpatient costs; fixed per case payments that cover all inpatient costs; fixed global payments for an entire course of treatment that cover the costs of all providers and settings needed; and withholds bonus payments tied to utilization and/or cost targets. Under these types of arrangements, plans retain the obligation to pay for covered benefits. As such, these payment arrangements do not constitute the business of insurance under ERISA. In these situations, the medical care providers are not selling coverage to individuals, they are contracting with the employer plans to deliver medical care services. Delivering medical care services is the purpose of the arrangement, not the provision of insurance coverage.

Section 5303 modifies the treatment of certain single employer arrangements under the section of ERISA that defines a multiple employer welfare arrangement (section 3(40)). The treatment of a single employer plan as being excluded from the definition of such an arrangement (and thus from state law) is clarified by defining the minimum interest required for two or more entities to be in “common control” as a percentage which cannot be required to be greater than 25%. Also a plan would be considered a single employer plan if less than 25% of the covered employees are employed by other participating employers.

Section 5304 clarifies the conditions under which multiemployer and other collectively-bargained arrangements are exempted from the definition of a multiple employer welfare arrangement, and thus exempt from state law. This is intended to address the problem of “bogus unions” and other illegitimate health insurance operators. The provision amends the definition of such an arrangement

to exclude a plan or arrangement which is established or maintained under or pursuant to a collective bargaining arrangement (as described in the National Labor Relations Act, the Railway Labor Act, and similar state public employee relations laws). (Current law requires the Secretary to “find” that a collective bargaining agreement exists, but no such finding has ever been issued). It then specifies additional conditions which must be met for such a plan to be a statutorily excluded collectively bargained arrangement and thus not a multiple employer welfare arrangement. These include:

(1) The plan cannot utilize the services of any licensed insurance agent or broker to solicit or enroll employers or pay a commission or other form of compensation to certain persons that is related to the volume or number of employers or individuals solicited or enrolled in the plan.

(2) A maximum 15 percent rule applies to the number of covered individuals in the plan who are not employees (or their beneficiaries) within a bargaining unit covered by any of the collective bargaining agreements with a participating employer or who are not present or former employees (or their beneficiaries) of sponsoring employee organizations or employers who are or were a party to any of the collective bargaining agreements.

(3) The employee organization or other entity sponsoring the plan or arrangement must certify annually to the Secretary the plan has met the previous requirements.

(4) If the plan or arrangement is not fully insured, it must be a multiemployer plan meeting specific requirements of the Labor Management Relations Act (i.e., the requirement for joint labor-management trusteeship under section 302(c)(5)(B)).

(5) If the plan or arrangement is not in effect as of the date of enactment, the employee organization or other entity sponsoring the plan or arrangement must have existed for at least 3 years or have been affiliated with another employee organization in existence for at least 3 years, or demonstrate to the Secretary that certain of the above requirements have been met.

Section 5305 amends ERISA to establish enforcement provisions relating to association health plans and multiple employer welfare arrangements: (1) willful misrepresentation that an entity is an exempted AHP or collectively-bargained arrangement may result in criminal penalties; (2) the section provides for cease activity orders for arrangements found to be neither licensed, registered, or otherwise approved under State insurance law, or operating in accordance with the terms of a certification granted by the Secretary under part 8; and (3) the section provides for the responsibility of the named fiduciary or board of trustees of an AHP to comply with the required claims procedure under ERISA.

Section 5306 amends section 506 of ERISA (relating to coordination and responsibility of agencies enforcing ERISA and related laws) to specify State responsibility with respect to Association Health Plans. A State may enter into an agreement with the Secretary for delegation to the State of some or all of the Secretary's authority under section 502 and 504 to enforce provisions applica-

ble to certified AHPs. The Secretary is required to enter into the agreement if the Secretary determines that delegation to the State would not result in a lower level or quality of enforcement. However, if the Secretary delegates authority to a State, the Secretary can continue to exercise such authority concurrently with the State.

Section 5307 states that in general, the amendments made by the Act are effective January 1, 1999. Sections 3 and 4 are effective upon date of enactment. In addition, the Secretary is required to issue all regulations needed to carry out the amendments before January 1, 1999.

The provisions of section 801(a)(2) relating to health insurance coverage do not apply to group health plans existing on April 1, 1997 if they do not provide fully-insured health insurance coverage, but later qualify for certification.

STATEMENT OF OVERSIGHT FINDINGS AND RECOMMENDATIONS OF THE COMMITTEE

In compliance with clause 2(1)(3)(A) of rule XI of the Rules of the House of Representatives and 2(b)(1) of rule X of the Rules of the House of Representatives, the Committee's oversight findings and recommendations are reflected in the body of this report.

GOVERNMENT REFORM AND OVERSIGHT

With respect to the requirement of clause 2(1)(3)(D) of rule XI of the Rules of the House of Representatives, the Committee has received no report of oversight findings and recommendations from the Committee on Government Reform and Oversight on the subject of the Committee recommendations.

COMMITTEE ESTIMATE

Clause 7 of rule XIII of the Rules of the House of Representatives requires an estimate and a comparison by the Committee of the costs which would be incurred in carrying out the Committee Recommendations. However, clause 7(d) of that rule provides that this requirement when the Committee has included in its report a timely submitted cost estimate of the bill prepared by the Director of the Congressional Budget Office under section 403 of the Congressional Budget Act of 1974.

APPLICATION OF LAW TO THE LEGISLATIVE BRANCH

Section 102(b)(3) OF Public Law 104-1 requires a description of the application of this bill to the legislative branch. The reconciliation recommendations make administrative reforms in student loan programs, establishes a system for spending an additional money through the Temporary Assistance to Needy Families block grant, repeals the Smith-Hughes Act of 1917, and expands the portability of employer provided health insurance. These recommendations do not otherwise prohibit legislative branch employees from receiving the benefits of this legislation.

UNFUNDED MANDATE STATEMENT

Section 423 of the Congressional Budget and Impoundment Control Act requires a statement of whether the provisions of the reported bill include unfunded mandates. The Committee received a letter regarding unfunded mandates from the Director of the Congressional Budget Office. See *infra*.

BUDGET AUTHORITY AND CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

With respect to the requirement of clause 2(1)(3)(B) of rule XI of the House of Representatives and section 308(a) of the Congressional Budget Act of 1974 and with respect to requirements of clause 2(1)(3)(C) of rule XI of the House of Representatives and section 403 of the Congressional Budget Act of 1974, the Committee has received a cost estimate for the Committee Recommendation from the Director of the Congressional Budget Office.

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, June 16, 1997.

Hon. WILLIAM F. GOODLING,
*Chairman, Committee on Education and the Workforce,
House of Representatives, Washington, DC.*

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the enclosed cost estimate for the reconciliation recommendations of the House Committee on Education and the Workforce.

The estimate shows the budgetary effects of the committee's proposals over the 1998–2007 period. CBO understands that the Committee on the Budget will be responsible for interpreting how these proposals compare with the resolution instructions in the budget resolution. This estimate assumes the reconciliation bill will be enacted by August 15, 1997; the estimate could change if the bill is enacted later.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contacts are Sheila Dacey (for Subtitle A), Deborah Kalcevic (for Subtitle B), and Christi Sadoti (for Subtitle C), Jeffrey Lemieux (for Subtitle D), and Marc Nicole and John Patterson (for state and local government impacts).

Sincerely,

JUNE E. O'NEILL, *Director.*

Enclosure.

Reconciliation Recommendations of the House Committee on Education and the Workforce (Title V)

Summary: This bill would mandate a new welfare-to-work program, reduce the cost of the federal student loan programs, repeal the Smith-Hughes Act (which provides funds for vocational education), and modify the standards under which certain health plans can be certified. The bill would increase spending by \$2.8 billion over the 1998–2002 period on the new welfare-to-work grant and save \$1.8 billion in the student loan program.

By preempting states from taking various regulatory actions in the health insurance market, Subtitle D of Title V would impose

several intergovernmental mandates as defined in the Unfunded Mandates Reform Act of 1995 (UMRA). CBO is unable to estimate the size or direction of the impact that these mandates would have on state budgets and, therefore, cannot determine if the threshold established in UMRA would be exceeded. Title V contains no private-sector mandates as defined in UMRA.

Estimated cost to the Federal Government: CBO estimates the committee's proposals would reduce federal outlays by \$14 million in 1998 and \$794 million in 2002 but increase outlays by \$1 billion over the 1998–2002 period. The estimated budgetary impact of these proposals over the 1998–2002 period is shown in the following table. The appendix table shows the budgetary effects through 2007.

The budgetary impact of Title V falls within budget functions 500 (education, training, employment, and social services) and 550 (health).

ESTIMATED BUDGETARY IMPACT OF THE RECONCILIATION RECOMMENDATIONS OF THE HOUSE
COMMITTEE ON EDUCATION AND THE WORKFORCE

[By fiscal year in millions of dollars]

	1997	1998	1999	2000	2001	2002
Subtitle A—Welfare-to-Work Program:						
Budget Authority		750	1,250	1,000	.....	.....
Estimated Outlays		226	782	1,049	489	265
Subtitle B—Student Loans:						
Estimated Budget Authority	(1)	–456	–175	–85	–40	–1,045
Estimated Outlays	(1)	–239	–233	–155	–85	–1,052
Subtitle C—Vocational Education:						
Budget Authority		–7	–7	–7	–7	–7
Estimated Outlays		–1	–7	–7	–7	–7
Subtitle D—Expansion of Portability and Health Insurance Coverage:						
Estimated Budget Authority		0	0	0	0	0
Estimated Outlays		0	0	0	0	0
Total Changes in Direct Spending:						
Estimated Budget Authority		287	1,068	908	–47	–1,052
Estimated Outlays		–14	542	887	397	–794

¹ Less than \$500,000.

Basis of Estimate:

Subtitle A—Welfare-to-work grants

Subtitle A of the bill would establish welfare-to-work grants for states and localities to help recipients of Temporary Assistance for Needy Families (TANF) find jobs. Grants totaling up to \$3 billion would be awarded—\$750 million in 1998, \$1.25 billion in 1999, and \$1 billion in 2000. A small amount of the grant money would be set aside for special purposes: 1 percent for Indian tribes and 0.5 percent for evaluation of welfare-to-work programs. Of the remaining grant money, 95 percent would be allocated to non-competitive grants to states and 5 percent would go towards competitive grants to localities and private industry councils for demonstration projects.

Non-competitive grants would be allocated to states based on a formula that equally considers states' shares of the national number of poor individuals and adult recipients of TANF. States must match the federal funds spending one dollar of state money for

every two dollars of federal money (a 67 percent federal match rate). Any funds that are not obligated by a state by the end of the fiscal year would be distributed as a competitive grant in the following year. To be eligible for federal matching, the state spending must be in addition to the maintenance of effort spending for the TANF program (80 percent of a state's historic spending on Aid to Families with Dependent Children and related programs, or 75 percent if a state meets the work requirement of the TANF program). States would be required to pass through 85 percent of the grant money to private industry councils, which would have sole authority to spend the money after consulting with the state agency that administers the grant. The state could retain 15 percent of the money to fund welfare-to-work projects of the state's choice. Competitive grants for demonstration projects would be awarded directly to local governments and private industry councils and would not need to be matched by any state or local spending.

Grantees could spend grant funds, either non-competitive or competitive, to help move recipients of TANF assistance into the workforce by means of job creation, on-the-job training, job placement, job vouchers or job retention and support services. Any funds that were not expended after three years would be returned.

Based on conversations with officials in half a dozen large states, we believe that states would draw down most of the non-competitive grant money. The officials indicated that the 67 percent match rate would be very attractive to their states and that spending on welfare-to-work programs is politically popular. We assume most states would spend more than 80 percent of their historic level on benefit and work programs over this period under current law, and thus could draw down the federal grant without spending any additional state money.

However, not all of the state officials were confident that their state would access all the money available. Some states with particularly low spending relative to their historic level would need to make a significant expansion of state spending in order to draw down the federal funds. Also, the requirement to pass most of the money through to private industry councils would make it less attractive for states to spend match money. The estimate assumes that 30 percent of the grant funds available in 1998 and 20 percent of the grant funds available in 1999 would not be used in those years but would be distributed in the immediately following years as competitive grants for demonstration projects. The estimate assumes that states would not use 20 percent of the funds available in 2000, but that these funds would not be redistributed because the bill does not allow grants to be made after 2000. The estimate assumes that states would spend the grant funds they draw down more slowly in the start-up years of the program than in the later years.

Because no match is required, CBO assumes that all of the competitive grant money would be spent. However, the competitive grant funds would be spent a little more slowly than the non-competitive grant money because the process of awarding the money would delay spending.

Based on discussions with committee staff, the estimate assumes that the legislative language will be changed in three ways. First,

the bill would clarify that state spending that is used to match welfare-to-work grant dollars cannot also be used to match contingency fund dollars or child care matching program dollars. Second, the language would be modified to direct that the baseline will assume that no welfare-to-work grants are made after 2000, rather than 2001. Third, the committee staff indicated that revised language would adopt the Ways and Means Committee technical changes to the definition of expenditures by the state.

CBO estimates that only \$226 million of the \$750 million available will be spent in 1998. This would increase to \$1 billion by 2000 and then decline to \$265 million by 2002. In total, all but \$189 million of the \$3 billion would be spent.

Subtitle B—Student loans

Subtitle B of the bill would make three changes in the federal administrative costs and federal cash management of the student loan programs, which under current law are expected to guarantee or issue about 40 million new loans totaling \$160 billion over the next five years. The revisions to the program would leave program eligibility and loan capital financing unchanged. In combination, the proposed changes would lower program costs by \$239 million in 1998 and \$1.8 billion over the 1998–2002 period, as shown in the following table.

ESTIMATED FEDERAL COST OF STUDENT LOANS
[By fiscal year, in millions of dollars]

	1997	1998	1999	2000	2001	2002
Spending current law:						
Budget authority	1,009	3,911	3,567	3,367	3,418	3,533
Estimated outlays	578	3,378	3,325	3,162	3,138	3,223
Proposed changes:						
Section 5101—Guaranty Agency reserves:						
Budget authority						–1,000
Estimated outlays						–1,000
Section 5102—Direct loan processing fee:						
Budget authority		–35	–35	–40	–40	–45
Estimated outlays		–20	–30	–35	–35	–40
Section 5103—Section 458 funds						
Budget authority		–421	–140	–45	0	0
Estimated outlays		–219	–203	–120	–50	–12
Section 5104—Guaranty Agency retention allowances:						
Budget authority	(¹)	(^{1})	(^{1})	(^{1})	(^{1})	(^{1})
Estimated outlays .....	(^{1})	(^{1})	(^{1})	(^{1})	(^{1})	(¹)
Subtotal, proposed changes:						
Budget authority	(¹)	–456	–175	–85	–46	–1,045
Estimated outlays	(¹)	–239	–233	–155	–85	–1,052
Spending under reconciliation recommendations:						
Budget authority	1,009	3,455	3,392	3,282	3,378	2,488
Estimated outlays	578	3,139	3,092	3,007	3,053	2,171

¹ Less than \$500,000

Management and Recovery of Reserves. Section 5101 of this bill would require that the 36 guaranty agencies currently participating in the guaranteed student loan program return \$1 billion of their cash reserve funds to the federal government in 2002. The net cash reserves held by guaranty agencies have been growing in re-

cent years due to recent changes in law that expanded borrowing levels and resulted in increased premium collections and lower default claims. As of September 1996, these agencies had combined net cash reserves of just over \$2 billion. The amount to be recalled exceeds the amount needed by these agencies to operate over the next five years. The bill would recall more of the funds from agencies with proportionately larger cash reserves. The CBO estimate assumes that the agencies would continue to receive insurance premiums, reinsurance payments, and federal administrative cost allowances, which are all provided for under current law. If these revenues were to be diminished, CBO would reassess the likelihood that the recall target could be attained.

Repeal of Direct Loan Origination Fees to Institutions of Higher Education. Section 5102 would eliminate the separate per loan federal subsidy to schools or alternate originators to process applications for direct student loans. Direct payments to schools have been prohibited in the last two appropriations bills, allowing payment only to alternate originators. Eliminating these mandated payments would save \$20 million in 1998 and \$160 million over the 1998–2002 period. The proposal would not prevent the Secretary of Education from using funds available under the capped administrative entitlement fund (Section 458 monies) to pay either schools or alternate originators to process the applications for direct student loans.

Funds for Administrative Expenses. The Department of Education's Section 458 capped administrative entitlement fund would be reduced by \$604 million over the five-year period to a new five-year total of \$3.1 billion. Section 5103 would set new annual limits for this fund at \$532 million in 1998, \$610 million in 1999, \$705 million in 2000, and \$750 million in 2001 and 2002. The current five-year cumulative ceiling would be eliminated, and funds would be available for obligation until expended.

Collections on Consolidated Defaulted Loans. Section 5104 of this subtitle stipulates that the guaranty agency retention allowance on default collections that result from defaulted loans reentering repayment through loan consolidation would be 18.5 percent. A new regulation, which takes effect July 1, 1997, stipulates an amount to cover the collection cost of up to 18.5 percent. This provision would codify this share at 18.5 percent and would make the 18.5 percent retention allowance retroactive to the enactment date of the Higher Education Act Amendments of 1992 for those agencies that had retained 18.5 percent since 1992, reinforcing the effects of earlier Department of Education directives. This change is expected to have a negligible effect on program costs.

Subtitle C—Vocational education

This subtitle of the bill would repeal the Smith-Hughes Act, which permanently authorizes \$7 million annually for grants to states for vocational education.

ESTIMATED FEDERAL COST OF SMITH-HUGHES ACT

[By fiscal year, in millions of dollars]

	1997	1998	1999	2000	2001	2002
DIRECT SPENDING						
Spending current law:						
Budget authority	7	7	7	7	7	7
Estimated outlays	7	7	7	7	7	7
Proposed changes:						
Budget authority		-7	-7	-7	-7	-7
Estimated outlays		-1	-7	-7	-7	-7
Spending under reconciliation recommendations:						
Budget authority	7	0	0	0	0	0
Estimated outlays	7	6	0	0	0	0

Subtitle D—Expansion of portability and health insurance coverage

Subtitle D would allow organizations such as trade, industry, and professional associations and chambers of commerce to sponsor association health plans (AHPs) for their members and affiliated members. They could obtain federal certification for those plans, which would then be exempt from state regulation. Other health plans would also be eligible for certification as AHPs, including plans offered by franchisers to their franchisees, plans whose members are the employees of related employers, certain multiemployer plans and collectively bargained arrangements, and certain church plans.

In general, sponsors of AHPs would have to offer at least one fully-insured option, and those with at least 1,000 participants could also offer self-insured options. The bill specifies standards that such self-insured options would have to meet, but the solvency standards would probably be less rigorous than those required by the states for insured health plans. The bill provides that all AHPs would be assessed a percentage of their self-insured claims to pay the claims of insolvent self-insured AHPs. But that assessment would not be made until a plan had been terminated, so there could be considerable lag time before funding to pay the outstanding claims was available. Moreover, the assessment could not exceed 2 percent of annual self-insured claims.

Self-insured options would be exempt from state premium taxes, and all AHPs—both fully-insured and self-insured—would be exempt from state mandates for benefits. The effects of that exemption would extend beyond the members of AHPs. An insurer who offered a policy to an employer through an association plan could offer that same policy to any employer in the state who would be eligible for coverage under the association plan but did not participate. (It is unclear whether those eligible for coverage would include employers who were not members of the sponsoring association but would meet its eligibility criteria.)

The subtitle could affect the health insurance market in three important ways. First, by exempting additional plans from state laws mandating the coverage of certain benefits or providers, the subtitle would reduce the cost of insurance for those plans. Reduced costs could lead to additional employers offering coverage to the workers. Second, by allowing AHPs to form under special cir-

cumstances, the subtitle could further segment the insurance marketplace, allowing groups of healthier people more leeway to form and receive favorable rates, and leaving other groups with greater percentages of sick enrollees and higher rates. Finally, because federal regulatory standards would probably be less strict than the state standards that would apply under current law, the subtitle could increase the risk of plan failures, adding an increased potential for disruption to the insurance market.

Subtitle D could affect the federal budget in two ways. First, if the bill changed the amount of employer-paid health premiums, total federal revenues could change. Second, if the proposed changes caused people insured by government health programs to obtain private coverage, then federal outlays for those programs could change. Employer cost for current policies would be reduced if premiums fall. If lower premiums encouraged additional employers to offer coverage, however, the amount of employer-paid premiums would rise. On balance, CBO estimates that total employer contributions for health insurance would not change significantly. As a result, the Joint Committee on Taxation estimates that federal revenues would not change. CBO also estimates that the subtitle would cause no appreciable changes to federal outlays for Medicaid, Medicare, Federal Employees Health Benefits, or other government programs.

Estimated impact on State, local, and tribal governments: By preempting certain state regulation of the health insurance market, this title would impose several intergovernmental mandates as defined in UMRA. CBO is unable to estimate the size or direction of the impact that these mandates would have on state budgets and, therefore, cannot determine if the threshold established in UMRA (\$50 million in 1996, adjusted annually for inflation) would be exceeded. The title also contains other provisions that would have a significant impact of the budgets of state, local, and tribal governments.

Mandates

The title would preempt states from:

- Regulating or collecting premium taxes from association health plans;

- Requiring health insurers who offer coverage to AHPs to provide certain health benefits;

- Requiring health insurers to provide certain benefits in other situations; and

- Prohibiting health insurers from offering coverage to AHPs.

In addition, the bill would exempt other health plan arrangements from state regulation by expanding the definition of single-employer arrangements and certain collectively bargained arrangements (both of which are exempt from state regulation).

The health insurance market is extremely complex, and it is difficult to summarize the potential impacts that this title would have on state regulation and taxation. There are many types of health plans (indemnity, HMO, preferred provider organizations, and point of service). They can be insured or self-funded, and are provided by employers through a variety of arrangements (single employer, multiple employers, and collectively bargained under mul-

tiple employers). These factors combine to produce a vast array of health benefit arrangements that are regulated and taxed differently by states.

This title would create more options and incentives for employers to adjust their health care arrangements in order to obtain less expensive coverage, and the ultimate impact on state premium tax revenues is highly uncertain. The bill would also affect state income tax collections as employers make adjustments in their employees' compensation packages in response to these mandates making health benefits less expensive.

Other significant impacts

Welfare-to-Work. Subtitle A would provide states and tribal governments with between \$750 million and \$1.25 billion annually for fiscal years 1998 through 2000 to move welfare recipients to work. In order to receive these funds, a state would have to match each federal dollar with 50 cents of its own funds.

Work Requirement Under Temporary Assistance for Needy Families. The TANF work requirement (which specifies percentages of TANF families that must have a member engaged in work activities) would be modified in ways and CBO estimates would likely increase the net costs of meeting the work requirement. Such costs would not constitute a mandate as defined under UMRA because states have the flexibility to offset additional costs by tightening eligibility or reducing benefit levels.

Education. Subtitle B would eliminate the mandate that the federal government help cover the cost of originating direct student loans. CBO estimates that public institutions could lose federal subsidies totaling \$20 million in fiscal year 1998 and \$115 million over the 1998–2002 period. Subtitle C would repeal a grant program that provides \$7 million annually to states for vocational education.

Estimated impact on the private sector: Enactment of Title V would impose no private-sector mandates as defined under UMRA.

Estimate prepared by: Federal cost: Deborah Kalcevic, Sheila Dacey, and Christi Sadoti; and Jeffrey Lemieux; impact on State, Local, and Tribal Governments: Marc Nicole and John Patterson; impact on Private Sector: Bruce Vavrichek.

Estimate approved by: Paul N. Van de Water, Assistant Director for Budget Analysis.

ESTIMATED BUDGETARY EFFECTS OF TITLE V—RECONCILIATION RECOMMENDATIONS OF THE HOUSE COMMITTEE ON EDUCATION AND THE WORKFORCE

[In millions of dollars, by fiscal year]

	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	1998- 2007 total
CHANGES IN DIRECT SPENDING											
Subtitle A—Welfare-to-work:											
Estimated budget authority	750	1,250	1,000								3,000
Estimated outlays	226	782	1,049	489	265						2,811
Subtotal											
Subtitle B—Student loans:											
Estimated budget authority	-456	-175	-85	-40	-1,045	-45	-50	-50	-55	-55	-2,056
Estimated outlays	-239	-233	-155	-85	-1,052	-42	-45	-45	-50	-50	-1,996
Subtotal											
Subtitle C—Vocational education:											
Estimated budget authority	-7	-7	-7	-7	-7	-7	-7	-7	-7	-7	-70
Estimated outlays	-1	-7	-7	-7	-7	-7	-7	-7	-7	-7	-64
Subtotal											
Subtotal D—FEHB:											
Estimated budget authority	0	0	0	0	0	0	0	0	0	0	0
Estimated outlays	0	0	0	0	0	0	0	0	0	0	0
Subtotal											
Total	287	1,068	908	-47	-1,052	-52	-57	-67	-62	-62	874
Estimated outlays	-14	542	887	397	-794	-49	-52	-52	-57	-57	751

CONSTITUTIONAL AUTHORITY STATEMENT

Subtitles A, B, and C, are within the powers of Congress under the Tax and Spending Clause of the Constitution, Article I, Section 8, clause 1. Subtitle D is within the powers of Congress under the Commerce Clause of the Constitution, Article I, Section 8, clause 3.

EXPLANATION OF AMENDMENTS

An explanation of amendments adopted in Committee is included in the body of the report.

Rollcall: 1.

Bill: Committee Print.

Date: June 12, 1997.

Amendment number: 1.

Defeated: 19–25.

Sponsor/Amendment: Mr. Clay/Amendment regarding labor requirements for workfare recipients.

Member	Aye	No	Present	Not voting
Mr. Goodling, Chairman		X		
Mr. Petri, Vice Chairman		X		
Mrs. Roukema		X		
Mr. Fawell		X		
Mr. Ballenger		X		
Mr. Barrett		X		
Mr. Hoekstra		X		
Mr. McKeon		X		
Mr. Castle		X		
Mr. Johnson		X		
Mr. Talent		X		
Mr. Greenwood		X		
Mr. Knollenberg		X		
Mr. Riggs		X		
Mr. Graham		X		
Mr. Souder		X		
Mr. McIntosh		X		
Mr. Norwood		X		
Mr. Paul		X		
Mr. Schaffer		X		
Mr. Peterson		X		
Mr. Upton		X		
Mr. Deal		X		
Mr. Hilleary		X		
Mr. Scarborough		X		
Mr. Clay	X			
Mr. Miller	X			
Mr. Kildee	X			
Mr. Martinez				X
Mr. Owens	X			
Mr. Payne	X			
Mrs. Mink	X			
Mr. Andrews	X			
Mr. Roemer	X			
Mr. Scott	X			
Ms. Woolsey	X			
Mr. Romero-Barceló	X			
Mr. Fattah	X			
Mr. Hinojosa	X			
Mrs. McCarthy	X			
Mr. Tierney	X			
Mr. Kind	X			

Member	Aye	No	Present	Not voting
Ms. Sanchez	X	.....	.....	.....
Mr. Ford	X	.....	.....	.....
Mr. Kucinich	X	.....	.....	.....
Totals	19	25	.....	1

Rollcall: 2.

Bill: Committee Print.

Date: June 12, 1997.

Amendment number: 3.

Defeated: 15–20.

Sponsor/Amendment: Ms. Woolsey/Amendment regarding redundant non-discrimination requirements.

Member	Aye	No	Present	Not voting
Mr. Goodling, Chairman .....	.....	X	.....	.....
Mr. Petri, Vice Chairman .....	.....	.....	.....	X
Mrs. Roukema .....	.....	X	.....	.....
Mr. Fawell .....	.....	X	.....	.....
Mr. Ballenger .....	.....	X	.....	.....
Mr. Barrett .....	.....	X	.....	.....
Mr. Hoekstra .....	.....	X	.....	.....
Mr. McKeon .....	.....	X	.....	.....
Mr. Castle .....	.....	X	.....	.....
Mr. Johnson .....	.....	X	.....	.....
Mr. Talent .....	.....	X	.....	.....
Mr. Greenwood .....	.....	.....	.....	X
Mr. Knollenberg .....	.....	X	.....	.....
Mr. Riggs .....	.....	X	.....	.....
Mr. Graham .....	.....	X	.....	.....
Mr. Souder .....	.....	.....	.....	X
Mr. McIntosh .....	.....	X	.....	.....
Mr. Norwood .....	.....	X	.....	.....
Mr. Paul .....	.....	.....	.....	X
Mr. Schaffer .....	.....	X	.....	.....
Mr. Peterson .....	.....	X	.....	.....
Mr. Upton .....	.....	X	.....	.....
Mr. Deal .....	.....	X	.....	.....
Mr. Hilleary .....	.....	X	.....	.....
Mr. Scarborough .....	.....	.....	.....	X
Mr. Clay	X	.....	.....	.....
Mr. Miller .....	.....	.....	.....	X
Mr. Kildee	X	.....	.....	.....
Mr. Martinez	X	.....	.....	.....
Mr. Owens	X	.....	.....	.....
Mr. Payne	X	.....	.....	.....
Mrs. Mink	X	.....	.....	.....
Mr. Andrews	X	.....	.....	.....
Mr. Roemer	X	.....	.....	.....
Mr. Scott	X	.....	.....	.....
Ms. Woolsey	X	.....	.....	.....
Mr. Romero-Barceló .....	.....	.....	.....	X
Mr. Fattah	X	.....	.....	.....
Mr. Hinojosa	X	.....	.....	.....
Mrs. McCarthy	X	.....	.....	.....
Mr. Tierney .....	.....	.....	.....	X
Mr. Kind	X	.....	.....	.....
Mrs. Sanchez .....	.....	.....	.....	X
Mr. Ford .....	.....	.....	.....	X
Mr. Kucinich	X	.....	.....	.....

Member	Aye	No	Present	Not vot- ing
Totals	15	20	.....	10

Rollcall: 3.

Bill: Committee Print.

Date: June 12, 1997.

Amendment number: 4.

Defeated: 20-24.

Sponsor/Amendment: Mr. Roemer/Substitute (for Subtitle A).

Member	Aye	No	Present	Not vot- ing
Mr. Goodling, Chairman		X	.....	.....
Mr. Petri, Vice Chairman		X	.....	.....
Mrs. Roukema		X	.....	.....
Mr. Fawell		X	.....	.....
Mr. Ballenger		X	.....	.....
Mr. Barrett		X	.....	.....
Mr. Hoekstra		X	.....	.....
Mr. McKeon		X	.....	.....
Mr. Castle		X	.....	.....
Mr. Johnson		X	.....	.....
Mr. Talent		X	.....	.....
Mr. Greenwood .....		.....	.....	X
Mr. Knollenberg		X	.....	.....
Mr. Riggs		X	.....	.....
Mr. Graham		X	.....	.....
Mr. Souder		X	.....	.....
Mr. McIntosh		X	.....	.....
Mr. Norwood		X	.....	.....
Mr. Paul		X	.....	.....
Mr. Schaffer		X	.....	.....
Mr. Peterson		X	.....	.....
Mr. Upton		X	.....	.....
Mr. Deal		X	.....	.....
Mr. Hilleary		X	.....	.....
Mr. Scarborough		X	.....	.....
Mr. Clay	X	.....	.....	.....
Mr. Miller	X	.....	.....	.....
Mr. Kildee	X	.....	.....	.....
Mr. Martinez	X	.....	.....	.....
Mr. Owens	X	.....	.....	.....
Mr. Payne	X	.....	.....	.....
Mrs. Mink	X	.....	.....	.....
Mr. Andrews	X	.....	.....	.....
Mr. Roemer	X	.....	.....	.....
Mr. Scott	X	.....	.....	.....
Ms. Woolsey	X	.....	.....	.....
Mr. Romero-Barceló	X	.....	.....	.....
Mr. Fattah	X	.....	.....	.....
Mr. Hinojosa	X	.....	.....	.....
Mrs. McCarthy	X	.....	.....	.....
Mr. Tierney	X	.....	.....	.....
Mr. Kind	X	.....	.....	.....
Ms. Sanchez	X	.....	.....	.....
Mr. Ford	X	.....	.....	.....
Mr. Kucinich	X	.....	.....	.....
Totals	20	24	.....	1

Rollcall: 4.

Bill: Committee Print.

Date: June 12, 1997.

Amendment number: 7.
 Passed: 25-20.
 Sponsor/Amendment: Mrs. Mink/To sustain the Ruling of the Chair.

Member	Aye	No	Present	Not voting
Mr. Goodling, Chairman	X			
Mr. Petri, Vice Chairman	X			
Mrs. Roukema	X			
Mr. Fawell	X			
Mr. Ballenger	X			
Mr. Barrett	X			
Mr. Hoekstra	X			
Mr. McKeon	X			
Mr. Castle	X			
Mr. Johnson	X			
Mr. Talent	X			
Mr. Greenwood	X			
Mr. Knollenberg	X			
Mr. Riggs	X			
Mr. Graham	X			
Mr. Souder	X			
Mr. McIntosh	X			
Mr. Norwood	X			
Mr. Paul	X			
Mr. Schaffer	X			
Mr. Peterson	X			
Mr. Upton	X			
Mr. Deal	X			
Mr. Hilleary	X			
Mr. Scarborough	X			
Mr. Clay		X		
Mr. Miller		X		
Mr. Kildee		X		
Mr. Martinez		X		
Mr. Owens		X		
Mr. Payne		X		
Mrs. Mink		X		
Mr. Andrews		X		
Mr. Roemer		X		
Mr. Scott		X		
Ms. Woolsey		X		
Mr. Romero-Barceló		X		
Mr. Fattah		X		
Mr. Hinojosa		X		
Mrs. McCarthy		X		
Mr. Tierney		X		
Mr. Kind		X		
Ms. Sanchez		X		
Mr. Ford		X		
Mr. Kucinich		X		
Totals	25	20		

Rollcall: 5.
 Bill: Committee Print.
 Date: June 12, 1997.
 Amendment number: 8.
 Defeated: 21-24.
 Sponsor/Amendment: Mr. Andrews/Amendment regarding administrative costs of Loan Program.

Member	Aye	No	Present	Not voting
Mr. Goodling, Chairman		X		
Mr. Petri, Vice Chairman	X			
Mrs. Roukema		X		
Mr. Fawell		X		
Mr. Ballenger		X		
Mr. Barrett		X		
Mr. Hoekstra		X		
Mr. McKeon		X		
Mr. Castle		X		
Mr. Johnson		X		
Mr. Talent		X		
Mr. Greenwood		X		
Mr. Knollenberg		X		
Mr. Riggs		X		
Mr. Graham		X		
Mr. Souder		X		
Mr. McIntosh		X		
Mr. Norwood		X		
Mr. Paul		X		
Mr. Schaffer		X		
Mr. Peterson		X		
Mr. Upton		X		
Mr. Deal		X		
Mr. Hilleary		X		
Mr. Scarborough		X		
Mr. Clay	X			
Mr. Miller	X			
Mr. Kildee	X			
Mr. Martinez	X			
Mr. Owens	X			
Mr. Payne	X			
Mrs. Mink	X			
Mr. Andrews	X			
Mr. Roemer	X			
Mr. Scott	X			
Ms. Woolsey	X			
Mr. Romero-Barceló	X			
Mr. Fattah	X			
Mr. Hinojosa	X			
Mrs. McCarthy	X			
Mr. Tierney	X			
Mr. Kind	X			
Ms. Sanchez	X			
Mr. Ford	X			
Mr. Kucinich	X			
Totals	21	24		

Rollcall: 6.
 Bill: Committee Print.
 Date: June 12, 1997.
 Amendment number: 9.
 Defeated: 21-24.
 Sponsor/Amendment: Mr. Andrews/re: origination fee.

Member	Aye	No	Present	Not voting
Mr. Goodling, Chairman		X		
Mr. Petri, Vice Chairman	X			
Mrs. Roukema		X		
Mr. Fawell		X		
Mr. Ballenger		X		
Mr. Barrett		X		

Member	Aye	No	Present	Not voting
Mr. Hoekstra		X		
Mr. McKeon		X		
Mr. Castle		X		
Mr. Johnson		X		
Mr. Talent		X		
Mr. Greenwood		X		
Mr. Knollenberg		X		
Mr. Riggs		X		
Mr. Graham		X		
Mr. Souder		X		
Mr. McIntosh		X		
Mr. Norwood		X		
Mr. Paul		X		
Mr. Schaffer		X		
Mr. Peterson		X		
Mr. Upton		X		
Mr. Deal		X		
Mr. Hilleary		X		
Mr. Scarborough		X		
Mr. Clay	X			
Mr. Miller	X			
Mr. Kildee	X			
Mr. Martinez	X			
Mr. Owens	X			
Mr. Payne	X			
Mrs. Mink	X			
Mr. Andrews	X			
Mr. Roemer	X			
Mr. Scott	X			
Ms. Woolsey	X			
Mr. Romero-Barceló	X			
Mr. Fattah	X			
Mr. Hinojosa	X			
Mrs. McCarthy	X			
Mr. Tierney	X			
Mr. Kind	X			
Ms. Sanchez	X			
Mr. Ford	X			
Mr. Kucinich	X			
Totals	21	24		

Rollcall: 7.
 Bill: Committee Print.
 Date: June 12, 1997.
 Amendment number: 10.
 Passed: 24-21.
 Sponsor/Amendment: Mr. McKeon/establishes collection retention rate for guaranty agencies for student loans in good standing.

Member	Aye	No	Present	Not voting
Mr. Goodling, Chairman	X			
Mr. Petri, Vice Chairman		X		
Mrs. Roukema	X			
Mr. Fawell	X			
Mr. Ballenger	X			
Mr. Barrett	X			
Mr. Hoekstra	X			
Mr. McKeon	X			
Mr. Castle	X			
Mr. Johnson	X			
Mr. Talent	X			

Member	Aye	No	Present	Not voting
Mr. Greenwood	X			
Mr. Knollenberg	X			
Mr. Riggs	X			
Mr. Graham	X			
Mr. Souder	X			
Mr. McIntosh	X			
Mr. Norwood	X			
Mr. Paul	X			
Mr. Schaffer	X			
Mr. Peterson	X			
Mr. Upton	X			
Mr. Deal	X			
Mr. Hilleary	X			
Mr. Scarborough	X			
Mr. Clay		X		
Mr. Miller		X		
Mr. Kildee		X		
Mr. Martinez		X		
Mr. Owens		X		
Mr. Payne		X		
Mrs. Mink		X		
Mr. Andrews		X		
Mr. Roemer		X		
Mr. Scott		X		
Ms. Woolsey		X		
Mr. Romero-Barceló		X		
Mr. Fattah		X		
Mr. Hinojosa		X		
Mrs. McCarthy		X		
Mr. Tierney		X		
Mr. Kind		X		
Mr. Sanchez		X		
Mr. Ford		X		
Mr. Kucinich		X		
Totals	24	21		

Rollcall: 8.
 Bill: H.R. 1515.
 Date: June 12, 1997.
 Amendment number: 3.
 Passed: 25-20.
 Sponsor/Amendment: Mr. Payne/To sustain the Ruling of the Chair.

Member	Aye	No	Present	Not voting
Mr. Goodling, Chairman	X			
Mr. Petri, Vice Chairman	X			
Mrs. Roukema	X			
Mr. Fawell	X			
Mr. Ballenger	X			
Mr. Barrett	X			
Mr. Hoekstra	X			
Mr. McKeon	X			
Mr. Castle	X			
Mr. Johnson	X			
Mr. Talent	X			
Mr. Greenwood	X			
Mr. Knollenberg	X			
Mr. Riggs	X			
Mr. Graham	X			
Mr. Souder	X			

Member	Aye	No	Present	Not voting
Mr. McIntosh	X			
Mr. Norwood	X			
Mr. Paul	X			
Mr. Schaffer	X			
Mr. Peterson	X			
Mr. Upton	X			
Mr. Deal	X			
Mr. Hilleary	X			
Mr. Scarborough	X			
Mr. Clay		X		
Mr. Miller		X		
Mr. Kildee		X		
Mr. Martinez		X		
Mr. Owens		X		
Mr. Payne		X		
Mrs. Mink		X		
Mr. Andrews		X		
Mr. Roemer		X		
Mr. Scott		X		
Ms. Woolsey		X		
Mr. Romero-Barceló		X		
Mr. Fattah		X		
Mr. Hinojosa		X		
Mrs. McCarthy		X		
Mr. Tierney		X		
Mr. Kind		X		
Ms. Sanchez		X		
Mr. Ford		X		
Mr. Kucinich		X		
Totals	25	20		

Rollcall: 9.

Bill: H.R. 1515.

Date: June 12, 1997.

Amendment number: 4A.

Passed 25–20.

Sponsor/amendment: Mr. Fawell/Amendment to the Payne Amendment.

Member	Aye	No	Present	Not voting
Mr. Goodling, Chairman	X			
Mr. Petri, Vice Chairman	X			
Mrs. Roukema	X			
Mr. Fawell	X			
Mr. Ballenger	X			
Mr. Barrett	X			
Mr. Hoekstra	X			
Mr. McKeon	X			
Mr. Castle	X			
Mr. Johnson	X			
Mr. Talent	X			
Mr. Greenwood	X			
Mr. Knollenberg	X			
Mr. Riggs	X			
Mr. Graham	X			
Mr. Souder	X			
Mr. McIntosh	X			
Mr. Norwood	X			
Mr. Paul	X			
Mr. Schaffer	X			
Mr. Peterson	X			

Member	Aye	No	Present	Not vot- ing
Mr. Upton	X	.....	.....	.....
Mr. Deal	X	.....	.....	.....
Mr. Hilleary	X	.....	.....	.....
Mr. Scarborough	X	.....	.....	.....
Mr. Clay	X	.....	.....
Mr. Miller	X	.....	.....
Mr. Kildee	X	.....	.....
Mr. Martinez	X	.....	.....
Mr. Owens	X	.....	.....
Mr. Payne	X	.....	.....
Mrs. Mink	X	.....	.....
Mr. Andrews	X	.....	.....
Mr. Roemer	X	.....	.....
Mr. Scott	X	.....	.....
Ms. Woolsey	X	.....	.....
Mr. Romero-Barceló	X	.....	.....
Mr. Fattah	X	.....	.....
Mr. Hinojosa	X	.....	.....
Mrs. McCarthy	X	.....	.....
Mr. Tierney	X	.....	.....
Mr. Kind	X	.....	.....
Ms. Sanchez	X	.....	.....
Mr. Ford	X	.....	.....
Mr. Kucinich	X	.....	.....
Totals	25	20	.....	.....

Rollcall: 10.

Bill: H.R. 1515.

Date: June 12, 1997.

Amendment number: 5.

Defeated: 22-22.

Sponsor/Amendment: Mr. Kildee/Amendment regarding Federal preemption of State law.

Member	Aye	No	Present	Not vot- ing
Mr. Goodling, Chairman	X	.....	.....
Mr. Petri, Vice Chairman	X	.....	.....
Mrs. Roukema	X	.....	.....	.....
Mr. Fawell	X	.....	.....
Mr. Ballenger	X	.....	.....
Mr. Barrett	X	.....	.....
Mr. Hoekstra	X	.....	.....
Mr. McKeon	X	.....	.....
Mr. Castle	X	.....	.....
Mr. Johnson	X	.....	.....
Mr. Talent	X	.....	.....
Mr. Greenwood	X	.....	.....
Mr. Knollenberg	X	.....	.....
Mr. Riggs	X	.....	.....
Mr. Graham	X	.....	.....
Mr. Souder	X
Mr. McIntosh	X	.....	.....
Mr. Norwood	X	.....	.....	.....
Mr. Paul	X	.....	.....
Mr. Schaffer	X	.....	.....
Mr. Peterson	X	.....	.....
Mr. Upton	X	.....	.....
Mr. Deal	X	.....	.....
Mr. Hilleary	X	.....	.....
Mr. Scarborough	X	.....	.....
Mr. Clay	X	.....	.....	.....

Member	Aye	No	Present	Not vot- ing
Mr. Miller	X			
Mr. Kildee	X			
Mr. Martinez	X			
Mr. Owens	X			
Mr. Payne	X			
Mrs. Mink	X			
Mr. Andrews	X			
Mr. Roemer	X			
Mr. Scott	X			
Ms. Woolsey	X			
Mr. Romero-Barceló	X			
Mr. Fattah	X			
Mr. Hinojosa	X			
Mrs. McCarthy	X			
Mr. Tierney	X			
Mr. Kind	X			
Ms. Sanchez	X			
Mr. Ford	X			
Mr. Kucinich	X			
Totals	22	22		1

Rollcall: 11.

Bill: H.R. 1515.

Date: June 12, 1997.

Amendment number: 6.

Defeated: 22–23.

Sponsor/Amendment: Mr. Tierney/Amendment regarding Federal preemption of State law.

Member	Aye	No	Present	Not vot- ing
Mr. Goodling, Chairman		X		
Mr. Petri, Vice Chairman		X		
Mrs. Roukema	X			
Mr. Fawell		X		
Mr. Ballenger		X		
Mr. Barrett		X		
Mr. Hoekstra		X		
Mr. McKeon		X		
Mr. Castle		X		
Mr. Johnson		X		
Mr. Talent		X		
Mr. Greenwood		X		
Mr. Knollenberg		X		
Mr. Riggs		X		
Mr. Graham		X		
Mr. Souder		X		
Mr. McIntosh		X		
Mr. Norwood	X			
Mr. Paul		X		
Mr. Schaffer		X		
Mr. Peterson		X		
Mr. Upton		X		
Mr. Deal		X		
Mr. Hilleary		X		
Mr. Scarborough		X		
Mr. Clay	X			
Mr. Miller	X			
Mr. Kildee	X			
Mr. Martinez	X			
Mr. Owens	X			
Mr. Payne	X			

Member	Aye	No	Present	Not voting
Mrs. Mink	X			
Mr. Andrews	X			
Mr. Roemer	X			
Mr. Scott	X			
Ms. Woolsey	X			
Mr. Romero-Barceló	X			
Mr. Fattah	X			
Mr. Hinojosa	X			
Mrs. McCarthy	X			
Mr. Tierney	X			
Mr. Kind	X			
Ms. Sanchez	X			
Mr. Ford	X			
Mr. Kucinich	X			
Totals	22	23		

Rollcall: 12.
 Bill: H.R. 1515.
 Date: June 12, 1997.
 Amendment Number: 7.
 Passed: 25–20.
 Sponsor/Amendment: Mr. Miller/To sustain the Ruling of the Chair.

Member	Aye	No	Present	Not voting
Mr. Goodling, Chairman	X			
Mr. Petri, Vice Chairman	X			
Mrs. Roukema	X			
Mr. Fawell	X			
Mr. Ballenger	X			
Mr. Barrett	X			
Mr. Hoekstra	X			
Mr. McKeon	X			
Mr. Castle	X			
Mr. Johnson	X			
Mr. Talent	X			
Mr. Greenwood	X			
Mr. Knollenberg	X			
Mr. Riggs	X			
Mr. Graham	X			
Mr. Souder	X			
Mr. McIntosh	X			
Mr. Norwood	X			
Mr. Paul	X			
Mr. Schaffer	X			
Mr. Peterson	X			
Mr. Upton	X			
Mr. Deal	X			
Mr. Hilleary	X			
Mr. Scarborough	X			
Mr. Clay		X		
Mr. Miller		X		
Mr. Kildee		X		
Mr. Martinez		X		
Mr. Owens		X		
Mr. Payne		X		
Mrs. Mink		X		
Mr. Andrews		X		
Mr. Roemer		X		
Mr. Scott		X		
Ms. Woolsey		X		

Member	Aye	No	Present	Not voting
Mr. Romero-Barceló		X		
Mr. Fattah		X		
Mr. Hinojosa		X		
Mrs. McCarthy		X		
Mr. Tierney		X		
Mr. Kind		X		
Ms. Sanchez		X		
Mr. Ford		X		
Mr. Kucinich		X		
Totals	25	20		

Rollcall: 13.

Bill: H.R. 1515.

Date: June 12, 1997.

Passed: 23-21.

Sponsor/Amendment: Chairman Goodling/Motion to adopt the Fawell Amendment in the Nature of a Substitute to H.R. 1515.

Member	Aye	No	Present	Not voting
Mr. Goodling, Chairman	X			
Mr. Petri, Vice Chairman	X			
Mrs. Roukema		X		
Mr. Fawell	X			
Mr. Ballenger	X			
Mr. Barrett	X			
Mr. Hoekstra	X			
Mr. McKeon	X			
Mr. Castle	X			
Mr. Johnson	X			
Mr. Talent	X			
Mr. Greenwood	X			
Mr. Knollenberg	X			
Mr. Riggs	X			
Mr. Graham	X			
Mr. Souder	X			
Mr. McIntosh	X			
Mr. Norwood		X		
Mr. Paul	X			
Mr. Schaffer	X			
Mr. Peterson	X			
Mr. Upton	X			
Mr. Deal	X			
Mr. Hilleary	X			
Mr. Scarborough	X			
Mr. Clay		X		
Mr. Miller				X
Mr. Kildee		X		
Mr. Martinez		X		
Mr. Owens		X		
Mr. Payne		X		
Mrs. Mink		X		
Mr. Andrews		X		
Mr. Roemer		X		
Mr. Scott		X		
Ms. Woolsey		X		
Mr. Romero-Barceló		X		
Mr. Fattah		X		
Mr. Hinojosa		X		
Mrs. McCarthy		X		
Mr. Tierney		X		
Mr. Kind		X		

Member	Aye	No	Present	Not voting
Ms. Sanchez .....	.....	X	.....	.....
Mr. Ford .....	.....	X	.....	.....
Mr. Kucinich .....	.....	X	.....	.....
Totals	23	21	.....	21

Rollcall: 14.

Bill: Reconciliation.

Passed: 24-20.

Date: June 12, 1997.

Sponsor/Amendment: Mr. Petri/Transmit Committee Print as amended to the Budget Committee.

Member	Aye	No	Present	Not voting
Mr. Goodling, Chairman	X	.....	.....	.....
Mr. Petri, Vice Chairman	X	.....	.....	.....
Mrs. Roukema	X	.....	.....	.....
Mr. Fawell	X	.....	.....	.....
Mr. Ballenger	X	.....	.....	.....
Mr. Barrett	X	.....	.....	.....
Mr. Hoekstra	X	.....	.....	.....
Mr. McKeon	X	.....	.....	.....
Mr. Castle	X	.....	.....	.....
Mr. Johnson	X	.....	.....	.....
Mr. Talent	X	.....	.....	.....
Mr. Greenwood	X	.....	.....	.....
Mr. Knollenberg	X	.....	.....	.....
Mr. Riggs	X	.....	.....	.....
Mr. Graham	X	.....	.....	.....
Mr. Souder	X	.....	.....	.....
Mr. McIntosh	X	.....	.....	.....
Mr. Norwood	X	.....	.....	.....
Mr. Paul .....	.....	X	.....	.....
Mr. Schaffer	X	.....	.....	.....
Mr. Peterson	X	.....	.....	.....
Mr. Upton	X	.....	.....	.....
Mr. Deal	X	.....	.....	.....
Mr. Hilleary	X	.....	.....	.....
Mr. Scarborough	X	.....	.....	.....
Mr. Clay .....	.....	X	.....	.....
Mr. Miller .....	.....	.....	.....	X
Mr. Kildee .....	.....	X	.....	.....
Mr. Martinez .....	.....	X	.....	.....
Mr. Owens .....	.....	X	.....	.....
Mr. Payne .....	.....	X	.....	.....
Mrs. Mink .....	.....	X	.....	.....
Mr. Andrews .....	.....	X	.....	.....
Mr. Roemer .....	.....	X	.....	.....
Mr. Scott .....	.....	X	.....	.....
Ms. Woolsey .....	.....	X	.....	.....
Mr. Romero-Barceló .....	.....	X	.....	.....
Mr. Fattah .....	.....	X	.....	.....
Mr. Hinojosa .....	.....	X	.....	.....
Mrs. McCarthy .....	.....	X	.....	.....
Mr. Tierney .....	.....	X	.....	.....
Mr. Kind .....	.....	X	.....	.....
Ms. Sanchez .....	.....	X	.....	.....
Mr. Ford .....	.....	X	.....	.....
Mr. Kucinich .....	.....	X	.....	.....
Totals	24	20	.....	1

Rollcall: 15.
 Bill: H.R. 1515/Reconciliation.
 Date: June 12, 1997.
 Passed: 24–20.

Sponsor/Amendment: Mr. Petri/Report Reconciliation Recommendations to Budget Committee and Report to the House the bill H.R. 1515 as amended.

Member	Aye	No	Present	Not voting
Mr. Goodling, Chairman	X			
Mr. Petri, Vice Chairman	X			
Mrs. Roukema		X		
Mr. Fawell	X			
Mr. Ballenger	X			
Mr. Barrett	X			
Mr. Hoekstra	X			
Mr. McKeon	X			
Mr. Castle	X			
Mr. Johnson	X			
Mr. Talent	X			
Mr. Greenwood	X			
Mr. Knollenberg	X			
Mr. Riggs	X			
Mr. Graham	X			
Mr. Souder	X			
Mr. McIntosh	X			
Mr. Norwood		X		
Mr. Paul	X			
Mr. Schaffer	X			
Mr. Peterson	X			
Mr. Upton	X			
Mr. Deal	X			
Mr. Hilleary	X			
Mr. Scarborough	X			
Mr. Clay		X		
Mr. Miller		X		
Mr. Kildee		X		
Mr. Martinez				X
Mr. Owens		X		
Mr. Payne		X		
Mrs. Mink		X		
Mr. Andrews		X		
Mr. Roemer	X			
Mr. Scott		X		
Ms. Woolsey		X		
Mr. Romero-Barceló		X		
Mr. Fattah		X		
Mr. Hinojosa		X		
Mrs. McCarthy		X		
Mr. Tierney		X		
Mr. Kind		X		
Ms. Sanchez		X		
Mr. Ford		X		
Mr. Kucinich		X		
Totals	24	20		1

CHANGES IN EXISTING LAW MADE BY TITLE V OF THE BILL, AS REPORTED

In compliance with clause 3 of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted

is enclosed in black brackets, new matter is printed in italics, existing law in which no change is proposed is shown in roman):

SOCIAL SECURITY ACT

* * * * *

**TITLE IV—GRANTS TO STATES FOR AID AND SERVICES TO
NEEDY FAMILIES WITH CHILDREN AND FOR CHILD-WEL-
FARE SERVICES**

* * * * *

PART A—AID TO FAMILIES WITH DEPENDENT CHILDREN

* * * * *

SEC. 403. GRANTS TO STATES.

(a) GRANTS.—

(1) * * *

* * * * *

(5) *WELFARE-TO-WORK GRANTS.*—

(A) *FORMULA GRANTS.*—

(i) *ENTITLEMENT.*—A State shall be entitled to receive from the Secretary a grant for each fiscal year specified in subparagraph (H) of this paragraph for which the State is a welfare-to-work State, in an amount that does not exceed the lesser of—

(I) 2 times the total of the expenditures by the State (excluding qualified State expenditures (as defined in section 409(a)(7)(B)(i)) and expenditures described in section 409(a)(7)(B)(iv)) during the fiscal year for activities described in subparagraph (C)(i) of this paragraph; or

(II) the allotment of the State under clause (iii) of this subparagraph for the fiscal year.

(ii) *WELFARE-TO-WORK STATE.*—A State shall be considered a welfare-to-work State for a fiscal year for purposes of this subparagraph if the Secretary, after consultation (and the sharing of any plan or amendment thereto submitted under this clause) with the Secretary of Health and Human Services and the Secretary of Housing and Urban Development, determines that the State meets the following requirements:

(I) The State has submitted to the Secretary (in the form of an addendum to the State plan submitted under section 402) a plan which—

(aa) describes how, consistent with this subparagraph, the State will use any funds provided under this subparagraph during the fiscal year;

(bb) specifies the formula to be used pursuant to clause (vi) to distribute funds in the State, and describes the process by which the formula was developed; and

(cc) contains evidence that the plan was developed through a collaborative process that, at a minimum, included sub-State areas.

(II) The State has provided the Secretary with an estimate of the amount that the State intends to expend during the fiscal year (excluding expenditures described in section 409(a)(7)(B)(iv)) for activities described in subparagraph (C)(i) of this paragraph.

(III) The State has agreed to negotiate in good faith with the Secretary of Health and Human Services with respect to the substance of any evaluation under section 413(j), and to cooperate with the conduct of any such evaluation.

(IV) The State is an eligible State for the fiscal year.

(iii) ALLOTMENTS TO WELFARE-TO-WORK STATES.—The allotment of a welfare-to-work State for a fiscal year shall be the available amount for the fiscal year multiplied by the State percentage for the fiscal year.

(iv) AVAILABLE AMOUNT.—As used in clause (iii), the term “available amount” means, for a fiscal year, 95 percent of—

(I) the amount specified in subparagraph (H) for the fiscal year; minus

(II) the total of the amounts reserved pursuant to subparagraphs (F) and (G) for the fiscal year.

(v) STATE PERCENTAGE.—As used in clause (iii), the term “State percentage” means, with respect to a fiscal year, $\frac{1}{2}$ of the sum of—

(aa) the percentage represented by the number of individuals in the State whose income is less than the poverty line divided by the number of such individuals in the United States; and

(bb) the percentage represented by the number of individuals who are adult recipients of assistance under the State program funded under this part divided by the number of individuals in the United States who are adult recipients of assistance under any State program funded under this part.

(vi) DISTRIBUTION OF FUNDS WITHIN STATES.—

(I) IN GENERAL.—A State to which a grant is made under this subparagraph shall distribute not less than 85 percent of the grant funds among the service delivery areas in the State, in accordance with a formula which—

(aa) determines the amount to be distributed for the benefit of a service delivery area in proportion to the number (if any) by which the number of individuals residing in the service delivery area with an income that is less than the poverty line exceeds 5 percent of the popu-

lation of the service delivery area, relative to such number for the other service delivery areas in the State, and accords a weight of not less than 50 percent to this factor;

(bb) may determine the amount to be distributed for the benefit of a service delivery area in proportion to the number of adults residing in the service delivery area who are recipients of assistance under the State program funded under this part (whether in effect before or after the amendments made by section 103(a) of the Personal Responsibility and Work Opportunity Reconciliation Act first applied to the State) for at least 30 months (whether or not consecutive) relative to the number of such adults residing in the other service delivery areas in the State; and

(cc) may determine the amount to be distributed for the benefit of a service delivery area in proportion to the number of unemployed individuals residing in the service delivery area relative to the number of such individuals residing in the other service delivery areas in the State.

(II) SPECIAL RULE.—Notwithstanding subclause (I), if the formula used pursuant to subclause (I) would result in the distribution of less than \$100,000 during a fiscal year for the benefit of a service delivery area, then in lieu of distributing such sum in accordance with the formula, such sum shall be available for distribution under subclause (III) during the fiscal year.

(III) PROJECTS TO HELP LONG-TERM RECIPIENTS OF ASSISTANCE INTO THE WORK FORCE.—The Governor of a State to which a grant is made under this subparagraph may distribute not more than 15 percent of the grant funds (plus any amount required to be distributed under this subclause by reason of subclause (II)) to projects that appear likely to help long-term recipients of assistance under the State program funded under this part (whether in effect before or after the amendments made by section 103(a) of the Personal Responsibility and Work Opportunity Reconciliation Act first applied to the State) enter the work force.

(vii) ADMINISTRATION.—

(I) IN GENERAL.—A grant made under this subparagraph to a State shall be administered by the State agency that is administering, or supervising the administration of, the State program funded under this part, or by another State agency designated by the Governor of the State.

(II) SPENDING BY PRIVATE INDUSTRY COUNCILS.—The private industry council for a service

delivery area shall have sole authority, in coordination with the chief elected official (as described in section 103(c) of the Job Training Partnership Act) of the service delivery area, to expend the amounts provided for a service delivery area under subparagraph (vi)(I).

(B) DEMONSTRATION PROJECTS.—

(i) **IN GENERAL.**—The Secretary, in consultation with the Secretary of Health and Human Services and the Secretary of Housing and Urban Development, shall make grants in accordance with this subparagraph among eligible applicants based on the likelihood that the applicant can successfully make long-term placements of individuals into the work force.

(ii) **ELIGIBLE APPLICANTS.**—As used in clause (i), the term “eligible applicant” means a private industry council or a political subdivision of a State.

(iii) **DETERMINATION OF GRANT AMOUNT.**—In determining the amount of a grant to be made under this subparagraph for a demonstration project proposed by an applicant, the Secretary shall provide the applicant with an amount sufficient to ensure that the project has a reasonable opportunity to be successful, taking into account the number of long-term recipients of assistance under a State program funded under this part, the level of unemployment, the job opportunities and job growth, the poverty rate, and such other factors as the Secretary deems appropriate, in the area to be served by the project.

(iv) **FUNDING.**—For grants under this subparagraph for each fiscal year specified in subparagraph (H), there shall be available to the Secretary an amount equal to the sum of—

(I) 5 percent of—

(aa) the amount specified in subparagraph (H) for the fiscal year; minus

(bb) the total of the amounts reserved pursuant to subparagraphs (F) and (G) for the fiscal year;

(II) any amount available for grants under this paragraph for the immediately preceding fiscal year that has not been obligated;

(III) any amount reserved pursuant to subparagraph (F) for the immediately preceding fiscal year that has not been obligated; and

(IV) any available amount (as defined in subparagraph (A)(iv)) for the immediately preceding fiscal year that has not been obligated by a State or sub-State entity.

Amounts made available pursuant to this clause are authorized to remain available until the end of fiscal year 2001.

(C) LIMITATIONS ON USE OF FUNDS.—

(i) *ALLOWABLE ACTIVITIES.*—An entity to which funds are provided under this paragraph may use the funds to move into the work force recipients of assistance under the program funded under this part of the State in which the entity is located, by means of any of the following:

(I) Job creation through public or private sector employment wage subsidies.

(II) On-the-job training.

(III) Contracts with job placement companies or public job placement programs.

(IV) Job vouchers.

(V) Job retention or support services if such services are not otherwise available.

(ii) *REQUIRED BENEFICIARIES.*—An entity that operates a project with funds provided under this paragraph shall expend at least 90 percent of all funds provided to the project for the benefit of recipients of assistance under the program funded under this part of the State in which the entity is located who meet the requirements of any of the following subclauses:

(I) The individual has received assistance under the State program funded under this part (whether in effect before or after the amendments made by section 103 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 first apply to the State) for at least 30 months (whether or not consecutive).

(II) At least 2 of the following apply to the recipient:

(aa) The individual has not completed secondary school or obtained a certificate of general equivalency, and has low skills in reading and mathematics.

(bb) The individual requires substance abuse treatment for employment.

(cc) The individual has a poor work history. The Secretary shall prescribe such regulations as may be necessary to interpret this subclause.

(III) Within 12 months, the individual will become ineligible for assistance under the State program funded under this part by reason of a durational limit on such assistance, without regard to any exemption provided pursuant to section 408(a)(7)(C) that may apply to the individual.

(iii) *LIMITATION ON APPLICABILITY OF SECTION 404.*—The rules of section 404, other than subsections (b), (f), and (h) of section 404, shall not apply to a grant made under this paragraph.

(iv) *PROHIBITION AGAINST PROVISION OF SERVICES BY PRIVATE INDUSTRY COUNCIL.*—A private industry council may not directly provide services using funds provided under this paragraph.

(v) *PROHIBITION AGAINST USE OF GRANT FUNDS FOR ANY OTHER FUND MATCHING REQUIREMENT.*—An entity to which funds are provided under this paragraph shall not use any part of the funds to fulfill any obligation of any State, political subdivision, or private industry council to contribute funds under other Federal law.

(vi) *DEADLINE FOR EXPENDITURE.*—An entity to which funds are provided under this paragraph shall remit to the Secretary any part of the funds that are not expended within 3 years after the date the funds are so provided.

(D) *INDIVIDUALS WITH INCOME LESS THAN THE POVERTY LINE.*—For purposes of this paragraph, the number of individuals with an income that is less than the poverty line shall be determined based on the methodology used by the Bureau of the Census to produce and publish intercensal poverty data for 1993 for States and counties.

(E) *DEFINITIONS.*—As used in this paragraph:

(i) *PRIVATE INDUSTRY COUNCIL.*—The term “private industry council” means, with respect to a service delivery area, the private industry council (or successor entity) established for the service delivery area pursuant to the Job Training Partnership Act.

(ii) *SECRETARY.*—The term “Secretary” means the Secretary of Labor, except as otherwise expressly provided.

(iii) *SERVICE DELIVERY AREA.*—The term “service delivery area” shall have the meaning given such term for purposes of the Job Training Partnership Act (or successor area).

(F) *FUNDING FOR INDIAN TRIBES.*—1 percent of the amount specified in subparagraph (H) for each fiscal year shall be reserved for grants to Indian tribes under section 412(a)(3).

(G) *EVALUATIONS.*—0.5 percent of the amount specified in subparagraph (H) for each fiscal year shall be reserved for use by the Secretary of Health and Human Services to carry out section 413(j).

(H) *FUNDING.*—The amount specified in this subparagraph is—

- (i) \$750,000,000 for fiscal year 1998;
- (ii) \$1,250,000,000 for fiscal year 1999; and
- (iii) \$1,000,000,000 for fiscal year 2000.

(I) *BUDGET SCORING.*—Notwithstanding section 457(b)(2) of the Balanced Budget and Emergency Deficit Control Act of 1985, the baseline shall assume that no grant shall be made under this paragraph or under section 412(a)(3) after fiscal year 2001.

* * * * *

SEC. 407. MANDATORY WORK REQUIREMENTS.

(a) * * *

* * * * *

(c) ENGAGED IN WORK.—

(1) * * *

(2) LIMITATIONS AND SPECIAL RULES.—

(A) * * *

* * * * *

[(D) NUMBER OF PERSONS THAT MAY BE TREATED AS ENGAGED IN WORK BY VIRTUE OF PARTICIPATION IN VOCATIONAL EDUCATION ACTIVITIES OR BEING A TEEN HEAD OF HOUSEHOLD WHO MAINTAINS SATISFACTORY SCHOOL ATTENDANCE.—For purposes of determining monthly participation rates under paragraphs (1)(B)(i) and (2)(B) of subsection (b), not more than 20 percent of individuals in all families and in 2-parent families may be determined to be engaged in work in the State for a month by reason of participation in vocational educational training or deemed to be engaged in work by reason of subparagraph (C) of this paragraph.]

(D) LIMITATION ON NUMBER OF PERSONS WHO MAY BE TREATED AS ENGAGED IN WORK BY REASON OF PARTICIPATION IN EDUCATIONAL ACTIVITIES.—For purposes of determining monthly participation rates under paragraphs (1)(B)(i) and (2)(B) of subsection (b), not more than 20 percent of the number of individuals in all families and in 2-parent families, respectively, in a State who are treated as engaged in work for a month may consist of individuals who are determined to be engaged in work for the month by reason of participation in vocational educational training, or deemed to be engaged in work for the month by reason of subparagraph (C) of this paragraph.

* * * * *

[(f) NONDISPLACEMENT IN WORK ACTIVITIES.—

[(1) IN GENERAL.—Subject to paragraph (2), an adult in a family receiving assistance under a State program funded under this part attributable to funds provided by the Federal Government may fill a vacant employment position in order to engage in a work activity described in subsection (d).

[(2) NO FILLING OF CERTAIN VACANCIES.—No adult in a work activity described in subsection (d) which is funded, in whole or in part, by funds provided by the Federal Government shall be employed or assigned—

[(A) when any other individual is on layoff from the same or any substantially equivalent job; or

[(B) if the employer has terminated the employment of any regular employee or otherwise caused an involuntary reduction of its workforce in order to fill the vacancy so created with an adult described in paragraph (1).

[(3) GRIEVANCE PROCEDURE.—A State with a program funded under this part shall establish and maintain a grievance procedure for resolving complaints of alleged violations of paragraph (2).

[(4) NO PREEMPTION.—Nothing in this subsection shall preempt or supersede any provision of State or local law that provides greater protection for employees from displacement.]

(f) *NONDISPLACEMENT IN WORK ACTIVITIES.*—(1) *PROHIBITIONS.*—

(A) *GENERAL PROHIBITION.*—A participant in a work activity pursuant to section 403(a)(5) or this section shall not displace (including a partial displacement, such as a reduction in the hours of nonovertime work, wages, or employment benefits) any individual who, as of the date of the participation, is an employee.

(B) *PROHIBITION ON IMPAIRMENT OF CONTRACTS.*—A work activity shall not impair an existing contract for services or collective bargaining agreement, and a work activity that would be inconsistent with the terms of a collective bargaining agreement shall not be undertaken without the written concurrence of the labor organization and employer concerned.

(C) *OTHER PROHIBITIONS.*—A participant in a work activity shall not be employed in a job—

(i) when any other individual is on layoff from the same or any substantially equivalent job;

(ii) when the employer has terminated the employment of any regular employee or otherwise reduced the workforce of the employer with the intention of filling the vacancy so created with the participant; or

(iii) which is created in a promotional line that will infringe in any way upon the promotional opportunities of employed individuals.

(2) *HEALTH AND SAFETY.*—Health and safety standards established under Federal and State law otherwise applicable to working conditions of employees shall be equally applicable to working conditions of participants engaged in a work activity. To the extent that a State workers' compensation law applies, workers' compensation shall be provided to participants on the same basis as the compensation is provided to other individuals in the State in similar employment.

(3) *NONDISCRIMINATION.*—In addition to the protections provided under the provisions of law specified in section 408(c), an individual may not be discriminated against with respect to participation in work activities by reason of gender.

(4) *GRIEVANCE PROCEDURE.*—

(A) *IN GENERAL.*—Each State to which a grant is made under section 403 shall establish and maintain a procedure for grievances or complaints alleging violations of paragraph (1), (2), or (3) from participants and other interested or affected parties. The procedure shall include an opportunity for a hearing and be completed within 60 days after the grievance or complaint is filed.

(B) *INVESTIGATION.*—

(i) *IN GENERAL.*—The Secretary of Labor shall investigate an allegation of a violation of paragraph (1), (2), or (3) if—

(I) a decision relating to the violation is not reached within 60 days after the date of the filing of the grievance or complaint, and either party appeals to the Secretary of Labor; or

(II) a decision relating to the violation is reached within the 60-day period, and the party to which the decision is adverse appeals the decision to the Secretary of Labor.

(ii) **ADDITIONAL REQUIREMENT.**—The Secretary of Labor shall make a final determination relating to an appeal made under clause (i) no later than 120 days after receiving the appeal.

(C) **REMEDIES.**—Remedies for violation of paragraph (1), (2), or (3) shall be limited to—

(i) suspension or termination of payments under section 403;

(ii) prohibition of placement of a participant with an employer that has violated paragraph (1), (2), or (3);

(iii) where applicable, reinstatement of an employee, payment of lost wages and benefits, and reestablishment of other relevant terms, conditions and privileges of employment; and

(iv) where appropriate, other equitable relief.

* * * * *

(j) **COMPENSATION.**—A State to which a grant is made under section 403 may not require a recipient of assistance under the State program funded under this part to participate in a work activity described in paragraph (1), (2), or (3) of subsection (d) unless the recipient is compensated at the same rates, including periodic increases, as trainees or employees who are similarly situated in similar occupations by the same employer and who have similar training, experience and skills, and such rates shall be in accordance with applicable law.

(k) **LIMITATION ON NUMBER OF HOURS PER MONTH THAT A RECIPIENT OF ASSISTANCE MAY BE REQUIRED TO PARTICIPATE IN ON-THE-JOB TRAINING, AND WITH A PUBLIC AGENCY OR NONPROFIT ORGANIZATION.**—

(1) **IN GENERAL.**—A State to which a grant is made under section 403 may not require a recipient of assistance under the State program funded under this part to be assigned to on-the-job training, and to a work experience or community service position with a public agency or nonprofit organization during a month for more than the allowable number of hours determined for the month under paragraph (2).

(2) **ALLOWABLE NUMBER OF HOURS.**—

(A) **IN GENERAL.**—Subject to subparagraph (B), the allowable number of hours determined for a month under this paragraph is—

(i) the value of the includible benefits provided by the State to the recipient during the month; divided by

(ii) the minimum wage rate in effect during the month under section 6 of the Fair Labor Standards Act of 1938.

(B) **STATE OPTION TO TAKE ACCOUNT OF CERTAIN WORK ACTIVITIES.**—

(i) **IN GENERAL.**—In determining the allowable number of hours for a month for a sufficiently employed recipient, the State may subtract from the allowable

number of hours calculated under subparagraph (A) the number of hours during the month for which the recipient participates in a work activity described in paragraph (6), (8), (9), or (11) of subsection (d).

(ii) SUFFICIENTLY EMPLOYED RECIPIENT.—As used in clause (i), the term “sufficiently employed recipient” means, with respect to a month, a recipient who is employed during the month for a number of hours that is not less than—

(I) the sum of the dollar value of any assistance provided to the recipient during the month under the State program funded under this part, and the dollar value equivalent of any benefits provided to the recipient during the month under the food stamp program under the Food Stamp Act of 1977; divided by

(II) the minimum wage rate in effect during the month under section 6 of the Fair Labor Standards Act of 1938.

(3) DEFINITION OF VALUE OF THE INCLUDIBLE BENEFITS.—As used in paragraph (2)(A), the term “value of the includible benefits” means, with respect to a recipient—

(A) the dollar value of any assistance under the State program funded under this part;

(B) the dollar value equivalent of any benefits under the food stamp program under the Food Stamp Act of 1977;

(C) at the option of the State, the dollar value of benefits under the State plan approved under title XIX, as determined in accordance with paragraph (4);

(D) at the option of the State, the dollar value of child care assistance; and

(E) at the option of the State, the dollar value of housing benefits.

(4) VALUATION OF MEDICAID BENEFITS.—Annually, the Secretary shall publish a table that specifies the dollar value of the insurance coverage provided under title XIX to a family of each size, which may take account of geographical variations or other factors identified by the Secretary.

(5) TREATMENT OF RECIPIENTS ASSIGNED TO CERTAIN POSITIONS WITH A PUBLIC AGENCY OR NONPROFIT ORGANIZATION.—A recipient of assistance under a State program funded under this part who is engaged in work experience or community service with a public agency or nonprofit organization shall not be considered an employee of the public agency or the nonprofit organization.

SEC. 408. PROHIBITIONS; REQUIREMENTS.

(a) IN GENERAL.—

(1) * * *

* * * * *

(7) NO ASSISTANCE FOR MORE THAN 5 YEARS.—

(A) * * *

* * * * *

(G) *INAPPLICABILITY TO WELFARE-TO-WORK GRANTS AND ASSISTANCE.*—For purposes of subparagraph (A) of this paragraph, a grant made under section 403(a)(5) shall not be considered a grant made under section 403, and assistance from funds provided under section 403(a)(5) shall not be considered assistance.

* * * * *

SEC. 409. PENALTIES.

(a) *IN GENERAL.*—Subject to this section:

(1) * * *

* * * * *

(13) *PENALTY FOR FAILURE TO REDUCE ASSISTANCE FOR RECIPIENTS REFUSING WITHOUT GOOD CAUSE TO WORK.*—

(A) *IN GENERAL.*—If the Secretary determines that a State to which a grant is made under section 403 in a fiscal year has violated section 407(e) during the fiscal year, the Secretary shall reduce the grant payable to the State under section 403(a)(1) for the immediately succeeding fiscal year by an amount equal to not less than 1 percent and not more than 5 percent of the State family assistance grant.

(B) *PENALTY BASED ON SEVERITY OF FAILURE.*—The Secretary shall impose reductions under subparagraph (A) with respect to a fiscal year based on the degree of non-compliance.

* * * * *

SEC. 412. DIRECT FUNDING AND ADMINISTRATION BY INDIAN TRIBES.

(a) *GRANTS FOR INDIAN TRIBES.*—

(1) * * *

* * * * *

(3) *WELFARE-TO-WORK GRANTS.*—

(A) *IN GENERAL.*—The Secretary shall make a grant in accordance with this paragraph to an Indian tribe for each fiscal year specified in section 403(a)(5)(H) for which the Indian tribe is a welfare-to-work tribe, in such amount as the Secretary deems appropriate, subject to subparagraph (B) of this paragraph.

(B) *WELFARE-TO-WORK TRIBE.*—An Indian tribe shall be considered a welfare-to-work tribe for a fiscal year for purposes of this paragraph if the Indian tribe meets the following requirements:

(i) The Indian tribe has submitted to the Secretary (in the form of an addendum to the tribal family assistance plan, if any, of the Indian tribe) a plan which describes how, consistent with section 403(a)(5), the Indian tribe will use any funds provided under this paragraph during the fiscal year.

(ii) The Indian tribe has provided the Secretary with an estimate of the amount that the Indian tribe intends to expend during the fiscal year (excluding tribal expenditures described in section 409(a)(7)(B)(iv)) for activities described in section 403(a)(5)(C)(i).

(iii) *The Indian tribe has agreed to negotiate in good faith with the Secretary of Health and Human Services with respect to the substance of any evaluation under section 413(j), and to cooperate with the conduct of any such evaluation.*

(C) *LIMITATIONS ON USE OF FUNDS.—Section 403(a)(5)(C) shall apply to funds provided to Indian tribes under this paragraph in the same manner in which such section applies to funds provided under section 403(a)(5).*

* * * * *

SEC. 413. RESEARCH, EVALUATIONS, AND NATIONAL STUDIES.

(a) * * *

* * * * *

(j) *EVALUATION OF WELFARE-TO-WORK PROGRAMS.—The Secretary—*

(1) shall, in consultation with the Secretary of Labor, develop a plan to evaluate how grants made under sections 403(a)(5) and 412(a)(3) have been used; and

(2) may evaluate the use of such grants by such grantees as the Secretary deems appropriate, in accordance with an agreement entered into with the grantees after good-faith negotiations.

* * * * *

TITLE XI—GENERAL PROVISIONS, PEER REVIEW, AND ADMINISTRATIVE SIMPLIFICATION

* * * * *

SEC. 1108. ADDITIONAL GRANTS TO PUERTO RICO, THE VIRGIN ISLANDS, GUAM, AND AMERICAN SAMOA; LIMITATION ON TOTAL PAYMENTS.

(a) **LIMITATION ON TOTAL PAYMENTS TO EACH TERRITORY.**—Notwithstanding any other provision of this Act, the total amount certified by the Secretary of Health and Human Services under titles I, X, XIV, and XVI, under parts A and E of title IV (*except section 403(a)(5)*), and under subsection (b) of this section, for payment to any territory for a fiscal year shall not exceed the ceiling amount for the territory for the fiscal year.

* * * * *

HIGHER EDUCATION ACT OF 1965

* * * * *

TITLE IV—STUDENT ASSISTANCE

* * * * *

PART B—FEDERAL FAMILY EDUCATION LOAN PROGRAM

* * * * *

SEC. 422. ADVANCES FOR RESERVE FUNDS OF STATE AND NONPROFIT PRIVATE LOAN INSURANCE PROGRAMS.

(a) * * *

* * * * *

(h) *RECALL OF RESERVES; LIMITATIONS ON USE OF RESERVE FUNDS AND ASSETS.*—(1) *Notwithstanding any other provision of law, the Secretary shall, except as otherwise provided in this subsection, recall \$1,000,000,000 from the reserve funds held by guaranty agencies on September 1, 2002.*

(2) *Funds recalled by the Secretary under this subsection shall be deposited in the Treasury.*

(3) *The Secretary shall require each guaranty agency to return reserve funds under paragraph (1) based on such agency's required share of recalled reserve funds held by guaranty agencies as of September 30, 1996. For purposes of this paragraph, a guaranty agency's required share of recalled reserve funds shall be determined as follows:*

(A) *The Secretary shall compute each agency's reserve ratio by dividing (i) the amount held in such agency's reserve funds as of September 30, 1996 (but reflecting later accounting or auditing adjustments approved by the Secretary), by (ii) the original principal amount of all loans for which such agency has an outstanding insurance obligation as of such date.*

(B) *If the reserve ratio of any agency as computed under subparagraph (A) exceeds 2.0 percent, the agency's required share shall include so much of the amounts held in such agency's reserve fund as exceed a reserve ratio of 2.0 percent.*

(C) *If any additional amount is required to be recalled under paragraph (1) (after deducting the total of the required shares calculated under subparagraph (B)), the agencies' required shares shall include additional amounts—*

(i) *determined by imposing on each such agency an equal percentage reduction in the amount of each agency's reserve fund remaining after deduction of the amount recalled under subparagraph (B); and*

(ii) *the total of which equals the additional amount that is required to be recalled under paragraph (1) (after deducting the total of the required shares calculated under subparagraph (B)).*

(4) *Within 90 days after the beginning of each of fiscal years 1998 through 2002, each guaranty agency shall transfer a portion of each agency's required share determined under paragraph (3) to a restricted account established by the guaranty agency that is of a type selected by the guaranty agency with the approval of the Secretary. Funds transferred to such restricted accounts shall be invested in obligations issued or guaranteed by the United States or in other similarly low-risk securities. A guaranty agency shall not use the funds in such a restricted account for any purpose without the express written permission of the Secretary, except that a guaranty agency may use the earnings from such restricted account to assist in meeting the agency's operational expenses under this part. In each of fiscal years 1998 through 2002, each agency shall transfer its required share to such restricted account in 5 equal annual installments, except that—*

(A) a guarantee agency that has a reserve ratio (as computed under subparagraph (3)(A)) equal to or less than 1.10 percent may transfer its required share to such account in 4 equal installments beginning in fiscal year 1999; and

(B) a guarantee agency may transfer such required share to such account in accordance with such other payment schedules as are approved by the Secretary.

(5) If, on September 1, 2002, the total amount in the restricted accounts described in paragraph (4) is less than the amount the Secretary is required to recall under paragraph (1), the Secretary may require the return of the amount of the shortage from other reserve funds held by guaranty agencies under procedures established by the Secretary.

(6) The Secretary may take such reasonable measures, and require such information, as may be necessary to ensure that guaranty agencies comply with the requirements of this subsection. Notwithstanding any other provision of this part, if the Secretary determines that a guaranty agency is not in compliance with the requirements of this subsection, such agency may not receive any other funds under this part until the Secretary determines that such agency is in compliance.

(7) The Secretary shall not have any authority to direct a guaranty agency to return reserve funds under subsection (g)(1)(A) during the period from the date of enactment of this subsection through September 30, 2002, and any reserve funds otherwise returned under subsection (g)(1) during such period shall be treated as amounts recalled under this subsection and shall not be available under subsection (g)(4).

(8) For purposes of this subsection, the term “reserve funds” when used with respect to a guaranty agency—

(A) includes any cash reserve funds held by the guaranty agency, or held by, or under the control of, any other entity; and

(B) does not include buildings, equipment, or other nonliquid assets.

* * * * *

SEC. 424. SCOPE AND DURATION OF FEDERAL LOAN INSURANCE PROGRAM.

(a) LIMITATIONS ON AMOUNTS OF LOANS COVERED BY FEDERAL INSURANCE.—The total principal amount of new loans made and installments paid pursuant to lines of credit (as defined in section 435) to students covered by Federal loan insurance under this part shall not exceed \$2,000,000,000 for the period from July 1, 1976, to September 30, 1976, and for each of the succeeding fiscal years ending prior to October 1, [1998.] 2002. Thereafter, Federal loan insurance pursuant to this part may be granted only for loans made (or for loan installments paid pursuant to lines of credit) to enable students, who have obtained prior loans insured under this part, to continue or complete their educational program; but no insurance may be granted for any loan made or installment paid after September 30, [2002.] 2006.

* * * * *

SEC. 428. FEDERAL PAYMENTS TO REDUCE STUDENT INTEREST COSTS.

(a) FEDERAL INTEREST SUBSIDIES.—

(1) * * *

* * * * *

(5) DURATION OF AUTHORITY TO MAKE INTEREST SUBSIDIZED LOANS.—The period referred to in subparagraph (B) of paragraph (1) of this subsection shall begin on the date of enactment of this Act and end at the close of September 30, **[1998,] 2002**, except that, in the case of a loan made or insured under a student loan or loan insurance program to enable a student who has obtained a prior loan made or insured under such program to continue his or her education program, such period shall end at the close of September 30, **[2002.] 2006**.

* * * * *

(c) GUARANTY AGREEMENTS FOR REIMBURSING LOSSES.—

(1) * * *

* * * * *

(6) SECRETARY'S EQUITABLE SHARE.—(A) For the purpose of paragraph (2)(D), the Secretary's equitable share of payments **[made by the borrower]** *made by or on behalf of the borrower, including payments made to discharge loans made under this title to obtain a consolidation loan pursuant to this part or part D*, shall be that portion of the payments remaining after the guaranty agency with which the Secretary has an agreement under this subsection has deducted from such payments—

(i) a percentage amount equal to the complement of the reinsurance percentage in effect when payment under the guaranty agreement was made with respect to the loan; and

[(ii) an amount equal to 27 percent of such payments (subject to subparagraph (D) of this paragraph) for costs related] *(ii) an amount equal to 27 percent of such payments for covered costs, except that the amount determined under this clause for such covered costs shall be (I) 18.5 percent of such payments for defaulted loans consolidated pursuant to this part or part D on or after July 1, 1997; and (II) 18.5 percent of such payments for defaulted loans consolidated pursuant to this part or part D on or after the date of enactment of the Higher Education Amendments of 1992 with respect to any guaranty agency that has, after such date, made deductions from such payments under this clause (ii) in an amount equal to 18.5 percent of such payments.*

For purposes of clause (i) of this subparagraph, the term "covered costs" means costs related to the student loan insurance program, including the administrative costs of collection of loans reimbursed under this subsection, the administrative costs of preclaims assistance for default prevention, the administrative costs of supplemental preclaims assistance for default prevention, and the administrative costs of monitoring the enrollment and payment status of

students (as such terms are defined in subparagraph (B) or (C) of this paragraph).

* * * * *

(9) Guaranty agency reserve level.—(A) Each guaranty agency which has entered into an agreement with the Secretary pursuant to this subsection shall maintain a current minimum reserve level of at least .5 percent of the total attributable amount of all outstanding loans guaranteed by such agency **for the fiscal year of the agency that begins in 1993**. For purposes of this paragraph, such total attributable amount does not include amounts of outstanding loans transferred to the guaranty agency from another guaranty agency pursuant to a plan of the Secretary in response to the insolvency of the latter such guaranty agency. **The minimum reserve level shall increase to—**

[(i) .7 percent of such total attributable amount for the fiscal year of the agency that begins in 1994;

[(ii) .9 percent of such total attributable amount for the fiscal year of the agency that begins in 1995; and

[(iii) 1.1 percent of such total attributable amount for each fiscal year of the agency that begins on or after January 1, 1996.]

* * * * *

SEC. 428C. FEDERAL CONSOLIDATION LOANS.

(a) * * *

* * * * *

(e) **TERMINATION OF AUTHORITY.**—The authority to make loans under this section expires at the close of September 30, **1998**. **2002**. Nothing in this section shall be construed to authorize the Secretary to promulgate rules or regulations governing the terms or conditions of the agreements and certificates under subsection (b). Loans made under this section which are insured by the Secretary shall be considered to be new loans made to students for the purpose of section 424(a).

* * * * *

SEC. 452. FUNDS FOR ORIGATION OF DIRECT STUDENT LOANS.

(a) * * *

[(b) FEES FOR ORIGATION SERVICES.—

[(1) FEES FOR INSTITUTIONS.—The Secretary shall pay fees to institutions of higher education (or a consortium of such institutions) with agreements under section 454(b), in an amount established by the Secretary, to assist in meeting the costs of loan origination. Such fees—

[(A) shall be paid by the Secretary based on all the loans made under this part to a particular borrower in the same academic year;

[(B) shall be subject to a sliding scale that decreases the per borrower amount of such fees as the number of borrowers increases; and

[(C)(i) for academic year 1994–1995, shall not exceed a program-wide average of \$10 per borrower for all the loans

made under this part to such borrower in the same academic year; and

[(ii) for succeeding academic years, shall not exceed such average fee as the Secretary shall establish pursuant to regulations.

[(2) FEES FOR ALTERNATIVE ORIGINATORS.—The Secretary shall pay fees for loan origination services to alternative originators of loans made under this part in an amount established by the Secretary in accordance with the terms of the contract described in section 456(b) between the Secretary and each such alternative originator.]

[(c) (b) NO ENTITLEMENT TO PARTICIPATE OR ORIGINATE.—No institution of higher education shall have a right to participate in the programs authorized by this part, to originate loans, or to perform any program function under this part. Nothing in this subsection shall be construed so as to limit the entitlement of an eligible student attending a participating institution (or the eligible parent of such student) to borrow under this part.

[(d) (c) DELIVERY OF LOAN FUNDS.—Loan funds shall be paid and delivered to an institution by the Secretary prior to the beginning of the payment period established by the Secretary in a manner that is consistent with payment and delivery of basic grants under subpart 1 of part A of this title.

* * * * *

ACT OF FEBRUARY 23, 1917

(Commonly known as the "Smith-Hughes Vocational Education Act")

[CHAP. 114.—An Act To provide for the promotion of vocational education; to provide for cooperation with the States in the promotion of such education in agriculture and the trades and industries; to provide for cooperation with the States in the preparation of teachers of vocational subjects; and to appropriate money and regulate its expenditure.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That there is hereby annually appropriated, out of any money in the Treasury not otherwise appropriated, the sums provided in sections two, three, and four of this Act, to be paid to the respective States for the purpose of cooperating with the States in paying the salaries of teachers, supervisors, and directors of agricultural subjects, and teachers of trade, home economics, and industrial subjects, and in the preparation of teachers of agricultural, trade, industrial, and home economics subjects; and the sum provided for in section seven for the use of the Federal Board for Vocational Education for the administration of this Act and for the purpose of making studies, investigations, and reports to aid in the organization and conduct of vocational education, which sums shall be expended, as hereinafter provided.

[SEC. 2. That for the purpose of cooperating with the States in paying the salaries of teachers, supervisors, or directors of agricultural subjects there is hereby appropriated for the use of the States, subject to the provisions of this Act, for the fiscal year ending June thirtieth, nineteen hundred and eighteen, the sum of

\$500,000; for the fiscal year ending June thirtieth, nineteen hundred and nineteen; the sum of \$750,000; for the fiscal year ending June thirtieth, nineteen hundred and twenty, the sum of \$1,000,000; for the fiscal year ending June thirtieth, nineteen hundred and twenty-one, the sum of \$1,250,000; for the fiscal year ending June thirtieth, nineteen hundred and twenty-two, the sum of \$1,500,000; for the fiscal year ending June thirtieth, nineteen hundred and twenty-three, the sum of \$1,750,000; for the fiscal year ending June thirtieth, nineteen hundred and twenty-four, the sum of \$2,000,000; for the fiscal year ending June thirtieth, nineteen hundred and twenty-five, the sum of \$2,500,000; for the fiscal year ending June thirtieth, nineteen hundred and twenty-six, and annually thereafter, the sum of \$3,000,000. Said sums shall be allotted to the States in the proportion which their rural population bears to the total rural population in the United States, not including outlying possessions, according to the last preceding United States census: *Provided*, That the allotment of funds to any State shall be not less than a minimum of \$5,000 for any fiscal year prior to and including the fiscal year ending June thirtieth, nineteen hundred and twenty-three, nor less than \$10,000 for any fiscal year thereafter, and there is hereby appropriated the following sums, or so much thereof as may be necessary, which shall be used for the purpose of providing the minimum allotment to the States provided for in this section: For the fiscal year ending June thirtieth, nineteen hundred and eighteen, the sum of \$48,000; for the fiscal year ending June thirtieth, nineteen hundred and nineteen, the sum of \$34,000; for the fiscal year ending June thirtieth, nineteen hundred and twenty, the sum of \$24,000; for the fiscal year ending June thirtieth, nineteen hundred and twenty-one, the sum of \$18,000; for the fiscal year ending June thirtieth, nineteen hundred and twenty-two, the sum of \$14,000; for the fiscal year ending June thirtieth, nineteen hundred and twenty-three, the sum of \$11,000; for the fiscal year ending June thirtieth, nineteen hundred and twenty-four, the sum of \$9,000; for the fiscal year ending June thirtieth, nineteen hundred and twenty-five, the sum of \$34,000; and annually thereafter the sum of \$28,500.

[SEC. 3. That for the purpose of cooperating with the states in paying the salaries of teachers of trade, home economics, and industrial subjects there is hereby appropriated for the use of the States for the fiscal year ending June thirtieth, nineteen hundred and eighteen, the sum of \$500,000; for the fiscal year ending June thirtieth, nineteen hundred and nineteen, the sum of \$750,000; for the fiscal year ending June thirtieth, nineteen hundred and twenty, the sum of \$1,000,000; for the fiscal year ending June thirtieth, nineteen hundred and twenty-one, the sum of \$1,250,000; for the fiscal year ending June thirtieth, nineteen hundred and twenty-two, the sum of \$1,500,000; for the fiscal year ending June thirtieth, nineteen hundred and twenty-three, the sum of \$1,750,000; for the fiscal year ending June thirtieth, nineteen hundred and twenty-four, the sum of \$2,000,000; for the fiscal year ending June thirtieth, nineteen hundred and twenty-five, the sum of \$2,500,000; for the fiscal year ending June thirtieth, nineteen hundred and twenty-six, the sum of \$3,000,000; and annually thereafter the sum of \$3,000,000. Said sums shall be allotted to the States in the propor-

tion which their urban population bears to the total urban population in the United States, not including outlying possessions, according to the last preceding United States census: *Provided*, That the allotment of funds to any State shall be not less than a minimum of \$5,000 for any fiscal year prior to and including the fiscal year ending June thirtieth, nineteen hundred and twenty-three, nor less than \$10,000 for any fiscal year thereafter, and there is hereby appropriated the following sums, or so much thereof as may be needed, which shall be used for the purpose of providing the minimum allotment to the States provided for in this section: For the fiscal year ending June thirtieth, nineteen hundred and eighteen, the sum of \$66,000; for the fiscal year ending June thirtieth, nineteen hundred and nineteen, the sum of \$46,000; for the fiscal year ending June thirtieth, nineteen hundred and twenty, the sum of \$34,000; for the fiscal year ending June thirtieth, nineteen hundred and twenty-one, the sum of \$28,000; for the fiscal year ending June thirtieth, nineteen hundred and twenty-two, the sum of \$25,000; for the fiscal year ending June thirtieth, nineteen hundred and twenty-three, the sum of \$22,000; for the fiscal year ending June thirtieth, nineteen hundred and twenty-four, the sum \$19,000; for the fiscal year ending June thirtieth, nineteen hundred and twenty-five, the sum of \$56,000; for the fiscal year ending June thirtieth, nineteen hundred and twenty-six and annually thereafter, the sum of \$50,000.

¶ That not more than twenty per centum of the money appropriated under this Act for the payment of salaries of teachers of trade, home economics, and industrial subjects, for any year shall be expended for the salaries of teachers of home economics subjects.

¶ SEC. 4. That for the purpose of cooperating with the States in preparing teachers, supervisors, and directors of agricultural subjects and teachers of trade and industrial and home economics subjects there is hereby appropriated for the use of the States for the fiscal year ending June thirtieth, nineteen hundred and eighteen, the sum of \$500,000; for the fiscal year ending June thirtieth, nineteen hundred and nineteen, the sum of \$700,000; for the fiscal year ending June thirtieth, nineteen hundred and twenty, the sum of \$900,000; for the fiscal year ending June thirtieth, nineteen hundred and twenty-one, and annually thereafter, the sum of \$1,000,000. Said sums shall be allotted to the States in the proportion which their population bears to the total population of the United States, not including outlying possessions, according to the last preceding United States census: *Provided*, That the allotment of funds to any State shall be not less than a minimum of \$5,000 for any fiscal year prior to and including the fiscal year ending June thirtieth, nineteen hundred and nineteen, nor less than \$10,000 for any fiscal year thereafter. And there is hereby appropriated the following sums, or so much thereof as may be needed, which shall be used for the purpose of providing the minimum allotment provided for in this section: For the fiscal year ending June, thirtieth, nineteen hundred and eighteen, the sum of \$46,000; for the fiscal year ending June thirtieth, nineteen hundred and nineteen, the sum of \$32,000; for the fiscal year ending June thirtieth, nineteen hundred and twenty, the sum of \$24,000; for the

fiscal year ending June thirtieth, nineteen hundred and twenty-one, and annually thereafter, the sum of \$105,200.

【SEC. 5. That in order to secure the benefits of the appropriations provided for in sections two, three, and four of this Act, any State shall, through the legislative authority thereof, accept the provisions of this Act and designate or create a State board, consisting of not less than three members, and having all necessary power to cooperate, as herein provided, with the Federal Board for Vocational Education in the administration of the provisions of this Act. The State board of education, or other board having charge of the administration of public education in the State, or any State board having charge of the administration of any kind of vocational education in the State may, if the State so elect, be designated as the State board for the purposes of this Act.

【In any State the legislature of which does not meet in nineteen hundred and seventeen, if the governor of that State, so far as he is authorized to do so, shall accept the provisions of this Act and designate or create a State board of not less than three members to act in cooperation with the Federal Board for Vocational Education the Federal board shall recognize such local board for the purposes of this Act until the legislature of such State meets in due course and has been in session sixty days.

【Any State may accept the benefits of any one or more of the respective funds herein appropriated, and it may defer the acceptance of the benefits of any one or more of such funds, and shall be required to meet only the conditions relative to the fund or funds the benefits of which it has accepted: *Provided*, That after June thirtieth nineteen hundred and twenty, no State shall receive any appropriation for salaries of teaches, supervisors, or directors of agricultural subjects, until it shall have taken advantage of at least the minimum amount appropriated for the training of teachers, supervisors, or directors of agricultural subjects, as provided for in this Act, and that after said date no State shall receive any appropriation for the salaries of teachers of trade, home economics, and industrial subjects until it shall have taken advantage of at least the minimum amount appropriated for the training of teachers of trade, home economics, and industrial subjects, as provided for in this Act.

【SEC. 7. That there is hereby appropriated to the Federal Board for Vocational Education the sum of \$200,000 annually, to be available from and after the passage of this Act, for the purpose of making or cooperating in making the studies, investigations, and reports provided for in section six of this Act, and for the purpose of paying the salaries of the officers, the assistants, and such office and other expenses as the board may deem necessary to the execution and administration of this Act.

【SEC. 8. That in order to secure the benefits of the appropriation for any purpose specified in this Act, the State board shall prepare plans, showing the kinds of vocational education for which it is proposed that the appropriation shall be used; the kinds of schools and equipment; courses of study; methods of instruction; qualifications and in case of agricultural subjects the qualifications of supervisors or directors; plans for the training of teachers; and, in the case of agricultural subjects, plans for the supervision of agricultural edu-

cation, as provided for in section ten. Such plans shall be submitted by the State board to the federal Board for Vocational Education, and if the Federal board finds the same to be in conformity with the provisions and purposes of this Act, the same shall be approved. The State board shall make an annual report to the Federal Board for Vocational Education, on or before September first of each year, on the work done in the State and the receipts and expenditures of money under the provisions of this Act.

[SEC. 9. That the appropriation for the salaries of teachers, supervisors, or directors of agricultural subjects and of teachers of trade, home economics, and industrial subjects shall be devoted exclusively to the payment of salaries of such teachers, supervisors, or directors having the minimum qualifications set up for the State by the State board, with the approval of the Federal Board for Vocational Education. The cost of instruction supplementary to the instruction in agricultural and in trade, home economics, and industrial subjects provided for in this Act, necessary to build a well-rounded course of training, shall be borne by the State and local communities, and no part of the cost thereof shall be borne out of the appropriations herein made. The moneys expended under the provisions of this Act, in cooperation with the States, for the salaries of teachers, supervisors, or directors of agricultural subjects, or for the salaries of teachers of trade, home economics, and industrial subjects, shall be conditioned that for each dollar of Federal money expended for such salaries the State or local community, or both, shall expend an equal amount for such salaries; and that appropriations for the training of teachers of vocational subjects, as herein provided, shall be conditioned that such money be expended for maintenance of such training and that for each dollar of Federal money so expended for maintenance, the State or local community, or both, shall expend an equal amount for the maintenance of such training.

[SEC. 10. That any State may use the appropriation for agricultural purposes, or any part thereof allotted to it, under the provisions of the Act, for the salaries of teachers, supervisors, or directors of agricultural subjects, either for the salaries of teachers of such subjects in schools or classes or for the salaries of supervisors or directors of such subjects under a plan of supervision for the State to be set up by the State board, with the approval of the Federal Board for Vocational Education. That in order to receive the benefits of such appropriation for the salaries of teachers, supervisors, or directors of agricultural subjects the State board of any State shall provide in its plan for agricultural education that such education shall be that which is under public supervision or control; that the controlling purpose of such education shall be to fit for useful employment; that such education shall be of less than college grade and be designed to meet the needs of persons over fourteen years of age who have entered upon or who are preparing to enter upon the work of the farm or of the farm home; that the State or local community, or both, shall provide the necessary plant and equipment determined upon by the State board, with the approval of the Federal Board for Vocational Education, as the minimum requirement for such education in schools and classes in the State; that the amount expended for the maintenance of such edu-

cation in any school or class receiving the benefit of such appropriation shall be not less annually than the amount fixed by the State board, with the approval of the Federal board as the minimum for such schools or classes in the State; that such schools shall provide for directed or supervised practice in agriculture, either on a farm provided for by the school or other farm, for at least six months per year; that the teachers, supervisors, or directors of agricultural subjects shall have at least the minimum qualifications determined for the State by the State board, with the approval of the Federal Board for Vocational Education.

[SEC. 11. That in order to receive the benefits of the appropriation for the salaries of teachers of trade, home economics, and industrial subjects the State board of any State shall provide in its plan for trade, home economics, and industrial education that such education shall be given in schools or classes under public supervision or control; that the controlling purpose of such education shall be to fit for useful employment; that such education shall be of less than college grade and shall be designed to meet the needs of persons over fourteen years of age who are preparing for a trade or industrial pursuit or who have entered upon the work of a trade or industrial pursuit; that the State or local community, or both, shall provide the necessary plant and equipment determined upon by the State board, with the approval of the Federal Board for Vocational Education, as the minimum requirements in such State for education for any given trade or industrial pursuit; that the total amount expended for the maintenance of such education in any school or class receiving the benefit of such appropriation shall be not less annually than the amount fixed by the State board, with the approval of the Federal board, as the minimum for such schools or classes in the State; that such schools or classes giving instruction to persons who have not entered upon employment shall require that at least half of the time of such instruction be given to practical work on a useful or productive basis, such instruction to extend over not less than nine months per year and not less than thirty hours per week; that at least one-third of the sum appropriated to any State for the salaries of teachers of trade, home economics, and industrial subjects shall, if expended, be applied to part-time schools or classes for workers over fourteen years of age who have entered upon employment, and such subjects in a part-time school or class may mean any subject given to enlarge the civic or vocational intelligence of such workers over fourteen and less than eighteen years of age; that such part-time schools or classes shall provide for not less than one hundred and forty-four hours of classroom instruction per year; that evening industrial schools shall fix the age of sixteen years as a minimum entrance requirement and shall confine instruction to that which is supplemental to the daily employment; that the teachers of any trade or industrial subject in any State shall have at least the minimum qualifications for teachers of such subject determined upon for such State by the State board, with the approval of the Federal Board for Vocational Education: *Provided*, That for cities and towns of less than twenty-five thousand population, according to the last preceding United States census, the State board, with the approval of the Federal Board for Vocational Education, may modify the con-

ditions as to the length of course and hours of instruction per week for schools and classes giving instruction to those who have not entered upon employment, in order to meet the particular needs of such cities and towns.

【SEC. 12. That is order for any State to receive the benefits of the appropriation in this Act for the training of teachers, supervisors, or directors of agricultural subjects, or of teachers of trade, industrial or home economics subjects, the State board of such State shall provide in its plan for such training that the same shall be carried out under the supervision of the State board; that such training shall be given in schools or classes under public supervision or control; that such training shall be given only to persons who have had adequate vocational experience or contact in the line of work for which they are preparing themselves as teachers, supervisors, or directors, or who are acquiring such experience or contact as a part of their training; and that the State board, with the approval of the Federal board, shall establish minimum requirements for such experience or contact for teachers, supervisors, or directors of agricultural subjects and for teachers of trade, industrial, and home economics subjects; that not more than sixty per centum nor less than twenty per centum of the money appropriated under this Act for the training of teachers of vocational subjects to any State for any year shall be expended for any one of the following purposes: For the preparation of teachers, supervisors, or directors of agricultural subjects, or the preparation of teachers of trade and industrial subjects, or the preparation of teachers of home economics subjects.

【SEC. 13. That is order to secure the benefits of the appropriations for the salaries of teachers, supervisors, or directors of agricultural subjects, or for the salaries of teachers of trade, home economics, and industrial subjects, or for the training of teachers as herein provided, any State shall, through the legislative authority thereof, appoint as custodian for said appropriations its State treasurer, who shall receive and provide for the proper custody and disbursements of all money paid to the State from said appropriations.

【SEC. 14. That the Federal Board for Vocational Education shall annually ascertain whether the several States are using, or are prepared to use, the money received by them in accordance with the provisions of this Act. On or before the first day of January of each year the Federal Board for Vocational Education shall certify to the Secretary of the Treasury each State which has accepted the provisions of this Act and complied therewith, certifying the amounts which each State is entitled to receive under the provisions of this Act. Upon such certification the Secretary of the Treasury shall pay quarterly to the custodian for vocational education of each State the moneys to which it is entitled under the provision of this Act. The moneys so received by the custodian for vocational education for any State and be paid out on the requisition of the State board as reimbursement for expenditures already incurred to such schools as are approved by said State board and are entitled to receive such moneys under the provisions of this Act.

【SEC. 15. That whenever any portion of the fund annually allotted to any State has not been expended for the purpose provided for in this Act, a sum equal to such portion shall be deducted by the Federal board from the next succeeding annual allotment from such fund to such State.

【SEC. 16. That the Federal Board for Vocational Education may withhold the allotment of moneys to any State whenever it shall be determined that such moneys are not being expended for the purposes and under the conditions of this Act.

If any allotment is withheld from any State, the State board of such State may appeal to the Congress of the United States, and if the Congress shall not direct such sum to be paid it shall be covered into the Treasury.

【SEC. 17. That if any portion of the moneys received by the custodian for vocational education of any State under this Act, for any given purpose named in this Act, shall, by any action or contingency, be diminished or lost, it shall be replaced by such State, and until so replaced no subsequent appropriation for such education shall be paid to such State. No portion of any moneys appropriated under this Act for the benefit of the States shall be applied directly or indirectly, to the purchase, erection, preservation, or repair of any building or buildings or equipment, or for the purchase or rental of lands, or for the support of any religious or privately owned or conducted school or college.

【SEC. 18. That the Federal Board for Vocational Education shall make an annual report to Congress, on or before December first on the administration of this Act and shall include in such report the reports made by the State boards on the administration of this Act by each state and the expenditure of the money allotted to each State.】

CHANGES IN EXISTING LAW MADE BY SUBTITLE D OF TITLE V OF
THE BILL, AS REPORTED

In compliance with clause 3 of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italics, existing law in which no change is proposed is shown in roman):

**EMPLOYEE RETIREMENT INCOME SECURITY ACT OF
1974**

*	*	*	*	*	*	*
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PART 8—RULES GOVERNING ASSOCIATION HEALTH PLANS

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Sec. 802. Certification of association health plans.

- Sec. 803. Requirements relating to sponsors and boards of trustees.
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TITLE I—PROTECTION OF EMPLOYEE BENEFIT RIGHTS

SUBTITLE A—GENERAL PROVISIONS

* * * * *

DEFINITIONS

SEC. 3. For purposes of this title:

(1) * * *

* * * * *

(7) The term “participant” means any employee or former employee of an employer, or any member or former member of an employee organization, who is or may become eligible to receive a benefit of any type from an employee benefit plan which covers employees of such employer or members of such organization, or whose beneficiaries may be eligible to receive any such benefit. *Such term includes an individual who is a covered individual described in paragraph (40)(C)(ii).*

* * * * *

(16)(A) * * *

(B) The term “plan sponsor” means (i) the employer in the case of an employee benefit plan established or maintained by a single employer, (ii) the employee organization in the case of a plan established or maintained by an employee organization, or (iii) in the case of a plan 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 the parties who establish or maintain the plan. *Such term also includes a person serving as the sponsor of an association health plan under part 8.*

* * * * *

(40)(A) The term “multiple employer welfare arrangement” means an employee welfare benefit plan, or any other arrangement (other than an employee welfare benefit plan), which is established or maintained for the purpose of offering or providing any benefit described in paragraph (1) to the employees of two or more employers (including one or more self-employed individuals), or to their beneficiaries, except that such term does not include any such plan or other arrangement which is established or maintained—

【(i) under or pursuant to one or more agreements which the Secretary finds to be collective bargaining agreements,】

(i)(I) under or pursuant to one or more collective bargaining agreements which are reached pursuant to collective bargaining described in section 8(d) of the National Labor Relations Act (29 U.S.C. 158(d)) or paragraph Fourth of section 2 of the Railway Labor Act (45 U.S.C. 152, paragraph Fourth) or which are reached pursuant to labor-management negotiations under similar provisions of State public employee relations laws, and (II) in accordance with subparagraphs (C), (D), and (E),

* * * * *

(B) For purposes of this paragraph—

(i) two or more trades or businesses, whether or not incorporated, shall be deemed a single employer *for any plan year of any such plan, or any fiscal year of any such other arrangement*; if such trades or businesses are within the same control group *during such year or at any time during the preceding 1-year period*,

(ii) the term “control group” means a group of trades or businesses under common control,

(iii) the determination of whether a trade or business is under “common control” with another trade or business shall be determined under regulations of the Secretary applying principles **【similar to】** *consistent and coextensive with the principles applied in determining whether employees of two or more trades or businesses are treated as employed by a single employer under section 4001(b), except that, for purposes of this paragraph, 【common control shall not be based on an interest of less than 25 percent】 an interest of greater than 25 percent may not be required as the minimum interest necessary for common control.*

(iv) in determining, after the application of clause (i), whether benefits are provided to employees of two or more employers, the arrangement shall be treated as having only 1 participating employer if, after the application of clause (i), the number of individuals who are employees and former employees of any one participating employer and who are covered under the arrangement is greater than 75 percent of the aggregate number of all individuals who are employees or former employees of participating employers and who are covered under the arrangement,

【(iv)】 (v) the term “rural electric cooperative” means—

(I) any organization which is exempt from tax under section 501(a) of the Internal Revenue Code of 1986 and which is engaged primarily in providing electric service on a mutual or cooperative basis, and

(II) any organization described in paragraph (4) or (6) of section 501(c) of the Internal Revenue Code of 1986 which is exempt from tax under section 501(a) of such Code and at least 80 percent of the members of which are organizations described in subclause (I), and

【(v)】 (vi) the term “rural telephone cooperative association” means an organization described in paragraph (4) or (6) of section 501(c) of the Internal Revenue Code of 1986 which is exempt from tax under section 501(a) of such Code and at least 80 percent of the members of which are organizations engaged

primarily in providing telephone service to rural areas of the United States on a mutual, cooperative, or other basis.

(C) For purposes of subparagraph (A)(i)(II), a plan or other arrangement shall be treated as established or maintained in accordance with this subparagraph only if the following requirements are met:

(i) The plan or other arrangement, and the employee organization or any other entity sponsoring the plan or other arrangement, do not—

(I) utilize the services of any licensed insurance agent or broker for soliciting or enrolling employers or individuals as participating employers or covered individuals under the plan or other arrangement; or

(II) pay a commission or any other type of compensation to a person, other than a full time employee of the employee organization (or a member of the organization to the extent provided in regulations of the Secretary), that is related either to the volume or number of employers or individuals solicited or enrolled as participating employers or covered individuals under the plan or other arrangement, or to the dollar amount or size of the contributions made by participating employers or covered individuals to the plan or other arrangement;

except to the extent that the services used by the plan, arrangement, organization, or other entity consist solely of preparation of documents necessary for compliance with the reporting and disclosure requirements of part 1 or administrative, investment, or consulting services unrelated to solicitation or enrollment of covered individuals.

(ii) As of the end of the preceding plan year, the number of covered individuals under the plan or other arrangement who are identified to the plan or arrangement and who are neither—

(I) employed within a bargaining unit covered by any of the collective bargaining agreements with a participating employer (nor covered on the basis of an individual's employment in such a bargaining unit); nor

(II) present employees (or former employees who were covered while employed) of the sponsoring employee organization, of an employer who is or was a party to any of the collective bargaining agreements, or of the plan or other arrangement or a related plan or arrangement (nor covered on the basis of such present or former employment);

does not exceed 15 percent of the total number of individuals who are covered under the plan or arrangement and who are present or former employees who are or were covered under the plan or arrangement pursuant to a collective bargaining agreement with a participating employer. The requirements of the preceding provisions of this clause shall be treated as satisfied if, as of the end of the preceding plan year, such covered individuals are comprised solely of individuals who were covered individuals under the plan or other arrangement as of the date of the enactment of the Expansion of Portability and Health Insurance Coverage Act of 1997 and, as of the end of the preceding plan year, the number of such covered individuals does not

exceed 25 percent of the total number of present and former employees enrolled under the plan or other arrangement.

(iii) The employee organization or other entity sponsoring the plan or other arrangement certifies to the Secretary each year, in a form and manner which shall be prescribed in regulations of the Secretary that the plan or other arrangement meets the requirements of clauses (i) and (ii).

(D) For purposes of subparagraph (A)(i)(II), a plan or arrangement shall be treated as established or maintained in accordance with this subparagraph only if—

(i) all of the benefits provided under the plan or arrangement consist of health insurance coverage; or

(ii)(I) the plan or arrangement is a multiemployer plan; and

(II) the requirements of clause (B) of the proviso to clause (5) of section 302(c) of the Labor Management Relations Act, 1947 (29 U.S.C. 186(c)) are met with respect to such plan or other arrangement.

(E) For purposes of subparagraph (A)(i)(II), a plan or arrangement shall be treated as established or maintained in accordance with this subparagraph only if—

(i) the plan or arrangement is in effect as of the date of the enactment of the Expansion of Portability and Health Insurance Coverage Act of 1997, or

(ii) the employee organization or other entity sponsoring the plan or arrangement—

(I) has been in existence for at least 3 years or is affiliated with another employee organization which has been in existence for at least 3 years, or

(II) demonstrates to the satisfaction of the Secretary that the requirements of subparagraphs (C) and (D) are met with respect to the plan or other arrangement.

* * * * *

PART 5—ADMINISTRATION AND ENFORCEMENT

CRIMINAL PENALTIES

SEC. 501. (a) Any person who willfully violates any provision of part 1 of this subtitle, or any regulation or order issued under any such provision, shall upon conviction be fined not more than \$5,000 or imprisoned not more than one year, or both; except that in the case of such violation by a person not an individual, the fine imposed upon such person shall be a fine not exceeding \$100,000.

(b) Any person who, either willfully or with willful blindness, falsely represents, to any employee, any employee's beneficiary, any employer, the Secretary, or any State, a plan or other arrangement established or maintained for the purpose of offering or providing any benefit described in section 3(1) to employees or their beneficiaries as—

(1) being an association health plan which has been certified under part 8;

(2) having been established or maintained under or pursuant to one or more collective bargaining agreements which are reached pursuant to collective bargaining described in section

8(d) of the National Labor Relations Act (29 U.S.C. 158(d)) or paragraph Fourth of section 2 of the Railway Labor Act (45 U.S.C. 152, paragraph Fourth) or which are reached pursuant to labor-management negotiations under similar provisions of State public employee relations laws; or

(3) being a plan or arrangement with respect to which the requirements of subparagraph (C), (D), or (E) of section 3(40) are met;

shall, upon conviction, be imprisoned not more than five years, be fined under title 18, United States Code, or both.

CIVIL ENFORCEMENT

SEC. 502. (a) * * *

* * * * *

(n)(1) Subject to paragraph (2), upon application by the Secretary showing the operation, promotion, or marketing of an association health plan (or similar arrangement providing benefits consisting of medical care (as defined in section 733(a)(2))) that—

(A) is not certified under part 8, is subject under section 514(b)(6) to the insurance laws of any State in which the plan or arrangement offers or provides benefits, and is not licensed, registered, or otherwise approved under the insurance laws of such State; or

(B) is an association health plan certified under part 8 and is not operating in accordance with the requirements under part 8 for such certification,

a district court of the United States shall enter an order requiring that the plan or arrangement cease activities.

(2) Paragraph (1) shall not apply in the case of an association health plan or other arrangement if the plan or arrangement shows that—

(A) all benefits under it referred to in paragraph (1) consist of health insurance coverage; and

(B) with respect to each State in which the plan or arrangement offers or provides benefits, the plan or arrangement is operating in accordance with applicable State laws that are not superseded under section 514.

(3) The court may grant such additional equitable relief, including any relief available under this title, as it deems necessary to protect the interests of the public and of persons having claims for benefits against the plan.

CLAIMS PROCEDURE

SEC. 503. In accordance with regulations of the Secretary, every employee benefit plan shall—

(1) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant, and

(2) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by

the appropriate named fiduciary of the decision denying the claim.

The terms of each association health plan which is or has been certified under part 8 shall require the board of trustees or the named fiduciary (as applicable) to ensure that the requirements of this section are met in connection with claims filed under the plan.

* * * * *

COORDINATION AND RESPONSIBILITY OF AGENCIES ENFORCING EMPLOYEE RETIREMENT INCOME SECURITY ACT AND RELATED FEDERAL LAWS

SEC. 506. (a) * * *

* * * * *

(c) *RESPONSIBILITY OF STATES WITH RESPECT TO ASSOCIATION HEALTH PLANS.—*

(1) *AGREEMENTS WITH STATES.—A State may enter into an agreement with the Secretary for delegation to the State of some or all of the Secretary’s authority under sections 502 and 504 to enforce the requirements for certification under part 8. The Secretary shall enter into the agreement if the Secretary determines that the delegation provided for therein would not result in a lower level or quality of enforcement of the provisions of this title.*

(2) *DELEGATIONS.—Any department, agency, or instrumentality of a State to which authority is delegated pursuant to an agreement entered into under this paragraph may, if authorized under State law and to the extent consistent with such agreement, exercise the powers of the Secretary under this title which relate to such authority.*

(3) *RECOGNITION OF PRIMARY DOMICILE STATE.—In entering into any agreement with a State under subparagraph (A), the Secretary shall ensure that, as a result of such agreement and all other agreements entered into under subparagraph (A), only one State will be recognized, with respect to any particular association health plan, as the primary domicile State to which authority has been delegated pursuant to such agreements.*

* * * * *

EFFECT ON OTHER LAWS

SEC. 514. (a) * * *

(b)(1) * * *

* * * * *

(4) **Subsection (a)** Subsections (a) and (d) shall not apply to any generally applicable criminal law of a State.

(5)(A) Except as provided in subparagraph (B), **subsection (a)** subsection (a) of this section and subsections (a)(2)(B) and (b) of section 805 shall not apply to the Hawaii Prepaid Health Care Act (Haw. Rev. Stat. §§393–1 through 393–51).

(B) Nothing in subparagraph (A) shall be construed to exempt from **subsection (a)** subsection (a) of this section and subsections (a)(2)(B) and (b) of section 805—

(i) * * *

* * * * *

(6)(A) Notwithstanding any other provision of this section—

(i) in the case of an employee welfare benefit plan which is a multiple employer welfare arrangement and is fully insured (or which is a multiple employer welfare arrangement subject to an exemption under subparagraph (B)), any law of any State which regulates insurance may apply to such arrangement to the extent that such law provides—

(I) standards, requiring the maintenance of specified levels of reserves and specified levels of contributions, which any such plan, or any trust established under such a plan, must meet in order to be considered under such law able to pay benefits in full when due, and

(II) provisions to enforce such standards, [and]

(ii) in the case of any other employee welfare benefit plan which is a multiple employer welfare arrangement, *and which does not provide medical care (within the meaning of section 733(a)(2))*, in addition to this title, any law of any State which regulates insurance may apply to the extent not inconsistent with the preceding sections of this [title.] title, and

(iii) *subject to subparagraph (E), in the case of any other employee welfare benefit plan which is a multiple employer welfare arrangement and which provides medical care (within the meaning of section 733(a)(2)), any law of any State which regulates insurance may apply.*

* * * * *

(E) The preceding subparagraphs of this paragraph do not apply with respect to any State law in the case of an association health plan which is certified under part 8.

* * * * *

(d)(1) Except as provided in subsection (b)(4), the provisions of this title shall supersede any and all State laws insofar as they may now or hereafter preclude a health insurance issuer from offering health insurance coverage in connection with an association health plan which is certified under part 8.

(2) Except as provided in paragraphs (4) and (5) of subsection (b) of this section—

(A) In any case in which health insurance coverage of any policy type is offered under an association health plan certified under part 8 to a participating employer operating in such State, the provisions of this title shall supersede any and all laws of such State insofar as they may preclude a health insurance issuer from offering health insurance coverage of the same policy type to other employers operating in the State which are eligible for coverage under such association health plan, whether or not such other employers are participating employers in such plan.

(B) In any case in which health insurance coverage of any policy type is offered under an association health plan in a State and the filing, with the applicable State authority, of the policy form in connection with such policy type is approved by

such State authority, the provisions of this title shall supersede any and all laws of any other State in which health insurance coverage of such type is offered, insofar as they may preclude, upon the filing in the same form and manner of such policy form with the applicable State authority in such other State, the approval of the filing in such other State.

(3) For additional provisions relating to association health plans, see subsections (a)(2)(B) and (b) of section 805.

(4) For purposes of this subsection, the term “association health plan” has the meaning provided in section 801(a), and the terms “health insurance coverage”, “participating employer”, and “health insurance issuer” have the meanings provided such terms in section 811, respectively.

[(d)] *(e) Nothing in this title shall be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States (except as provided in sections 111 and 507(b)) or any rule or regulation issued under any such law.*

* * * * *

SEC. 731. PREEMPTION; STATE FLEXIBILITY; CONSTRUCTION.

(a) * * *

* * * * *

(c) RULES OF CONSTRUCTION.—Except as provided in section 711, nothing in this part or part 8 shall be construed as requiring a group health plan or health insurance coverage to provide specific benefits under the terms of such plan or coverage.

* * * * *

PART 8—RULES GOVERNING ASSOCIATION HEALTH PLANS

SEC. 801. ASSOCIATION HEALTH PLANS.

(a) IN GENERAL.—For purposes of this part, the term “association health plan” means a group health plan—

(1) whose sponsor is (or is deemed under this part to be) described in subsection (b), and

(2) under which at least one option of health insurance coverage offered by a health insurance issuer (which may include, among other options, managed care options, point of service options, and preferred provider options) is provided to participants and beneficiaries.

(b) SPONSORSHIP.—The sponsor of a group health plan is described in this subsection if such sponsor—

(1) is organized and maintained in good faith, with a constitution and bylaws specifically stating its purpose and providing for periodic meetings on at least an annual basis, as a trade association, an industry association (including a rural electric cooperative association or a rural telephone cooperative association), a professional association, or a chamber of commerce (or similar business group, including a corporation or similar organization that operates on a cooperative basis (within the meaning of section 1381 of the Internal Revenue Code of 1986)), for substantial purposes other than that of obtaining or providing medical care,

(2) is established as a permanent entity which receives the active support of its members and collects from its members on a periodic basis dues or payments necessary to maintain eligibility for membership in the sponsor, and

(3) does not condition such dues or payments or coverage under the plan on the basis of health status-related factors with respect to the employees of its members (or affiliated members), or the dependents of such employees, and does not condition such dues or payments on the basis of group health plan participation.

Any sponsor consisting of an association of entities which meet the requirements of paragraphs (1) and (2) shall be deemed to be a sponsor described in this subsection.

SEC. 802. CERTIFICATION OF ASSOCIATION HEALTH PLANS.

(a) *IN GENERAL.*—The Secretary shall prescribe by regulation a procedure under which, subject to subsection (b), the Secretary shall certify association health plans which apply for certification as meeting the requirements of this part.

(b) *STANDARDS.*—Under the procedure prescribed pursuant to subsection (a), the Secretary shall certify an association health plan as meeting the requirements of this part only if the Secretary is satisfied that—

(1) such certification—

(A) is administratively feasible,

(B) is not adverse to the interests of the individuals covered under the plan, and

(C) is protective of the rights and benefits of the individuals covered under the plan, and

(2) the applicable requirements of this part are met (or, upon the date on which the plan is to commence operations, will be met) with respect to the plan.

(c) *REQUIREMENTS APPLICABLE TO CERTIFIED PLANS.*—An association health plan with respect to which certification under this part is in effect shall meet the applicable requirements of this part, effective on the date of certification (or, if later, on the date on which the plan is to commence operations).

(d) *REQUIREMENTS FOR CONTINUED CERTIFICATION.*—The Secretary may provide by regulation for continued certification under this part, including requirements relating to any commencement, by an association health plan which has been certified under this part, of a benefit option which does not consist of health insurance coverage.

(e) *CLASS CERTIFICATION FOR FULLY-INSURED PLANS.*—The Secretary shall establish a class certification procedure for association health plans under which all benefits consist of health insurance coverage. Under such procedure, the Secretary shall provide for the granting of certification under this part to the plans in each class of such association health plans upon appropriate filing under such procedure in connection with plans in such class and payment of the prescribed fee under section 807(a).

SEC. 803. REQUIREMENTS RELATING TO SPONSORS AND BOARDS OF TRUSTEES.

(a) *SPONSOR.*—The requirements of this subsection are met with respect to an association health plan if—

(1) the sponsor (together with its immediate predecessor, if any) has met (or is deemed under this part to have met) for a continuous period of not less than 3 years ending with the date of the application for certification under this part, the requirements of paragraphs (1) and (2) of section 801(b), and

(2) the sponsor meets (or is deemed under this part to meet) the requirements of section 801(b)(3).

(b) *BOARD OF TRUSTEES.*—The requirements of this subsection are met with respect to an association health plan if the following requirements are met:

(1) *FISCAL CONTROL.*—The plan is operated, pursuant to a trust agreement, by a board of trustees which has complete fiscal control over the plan and which is responsible for all operations of the plan.

(2) *RULES OF OPERATION AND FINANCIAL CONTROLS.*—The board of trustees has in effect rules of operation and financial controls, based on a 3-year plan of operation, adequate to carry out the terms of the plan and to meet all requirements of this title applicable to the plan.

(3) *RULES GOVERNING RELATIONSHIP TO PARTICIPATING EMPLOYERS AND TO CONTRACTORS.*—

(A) *IN GENERAL.*—Except as provided in subparagraph (B), the members of the board of trustees are individuals selected from individuals who are the owners, officers, directors, or employees of the participating employers or who are partners in the participating employers and actively participate in the business.

(B) *LIMITATION.*—

(i) *GENERAL RULE.*—Except as provided in clauses (ii) and (iii), no such member is an owner, officer, director, or employee of, or partner in, a contract administrator or other service provider to the plan.

(ii) *LIMITED EXCEPTION FOR PROVIDERS OF SERVICES SOLELY ON BEHALF OF THE SPONSOR.*—Officers or employees of a sponsor which is a service provider (other than a contract administrator) to the plan may be members of the board if they constitute not more than 25 percent of the membership of the board and they do not provide services to the plan other than on behalf of the sponsor.

(iii) *TREATMENT OF PROVIDERS OF MEDICAL CARE.*—In the case of a sponsor which is an association whose membership consists primarily of providers of medical care, clause (i) shall not apply in the case of any service provider described in subparagraph (A) who is a provider of medical care under the plan.

(C) *SOLE AUTHORITY.*—The board has sole authority to approve applications for participation in the plan and to contract with a service provider to administer the day-to-day affairs of the plan.

(c) *TREATMENT OF FRANCHISE NETWORKS.*—*In the case of a group health plan which is established and maintained by a franchiser for a franchise network consisting of its franchisees—*

(1) *the requirements of subsection (a) and section 801(a)(1) shall be deemed met if such requirements would otherwise be met if the franchiser were deemed to be the sponsor referred to in section 801(b), such network were deemed to be an association described in section 801(b), and each franchisee were deemed to be a member (of the association and the sponsor) referred to in section 801(b), and*

(2) *the requirements of section 804(a)(1) shall be deemed met.*

(d) *CERTAIN COLLECTIVELY BARGAINED PLANS.*—

(1) *IN GENERAL.*—*In the case of a group health plan described in paragraph (2)—*

(A) *the requirements of subsection (a) and section 801(a)(1) shall be deemed met,*

(B) *the joint board of trustees shall be deemed a board of trustees with respect to which the requirements of subsection (b) are met, and*

(C) *the requirements of section 804 shall be deemed met.*

(2) *REQUIREMENTS.*—*A group health plan is described in this paragraph if—*

(A) *the plan is a multiemployer plan,*

(B) *the plan is in existence on April 1, 1997, and would be described in section 3(40)(A)(i) but solely for the failure to meet the requirements of section 3(40)(C)(ii) or (to the extent provided in regulations of the Secretary) solely for the failure to meet the requirements of subparagraph (D) of section 3(40), or*

(C)(i) *the plan is in existence on April 1, 1997, has been in existence as of such date for at least 3 years, meets the requirements of paragraphs (2) and (3) of section 801(b), and would be described in section 3(40)(A)(i) but solely for the failure to meet the requirements of subparagraph (C)(i) or (C)(ii), and*

(ii) *individuals who are members of the plan sponsor—*

(I) *participate by elections in the organizational governance of the plan sponsor,*

(II) *are eligible for appointment as trustee of the plan or for participation in the appointment of trustees of the plan, and*

(III) *if covered under the plan, have full rights under the plan of a participant in an employee welfare benefit plan.*

(e) *CERTAIN PLANS NOT MEETING SINGLE EMPLOYER REQUIREMENT.*—

(1) *IN GENERAL.*—*In any case in which the majority of the employees covered under a group health plan are employees of a single employer (within the meaning of clauses (i) and (ii) of section 3(40)(B)), if all other employees covered under the plan are employed by employers who are related to such single employer—*

(A) the requirements of subsection (a) and section 801(a)(1) shall not apply if such single employer is the sponsor of the plan, and

(B) the requirements of subsection (b) shall be deemed met if the board of trustees is the named fiduciary in connection with the plan.

(2) **RELATED EMPLOYERS.**—For purposes of paragraph (1), employers are “related” if there is among all such employers a common ownership interest or a substantial commonality of business operations based on common suppliers or customers.

SEC. 804. PARTICIPATION AND COVERAGE REQUIREMENTS.

(a) **COVERED EMPLOYERS AND INDIVIDUALS.**—The requirements of this subsection are met with respect to an association health plan if, under the terms of the plan—

(1) all participating employers must be members or affiliated members of the sponsor, except that, in the case of a sponsor which is a professional association or other individual-based association, if at least one of the officers, directors, or employees of an employer, or at least one of the individuals who are partners in an employer and who actively participates in the business, is a member or affiliated member of the sponsor, participating employers may also include such employer, and

(2) all individuals commencing coverage under the plan after certification under this part must be—

(A) active or retired owners (including self-employed individuals), officers, directors, or employees of, or partners in, participating employers, or

(B) the beneficiaries of individuals described in subparagraph (A).

(b) **COVERAGE OF PREVIOUSLY UNINSURED EMPLOYEES.**—The requirements of this subsection are met with respect to an association health plan if, under the terms of the plan, no affiliated member of the sponsor may be offered coverage under the plan as a participating employer unless—

(1) the affiliated member was an affiliated member on the date of certification under this part, or

(2) during the 12-month period preceding the date of the offering of such coverage, the affiliated member has not maintained or contributed to a group health plan with respect to any of its employees who would otherwise be eligible to participate in such association health plan.

(c) **INDIVIDUAL MARKET UNAFFECTED.**—The requirements of this subsection are met with respect to an association health plan if, under the terms of the plan, no participating employer may provide health insurance coverage in the individual market for any employee not covered under the plan which is similar to the coverage contemporaneously provided to employees of the employer under the plan, if such exclusion of the employee from coverage under the plan is based on a health status-related factor with respect to the employee and such employee would, but for such exclusion on such basis, be eligible for coverage under the plan.

(d) **PROHIBITION OF DISCRIMINATION AGAINST EMPLOYERS AND EMPLOYEES ELIGIBLE TO PARTICIPATE.**—The requirements of this subsection are met with respect to an association health plan if—

(1) under the terms of the plan, no employer meeting the preceding requirements of this section is excluded as a participating employer, unless—

(A) participation or contribution requirements of the type referred to in section 2711 of the Public Health Service Act are not met with respect to the excluded employer, or

(B) the excluded employer does not satisfy a required minimum level of employment uniformly applicable to participating employers,

(2) the applicable requirements of sections 701, 702, and 703 are met with respect to the plan, and

(3) applicable benefit options under the plan are actively marketed to all eligible participating employers.

SEC. 805. OTHER REQUIREMENTS RELATING TO PLAN DOCUMENTS, CONTRIBUTION RATES, AND BENEFIT OPTIONS.

(a) *IN GENERAL.*—The requirements of this section are met with respect to an association health plan if the following requirements are met:

(1) *CONTENTS OF GOVERNING INSTRUMENTS.*—The instruments governing the plan include a written instrument, meeting the requirements of an instrument required under section 402(a)(1), which—

(A) provides that the board of trustees serves as the named fiduciary required for plans under section 402(a)(1) and serves in the capacity of a plan administrator (referred to in section 3(16)(A)),

(B) provides that the sponsor of the plan is to serve as plan sponsor (referred to in section 3(16)(B)), and

(C) incorporates the requirements of section 806.

(2) *CONTRIBUTION RATES MUST BE NONDISCRIMINATORY.*—

(A) The contribution rates for any participating employer do not vary significantly on the basis of the claims experience of such employer and do not vary on the basis of the type of business or industry in which such employer is engaged.

(B) Nothing in this title or any other provision of law shall be construed to preclude an association health plan, or a health insurance issuer offering health insurance coverage in connection with an association health plan, from setting contribution rates based on the claims experience of the plan, to the extent contribution rates under the plan meet the requirements of section 702(b).

(3) *FLOOR FOR NUMBER OF COVERED INDIVIDUALS WITH RESPECT TO CERTAIN PLANS.*—If any benefit option under the plan does not consist of health insurance coverage, the plan has as of the beginning of the plan year not fewer than 1,000 participants and beneficiaries.

(4) *REGULATORY REQUIREMENTS.*—Such other requirements as the Secretary may prescribe by regulation as necessary to carry out the purposes of this part.

(b) *ABILITY OF ASSOCIATION HEALTH PLANS TO DESIGN BENEFIT OPTIONS.*—Nothing in this part or any provision of State law (as defined in section 514(c)(1)) shall be construed to preclude an association health plan, or a health insurance issuer offering health in-

insurance coverage in connection with an association health plan, from exercising its sole discretion in selecting the specific items and services consisting of medical care to be included as benefits under such plan or coverage, except in the case of any law to the extent that it (1) prohibits an exclusion of a specific disease from such coverage, or (2) is not preempted under section 731(a)(1) with respect to matters governed by section 711 or 712.

SEC. 806. MAINTENANCE OF RESERVES AND PROVISIONS FOR SOLVENCY FOR PLANS PROVIDING HEALTH BENEFITS IN ADDITION TO HEALTH INSURANCE COVERAGE.

(a) *IN GENERAL.*—The requirements of this section are met with respect to an association health plan if—

(1) the benefits under the plan consist solely of health insurance coverage, or

(2) if the plan provides any additional benefit options which do not consist of health insurance coverage, the plan—

(A) establishes and maintains reserves with respect to such additional benefit options, in amounts recommended by the qualified actuary, consisting of—

(i) a reserve sufficient for unearned contributions,

(ii) a reserve sufficient for benefit liabilities which have been incurred, which have not been satisfied, and for which risk of loss has not yet been transferred, and for expected administrative costs with respect to such benefit liabilities,

(iii) a reserve sufficient for any other obligations of the plan, and

(iv) a reserve sufficient for a margin of error and other fluctuations, taking into account the specific circumstances of the plan,

and

(B) establishes and maintains aggregate excess/stop loss insurance and solvency indemnification, with respect to such additional benefit options for which risk of loss has not yet been transferred, as follows:

(i) The plan shall secure aggregate excess/stop loss insurance for the plan with an attachment point which is not greater than 125 percent of expected gross annual claims. The Secretary may by regulation provide for upward adjustments in the amount of such percentage in specified circumstances in which the plan specifically provides for and maintains reserves in excess of the amounts required under subparagraph (A).

(ii) The plan shall secure a means of indemnification for any claims which the plan is unable to satisfy by reason of a termination pursuant to section 809(b) (relating to mandatory termination).

Any regulations prescribed by the Secretary pursuant to paragraph (2)(B)(i) may allow for such adjustments in the required levels of excess/stop loss insurance as the qualified actuary may recommend, taking into account the specific circumstances of the plan.

(b) *MINIMUM SURPLUS IN ADDITION TO CLAIMS RESERVES.*—The requirements of this subsection are met if the plan establishes and maintains surplus in an amount at least equal to the excess of—

- (1) the greater of—
 (A) 25 percent of expected incurred claims and expenses for the plan year, or
 (B) \$400,000,

over

- (2) the amount required under subsection (a)(2)(A)(ii).

(c) **ADDITIONAL REQUIREMENTS.**—In the case of any association health plan described in subsection (a)(2), the Secretary may provide such additional requirements relating to reserves and excess/stop loss insurance as the Secretary considers appropriate. Such requirements may be provided, by regulation or otherwise, with respect to any such plan or any class of such plans.

(d) **ADJUSTMENTS FOR EXCESS/STOP LOSS INSURANCE.**—The Secretary may provide for adjustments to the levels of reserves otherwise required under subsections (a) and (b) with respect to any plan or class of plans to take into account excess/stop loss insurance provided with respect to such plan or plans.

(e) **ALTERNATIVE MEANS OF COMPLIANCE.**—The Secretary may permit an association health plan described in subsection (a)(2) to substitute, for all or part of the requirements of this section, such security, guarantee, hold-harmless arrangement, or other financial arrangement as the Secretary determines to be adequate to enable the plan to fully meet all its financial obligations on a timely basis and is otherwise no less protective of the interests of participants and beneficiaries than the requirements for which it is substituted. The Secretary may take into account, for purposes of this subsection, evidence provided by the plan or sponsor which demonstrates an assumption of liability with respect to the plan. Such evidence may be in the form of a contract of indemnification, lien, bonding, insurance, letter of credit, recourse under applicable terms of the plan in the form of assessments of participating employers, security, or other financial arrangement.

(f) **EXCESS/STOP LOSS INSURANCE.**—For purposes of this section, the term “excess/stop loss insurance” means, in connection with an association health plan, a contract under which an insurer (meeting such minimum standards as may be prescribed in regulations of the Secretary) provides for payment to the plan with respect to claims under the plan in excess of an amount or amounts specified in such contract.

SEC. 807. REQUIREMENTS FOR APPLICATION AND RELATED REQUIREMENTS.

(a) **FILING FEE.**—Under the procedure prescribed pursuant to section 802(a), an association health plan shall pay to the Secretary at the time of filing an application for certification under this part a filing fee in the amount of \$5,000, which shall be available, to the extent provided in appropriation Acts, to the Secretary for the sole purpose of administering the certification procedures applicable with respect to association health plans.

(b) **INFORMATION TO BE INCLUDED IN APPLICATION FOR CERTIFICATION.**—An application for certification under this part meets the requirements of this section only if it includes, in a manner and form prescribed in regulations of the Secretary, at least the following information:

(1) *IDENTIFYING INFORMATION.*—*The names and addresses of—*

(A) *the sponsor, and*

(B) *the members of the board of trustees of the plan.*

(2) *STATES IN WHICH PLAN INTENDS TO DO BUSINESS.*—*The States in which participants and beneficiaries under the plan are to be located and the number of them expected to be located in each such State.*

(3) *BONDING REQUIREMENTS.*—*Evidence provided by the board of trustees that the bonding requirements of section 412 will be met as of the date of the application or (if later) commencement of operations.*

(4) *PLAN DOCUMENTS.*—*A copy of the documents governing the plan (including any bylaws and trust agreements), the summary plan description, and other material describing the benefits that will be provided to participants and beneficiaries under the plan.*

(5) *AGREEMENTS WITH SERVICE PROVIDERS.*—*A copy of any agreements between the plan and contract administrators and other service providers.*

(6) *FUNDING REPORT.*—*In the case of association health plans providing benefits options in addition to health insurance coverage, a report setting forth information with respect to such additional benefit options determined as of a date within the 120-day period ending with the date of the application, including the following:*

(A) *RESERVES.*—*A statement, certified by the board of trustees of the plan, and a statement of actuarial opinion, signed by a qualified actuary, that all applicable requirements of section 806 are or will be met in accordance with regulations which the Secretary shall prescribe.*

(B) *ADEQUACY OF CONTRIBUTION RATES.*—*A statement of actuarial opinion, signed by a qualified actuary, which sets forth a description of the extent to which contribution rates are adequate to provide for the payment of all obligations and the maintenance of required reserves under the plan for the 12-month period beginning with such date within such 120-day period, taking into account the expected coverage and experience of the plan. If the contribution rates are not fully adequate, the statement of actuarial opinion shall indicate the extent to which the rates are inadequate and the changes needed to ensure adequacy.*

(C) *CURRENT AND PROJECTED VALUE OF ASSETS AND LIABILITIES.*—*A statement of actuarial opinion signed by a qualified actuary, which sets forth the current value of the assets and liabilities accumulated under the plan and a projection of the assets, liabilities, income, and expenses of the plan for the 12-month period referred to in subparagraph (B). The income statement shall identify separately the plan's administrative expenses and claims.*

(D) *COSTS OF COVERAGE TO BE CHARGED AND OTHER EXPENSES.*—*A statement of the costs of coverage to be charged, including an itemization of amounts for administration, re-*

erves, and other expenses associated with the operation of the plan.

(E) *OTHER INFORMATION.*—Any other information which may be prescribed in regulations of the Secretary as necessary to carry out the purposes of this part.

(c) *FILING NOTICE OF CERTIFICATION WITH STATES.*—A certification granted under this part to an association health plan shall not be effective unless written notice of such certification is filed with the applicable State authority of each State in which at least 25 percent of the participants and beneficiaries under the plan are located. For purposes of this subsection, an individual shall be considered to be located in the State in which a known address of such individual is located or in which such individual is employed.

(d) *NOTICE OF MATERIAL CHANGES.*—In the case of any association health plan certified under this part, descriptions of material changes in any information which was required to be submitted with the application for the certification under this part shall be filed in such form and manner as shall be prescribed in regulations of the Secretary. The Secretary may require by regulation prior notice of material changes with respect to specified matters which might serve as the basis for suspension or revocation of the certification.

(e) *REPORTING REQUIREMENTS FOR CERTAIN ASSOCIATION HEALTH PLANS.*—An association health plan certified under this part which provides benefit options in addition to health insurance coverage for such plan year shall meet the requirements of section 103 by filing an annual report under such section which shall include information described in subsection (b)(6) with respect to the plan year and, notwithstanding section 104(a)(1)(A), shall be filed not later than 90 days after the close of the plan year (or on such later date as may be prescribed by the Secretary).

(f) *ENGAGEMENT OF QUALIFIED ACTUARY.*—The board of trustees of each association health plan which provides benefits options in addition to health insurance coverage and which is applying for certification under this part or is certified under this part shall engage, on behalf of all participants and beneficiaries, a qualified actuary who shall be responsible for the preparation of the materials comprising information necessary to be submitted by a qualified actuary under this part. The qualified actuary shall utilize such assumptions and techniques as are necessary to enable such actuary to form an opinion as to whether the contents of the matters reported under this part—

(1) are in the aggregate reasonably related to the experience of the plan and to reasonable expectations, and

(2) represent such actuary's best estimate of anticipated experience under the plan.

The opinion by the qualified actuary shall be made with respect to, and shall be made a part of, the annual report.

SEC. 808. NOTICE REQUIREMENTS FOR VOLUNTARY TERMINATION.

Except as provided in section 809(b), an association health plan which is or has been certified under this part may terminate (upon or at any time after cessation of accruals in benefit liabilities) only if the board of trustees—

(1) not less than 60 days before the proposed termination date, provides to the participants and beneficiaries a written notice of intent to terminate stating that such termination is intended and the proposed termination date,

(2) develops a plan for winding up the affairs of the plan in connection with such termination in a manner which will result in timely payment of all benefits for which the plan is obligated, and

(3) submits such plan in writing to the Secretary.

Actions required under this section shall be taken in such form and manner as may be prescribed in regulations of the Secretary.

SEC. 809. CORRECTIVE ACTIONS AND MANDATORY TERMINATION.

(a) **ACTIONS TO AVOID DEPLETION OF RESERVES.**—An association health plan which is certified under this part and which provides benefits other than health insurance coverage shall continue to meet the requirements of section 806, irrespective of whether such certification continues in effect. The board of trustees of such plan shall determine quarterly whether the requirements of section 806 are met. In any case in which the board determines that there is reason to believe that there is or will be a failure to meet such requirements, or the Secretary makes such a determination and so notifies the board, the board shall immediately notify the qualified actuary engaged by the plan, and such actuary shall, not later than the end of the next following month, make such recommendations to the board for corrective action as the actuary determines necessary to ensure compliance with section 806. Not later than 30 days after receiving from the actuary recommendations for corrective actions, the board shall notify the Secretary (in such form and manner as the Secretary may prescribe by regulation) of such recommendations of the actuary for corrective action, together with a description of the actions (if any) that the board has taken or plans to take in response to such recommendations. The board shall thereafter report to the Secretary, in such form and frequency as the Secretary may specify to the board, regarding corrective action taken by the board until the requirements of section 806 are met.

(b) **MANDATORY TERMINATION.**—In any case in which—

(1) the Secretary has been notified under subsection (a) of a failure of an association health plan which is or has been certified under this part and is described in section 806(a)(2) to meet the requirements of section 806 and has not been notified by the board of trustees of the plan that corrective action has restored compliance with such requirements, and

(2) the Secretary determines that there is a reasonable expectation that the plan will continue to fail to meet the requirements of section 806,

the board of trustees of the plan shall, at the direction of the Secretary, terminate the plan and, in the course of the termination, take such actions as the Secretary may require, including satisfying any claims referred to in section 806(a)(2)(B)(ii) and recovering for the plan any liability under section 806(f), as necessary to ensure that the affairs of the plan will be, to the maximum extent possible, wound up in a manner which will result in timely provision of all benefits for which the plan is obligated.

(c) *GUARANTEE FUND.*—*In any case in which claims against an association health plan terminated under subsection (b) remain outstanding after all actions required under subsection (b) have been undertaken in connection with the termination, the Secretary shall assess all ongoing association health plans which are or have been certified under this part and are described in section 806(a)(2) in an amount—*

(1) *expressed as a uniform percentage of claims paid by such plans per year for coverage, other than health insurance coverage, commencing with the last plan year ending before the date of the termination, and*

(2) *equal, in the aggregate, to the total amount of such outstanding claims,*

except that any such assessment shall not exceed 2 percent per year. The Secretary shall promptly pay such outstanding claims with the amounts assessed pursuant to this subsection. The Secretary shall deposit and hold such assessments in a guarantee fund which shall be established by the Secretary for payment of such claims until such payment of such claims has been completed. The Secretary may invest amounts of the fund in such obligations as the Secretary considers appropriate.

SEC. 810. SPECIAL RULES FOR CHURCH PLANS.

(a) *ELECTION FOR CHURCH PLANS.*—*Notwithstanding section 4(b)(2), if a church, a convention or association of churches, or an organization described in section 3(33)(C)(i) maintains a church plan which is a group health plan (as defined in section 733(a)(1)), and such church, convention, association, or organization makes an election with respect to such plan under this subsection (in such form and manner as the Secretary may by regulation prescribe), then the provisions of this section shall apply to such plan, with respect to benefits provided under such plan consisting of medical care, as if section 4(b)(2) did not contain an exclusion for church plans. Nothing in this paragraph shall be construed to render any other section of this title applicable to church plans, except to the extent that such other section is incorporated by reference in this section.*

(b) *EFFECT OF ELECTION.*—

(1) *PREEMPTION OF STATE INSURANCE LAWS REGULATING COVERED CHURCH PLANS.*—*Subject to paragraphs (2) and (3), this section shall supersede any and all State laws which regulate insurance insofar as they may now or hereafter regulate church plans to which this section applies or trusts established under such church plans.*

(2) *GENERAL STATE INSURANCE REGULATION UNAFFECTED.*—

(A) *IN GENERAL.*—*Except as provided in subparagraph (B) and paragraph (3), nothing in this section shall be construed to exempt or relieve any person from any provision of State law which regulates insurance.*

(B) *CHURCH PLANS NOT TO BE DEEMED INSURANCE COMPANIES OR INSURERS.*—*Neither a church plan to which this section applies, nor any trust established under such a church plan, shall be deemed to be an insurance company or other insurer or to be engaged in the business of insur-*

ance for purposes of any State law purporting to regulate insurance companies or insurance contracts.

(3) *PREEMPTION OF CERTAIN STATE LAWS RELATING TO PREMIUM RATE REGULATION AND BENEFIT MANDATES.*—The provisions of subsections (a)(2)(B) and (b) of section 805 shall apply with respect to a church plan to which this section applies in the same manner and to the same extent as such provisions apply with respect to association health plans.

(4) *DEFINITIONS.*—For purposes of this subsection—

(A) *STATE LAW.*—The term “State law” includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State. A law of the United States applicable only to the District of Columbia shall be treated as a State law rather than a law of the United States.

(B) *STATE.*—The term “State” includes a State, any political subdivision thereof, or any agency or instrumentality of either, which purports to regulate, directly or indirectly, the terms and conditions of church plans covered by this section.

(c) *REQUIREMENTS FOR COVERED CHURCH PLANS.*—

(1) *FIDUCIARY RULES AND EXCLUSIVE PURPOSE.*—A fiduciary shall discharge his duties with respect to a church plan to which this section applies—

(A) for the exclusive purpose of:

(i) providing benefits to participants and their beneficiaries; and

(ii) defraying reasonable expenses of administering the plan;

(B) with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims; and

(C) in accordance with the documents and instruments governing the plan.

The requirements of this paragraph shall not be treated as not satisfied solely because the plan assets are commingled with other church assets, to the extent that such plan assets are separately accounted for.

(2) *CLAIMS PROCEDURE.*—In accordance with regulations of the Secretary, every church plan to which this section applies shall—

(A) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant;

(B) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate fiduciary of the decision denying the claim; and

(C) provide a written statement to each participant describing the procedures established pursuant to this paragraph.

(3) **ANNUAL STATEMENTS.**—*In accordance with regulations of the Secretary, every church plan to which this section applies shall file with the Secretary an annual statement—*

(A) *stating the names and addresses of the plan and of the church, convention, or association maintaining the plan (and its principal place of business);*

(B) *certifying that it is a church plan to which this section applies and that it complies with the requirements of paragraphs (1) and (2);*

(C) *identifying the States in which participants and beneficiaries under the plan are or likely will be located during the 1-year period covered by the statement; and*

(D) *containing a copy of a statement of actuarial opinion signed by a qualified actuary that the plan maintains capital, reserves, insurance, other financial arrangements, or any combination thereof adequate to enable the plan to fully meet all of its financial obligations on a timely basis.*

(4) **DISCLOSURE.**—*At the time that the annual statement is filed by a church plan with the Secretary pursuant to paragraph (3), a copy of such statement shall be made available by the Secretary to the State insurance commissioner (or similar official) of any State. The name of each church plan and sponsoring organization filing an annual statement in compliance with paragraph (3) shall be published annually in the Federal Register.*

(c) **ENFORCEMENT.**—*The Secretary may enforce the provisions of this section in a manner consistent with section 502, to the extent applicable with respect to actions under section 502(a)(5), and with section 3(33)(D), except that, other than for the purpose of seeking a temporary restraining order, a civil action may be brought with respect to the plan's failure to meet any requirement of this section only if the plan fails to correct its failure within the correction period described in section 3(33)(D). The other provisions of part 5 (except sections 501(a), 503, 512, 514, and 515) shall apply with respect to the enforcement and administration of this section.*

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

(1) **IN GENERAL.**—*Except as otherwise provided in this section, any term used in this section which is defined in any provision of this title shall have the definition provided such term by such provision.*

(2) **SEMINARY STUDENTS.**—*Seminary students who are enrolled in an institution of higher learning described in section 3(33)(C)(iv) and who are treated as participants under the terms of a church plan to which this section applies shall be deemed to be employees as defined in section 3(6) if the number of such students constitutes an insignificant portion of the total number of individuals who are treated as participants under the terms of the plan.*

SEC. 811. DEFINITIONS AND RULES OF CONSTRUCTION.

(a) **DEFINITIONS.**—*For purposes of this part—*

(1) **GROUP HEALTH PLAN.**—*The term “group health plan” has the meaning provided in section 733(a)(1).*

(2) *MEDICAL CARE.*—The term “medical care” has the meaning provided in section 733(a)(2).

(3) *HEALTH INSURANCE COVERAGE.*—The term “health insurance coverage” has the meaning provided in section 733(b)(1).

(4) *HEALTH INSURANCE ISSUER.*—The term “health insurance issuer” has the meaning provided in section 733(b)(2).

(5) *HEALTH STATUS-RELATED FACTOR.*—The term “health status-related factor” has the meaning provided in section 733(d)(2).

(6) *INDIVIDUAL MARKET.*—

(A) *IN GENERAL.*—The term “individual market” means the market for health insurance coverage offered to individuals other than in connection with a group health plan.

(B) *TREATMENT OF VERY SMALL GROUPS.*—

(i) *IN GENERAL.*—Subject to clause (ii), such term includes coverage offered in connection with a group health plan that has fewer than 2 participants as current employees or participants described in section 732(d)(3) on the first day of the plan year.

(ii) *STATE EXCEPTION.*—Clause (i) shall not apply in the case of health insurance coverage offered in a State if such State regulates the coverage described in such clause in the same manner and to the same extent as coverage in the small group market (as defined in section 2791(e)(5) of the Public Health Service Act) is regulated by such State.

(7) *PARTICIPATING EMPLOYER.*—The term “participating employer” means, in connection with an association health plan, any employer, if any individual who is an employee of such employer, a partner in such employer, or a self-employed individual who is such employer (or any dependent, as defined under the terms of the plan, of such individual) is or was covered under such plan in connection with the status of such individual as such an employee, partner, or self-employed individual in relation to the plan.

(8) *APPLICABLE STATE AUTHORITY.*—The term “applicable State authority” means, with respect to a health insurance issuer in a State, the State insurance commissioner or official or officials designated by the State to enforce the requirements of title XXVII of the Public Health Service Act for the State involved with respect to such issuer.

(9) *QUALIFIED ACTUARY.*—The term “qualified actuary” means an individual who is a member of the American Academy of Actuaries or meets such reasonable standards and qualifications as the Secretary may provide by regulation.

(10) *AFFILIATED MEMBER.*—The term “affiliated member” means, in connection with a sponsor, a person eligible to be a member of the sponsor or, in the case of a sponsor with member associations, a person who is a member, or is eligible to be a member, of a member association.

(b) *RULES OF CONSTRUCTION.*—

(1) *EMPLOYERS AND EMPLOYEES.*—For purposes of determining whether a plan, fund, or program is an employee welfare benefit plan which is an association health plan, and for pur-

poses of applying this title in connection with such plan, fund, or program so determined to be such an employee welfare benefit plan—

(A) in the case of a partnership, the term “employer” (as defined in section 3(5)) includes the partnership in relation to the partners, and the term “employee” (as defined in section 3(6)) includes any partner in relation to the partnership, and

(B) in the case of a self-employed individual, the term “employer” (as defined in section 3(5)) and the term “employee” (as defined in section 3(6)) shall include such individual.

(2) PLANS, FUNDS, AND PROGRAMS TREATED AS EMPLOYEE WELFARE BENEFIT PLANS.—In the case of any plan, fund, or program which was established or is maintained for the purpose of providing medical care (through the purchase of insurance or otherwise) for employees (or their dependents) covered thereunder and which demonstrates to the Secretary that all requirements for certification under this part would be met with respect to such plan, fund, or program if such plan, fund, or program were a group health plan, such plan, fund, or program shall be treated for purposes of this title as an employee welfare benefit plan on and after the date of such demonstration.

HOUSE OF REPRESENTATIVES,
COMMITTEE ON GOVERNMENT REFORM AND OVERSIGHT,
Washington, DC, June 13, 1997.

Hon. JOHN R. KASICH,
Chairman, Committee on the Budget,
Washington, DC.

DEAR MR. CHAIRMAN: Pursuant to the reconciliation instructions of H. Con. Res. 84, the Concurrent Resolution on the Budget, I am pleased to transmit the recommendations of the Government Reform and Oversight Committee for inclusion of the 1997 Reconciliation bill.

Our package includes the federal civil service retirement reform proposals, as well as the proposal to eliminate transition payments to the U.S. Postal Service, as included in the fiscal year 1997 Budget Resolution.

With best regards,
Sincerely,

DAN BURTON, *Chairman.*

I. PURPOSE AND SUMMARY

Pursuant to the reconciliation instructions of H. Con. Res. 84, the Concurrent Resolution on the Budget, committees are required to achieve their reconciliation targets through changes in programs that reduce direct spending. Direct spending is defined as budget authority provided by law other than appropriations acts, entitlement authority, and the Food Stamp program. The Committee on Government Reform and Oversight is directed to meet a deficit reduction amount that theoretically can be met through legislation reducing direct spending or increasing revenue. All reconciled committees are required to meet targets for fiscal year 1998 and 2002, and for the total for fiscal years 1998 through 2002. The following report language and legislative text represents the Committee on Government Reform and Oversight's official submission to the Budget Committee to comply with the reconciliation guidelines as provided by the Committee on the Budget.

II. BACKGROUND AND NEED FOR THE LEGISLATION

The Committee on the Budget approved a reconciliation resolution for fiscal year 1997 in the course of which it assigned the Committee on Government Reform and Oversight a target of \$4.9 billion in savings over 5 years in Federal retirement programs. These savings, according to the Budget agreement reached between the President and the Congressional leadership, would be achieved by: (1) increasing the payment that agencies make to the Civil Service Retirement and Disability Fund (CSRDF) for their employees enrolled in the Civil Service Retirement System (CSRS); (2) by in-

creasing the payroll deductions from civilian employees in Federal retirement systems; and (3) shifting to the Postal Service the cost of financing workers compensation benefits for pre-1971 postal employees. The following table reflects the proposed increases and their scheduled effective dates.

BUDGET RESOLUTION PROPOSAL
[Savings attributed, dollars in billions]

	1998	1999	2000	2001	2002	Total
Agency Increase (1.51%) (CSRS Only)	\$0.597	\$0.591	\$0.586	\$0.582	\$0.577	\$2.933
CSRS & FERS Increase Employee Deduction (Incl. postal employees)	0	0.25%	0.15%	0.10%	0	0
	0	\$0.214	\$0.423	\$0.571	\$0.621	\$1.829
FECA reimbursement to Postal Service	\$0.035	\$0.034	\$0.033	\$0.032	\$0.031	\$0.165
Total Savings						\$4.927

Savings data reflect scoring by Congressional Budget Office.

III. LEGISLATIVE HEARINGS AND COMMITTEE ACTION

Neither the Subcommittee on the Postal Service nor the Subcommittee on Civil Service held hearings in the 105th Congress on the Budget Reconciliation targets for the items within their jurisdiction. However, both subcommittees produced and marked up legislation which was considered by the full Committee on Government Reform and Oversight on June 11, 1997.

On June 5, 1997, the Subcommittee on the Postal Service approved its legislative language that conforms to the 1997 Budget Resolution target of \$165 million in savings by shifting to the Postal Service the cost of financing workers compensation benefits for pre-1971 postal employees. No amendments were offered. The subject of this proposal is substantially similar to H.R. 1826, introduced in the 104th Congress by Subcommittee Chairman John M. McHugh, and acted on favorably by both the Subcommittee on the Postal Service and the Committee.

On June 10, 1997, the Subcommittee on the Civil Service favorably passed legislative language that conforms to the 1997 Budget Resolution target of \$4.762 billion in savings by increasing the payment that agencies make to the Civil Service Retirement and Disability Fund (CSRDF) for their employees enrolled in the Civil Service Retirement System (CSRS) and by increasing the payroll deductions from civilian employees in Federal retirement systems.

An amendment to address a shortcoming in the budget reconciliation instructions was offered by Representative Pete Sessions of the Civil Service Subcommittee, but failed. Rep. Sessions argued that the approach put forward in the 1997 Budget Resolution forces Postal Employees and employees who contribute to the Federal Employee Retirement System (FERS), to subsidize the retirement benefits of other Federal employees. Both the Postal Service and its employees and the employees in the FERS currently pay the full or "normal cost" of their retirement. The Sessions amendment was an attempt to rectify this problem by having Civil Service Retirement System employees and employers to properly pay for their retirement benefits by contributing additional funds to fully fund the outstanding liabilities of the Civil Service Retirement System. Let-

ters indicating support for this amendment from the postal community are provided in the Appendix.

On June 11, 1997, the full Committee on Government Reform and Oversight favorably considered the legislative language which had passed the Subcommittee on the Postal Service and the Subcommittee on Civil Service, bringing the Committee in full compliance with its Budget Reconciliation target of \$4.927 billion over 5 years. An amendment to establish a permanent formula for calculating the Government's share of subscription charges (i.e., premiums) for the Federal Employee Health Benefits Program was offered by Rep. Connie Morella, and accepted.

IV. OVERSIGHT FINDINGS

A. POSTAL SERVICE SUBCOMMITTEE

Under House Concurrent Resolution 84 which establishes the congressional budget for the United States Government for fiscal years, 1998–2002, the Committee on Government Reform and Oversight was instructed to generate total savings in mandatory spending of \$165 million by fiscal year 2002 from programs within the jurisdiction of the Subcommittee on the Postal Service. To achieve this reduction in mandatory spending, the Subcommittee recommended the repeal of the Transitional Appropriation paid to the U.S. Postal Service. This action will produce on-budget savings of \$35 million in 1998; \$34 million in 1999; \$33 million in 2000; \$32 million in 2001, and \$31 million in 2002.

5 U.S.C. § 8147 established an account within the U.S. Treasury, the Employee Compensation Fund, to pay worker's compensation and other benefit claims of Federal Government employees. Upon enactment of the Postal Reorganization Act of 1970, P.L. 91–375 (the Act), a method was implemented for the U.S. Postal Service to reimburse the fund for the claims of its employees.

The Act, however, provided that such liabilities of the former Post Office Department were not the liabilities of the U.S. Postal Service. Since its inception, the U.S. Postal Service has requested an annual appropriation pursuant to 39 U.S.C. § 2004 to reimburse its contributions to the Employee Compensation Fund and offset the accrued annual leave benefits of former Post Office Department employees. The intent of Congress was to protect the U.S. Postal Service from the financial liabilities of the former Post Office Department.

Prior to 1981, appropriation requests for Transitional Appropriations were approved on an annual basis. However, the Omnibus Budget Reconciliation Act of 1981, P.L. 97–35, deferred funding for most of the 1980's, except for fiscal year 1985. For fiscal year 1985, appropriations reimbursed the U.S. Postal Service for the deferred liabilities of fiscal years 1982, 1983, and 1984 (P.L. 98–473). That Act also halted the appropriation to the U.S. Postal Service for the accrued annual leave liabilities of former Post Office Department employees. Since that time, the Transitional Appropriation request of the U.S. Postal Service has reflected only liabilities to the Employee Compensation Fund. Except for a \$1,000 appropriation in fiscal year 1988, no Transitional Appropriations were provided to the U.S. Postal Service during the fiscal years 1986 through 1989.

From the introduction of the Postal Reorganization Act of 1970 and throughout its consideration, Congress intended for the U.S. Postal Service to be self-financing and self-sustaining. Indeed, many amendments passed by Congress in recent years have moved the U.S. Postal Service towards that goal, beginning with the removal of the U.S. Postal Service from the Federal budget with the enactment of the Omnibus Budget Reconciliation Act of 1989, P.L. 101-239.

The Committee recognizes the progress the U.S. Postal Service has made in the twenty-seven years following enactment of the Postal Reorganization Act. The Postal Service has evolved from a taxpayer-subsidized executive branch department to a ratepayer-financed government corporation receiving less annual appropriation each year. Additionally, the U.S. Postal Service has reported approximately \$3.5 billion in surplus revenues during the past two fiscal years.

This fiscal surplus contrasts with the budget of the U.S. Government. Elimination of the authorization of the Transitional Appropriation assists the Federal Government in balancing its budget and is consistent with the intent of Congress that the U.S. Postal Service be financially self-sufficient as envisioned in the passage of the Postal Reorganization Act of 1970.

Adoption of this provision should have no measurable impact on postal finances, delivery and service. Legislative history of the Transitional Appropriation shows that Congress has routinely denied the U.S. Postal Service's request for reimbursement of these expenses during the past decade. Transitional Appropriations are estimated to be less than one percent of estimated operating expenses of the Postal Service. Furthermore, the Postal Service incurs workers' compensation costs in excess of \$500 million annually for current employees. The addition of this small increased liability to that amount should not affect the overall fiscal stability of the Postal Service or its operations and service.

The Committee recognizes that deficit reduction is not painless and commitments of taxpayer money made by previous Congresses may need to be modified to reflect current fiscal concerns. The obligation of this legislation is not unfairly burdensome nor inconsistent with past actions. Enactment of this measure will not alter the level of benefits paid to beneficiaries of the fund. It will consolidate and streamline a bifurcated workers' compensation financing system that will be funded by ratepayer revenues rather than taxpayer subsidies. The Committee, therefore, finds no compelling reason to continue authorization of the transitional appropriations and believes that repeal of authorization of transitional appropriation for the Postal Service will advance efforts to reduce the nation's deficit and further promote financial self-sufficiency for the Postal Service.

B. CIVIL SERVICE SUBCOMMITTEE

The Committee on the Budget approved a reconciliation resolution for fiscal year 1997 in the course of which it assigned the Committee on Government Reform and Oversight a target of \$4.762 billion in savings over 5 years to be achieved by (1) increasing the payment that agencies make to the Civil Service Retirement and

Disability Fund (CSRDF) for their employees enrolled in the Civil Service Retirement System (CSRS); and (2) by increasing the payroll deductions from civilian employees in Federal retirement systems.

Agency payments incorporated into the budget resolution would increase 1.51 percent in FY 1998, and the same payment would be sustained throughout the five years of this budget cycle. This rate increase yields diminishing additional revenues each year because enrollment in the CSRS was closed effective January 1, 1984. As a result, CSRS employees are leaving Federal service (usually through retirement) and not being replaced in this retirement system.

This proposal appears to provide equal treatment by reaching to all categories of civil servants and applying the same increase in payroll deduction rates to all employees. The proposal, however, contains inherent inequities because of the different payment levels incorporated into Federal employee retirement programs during the past twenty-eight years. This is particularly true for employees of the U.S. Postal Service.

Full normal costing

The actuarial principle that governs most standards for payments into retirement systems is the concept that funds set aside today to pay for future benefits should reflect the future cost of providing the benefits earned by employees. When an amount equal to those benefits is set aside, the "full normal cost" of retirement is paid. Any funding above the "full normal cost" level reflects an "overfunding," while any shortfall would be described as an "underfunding," creating an "unfunded liability." Although the Office of Personnel Management has reported an aggregate unfunded liability for the CSRDF of \$540.7 billion as of FY 95, that liability is entirely attributable to the CSRS rather than to employees enrolled in the Federal Employees Retirement System (FERS).

FERS is fully funded in the sense that the combination of employee and agency contributions must equal the normal cost of the retirement benefit. Sections 8422 and 8423 of title 5, United States Code, define the cost sharing of the FERS benefit between the agency and the employee. For most employees, the employee share is determined by subtracting the Social Security (OASDI) rate (currently 6.2 percent) from 7 percent of basic pay, yielding a current rate of 0.8 percent. For Members of Congress, law enforcement officers, firefighters, air traffic controllers, and congressional employees, the Social Security rate is subtracted from 7.5% of basic pay, leaving a current rate of 1.3 percent.

The current normal cost of FERS is 12.2 percent of payroll for most employees. The employer is responsible for the 11.4 percent difference between the employee's 0.8 percent and the normal cost. (In April, the Office of Personnel Management announced that, because of changes in economic assumptions, the normal cost of FERS will drop from 12.2 percent to 11.5 percent, effective October 1, 1997.) Separate normal cost determinations are made for Members of Congress and certain other employees.

The CSRS cost sharing formulas are defined differently. For most CSRS employees, 7 percent of basic pay is deducted as their share

of the cost of the benefit. (Law enforcement officers, firefighters, and congressional employees contribute 7.5 percent of basic pay, while Members and certain Article I judges contribute 8 percent.) These amounts are set in statute, and the employer contributes a matching amount. The CSRS normal cost, however, is currently 25.14 percent of payroll. Thus, the matching employee and employer contributions does not fully fund the CSRS benefit. The additional shortfall, generally 11.14 percent of payroll, must be made up by additional transfers from the Treasury.

The Postal Service pays full normal cost for CSRS and FERS

The Postal Service, however, already pays the full normal cost of its employees' retirement benefits. Since the Postal Reorganization Act of 1970, postal employees' retirement payments have been the same as other federal employees. Since 1974, however, Congress has required the Postal Service to pay the 11.14 percent of payroll costs (above and beyond employees' deductions and the agency's matching contribution) necessary to pay the full normal costs of CSRS retirement. The attached Table 1¹ outlines the series of legislative actions through which these payments have been required and, documents the \$37.5 billion additional costs of employees' benefits that have been borne by the Postal Service since 1974. As CRS reports, "[T]he USPS fully funds the CSRS benefits for postal employees by paying the cost of retirement benefits attributable to pay raises and retiree COLAs.² CRS also reports, "For both postal workers and nonpostal federal employees, FERS is fully funded by the combination of employee contributions (currently 0.8 percent of pay for most workers) and agency contributions (currently 11.4 percent of pay)."³ In each of the laws cited on this table, the Postal Service has been required to pay, from its revenues, the costs of its employees' benefits, including unfunded liabilities of CSRS retirement costs. These payments include a revolving series of 15-year payments to the CSRDF. CRS concludes, "The effect of the various laws that have required the USPS to pay the total cost of CSRS benefits for postal workers is that, unlike the CSRS for nonpostal federal workers, there are no unfunded postal CSRS liabilities."⁴

TABLE 1. LAWS TRANSFERRING PENSION AND HEALTH INSURANCE COSTS TO THE USPS
[In millions of dollars]

Laws	FY 1990 and be- fore	Fiscal years—						Total
		1991	1992	1993	1994	1995	1996	
P.L. 93-349 CSRS	15,406	1,775	1,896	1,938	1,996	2,134	2,362	27,507
OBRA '85 FEHB	329							329
OBRA '87 FEHB	430							430
OBRA '87 CSRS	350							350
OBRA '89 CSRS, COLAs	74							74
OBRA '90 FEHB		328	380	510	519	523	497	2,757
OBRA '90 CSRS, COLAs		421	491	551	620	689	750	3,522

¹"Table 1. Laws Transferring Pension and Health Insurance Costs to the USPS," is from a Congressional Research Service Memorandum, "United States Postal Service Employee Benefit Costs," page CRS-6 (May 30, 1997).

²Page CRS-2.

³Page CRS-2.

⁴Page CRS-7.

TABLE 1. LAWS TRANSFERRING PENSION AND HEALTH INSURANCE COSTS TO THE USPS—
Continued
(In millions of dollars)

Laws	FY 1990 and be- fore	Fiscal years—						Total
		1991	1992	1993	1994	1995	1996	
OBRA '90 prior year COLAs and FEHB		272	313	378	472	705	.....	2,140
OBRA '93 ¹							347	347
Total	16,589	2,796	3,080	3,377	3,607	4,051	3,956	37,456

¹ The payments required by OBRA of 1993 are \$347 million in 1996, 1997, and 1998 for a total of \$1.041 billion over those three years.

Source: Comprehensive Statement on Postal Operations, p. 62.

As proposed by the Budget Committee, additional payments to the CSRDF by postal employees would result in employees from the USPS paying more than normal cost for their retirement benefits in both the FERS and CSRS systems.

Furthermore, the Budget Committee proposes that non-postal agency payments into FERS not be reduced to offset the increased employee contributions. This would create an inequity of FERS employees paying more than the actual cost of their retirement benefits, in effect subsidizing the benefits of CSRS employees. To correct this inequity, the agency's contribution must be allowed to decrease in order to offset the higher individual contributions. In that way, the principle of normal cost is maintained.

Differences in cost benefits and payroll deductions

Congress recognized the funding problems of the CSRS when it closed enrollment in that system effective January 1, 1984 and when it created FERS in 1987. Where CSRS had provided a single benefit, based on a 7 percent deduction from employees' pay and matching agency payments, FERS combined Social Security benefits, a defined benefit component (derived from the FERS payment), and a defined contribution component that would be derived from employees' contributions and matching agency payments to Thrift Savings Plan accounts.

When FERS was established, the projected growth of unfunded liabilities in CSRS had become unsustainable. From its creation in 1920 through 1969, the payroll deduction that supported the CSRS benefit was increased on average every 6 years, from 2.5 percent at the start to the 7 percent level that has been in place since 1969. The agency and employee deductions for CSRS have remained constant at 7 percent despite a period in the 1970s when the unfunded liability grew at a very rapid rate.

In contrast, since 1969, Social Security taxes have been increased steadily to provide additional funding for the benefits that are promised under the programs. In 1969, Social Security collected a 4.2 percent payroll tax to support Old Age, Survivors, and Disability Insurance and 0.6 percent to support Health Insurance (Medicare and Medicaid) on an earnings base of up to \$7,800. Since 1969, Congress has periodically increased both the payroll deductions (currently 6.2 percent OASDI and 1.45 percent HI) and the earnings base (currently \$65,400), as reflected in the attached table. Thus, while Congress required others, including FERS em-

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employees to contribute more in order to increase cash flows. CSRS contributions have remained frozen.

APPENDIX A. SOCIAL SECURITY FINANCING SCHEDULE FOR CALENDAR YEARS 1935-1997

Act of—	Calendar years	Earnings base		Tax rate (percent), employer and employee, each		Maximum employee tax	Tax rate (percent), self-employed		Maximum self-employment tax
		OASDI	HI	OASDI	HI		OASDI	HI		Total
1935-1947	1937-49	\$3,000	1.0	1.0	1.0	\$30.00			
1947	1950	3,000	1.5	1.5	1.5	45.00			
1950	1951-53	3,600	1.5	1.5	1.5	54.00	2.25	2.25	\$81.00
	1954	3,600	2.0	2.0	2.0	72.00	3.0	3.0	108.00
1954	1955-56	4,200	2.0	2.0	2.0	84.00	3.0	3.0	126.00
1956	1957-58	4,200	2.25	2.25	2.25	94.50	3.375	3.375	141.75
1958	1959	4,800	2.5	2.5	2.5	120.00	3.75	3.75	180.00
1961	1960-61	4,800	3.0	3.0	3.0	144.00	4.5	4.5	216.00
	1962	4,800	3.125	3.125	3.125	150.00	4.7	4.7	225.60
	1963-65	4,800	3.625	3.625	3.625	174.00	5.4	5.4	259.20
1965	1966	6,600	3.85	0.35	4.2	277.20	5.8	0.35	405.90
	1967	6,600	3.9	.5	4.4	290.40	5.9	.5	422.40
1967	1968	7,800	3.8	.6	4.4	343.20	5.8	.6	499.20
	1969	7,800	4.2	.6	4.8	374.40	6.3	.6	538.20
1969	1970	7,800	4.2	.6	4.8	374.40	6.3	.6	538.20
	1971	7,800	4.6	.6	5.2	405.60	6.9	.6	585.00
1971	1972	9,000	4.6	.6	5.2	468.00	6.9	.6	675.00
1972	1973	10,800	4.85	1.0	5.85	631.80	7.0	1.0	874.00
1973	1974	13,200	4.95	.9	5.85	772.20	7.0	.9	1,042.00
	1975	14,100	4.95	.9	5.85	824.85	7.0	.9	1,113.90
1976	1976	15,300	4.95	.9	5.85	895.05	7.0	.9	1,208.70
1977	1977	16,500	4.95	.9	5.85	965.25	7.0	.9	1,303.50
	1978	17,700	5.05	1.0	6.05	1,070.85	7.1	1.0	1,433.70
1979	1979	22,900	5.08	1.05	6.13	1,403.77	7.05	1.05	1,854.90
1980	1980	25,900	5.08	1.05	6.13	1,587.67	7.05	1.05	2,097.90
1981	1981	29,700	5.35	1.3	6.65	1,975.05	8.00	1.3	2,762.10
1982	1982	32,400	5.40	1.3	6.70	2,170.80	8.05	1.3	3,029.40
1983	1983	35,700	5.40	1.3	6.70	2,391.90	8.05	1.3	3,337.95
1984	1984	37,800	5.70	1.3	7.00	2,532.60	11.4	2.6	4,271.40
1985	1985	39,600	5.70	1.35	7.05	2,791.80	11.4	2.7	4,672.80
1986	1986	42,000	5.70	1.45	7.15	3,003.00	11.4	2.9	5,166.00
1987	1987	42,800	5.70	1.45	7.15	3,131.70	11.4	2.9	5,387.40
1988	1988	45,000	6.06	1.45	7.51	3,379.50	12.12	2.9	5,859.00
1989	1989	48,000	6.06	1.45	7.51	3,604.80	12.12	2.9	6,249.60

APPENDIX A. SOCIAL SECURITY FINANCING SCHEDULE FOR CALENDAR YEARS 1935-1997—Continued

Act of—	Calendar years	Earnings base	Tax rate (percent), employer and employee, each		Maximum employee tax		Tax rate (percent), self-employed		Maximum self-employment tax
			OASDI	HI	OASDI	HI	OASDI	HI		Total	Total
	1990	51,300	6.2	1.45	2,924.45	7.65	12.4	2.9	6,553.83
	1991	53,400	6.2	1.45	5,123.30	7.65	12.4	2.9	8,658.38
	1992	55,500	6.2	1.45	5,328.90	7.65	12.4	2.9	9,005.84
	1993	57,600	6.2	1.45	5,528.70	7.65	12.4	2.9	9,343.50
	1994	60,600	6.2	1.45	.....	7.65	12.4	2.9	.....
	1995	61,200	6.2	1.45	.....	7.65	12.4	2.9	.....
	1996	62,700	6.2	1.45	.....	7.65	12.4	2.9	.....
	1997	65,400	6.2	1.45	.....	7.65	12.4	2.9	.....

Source: "Summary of Major Changes in the Social Security Cash Benefits Program: 1935-1996." CRS (December 20, 1996).

V. EXPLANATION OF THE LEGISLATION

OVERVIEW

A. POSTAL SERVICE SUBTITLE

The bill eliminates the authorization for appropriation to the U.S. Postal Service for reimbursement for workers' compensation liabilities incurred by the former Post Office Department. The elimination of this funding will result in the Postal Service assuming the liabilities for this payment to the Employee Compensation Fund, within the Department of Labor, providing payments made to employees of the former Post Office Department.

Under the existing framework, the Department of Labor assesses the U.S. Postal Service for claims to both its employees and those of the former Post Office Department. The U.S. Postal Service pays for its own employees and requests funding from Congress for the amount attributable to former Post Office Department employees.

The legislation removes the Federal Government and Congress from the process and directs that employees of the former Post Office Department be treated the same as the current employees of the U.S. Postal Service for purposes of the Employee Compensation Fund.

B. CIVIL SERVICE SUBTITLE

The Committee on the Budget has approved a reconciliation resolution for the current fiscal year in the course of which it assigned the Committee on Government Reform and Oversight a target of \$4.762 billion in savings from the Federal retirement system. These savings, according to the Budget agreement reached between the President and the Congressional leadership, would be achieved by increasing the payment that agencies make to the Civil Service Retirement and Disability Fund (CSRDF) for their employees enrolled in the Civil Service Retirement System (CSRS) and by increasing the payroll deductions from civilian employees (including Postal Service employees) enrolled in CSRS and the Federal Employees' Retirement System (FERS).

An amendment offered by Rep. Connie Morella amends 5 U.S.C. § 8906 to establish a permanent formula for calculating the Government's share of subscription charges for the Federal Employees Health Benefits Program (FEHBP). The amendment requires the Office of Personnel Management (the Office) to determine, not later than October 1 of each year, the weighted average of the subscription charges that will be in effect during the following contract year by weighting the subscription charges of each option of each plan by the actual distribution of enrollments stated in the enrollment report as of March 31 of the year in which the determination is being made. The committee intends that the Office continue to produce and make publicly available the enrollment reports at least semi-annually.

It is intended that the enrollment used in weighting include all individuals who are eligible to receive a contribution, including active Postal Service employees, in participating plans that will be continuing in the FEHBP during the contract year to which the weighted average applies. In making what should be a straight-

forward arithmetic calculation, the Office is not authorized to assume or estimate future enrollments. Finally the Committee intends that actions that the Office may deem necessary to take before the first day of the contract year that begins in 1999 to ensure the timely implementation of this amendment be restricted to routine ministerial activities; no additional regulatory flexibility nor policy discretion is intended by this amendment.

SECTION-BY-SECTION

A. SUBTITLE A—POSTAL SERVICE

Section 6001. Repeal of authorization of transitional appropriations for the United States Postal Service

This section repeals Section 2004, of Title 39 United States Code and makes technical and conforming amendments. In particular, the section clarifies that liabilities of the former Post Office Department to the Employees' Compensation Fund (appropriations that were authorized by former section 2004) shall be liabilities payable out of the Fund. This section and the amendments made by this section indicate that changes shall take effect on the date of enactment of the Act or October 1, 1997, whichever is later. It also states that no payments may be made to the Postal Service Fund on or after the date of enactment pursuant to section 2004 of title 39 United States Code. If any payment to the Postal Service Fund is or has been made pursuant to an appropriation for fiscal year 1998 authorized by section 2004, then, an amount equal to the amount of the payment shall be paid from the Fund into the Treasury as miscellaneous receipts before October 1, 1998.

B. SUBTITLE B—CIVIL SERVICE

Section 6101. Contributions under the Civil Service Retirement System

This section amends 5 U.S.C. § 8334 to increase individual and Government retirement contributions under the Civil Service Retirement System. Subsection (a) gradually raises individual contributions by .5 percent of basic pay between January 1, 1999 through December 31, 2002. Individual contributions are increased by .25 percent on January 1, 1999, .15 percent on January 1, 2000, and .10 percent on January 1, 2001. The amounts required for deposits covering military or volunteer service during that period are also increased by a corresponding amount. Subsection (b) requires Government employers (other than the United States Postal Service) to contribute an additional 1.51 percent of basic pay of CSRS employees for the period between October 1, 1997 through December 31, 2002.

Section 6102. Contributions under the Federal Employees Retirement System

This section amends 5 U.S.C. §§ 8422 and 8423 to increase individual retirement contributions under the Federal employees Retirement System and to prevent offsetting decreases in Government contributions. Subsection (a) gradually raises individual contributions by .5 percent of basic pay between January 1, 1999 through

December 31, 2002. Individual contributions are increased by .25 percent on January 1, 1999, .15 percent on January 1, 2000, and .10 percent on January 1, 2001. The amounts required for deposits covering military or volunteer service during that period are also increased by a corresponding amount. Subsection (b) prevents the government contributions from declining as a result of the increased individual contributions required under subsection (a).

Section 6103. Government contribution for health benefits

This section amends 5 U.S.C. §8906 to revise the formula for computing the Government's share of premiums under the Federal Employees Health Benefits Program (FEHBP). Subsection (a) provides a new formula for determining the Government's share. Under the revised formula, not later than October 1 of each year, the Office of Personnel Management (Office) shall compute the weighted average of premiums that will be in effect during the following contract year with respect to self alone and self and family policies. The weight given to the premium for each plan (and option) shall be commensurate with the number of enrollees in such plan (and option) entitled to a Government contribution as of March 31 of the year in which the determination is being made. Subsection (b) provides that this formula shall take effect on the first day of the contract year beginning in 1999. However, before that date the Office may take any steps necessary to ensure the timely implementation of the revised formula.

Section 6104. Effective date

Except for section 6103, this subtitle shall take effect on the later of October 1, 1997 or the date of enactment. If the date of enactment is after October 1, 1997, references in this subtitle to October 1, 1997 and September 30, 1997 shall be treated as referring, respectively, to the date of enactment and the day before the date of enactment.

VI. COMPLIANCE WITH RULE XI

Pursuant to rule XI, clause 2(1)(3)(A) of the Rules of the House of Representatives, under the authority of rule X, clause 2(b)(1) and clause 3(f), the results and findings from Committee oversight activities are incorporated in the legislation and this report.

VII. STATEMENT OF CBO COST ESTIMATE

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, June 16, 1997.

Hon. DAN BURTON,
*Chairman, Committee on Government Reform and Oversight, U.S.
House of Representatives, Washington, DC.*

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the enclosed cost estimate for the reconciliation recommendations of the House Committee on Government Reform and Oversight.

The estimate shows the budgetary effects of the committee's proposals over the 1998–2007 period. CBO understands that the Com-

mittee on the Budget will be responsible for interpreting how these proposals compare with the reconciliation instructions in the budget resolution. The estimate assumes that the reconciliation bill will be enacted by August 15; the estimate could change if the bill is enacted later.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contact is Paul Cullinan.

Sincerely,

PAUL VAN DE WATER,
(for June E. O'Neill).

Enclosure.

Reconciliation recommendations of the House Committee on Government Reform and Oversight (Title VI)

Summary: Title VI would make a number of changes affecting the retirement and health insurance programs for federal employees and annuitants. It would also end a payment currently required from the Treasury to the United States Postal Service. In total, these provisions would reduce on-budget direct spending by \$3.0 billion, increase off-budget outlays by \$44 million, and increase federal revenues by \$1.8 billion over the 1998–2002 period. Part of these savings would result from increasing the amount of retirement costs charged to agency appropriations by a total of \$2.8 billion over the 1998–2002 period.

This title contains no intergovernmental mandates as defined in the Unfunded Mandates Reform Act of 1995 (UMRA) and would impose no costs on state, local, and tribal governments. By increasing contributions required of federal employees to the civilian retirement system, the legislation would impose a private-sector mandate with a cost exceeding the statutory threshold.

Estimated cost to the Federal Government: The estimated impact of the reconciliation recommendations of the House Committee on Government Reform and Oversight on direct spending and revenues through 2002 is shown in the following table. Tables in the basis of estimate provide more detail on the various subtitles, and the appendix table displays the budgetary effects through 2007.

The outlays impacts of changes proposed in Title VI fall in budget functions 370 (commerce and housing credit), 550 (health), and 950 (undistributed offsetting receipts).

ESTIMATED EFFECTS OF THE RECONCILIATION RECOMMENDATIONS OF THE HOUSE COMMITTEE ON GOVERNMENT REFORM AND OVERSIGHT ON DIRECT SPENDING AND REVENUES

[By fiscal year, in millions of dollars]

	1997	1998	1999	2000	2001	2002
DIRECT SPENDING						
Proposed Changes:						
Repeal of Transitional Appropriation for the U.S. Postal Service						
On-Budget	0	-35	-34	-33	-32	-31
Off-Budget	0	35	9	0	0	0
Total Budget	0	0	-25	-33	-32	-31
Increase CSRS Agency Contributions by						
1.51 percent beginning October 1997	0	-597	-580	-563	-548	-533

ESTIMATED EFFECTS OF THE RECONCILIATION RECOMMENDATIONS OF THE HOUSE COMMITTEE ON GOVERNMENT REFORM AND OVERSIGHT ON DIRECT SPENDING AND REVENUES—Continued

[By fiscal year, in millions of dollars]

	1997	1998	1999	2000	2001	2002
Modify Government Contributions under FEHB	0	0	-5	-7	-7	-8
Total Proposed Changes:						
On-Budget	0	-632	-619	-603	-587	-572
Off-Budget	0	35	9	0	0	0
Total Budget	0	-597	-610	-603	-587	-572
REVENUES						
Increase Employee Contributions to CSRS and FERS by 0.25 percent in January 1999, an additional 0.15 percent in January 2000, and another 0.1 percent in January 2001	0	0	208	413	551	598

Note: Components may not add to totals because of rounding.

Basis of Estimate:

Subtitle A, Postal Service

Postal Service Transitional Payments.—Under current law, the United States Postal Service (USPS) receives a mandatory appropriation for compensation to individuals who sustained injuries while employed by the former Post Office Department. This legislation would terminate this annual payment, effective October 1, 1997.

ESTIMATED BUDGETARY EFFECTS OF SUBTITLE A, POSTAL SERVICE

[By fiscal year, in millions of dollars]

	1997	1998	1999	2000	2001	2002
DIRECT SPENDING						
Spending Under Current Law:						
Postal Service						
On-Budget	36	35	34	33	32	31
Off-Budget	1,380	2,654	-964	-1,262	-532	224
Total Budget	1,416	2,689	-930	-1,229	-500	255
Proposed Changes:						
Repeal of Transitional Appropriation for the U.S.						
Postal Service						
On-Budget	0	-35	-34	-33	-32	-31
Off-Budget	0	35	9	0	0	0
Total Budget	0	0	-25	-33	-32	-31
Spending Under Proposed Changes:						
Postal Service						
On-Budget	36	0	0	0	0	0
Off-Budget	1,380	2,689	-955	-1,262	-532	224
Total Budget	1,416	2,689	-955	-1,262	-532	224

Note: Components may not add to totals because of rounding.

CBO estimates that enacting this legislation would reduce on-budget direct spending by \$35 million in fiscal year 1998, and that annual savings would decline to \$31 million by fiscal year 2002. But the USPS would have to continue to pay the costs that have been covered by the appropriation out of its own revenues. Thus, this legislation would cost the USPS, an off-budget agency, \$35 million in fiscal year 1998. Consistent with CBO's projections, we expect that the USPS would recover the additional cost of the transitional expenses by raising postal rates, which we assume will occur January 1, 1999. The net budgetary impact, combining on-budget

and off-budget effects, would be zero for fiscal year 1998, savings of \$25 million in 1999, and savings averaging \$32 million annually for fiscal years 2000 through 2002.

Subtitle B, Civil Service

The committee recommends changes in law affecting civilian employees of the federal government as well as enrollees in the Federal Employees Health Benefits (FEHB) program. The changes would affect the contributions made by both the employee and the employing agency for retirement and health benefits.

Employee Contributions for Civilian Retirement.—This legislation would increase contributions by federal employees to the civilian retirement systems. CBO estimates that revenue from additional employee contributions would total \$208 million in 1999 and \$1.8 billion over the 1999–2002 period.

Under current law, most workers covered by the Civil Service Retirement System (CSRS) contribute 7 percent of their basic pay to the retirement trust fund but pay no Social Security taxes. Employees covered by the Federal Employees' Retirement System (FERS) pay 6.2 percent in Social Security taxes (up to the ceiling on Social Security taxable wages) and 0.8 percent to the retirement trust fund. Certain groups of employees contribute slightly more for federal retirement coverage and in turn receive more generous benefits. Law enforcement personnel, firefighters, air traffic controllers, and Congressional employees contribute 7.5 percent of salary to CSRS. Members of Congress and certain judicial officials contribute 8 percent. Employees with special retirement provisions pay an extra 0.5 percent of pay if enrolled in FERS.

The legislation would set the contribution rate at 7.5 percent for all CSRS employees (except Congressional staff, firefighters, and law enforcement personnel, whose contribution rates would rise to 8 percent, and Members of Congress and certain judges and magistrates, whose rates would rise to 8.5 percent). FERS employees would also face the 0.5 percent contribution hike. These increases in contribution rates would be phased in over three years: 0.25 percentage points in January 1999, another 0.15 percentage points in 2000, and 0.1 percentage points in 2001. The contribution rates would remain 0.5 percentage points higher than under current law until the end of calendar year 2002, at which time the rates would return to their current level.

Based on data from the Office of Personnel Management (OPM), CBO estimates that the fiscal year 1997 payroll base covered by CSRS and FERS is \$80 billion for non-postal employees and about \$25 billion for postal employees. This estimate uses CBO's baseline projections of General Schedule pay raises—which run about 3.0 percent annually—to project the payroll base after 1997. CSRS and FERS each currently cover about one-half of federal payroll. CBO estimates that the percentage of total payroll covered by CSRS will decline by 2 to 3 percentage points each year, while the FERS payroll will grow at the same rate.

ESTIMATED BUDGETARY EFFECTS OF THE SUBTITLE B, CIVIL SERVICE

[By fiscal year, in millions of dollars]

	1997	1998	1999	2000	2001	2002
DIRECT SPENDING						
Spending Under Current Law:						
Receipts of Employer Contributions to Civilian Retirement	-16,366	-16,913	-17,160	-17,886	-18,520	-19,368
Federal Employees Health Benefits	3,920	4,165	4,474	4,907	5,256	5,655
Proposed Changes:						
Increase CSRS Agency Contributions by 1.51 percent beginning October 1997	0	-597	-580	-563	-548	-533
Government Contributions under FEHB	0	0	-5	-7	-7	-8
TOTAL PROPOSED CHANGES						
Spending Under Title VI:						
Receipts of Employer Contributions to Civilian Retirement	-16,366	-17,510	-17,740	-18,449	-19,068	-19,901
Federal Employees Health Benefits	3,920	4,165	4,469	4,900	5,249	5,647
REVENUES						
Increase Employee Contributions to CSRS and FERS by 0.25 percent in January 1999, an additional 0.15 percent in January 2000, and another 0.1 percent in January 2001			208	413	551	598

Note: Components may not add to totals because of rounding.

Employing Agency Contributions for Civilian Retirement. Subtitle B would also increase the contribution rates paid by federal agencies on behalf of their employees. CBO estimates that offsetting receipts (collections by the civilian retirement trust funds) would increase by \$597 million in 1998 and \$2.8 billion over the five-year period.

Under CSRS, each federal agency matches the employee contribution of 7.0, 7.5, or 8.0 percent, depending on the type of employee. Under FERS, the employer contributes an amount equal to a percentage of basic pay which when added to the employee contribution, equals the normal cost of FERS. The normal cost is the percentage of an employee's salary required to be contributed each year over the employee's working career to fully finance, with interest, all retirement benefits. The current normal cost for FERS used to determine most agency contributions is 12.2 percent, although this is scheduled to decline to 11.4 percent for most agencies in fiscal year 1998. Because employee contributions cover 0.8 percent of the normal cost most agencies now contribute 11.4 percent of each employee's salary to FERS, but this will fall to 10.6 percent in 1998. Agencies that employ those workers with special retirement provisions, like Congressional employees, Members of Congress, firefighters, and law enforcement personnel, are required to pay a higher percentage of salary to the retirement system, because these personnel have more costly retirement benefits and a greater normal cost.

This legislation would increase matching contributions for CSRS by non-postal agencies by raising the contribution rate by 1.51 percentage points (to 8.51 percent for most employees) from October 1997 through September 2002. Agency contributions are recorded as offsetting receipts of the retirement trust fund. Since CSRS is a closed system (federal employees hired after January 1, 1984, are covered under FERS), CBO expects the increase in contributions to

CSRS to decline each year after 1998. The legislation would maintain agency contributions for FERS at current levels, despite the fact that employee contributions are being increased. Consequently, the FERS program would receive more funding than would be required to ensure that total contributions per employee would be set at normal cost.

Government Contributions to Federal Employee Health Benefits. This portion of the bill modifies the procedure for determining the share of health insurance premiums that the federal government pays on behalf of its employees and retirees. The FEHB program provides health insurance coverage for 4 million workers and annuitants, as well as their 4.6 million dependents and survivors. Only the payments on behalf of annuitants are considered direct spending, because payments for employees are funded out of annual appropriations for the agencies that employ them. In 1997, the FEHB costs for annuitants are estimated to be \$3.9 billion.

The current formula used to calculate the federal share of premiums is based on the cost of five plans currently in the FEHB package and a “phantom” plan that acts as a placeholder for a former plan. The dollar amount of the maximum federal contribution is computed as 60 percent of the average costs of these six plans. However, in no plan can the federal contribution exceed 75 percent of the premium. The law establishing the current formula expires in 1999.

The committee’s recommendations would change the dollar limit on the federal contribution to 72 percent of the weighted average of the premiums of all plans to which federal workers and annuitants subscribe. Effectively, the federal share would be maintained at about its current level, but CBO estimates the new formula would establish a maximum contribution that would be very slightly lower than under the current formula. CBO estimates that the direct spending savings from the provisions would amount to less than \$10 million annually through 2002.

Estimated impact on State, local, and tribal governments: This title contains no intergovernmental mandates as defined in UMRA and would impose no costs on state, local, or tribal governments.

Estimated impact on the private sector: The reconciliation recommendations of the House Committee on Government Reform and Oversight would impose a new private-sector mandate as defined in UMRA by increasing the contributions required of federal employees to the civilian retirement systems. Contributions to the civilian retirement systems, which are compulsory withholdings made by the government, are equivalent to a tax on the wages of federal employees. That equivalence is evidenced by the classification of federal employees’ contributions to the retirement systems as a revenue in the federal budget. Therefore, CBO has determined that the increase in regulated contributions constitutes a new enforceable duty and fits the definition of a private-sector mandate under UMRA.

CBO estimates that the direct costs of the new private-sector mandate in Subtitle B would be \$1.9 billion from January 1999 until January 2003, at which time contribution rates would return to their current level. In effect, the proposed changes in Subtitle B increase taxes on the wages of federal employees starting in Janu-

ary 1999 and then sunset after four years. The table below shows the direct costs of increasing mandatory contributions by federal employees to CSRS and FERS.

	1998	1999	2000	2001	2002	2003	Total
Direct costs of increasing employee contributions to CSRS and FERS by 0.25 percent in Jan. 1999, an additional 0.15 percent in Jan. 2000, and another 0.1 percent in Jan. 2001 ...	0	208	413	551	598	153	1,923

Estimate prepared by: Federal Cost: Paul Cullinan and Jeffrey Lemieux; Impact on State, Local, and Tribal Governments: Theresa Gullo; and Impact on the Private Sector: Matthew Eyles.

Estimate approved by: Robert A. Sunshine, Deputy Assistant Director for Budget Analysis.

APPENDIX TABLE.—ESTIMATED BUDGETARY EFFECTS OF TITLE VI, FISCAL YEARS 1998–2007; RECONCILIATION RECOMMENDATIONS OF HOUSE COMMITTEE ON GOVERNMENTAL REFORM AND OVERSIGHT AS APPROVED ON JUNE 11, 1997

[By fiscal year, in millions of dollars]

	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	1998– 2002	1998– 2007
DIRECT SPENDING													
Proposed Changes:													
Repeal of Transitional Appropriation for the U.S. Postal Service:													
On-Budget	0	-35	-34	-33	-32	-31	-30	-29	-28	-27	-26	-165	-305
Off-Budget	0	35	9	0	0	0	0	0	0	0	0	44	44
Total Budget	0	0	-25	-33	-32	-31	-30	-29	-28	-27	-26	-121	-261
Increase CSRS Agency Contributions by 1.51 percent beg. October 1997													
On-Budget	0	-597	-580	-563	-546	-533	0	0	0	0	0	-2821	-2821
Off-Budget	0	0	-5	-7	-7	-8	-9	-9	-10	-11	-12	-28	-78
Total Budget	0	-632	-619	-603	-587	-572	-39	-38	-38	-38	-38	-3014	-3204
On-Budget	0	35	9	0	0	0	0	0	0	0	0	44	44
Total Budget	0	-597	-810	-603	-587	-572	-39	-38	-38	-38	-38	-2969	-3180
REVENUES													
Increase Employee Contributions to CSRS and FERS by 0.25 percent in Jan. 1999, an additional 0.15 percent in Jan. 2000, and another 0.1 percent in Jan. 2001			208	413	551	598	153	0	0	0	0	1770	1923

Note: Components may not add to totals because of rounding.

VIII. STATEMENT OF CONSTITUTIONAL AUTHORITY

Pursuant to rule XI, clause 2(1)(4) of the Rules of the House of Representatives, the Committee finds that Congress is specifically granted the power to enact this legislation under Article I, Section 8, clause 1 under which Congress is granted the "Power To * * * provide for the * * * general Welfare of the United States[.]"

IX. FEDERAL ADVISORY COMMITTEE ACT (5 U.S.C. APP.), SECTION 5(b)

The Committee finds that section 5(b) of Title 5 App., United States Code, is not applicable because this legislation does not authorize the establishment of any advisory committee.

X. CHANGES IN EXISTING LAW

In compliance with clause 3 of rule XIII of the Rules of the House of Representatives, changes in existing law made by the legislation, as reported, are shown as follows:

CHANGES IN EXISTING LAW MADE BY TITLE IV OF THE BILL, AS REPORTED

In compliance with clause 3 of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

TITLE 39, UNITED STATES CODE

* * * * *

PART III—MODERNIZATION AND FISCAL ADMINISTRATION

* * * * *

CHAPTER 20—FINANCE

Sec.

2001. Definitions.

* * * * *

[2004. Transitional appropriations.]

* * * * *

§ 2003. The Postal Service Fund

(a) * * *

* * * * *

(e)(1) The Fund shall be available for the payment of all expenses incurred by the Postal Service in carrying out its functions as provided by law and, subject to the provisions of section 3604 of this title, all of the expenses of the Postal Rate Commission. The Postmaster General shall transfer from the Fund to the Secretary of the Treasury for deposit in the Department of the Treasury Forfeiture Fund amounts appropriate to reflect the degree of participation

of Department of the Treasury law enforcement organizations (described in section 9703(p) of title 31) in the law enforcement effort resulting in the forfeiture pursuant to laws enforced or administered by the Postal Service. Neither the Fund nor any of the funds credited to it shall be subject to apportionment under the provisions of subchapter II of chapter 15 of title 31.

(2) Funds appropriated to the Postal Service under [sections 2401 and 2004] *section 2401* of this title shall be apportioned as provided in this paragraph. From the total amounts appropriated to the Postal Service for any fiscal year under the authorizations contained in [sections 2401 and 2004] *section 2401* of this title, the Secretary of the Treasury shall make available to the Postal Service 25 percent of such amount at the beginning of each quarter of such fiscal year.

* * * * *

(h) Liabilities of the former Post Office Department to the Employees' Compensation Fund (appropriations for which were authorized by former section 2004, as in effect before the effective date of this subsection) shall be liabilities of the Postal Service payable out of the Fund.

[§ 2004. Transitional appropriations

[Such sums as are necessary to insure a sound financial transition for the Postal Service and a rate policy consistent with chapter 36 of this title are hereby authorized to be appropriated to the Fund without regard to fiscal-year limitation.]

* * * * *

TITLE 5, UNITED STATES CODE

* * * * *

PART III—EMPLOYEES

* * * * *

Subpart G—Insurance and Annuities

* * * * *

CHAPTER 83—RETIREMENT

* * * * *

SUBCHAPTER III—CIVIL SERVICE RETIREMENT

* * * * *

§ 8334. Deductions, contributions, and deposits

(a)(1) [The employing agency shall deduct and withhold 7 percent of the basic pay of an employee, 7½ percent of the basic pay of a Congressional employee, a law enforcement officer, and a firefighter, and 8 percent of the basic pay of a Member, a Claims Court judge, a United States magistrate, a judge of the United States

Court of Appeals for the Armed Forces, and a bankruptcy judge.】
The employing agency shall deduct and withhold from the basic pay of an employee, Member, Congressional employee, law enforcement officer, firefighter, bankruptcy judge, judge of the United States Court of Appeals for the Armed Forces, United States magistrate, or Claims Court judge, as the case may be, the percentage of basic pay applicable under subsection (c). An equal amount shall be contributed from the appropriation or fund used to pay the employee or, in the case of an elected official, from an appropriation or fund available for payment of other salaries of the same office or establishment【.】, subject to subsection (m). When an employee in the legislative branch is paid by the Chief Administrative Officer of the House of Representatives, the Chief Administrative Officer may pay from the applicable accounts of the House of Representatives the contribution that otherwise would be contributed from the appropriation or fund used to pay the employee.

* * * * *

【(c) Each employee or Member credited with civilian service after July 31, 1920, for which retirement deductions or deposits have not been made, may deposit with interest an amount equal to the following percentages of his basic pay received for that service:

	Percentage of basic pay	Service period
Employee	2½	August 1, 1920, to June 30, 1926.
	3½	July 1, 1926, to June 30, 1942.
	5	July 1, 1942, to June 30, 1948.
	6	July 1, 1948, to October 31, 1956.
	6½	November 1, 1956, to December 31, 1969.
Member or employee for Congressional employee service	7	After December 31, 1969.
	2½	August 1, 1920, to June 30, 1926.
	3½	July 1, 1926, to June 30, 1942.
	5	July 1, 1942, to June 30, 1948.
	6	July 1, 1948, to October 31, 1956.
Member for Member service	6½	November 1, 1956, to December 31, 1969.
	7½	After December 31, 1969.
	2½	August 1, 1920, to June 30, 1926.
	3½	July 1, 1926, to June 30, 1942.
	5	July 1, 1942, to August 1, 1946.
Law enforcement officer for law enforcement service and firefighter for firefighter service.	6	August 2, 1946, to October 31, 1956.
	7½	November 1, 1956, to December 31, 1969.
	8	After December 31, 1969.
	2½	August 1, 1920, to June 30, 1926.
	3½	July 1, 1926, to June 30, 1942.
Bankruptcy judge	5	July 1, 1942, to June 30, 1948.
	6	July 1, 1948, to October 31, 1956.
	6½	November 1, 1956, to December 31, 1969.
	7	January 1, 1970, to December 31, 1974.
	7½	After December 31, 1974.

	Percentage of basic pay	Service period
	8	After December 31, 1983.
Judge of the United States Court of Appeals for the Armed Forces for service as a judge of that court.	6	May 5, 1950, to October 31, 1956.
	6½	November 1, 1956, to December 31, 1969.
	7	January 1, 1970, to (but not including) the date of the enactment of the De- partment of Defense Authorization Act, 1984.
	8	On and after the date of the enactment of the Department of Defense Au- thorization Act, 1984.
United States magistrate	2½	August 1, 1920, to June 30, 1926.
	3½	July 1, 1926, to June 30, 1942.
	5	July 1, 1942, to June 30, 1948.
	6	July 1, 1948, to October 31, 1956.
	6½	November 1, 1956, to December 31, 1969.
	7	January 1, 1970, to September 30, 1987.
	8	After September 30, 1987.
Claims Court Judge	2½	August 1, 1920, to June 30, 1926.
	3½	July 1, 1926, to June 30, 1942.
	5	July 1, 1942, to June 30, 1948.
	6	July 1, 1948, to October 31, 1956.
	6½	November 1, 1956, to December 31, 1969.
	7	January 1, 1970, to September 30, 1988.
	8	After September 30, 1988.

Notwithstanding the preceding provisions of this subsection and any provision of section 206(b)(3) of the Federal Employees' Retirement Contribution Temporary Adjustment Act of 1983, the percentage of basic pay required under this subsection in the case of an individual described in section 8402(b)(2) shall, with respect to any covered service (as defined by section 203(a)(3) of such Act) performed by such individual after December 31, 1983, and before January 1, 1987, be equal to 1.3 percent, and, with respect to any such service performed after December 31, 1986, be equal to the amount that would have been deducted from the employee's basic pay under subsection (k) of this section if the employee's pay had been subject to that subsection during such period.]

(c) *Each employee or Member credited with civilian service after July 31, 1920, for which retirement deductions or deposits have not been made, may deposit with interest an amount equal to the following percentages of his basic pay received for that service:*

	Percentage of basic pay	Service period
Employee	2.50	August 1, 1920, to June 30, 1926.
	3.50	July 1, 1926, to June 30, 1942.
	5	July 1, 1942, to June 30, 1948.
	6	July 1, 1948, to October 31, 1956.
	6.50	November 1, 1956, to December 31, 1969.
	7	January 1, 1970, to December 31, 1998.
	7.25	January 1, 1999, to December 31, 1999.
	7.40	January 1, 2000, to December 31, 2000.

	<i>Percentage of basic pay</i>	<i>Service period</i>
	7.50	January 1, 2001, to December 31, 2002.
	7	After December 31, 2002.
<i>Member or employee for Congressional employee service</i>	2.50	August 1, 1920, to June 30, 1926.
	3.50	July 1, 1926, to June 30, 1942.
	5	July 1, 1942, to June 30, 1948.
	6	July 1, 1948, to October 31, 1956.
	6.50	November 1, 1956, to December 31, 1969.
	7.50	January 1, 1970, to December 31, 1998.
	7.75	January 1, 1999, to December 31, 1999.
	7.90	January 1, 2000, to December 31, 2000.
	8	January 1, 2001, to December 31, 2002.
	7.50	After December 31, 2002.
<i>Member for Member service</i>	2.50	August 1, 1920, to June 30, 1926.
	3.50	July 1, 1926, to June 30, 1942.
	5	July 1, 1942, to August 1, 1946.
	6	August 2, 1946, to October 31, 1956.
	7.50	November 1, 1956, to December 31, 1969.
	8	January 1, 1970, to December 31, 1998.
	8.25	January 1, 1999, to December 31, 1999.
	8.40	January 1, 2000, to December 31, 2000.
	8.50	January 1, 2001, to December 31, 2002.
	8	After December 31, 2002.
<i>Law enforcement officer for law enforcement service and firefighter for firefighter service</i>	2.50	August 1, 1920, to June 30, 1926.
	3.50	July 1, 1926, to June 30, 1942.
	5	July 1, 1942, to June 30, 1948.
	6	July 1, 1948, to October 31, 1956.
	6.50	November 1, 1956, to December 31, 1969.
	7	January 1, 1970, to December 31, 1974.
	7.50	January 1, 1975, to December 31, 1998.
	7.75	January 1, 1999, to December 31, 1999.
	7.90	January 1, 2000, to December 31, 2000.
	8	January 1, 2001, to December 31, 2002.
	7.50	After December 31, 2002.
<i>Bankruptcy judge</i>	2.50	August 1, 1920, to June 30, 1926.
	3.50	July 3, 1926, to June 30, 1942.
	5	July 1, 1942, to June 30, 1948.
	6	July 1, 1948, to October 31, 1956.
	6.50	November 1, 1956, to December 31, 1969.
	7	January 1, 1970, to December 31, 1983.
	8	January 1, 1984, to December 31, 1998.
	8.25	January 1, 1999, to December 31, 1999.
	8.40	January 1, 2000, to December 31, 2000.

	<i>Percentage of basic pay</i>	<i>Service period</i>
	8.50	January 1, 2001, to December 31, 2002.
	8	After December 31, 2002.
<i>Judge of the United States Court of Appeals for the Armed Forces for service as a judge of that court</i>	6	May 5, 1950, to October 31, 1956.
	6.50	November 1, 1956, to December 31, 1969.
	7	January 1, 1970, to (but not including) the date of the enactment of the Department of Defense Authorization Act, 1984.
	8	The date of the enactment of the Department of Defense Authorization Act, 1984, to December 31, 1998.
	8.25	January 1, 1999, to December 31, 1999.
	8.40	January 1, 2000, to December 31, 2000.
	8.50	January 1, 2001, to December 31, 2002.
	8	After December 31, 2002.
<i>United States magistrate</i>	2.50	August 1, 1920, to June 30, 1926.
	3.50	July 1, 1926, to June 30, 1942.
	5	July 1, 1942, to June 30, 1948.
	6	July 1, 1948, to October 31, 1956.
	6.50	November 1, 1956, to December 31, 1969.
	7	January 1, 1970, to September 30, 1987.
	8	October 1, 1987, to December 31, 1998.
	8.25	January 1, 1999, to December 31, 1999.
	8.40	January 1, 2000, to December 31, 2000.
	8.50	January 1, 2001, to December 31, 2002.
	8	After December 31, 2002.
<i>Claims Court Judge</i>	2.50	August 1, 1920, to June 30, 1926.
	3.50	July 1, 1926, to June 30, 1942.
	5	July 1, 1942, to June 30, 1948.
	6	July 1, 1948, to October 31, 1956.
	6.50	November 1, 1956, to December 31, 1969.
	7	January 1, 1970, to September 30, 1988.
	8	October 1, 1988, to December 31, 1998.
	8.25	January 1, 1999, to December 31, 1999.
	8.40	January 1, 2000, to December 31, 2000.
	8.50	January 1, 2001, to December 31, 2002.
	8	After December 31, 2002.

Notwithstanding the preceding provisions of this subsection and any provision of section 206(b)(3) of the Federal Employees' Retirement Contribution Temporary Adjustment Act of 1983, the percentage of basic pay required under this subsection in the case of an individual described in section 8402(b)(2) shall, with respect to any covered service (as defined by section 203(a)(3) of such Act) performed by such individual after December 31, 1983, and before January 1,

1987, be equal to 1.3 percent, and, with respect to any such service performed after December 31, 1986, be equal to the amount that would have been deducted from the employee's basic pay under subsection (k) of this section if the employee's pay had been subject to that subsection during such period.

* * * * *

(j)(1)(A) Except as provided in subparagraph (B), and subject to paragraph (5), each employee or Member who has performed military service before the date of the separation on which the entitlement to any annuity under this subchapter is based may pay, in accordance with such regulations as the Office shall issue, to the agency by which the employee is employed, or, in the case of a Member or a Congressional employee, to the Secretary of the Senate or the Chief Administrative Officer of the House of Representatives, as appropriate, an amount equal to 7 percent of the amount of the basic pay paid under section 204 of title 37 to the employee or Member for each period of military service after December 1956. The amount of such payments shall be based on such evidence of basic pay for military service as the employee or Member may provide, or if the Office determines sufficient evidence has not been so provided to adequately determine basic pay for military service, such payment shall be based upon estimates of such basic pay provided to the Office under paragraph (4).

* * * * *

(5) Effective with respect to any period of military service performed after December 31, 1998, and before January 1, 2003, the percentage of basic pay under section 204 of title 37 payable under paragraph (1) shall be equal to the same percentage as would be applicable under section 8334(c) for that same period for service as an "employee", subject to paragraph (1)(B).

* * * * *

(l)(1) Each employee or Member who has performed service as a volunteer or volunteer leader under part A of title VIII of the Economic Opportunity Act of 1964, as a full-time volunteer enrolled in a program of at least 1 year's duration under part A, B, or C of title I of the Domestic Volunteer Service Act of 1973, or as a volunteer or volunteer leader under the Peace Corps Act before the date of the separation on which the entitlement to any annuity under this subchapter is based may pay, in accordance with such regulations as the Office of Personnel Management shall issue, an amount equal to 7 percent of the readjustment allowance paid to the employee or Member under title VIII of the Economic Opportunity Act of 1964 or section 5(c) or 6(1) of the Peace Corps Act or the stipend paid to the employee or Member under part A, B, or C of title I of the Domestic Volunteer Service Act of 1973, for each period of service as such a volunteer or volunteer leader[.], subject to paragraph (4).

* * * * *

(4) Effective with respect to any period of service as a volunteer or volunteer leader performed after December 31, 1998, and before January 1, 2003, the percentage of the readjustment allowance or stipend (as the case may be) payable under paragraph (1) shall be

equal to the same percentage as would be applicable under section 8334(c) for that same period for service as an “employee”.

(m)(1) This subsection shall govern for purposes of determining the amount to be contributed under the second sentence of subsection (a)(1) with respect to any service—

(A) which is performed after September 30, 1997, and before January 1, 2003; and

(B) as to which a contribution under such sentence would otherwise be payable.

(2) The amount of the contribution required under the second sentence of subsection (a)(1) with respect to any service described in paragraph (1) shall (instead of the amount which would otherwise apply under such sentence) be equal to the amount of basic pay received for such service by the employee or Member involved, multiplied by the percentage under paragraph (3).

(3)(A) The percentage under this paragraph is, with respect to any service, equal to the sum of—

(i) the percentage which would have been applicable under subsection (c), with respect to such service, if it had been performed in fiscal year 1997, plus

(ii) the applicable percentage under subparagraph (B).

(B) The applicable percentage under this subparagraph is, with respect to service performed—

(i) after September 30, 1997, and before October 1, 2002, 1.51 percent; or

(ii) after September 30, 2002, and before January 1, 2003, 0 percent.

(4) An amount determined under this subsection with respect to any period of service shall, for purposes of subsection (k)(1)(B) (and any other provision of law which similarly refers to contributions under the second sentence of subsection (a)(1)), be treated as the amount required under such sentence with respect to such service.

(5)(A) Notwithstanding paragraphs (1) through (4), the amount to be contributed by the Postal Service by reason of the second sentence of subsection (a)(1) with respect to any service performed by an officer or employee of the Postal Service during the period described in subparagraph (A) of paragraph (1) shall be determined as if section 6101 of the Balanced Budget Act of 1997 had never been enacted.

(B) For purposes of this paragraph, the term “Postal Service” means the United States Postal Service and the Postal Rate Commission.

* * * * *

CHAPTER 84—FEDERAL EMPLOYEES’ RETIREMENT SYSTEM

* * * * *

SUBCHAPTER II—BASIC ANNUITY

* * * * *

§ 8422. Deductions from pay; contributions for military service

(a)(1) The employing agency shall deduct and withhold from basic pay of each employee and Member a percentage of basic pay determined in accordance with [paragraph (2).] *paragraph (2) or (3), as applicable.*

(2) **【The applicable】** *Subject to paragraph (3), the applicable percentage under this subsection for any pay period shall be—*

(A) * * *

* * * * *

(3)(A) *The applicable percentage under this subsection shall, for purposes of service performed after December 31, 1998, and before January 1, 2003, be equal to—*

- (i) *the applicable percentage under subparagraph (B), minus*
- (ii) *the percentage then in effect under section 3101(a) of the Internal Revenue Code of 1986 (relating to rate of tax for old-age, survivors, and disability insurance).*

(B) *The applicable percentage under this subparagraph shall be as follows:*

	<i>Percentage of basic pay</i>	<i>Service period</i>
<i>Employee</i>	7.25	<i>January 1, 1999, to December 31, 1999.</i>
	7.40	<i>January 1, 2000, to December 31, 2000.</i>
	7.50	<i>January 1, 2001, to December 31, 2002.</i>
<i>Congressional employee</i>	7.75	<i>January 1, 1999, to December 31, 1999.</i>
	7.90	<i>January 1, 2000, to December 31, 2000.</i>
	8	<i>January 1, 2001, to December 31, 2002.</i>
<i>Member</i>	7.75	<i>January 1, 1999, to December 31, 1999.</i>
	7.90	<i>January 1, 2000, to December 31, 2000.</i>
	8	<i>January 1, 2001, to December 31, 2002.</i>
<i>Law enforcement officer</i>	7.75	<i>January 1, 1999, to December 31, 1999.</i>
	7.90	<i>January 1, 2000, to December 31, 2000.</i>
	8	<i>January 1, 2001, to December 31, 2002.</i>
<i>Firefighter</i>	7.75	<i>January 1, 1999, to December 31, 1999.</i>
	7.90	<i>January 1, 2000, to December 31, 2000.</i>
	8	<i>January 1, 2001, to December 31, 2002.</i>
<i>Air traffic controller</i>	7.75	<i>January 1, 1999, to December 31, 1999.</i>
	7.90	<i>January 1, 2000, to December 31, 2000.</i>
	8	<i>January 1, 2001, to December 31, 2002.</i>

* * * * *

(e)(1)(A) Except as provided in subparagraph (B), *and subject to paragraph (5)*, each employee or Member who has performed military service before the date of the separation on which the entitlement to any annuity under this subchapter, or subchapter V of this chapter, is based may pay, in accordance with such regulations as the Office shall issue, to the agency by which the employee is employed, or, in the case of a Member or a Congressional employee, to the Secretary of the Senate or the Chief Administrative Officer of the House of Representatives, as appropriate, an amount equal to 3 percent of the amount of the basic pay paid under section 204 of title 37 to the employee or Member for each period of military service after December 1956. The amount of such payments shall be based on such evidence of basic pay for military service as the employee or Member may provide, or if the Office determines sufficient evidence has not been so provided to adequately determine basic pay for military service, such payment shall be based on estimates of such basic pay provided to the Office under paragraph (4).

* * * * *

(5) *Effective with respect to any period of military service performed after December 31, 1998, and before January 1, 2003, the percentage of basic pay under section 204 of title 37 payable under paragraph (1) shall be equal to the sum of the percentage specified in paragraph (1), plus—*

(A) *.25 percent, if performed after December 31, 1998, and before January 1, 2000;*

(B) *.40 percent, if performed after December 31, 1999, and before January 1, 2001;*

(C) *.50 percent, if performed after December 31, 2000, and before January 1, 2003.*

(f)(1) Each employee or Member who has performed service as a volunteer or volunteer leader under part A of title VIII of the Economic Opportunity Act of 1964, as a full-time volunteer enrolled in a program of at least 1 year's duration under part A, B, or C of title I of the Domestic Volunteer Service Act of 1973, or as a volunteer or volunteer leader under the Peace Corps Act before the date of the separation on which the entitlement to any annuity under this subchapter, or subchapter V of this chapter, is based may pay, in accordance with such regulations as the Office of Personnel Management shall issue, an amount equal to 3 percent of the readjustment allowance paid to the employee or Member under title VIII of the Economic Opportunity Service Act of 1964 or section 5(c) or 6(1) of the Peace Corps Act or the stipend paid to the employee or Member under part A, B, or C of title I of the Domestic Volunteer Service Act of 1973, for each period of service as such a volunteer or volunteer leader[.], *subject to paragraph (4).*

* * * * *

(4) *Effective with respect to any period of service as a volunteer or volunteer leader performed after December 31, 1998, and before January 1, 2003, the percentage of the readjustment allowance or stipend (as the case may be) payable under paragraph (1) shall be equal to the sum of the percentage specified in paragraph (1), plus—*

(A) *.25 percent, if performed after December 31, 1998, and before January 1, 2000;*

(B) .40 percent, if performed after December 31, 1999, and before January 1, 2001;

(C) .50 percent, if performed after December 31, 2000, and before January 1, 2003.

* * * * *

§ 8423. Government contributions

(a)(1) **[Each]** Subject to subsection (d), each employing agency having any employees or Members subject to section 8422(a) shall contribute to the Fund an amount equal to the sum of—

(A) * * *

* * * * *

(d)(1) This subsection shall govern for purposes of determining the amount to be contributed by an employing agency for any period (or portion thereof)—

(A) which occurs after September 30, 1997, and before January 1, 2003; and

(B) as to which a contribution under subsection (a) would otherwise be payable by such agency.

(2) The amount of the contribution required under subsection (a) with respect to any period (or portion thereof) described in paragraph (1) shall (instead of the amount which would otherwise apply) be equal to the amount which would be required under subsection (a) if section 6102(a) of the Balanced Budget Act of 1997 had never been enacted.

* * * * *

CHAPTER 89—HEALTH INSURANCE

* * * * *

§ 8906. Contributions

[(a)] The Office of Personnel Management shall determine the average of the subscription charges in effect on the beginning date of each contract year with respect to self alone or self and family enrollments under this chapter, as applicable, for the highest level of benefits offered by—

[(1)] the service benefit plan;

[(2)] the indemnity benefit plan;

[(3)] the two employee organization plans with the largest number of enrollments, as determined by the Office; and

(4) the two comprehensive medical plans with the largest number of enrollments, as determined by the Office.

[(b)(1)] Except as provided by paragraphs (2) and (3) of this subsection, the biweekly Government contribution for health benefits for an employee or annuitant enrolled in a health benefits plan under this chapter is adjusted to an amount equal to 60 percent of the average subscription charge determined under subsection (a) of this section. For an employee, the adjustment begins on the first day of the employee's first pay period of each year. For an annuitant, the adjustment begins on the first day of the first period of each year for which an annuity payment is made.]

(a)(1) *The Office of Personnel Management shall, not later than October 1 of each year, determine the weighted average of the subscription charges that will be in effect during the following contract year with respect to—*

(A) enrollments under this chapter for self alone; and

(B) enrollments under this chapter for self and family.

(2) In determining each weighted average under paragraph (1), the weight to be given to a particular subscription charge shall, with respect to each plan (and option) to which it is to apply, be commensurate with the number of enrollees enrolled in such plan (and option) as of March 31 of the year in which the determination is being made.

(3) For purposes of paragraph (2), the term ‘enrollee’ means any individual who, during the contract year for which the weighted average is to be used under this section, will be eligible for a Government contribution for health benefits.

(b)(1) Except as provided in paragraphs (2) and (3), the biweekly Government contribution for health benefits for an employee or annuitant enrolled in a health benefits plan under this chapter is adjusted to an amount equal to 72 percent of the weighted average under subsection (a)(1) (A) or (B), as applicable. For an employee, the adjustment begins on the first day of the employee’s first pay period of each year. For an annuitant, the adjustment begins on the first day of the first period of each year for which an annuity payment is made.

* * * * *

XI. CONGRESSIONAL ACCOUNTABILITY ACT; PUBLIC LAW 104–1

The Committee finds that the legislation does not relate to the terms and conditions of employment or access to public services or accommodations within the meaning of section 102(b)(3) of the Congressional Accountability Act (P.L. 104–1).

XII. BUDGET ANALYSIS

Pursuant to rule XI, clause 2(1)(3)(B), and Section 308(a)(1) of the Congressional Budget Act of 1974, the Committee finds that no new budget authority, new spending authority, new credit authority or an increase or decrease in revenues or tax expenditures results from enactment of this legislation.

XIII. UNFUNDED MANDATES REFORM ACT; PUBLIC LAW 104–4, SECTION 423

The committee finds that the legislation does not impose any Federal mandates within the meaning of section 423 of the Unfunded Mandates Reform Act (P.L. 104–4).

XIV. APPENDIX

AMERICA'S POSTMASTERS,
June 8, 1997.

Hon. DAN BURTON,
*Chairman, Committee on Government Reform and Oversight, Wash-
ington, DC.*

DEAR CHAIRMAN BURTON: As the elected representatives of America's Postmasters, we would like to make clear our position on the federal budget resolution as it affects our members and all postal and federal employees. Singling out federal civil servants and reducing their incomes for the purpose of balancing the budget is "unfair" and "discriminatory" and we oppose this tactic.

However, we wish to commend Chairman Mica for recognizing that since 1974 the U.S. Postal Service has paid enormous amounts of revenue into the U.S. Treasury in order to fully fund the retirements of its employees. These payments were required by the OBRA's of 1974, 1987, 1989, 1990 and 1993. The amount paid as a result of these OBRA's combined with ongoing contributions by USPS and its employees fully funds the costs of postal retirement. Therefore, we support Chairman Mica's plan to prevent additional raids on Postal Service employees.

Unfortunately, past Congresses have turned to all federal civil servants, time and time again, as a source of ready funds to balance the budget. We do not need to recount the history for you. As you know, the figures are mind-boggling.

We were led to believe that the leadership which was ushered in after the Congressional upheaval and transition of power in 1995 would look for new ways to do things. We urge you to recognize the value and worth of the federal workforce as it serves this country everyday. Don't tap into their income again.

Thank you for your time and your consideration of our requests. We look forward to continuing to work with you in resolving these problems.

Sincerely,

WILLIAM P. BRENNAN,
*President, National League
of Postmasters of the U.S.*
HUGH BATES,
*President, National Associa-
tion of Postmasters of the
U.S.*

AMERICA'S POSTMASTERS,
June 10, 1997.

Members of the Full Committee,
*Committee on Government Reform and Oversight, House of Rep-
resentatives, Washington, DC.*

TO ALL MEMBERS: As the elected representatives of America's Postmasters, we wish to state our support of Rep. Pete Session's amendment to the budget resolution which would prevent additional raids on Postal Service employees as a means to balance the

budget. This amendment will be offered to the full Committee on Wednesday, June 11, and we ask you to support it.

We commend Rep. Sessions and Subcommittee Chairman John Mica for recognizing that since 1974 the U.S. Postal Service has paid enormous amounts of revenue into the U.S. Treasury in order to fully fund the retirements of its employees. These payments were required by P.L. 93-349 and the OBRAs of 1987, 1989, 1990 and 1993. The amount paid as a result of these OBRAs combined with ongoing contributions by USPS and its employees fully funds the costs of postal retirement.

Unfortunately, past Congresses have turned to all federal civil servants, time and time again, as a source of ready funds to balance the budget. In defense of our fellow civil servants, we oppose tapping their income even one more time.

At this time, Rep. Session's amendment is a step in the right direction. Again, we ask you to give it your full support.

Thank you for your time and your consideration of our requests. We look forward to continuing to work with you in resolving these problems.

Sincerely,

WILLIAM P. BRENNAN,
*President, National League
of Postmasters of the U.S.*

HUGH BATES,
*President, National Association
of Postmasters of the
U.S.*

HOUSE OF REPRESENTATIVES,
COMMITTEE ON TRANSPORTATION AND INFRASTRUCTURE,
Washington, DC, June 13, 1997.

Hon. JOHN R. KASICH,
Chairman, Committee on the Budget,
Washington, DC.

DEAR MR. CHAIRMAN: On June 11, 1997, the Committee on Transportation and Infrastructure approved, by voice vote, recommendations for budget reconciliation. The accompanying legislation and report language serves as the Transportation and Infrastructure Committee's submission for both reconciliation bills provided for in the conference report on the Budget Resolution.

The Congressional Budget Office (CBO) has advised the Committee that these recommendations will score as saving \$736 million in mandatory outlays over the next five fiscal years and meet all of the reconciliation instructions given to the Committee. CBO was unable to produce a written cost estimate prior to this transmittal. It is our understanding that CBO will be sending the cost estimate directly to the Budget Committee.

With warm personal regards, I remain
Sincerely,

BUD SHUSTER, *Chairman.*

**TITLE VII: COMMITTEE ON TRANSPORTATION AND
INFRASTRUCTURE**

PURPOSE AND SUMMARY

Sec. 7001. Extension of higher Vessel Tonnage Duties

This provision maintains the current level of vessel tonnage duties through fiscal year 2002.

The United States imposes a tonnage duty on a vessel which enters the U.S. from any port or place. The duty is also imposed on a vessel which departs from and returns to a U.S. port or place on a "voyage to nowhere".

The tonnage duty is imposed on the cargo-carrying capacity of the vessel and is assessed regardless of whether the vessel is empty or is carrying cargo.

A vessel arriving from a foreign port in the northern Western Hemisphere (Canada, Mexico, Central America, West Indies, Bahamas, Bermuda, and northern South America) and a vessel returning from a "voyage to nowhere" must pay a tonnage duty of nine cents per ton. However, the maximum payment for any vessel in a single year is 45 cents per ton.

A vessel arriving from a foreign port anywhere else in the world must pay a tonnage duty of 27 cents per ton, not to exceed \$1.35 per ton in a single year.

Under current law, after fiscal year 1998, the tonnage duties will revert to earlier, lesser amounts (two cents per ton, not to exceed ten cents per ton in a single year for vessels entering from the northern Western Hemisphere and from “voyages to nowhere”; six cents per ton, not to exceed 30 cents per ton for other vessels subject to the duty).

Sec. 7002. Sale of Governors Island, New York

This section requires the Administrator of the General Services Administration to sell Governors Island, New York, at fair market value. The section waives all provisions of the Federal Property and Administrative Services Act, as amended, and gives the State of New York and the City of New York a right of first refusal to purchase the property. The proceeds of the sale will be deposited in the miscellaneous account of the U.S. Treasury.

Governors Island is located in New York Harbor, south of Manhattan and west of Brooklyn. It houses the largest Coast Guard facility in the world, Support Center New York, which provides support for commands stationed on the island. The 172-acre island is surrounded by a seawall and is reached by ferry from Manhattan.

The Coast Guard must reduce its operating costs by \$400 million by the end of this fiscal year. To reach that goal, the Coast Guard has implemented a streamlining plan that includes a closure and relocation of the Coast Guard facilities on Governors Island.

This summer, the Coast Guard will complete the relocation of Coast Guard facilities from Governors Island to new locations.

Sec. 7003. Sale of Union Station Air Rights

This provision directs the sale of air rights over the train tracks at Union Station, Washington, D.C. These air rights cover approximately 16.5 acres and are bounded by Union Station on the south, 2nd Street NE on the east, K Street NE on the north and 1st Street NE on the west. The provision would direct the General Services Administration, notwithstanding any other provision of law, to sell these air rights, at fair market value, in a manner to be determined, with proceeds to be deposited prior to September 30, 2002 in the general fund of the Treasury and credited as miscellaneous accounts. The air rights are a combination of the Department of Transportation and AMTRAK air rights. The provision calls for the transfer of AMTRAK air rights to the DOT without compensation to AMTRAK, then GSA would sell the air rights. It is estimated that the air rights would support the development of 2.8 million square feet of office space, plus parking for 1,500 cars.

In 1992 the General Services Administration contracted for an appraisal of these air rights, and concluded that the value, net of construction of any supporting structure over the train tracks, was \$50 million. However, the Congressional Budget Office, in scoring the proposed sale, assigned a value of \$40 million. Furthermore, CBO estimated that GSA would require about 18 months to effectively market and sell the air rights, which would include updating the appraisal, and any buyer would require some preliminary determination on zoning the property for future development. The proposal language would provide GSA ample time to market the air rights and secure a top offer.

HEARINGS

The Committee did not conduct any hearings on the matters contained in this title. All three provisions were included, in nearly identical form, in the reconciliation title considered and approved by the committee last Congress.

SECTION-BY-SECTION ANALYSIS

Sec. 7001. Extension of higher tonnage duties

This section maintains the current level of vessel tonnage duties through fiscal year 2002, consistent with the reconciliation instructions the committee received from the Budget Committee.

A vessel arriving from a foreign port in the northern Western Hemisphere (Canada, Mexico, Central America, West Indies, Bahamas, Bermuda, and northern South America) and a vessel returning from a "voyage to nowhere" must pay a tonnage duty of 9 cents per ton. However, the maximum payment for any vessel in a single year is 45 cents per ton. A vessel arriving from a foreign port anywhere else in the world must pay a tonnage duty of 27 cents per ton, not to exceed \$1.35 per ton in a single year.

Sec. 7002. Sale of Governors Island, NY

This section requires the Administrator of the General Services Administration to sell Governors Island, NY, at fair market value. The section waives all provisions of the Federal Property and Administrative Services Act, as amended, and gives the State of New York and the city of New York a right to first refusal to purchase the property. The proceeds of the sale will be deposited in the miscellaneous account of the U.S. Treasury.

Sec. 7003. Sale of air rights

This section directs the Administrator of the General Services Administration to sell approximately 16.5 acres of air rights adjacent to Washington, D.C., Union Station at fair market value in a manner determined by the Administrator.

CHANGES IN EXISTING LAW MADE BY TITLE VII OF THE BILL, AS REPORTED

In compliance with clause 3 of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

SECTION 36 OF THE ACT OF AUGUST 5, 1909

CHAP. 6.—An Act to provide revenue, equalize duties and encourage the industries of the United States, and for other purposes.

SEC. 36. That a tonnage duty of 9 cents per ton, not to exceed in the aggregate 45 cents per ton in any one year, **[for fiscal years 1991, 1992, 1993, 1994, 1995, 1996, 1997, 1998,]** *for fiscal years through fiscal year 2002*, and 2 cents per ton, not to exceed in the aggregate 10 cents per ton in any one year, for each fiscal year thereafter is hereby imposed at each entry on all vessels which

shall be entered in any port of the United States from any foreign port or place in North America, Central America, the West India Islands, the Bahama Islands, the Bermuda Islands, or the coast of South America bordering on the Caribbean Sea, or Newfoundland, and on all vessels (except vessels of the United States, recreational vessels, and barges, as those terms are defined in section 2101 of title 46, United States Code) that depart a United States port or place and return to the same port or place without being entered in the United States from another port or place; and a duty of 27 cents per ton, not to exceed \$1.35 per ton per annum, [for fiscal years 1991, 1992, 1993, 1994, 1995, 1996, 1997, 1998,] *for fiscal years through fiscal year 2002*, and 6 cents per ton, not to exceed 30 cents per ton per annum, for each fiscal year thereafter is hereby imposed at each entry on all vessels which shall be entered in any port of the United States from any other foreign port. However, neither duty shall be imposed on vessels in distress or not engaged in trade.

* * * * *

ACT OF MARCH 8, 1910

CHAP. 86.—An Act Concerning tonnage on vessels entering otherwise than by sea.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That vessels entering otherwise than by sea from a foreign port at which tonnage or light-house dues or other equivalent tax or taxes are not imposed on vessels of the United States shall be exempt from the tonnage duty of 9 cents per ton, not to exceed in the aggregate 45 cents per ton in any one year, [for fiscal years 1991, 1992, 1993, 1994, 1995, 1996, 1997, and 1998,] *for fiscal years through fiscal year 2002*, and 2 cents per ton, not to exceed in the aggregate 10 cents per ton in any one year, for each fiscal year thereafter prescribed by section thirty-six of the Act approved August fifth, nineteen hundred and nine, entitled “An Act to provide revenue, equalize duties, and encourage the industries of the United States, and for other purposes.”

SUMMARY OF COMMITTEE VOTES

The Committee on Transportation and Infrastructure held a full committee markup on June 11, 1997. The committee print was adopted by voice vote.

CBO COST ESTIMATE

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, June 16, 1997.

Hon. BUD SHUSTER,
Chairman, Committee on Transportation and Infrastructure, House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the enclosed cost estimate for the reconciliation recommenda-

tions of the House Committee on Transportation and Infrastructure.

The estimate identifies the budgetary effects of the committee's proposals over the 1998–2007 period. CBO understands that the Committee on the Budget will be responsible for interpreting how these proposals compare with the reconciliation instructions in the budget resolution. This estimate assumes the reconciliation bill will be enacted by August 15, 1997.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contacts are Deborah Reis (for vessel tonnage duties and Governors Island) and Clare Doherty (for Union Station air rights).

Sincerely,

JUNE E. O'NEILL, *Director*.

Enclosure.

Reconciliation Recommendations of the House Committee on Transportation and Infrastructure (Title VII)

Summary: CBO estimates that the provisions of this title would reduce the deficit by \$736 million over the 1998–2002 period by extending previously enacted increases in vessel tonnage duties and providing for the sale of certain federal assets. Implementing this title would result in additional discretionary spending of about \$40 million over the same period, assuming appropriation of the necessary amounts. This title contains no intergovernmental mandates as defined in the Unfunded Mandates Reform Act of 1995 (UMRA) and would impose no costs on state, local, or tribal governments. The title would extend an expiring private-sector mandate on owners or operators of vessels that enter U.S. ports. It is unclear to CBO whether extension of an expiring mandate would impose new direct costs, as defined by UMRA, on the private sector. In any case, such costs would not exceed the \$100 million threshold specified in UMRA.

Estimated cost to the Federal Government: CBO estimates that the provisions of Title VII would reduce direct spending by \$196 million over the 1998–2002 period. We estimate that the title also would result in proceeds from asset sales totaling \$540 million in 2002. In addition, we estimate that implementing section 7002 would necessitate discretionary spending of about \$40 million over the 1999–2002 period for continued maintenance of governors Island prior to its mandated sale in 2002. None of these provisions would affect the federal budget after 2002; hence, their estimated impact on the budget over 10 years is identical to the impact estimated for the first five years. CBO's estimate of the budgetary effects of this legislation is shown in the following table.

ESTIMATED BUDGETARY IMPACT OF THE RECONCILIATION RECOMMENDATIONS OF THE HOUSE COMMITTEE ON TRANSPORTATION AND INFRASTRUCTURE

[By fiscal year, in millions of dollars]

	1997	1998	1999	2000	2001	2002
DIRECT SPENDING						
Vessel Tonnage Fees Under Current Law: ¹						
Estimated Budget Authority	–49	–49	0	0	0	0

ESTIMATED BUDGETARY IMPACT OF THE RECONCILIATION RECOMMENDATIONS OF THE HOUSE
COMMITTEE ON TRANSPORTATION AND INFRASTRUCTURE—Continued

[By fiscal year, in millions of dollars]

	1997	1998	1999	2000	2001	2002
Estimated Outlays	-49	-49	0	0	0	0
Proposed Changes:						
Estimated Budget Authority	0	0	-49	-49	-49	-49
Estimated Outlays	0	0	-49	-49	-49	-49
Vessel Tonnage Fees Under Proposal:						
Estimated Budget Authority	-49	-49	-49	-49	-49	-49
Estimated Outlays	-49	-49	-49	-49	-49	-49
RECEIPTS FROM ASSET SALES ²						
Estimated Budget Authority	0	0	0	0	0	-540
Estimated Outlays	0	0	0	0	0	-540
ADDITIONAL SPENDING SUBJECT TO APPROPRIATION						
Estimated Authorization Level	0	0	10	10	10	10
Estimated Outlays	0	0	10	10	10	10

¹These amounts represent proceeds from the increase in tonnage fees originally mandated in the Omnibus Budget Reconciliation Act of 1990, which are recorded in the budget as offsetting receipts. The tonnage fees that were established prior to that time (and that are still in effect) are recorded as governmental receipts (i.e., revenues); the proceeds from those fees (about \$15 million a year) are not included in this table.

²Based on criteria established in the 1998 budget resolution, CBO has determined that proceeds from the asset sales in this bill should be counted in the budget totals for purposes of Congressional scoring. Under the Balanced Budget Act, however, proceeds from asset sales are not counted in determining compliance with the discretionary spending limits or pay-as-you-go requirement.

The effects of this legislation fall within budget functions 400 (transportation), 800 (general government), and 950 (undistributed offsetting receipts).

Basis of estimate: For purposes of this estimate, CBO assumes that the asset sales mandated by this title will take place as specified in the legislation and that any amounts estimated to be necessary for interim maintenance of these assets will be appropriated.

Vessel tonnage duties

Section 7001 would extend, through fiscal year 2002, the increase in vessel tonnage duties that was enacted (and subsequently extended) in two earlier reconciliation acts. These earlier acts increased per-ton duties from \$0.02 to \$0.09 (up to a maximum of \$0.45 per ton per year) on vessels entering the United States from western hemisphere foreign ports and from \$0.06 to \$0.27 (up to a maximum annual duty of \$1.35 per ton) on those arriving from other foreign ports. As specified in the earlier acts, the additional amounts collected would be deposited into the general fund as offsetting receipts. Based on the current levels of shipping traffic at U.S. ports, CBO estimates that the enactment of this section would increase offsetting receipts by \$49 million in each of fiscal years 1999 through 2002.

Sale of Governors Island, New York

Section 7002 would direct the General Services Administration (GSA) to sell at fair market value all federal land and other property located on Governors Island in New York Harbor. The bill would grant New York City and the state of New York a right of first refusal to purchase all or part of the island. Proceeds from the sale would be deposited in the general fund of the U.S. Treasury as miscellaneous receipts. Based on information obtained from local

agencies, GSA, and others, CBO estimates that selling the 172-acre island would generate offsetting receipts of about \$500 million. Because the bill would prohibit the sale of this property before fiscal year 2002, we estimate that the \$500 million would be deposited into the Treasury in that year. We estimate that until then the federal government would spend about \$10 million annually to maintain the island, assuming appropriation of the necessary amounts. Such costs would be incurred under current law in 1998, but the costs for continued maintenance after 1998 are not likely to occur in the absence of this legislation.

Until recently, Governors Island was used by the U.S. Coast Guard as a major command center. That agency is in the process of closing the facility. Current plans call for relocation and certain restoration activities to be completed by the end of 1998. Disposition of the site under existing law is uncertain and could include transfers to other federal agencies, conveyances at no cost to non-federal agencies for public benefit uses, donations to nonprofit groups for homeless shelters, or sale. (Disposal of the island may not be possible without Congressional approval.) In any event, CBO believes that the federal government would realize little or no money from disposal of the island in the absence of legislation. Enacting section 7002 would ensure that the island would be sold rather than given away or retained by the federal government.

The value of Governors Island cannot be determined precisely in the absence of formal appraisals, which have not yet been conducted. Based on available information, we estimate that sale of this asset would generate about \$500 million. The proceeds would depend on whether disposal would occur in one transaction or as a combination of partial sales and on a variety of other factors, including future economic conditions and local zoning decisions. Thus, the government could receive considerably less than \$500 million or as much as \$1 billion. Moreover, conditions that might be imposed on the sale by federal agencies could delay or prevent any sale from taking place, as could expectations of restrictive zoning requirements.

Finally, until the island is sold, GSA and the Coast Guard would have to maintain the property and provide for security, transportation, and utilities. Based on information provided by the affected agencies and assuming appropriation of the necessary amounts, we estimate that costs for these purposes would total about \$10 million annually, beginning in 1999.

Union Station air rights

Section 7003 would compel Amtrak to convey the air rights that it owns behind the District of Columbia's Union Station to the Administrator of the General Services Administration. The Administrator would then be required to sell these air rights and other air rights that the federal government owns behind Union Station.

CBO estimates that selling the 16.5 acres of air rights would yield \$40 million in asset sale receipts in fiscal year 2002. This estimate assumes that Amtrak would convey its air rights to the federal government so they can be sold. If Amtrak does not convey the air rights on or before December 31, 1997, the bill would prohibit

Amtrak from obligating any of its federal grant money after March 1, 1998.

Estimated impact on State, local, and tribal governments: Title VII contains no intergovernmental mandates as defined in UMRA and would impose no costs on state, local, or tribal governments.

The bill provides the city and state of New York the right of first refusal in the purchase of Governors Island. Should either entity, or the two in partnership, choose to acquire the property in whole, CBO estimates that it would cost them approximately \$500 million.

Estimated impact on the private sector: Section 7001 would impose a mandate on the private sector by extending the current vessel tonnage duty. CBO estimates that the direct costs of this mandate would not exceed the annual \$100 million threshold specified in UMRA.

Under current law, the duty imposed on both domestic and foreign vessel owners at U.S. ports expires the end of the fiscal year 1998. At the time of expiration, this duty would revert to a prior lower amount. This bill would extend the current duty through fiscal year 2002.

The direct cost of this mandate would depend on what base case is used. Measured against the private-sector costs that would be incurred if current law remains in place and the amount of the duty declines, the total cost of extending this mandate would be \$49 million annually beginning in fiscal year 1999. The cost to domestic vessel owners would be less than this amount, however, because owners of foreign vessels would incur a portion of those costs. In contrast, measured against current private-sector costs, the direct cost of this mandate would be zero, because duties would be extended at their current levels. It is unclear to CBO which comparison is required by UMRA. In either case, the cost of the additional duties imposed on owners of domestic vessels would not exceed the statutory threshold for private-sector mandates.

Estimate prepared by—Federal Costs: Vessel Tonnage Fees and Government Island—Deborah Reis; Union Station Air Rights—Clare Doherty; Impact on State, Local, and Tribal Governments: Karen McVey; Impact on the Private Sector: Jean Wooster.

Estimate approved by: Robert A. Sunshine, Deputy Assistant Director for Budget Analysis.

COMMITTEE OVERSIGHT FINDINGS

Clause 2(1)(3)(A) of rule XI requires each committee report to contain oversight findings and recommendations required pursuant to clause 2(b)(1) of rule X. The Committee on Transportation and Infrastructure has no specific oversight findings.

OVERSIGHT OF COMMITTEE ON GOVERNMENT REFORM AND OVERSIGHT

Clause 2(1)(3)(D) of rule XI requires each committee report to contain a summary of the oversight findings and recommendations made by the Government Reform and Oversight Committee pursuant to clause 4(c)(2) of rule X, whenever such findings have been timely submitted. The Committee on Transportation and Infra-

structure has received no such findings or recommendations from the Committee on Government Reform and Oversight.

HOUSE OF REPRESENTATIVES,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC, June 13, 1997.

Hon. JOHN R. KASICH,
Chairman, Committee on the Budget,
Washington, DC.

DEAR JOHN: Pursuant to the reconciliation directives contained in the Conference Report on House Concurrent Resolution 84, the budget resolution for fiscal year 1998, I am pleased to transmit the reconciliation recommendations for programs within the jurisdiction of the VA Committee. These recommendations were approved by the full VA Committee on June 12, 1997, by a vote of 18 to 4. A copy of the legislative language is enclosed.

The budget resolution instructs the VA Committee to report changes in laws within its jurisdiction that provide direct spending levels of \$22,444,000,000 in outlays for fiscal year 1998, \$24,563,000,000 in outlays for fiscal year 2002, and \$117,959,000,000 in outlays in fiscal years 1997 through 2002.

The VA Committee recommendations include extensions of current laws, replacement of the Medical Care Cost Recovery Fund with a new fund, the Department of Veterans Affairs Medical Care Collections Fund, and other deficit reduction measures.

I hope these recommendations will be of assistance to your committee.

Sincerely,

BOB STUMP, *Chairman.*

RECONCILIATION RECOMMENDATIONS OF THE COMMITTEE ON
VETERANS' AFFAIRS

Submitted June 13, 1997

TITLE VIII—COMMITTEE ON VETERANS' AFFAIRS

Section 8001. Short title; table of contents.

Subtitle A—Extension of Temporary Authorities

Section 8011. Authority to require that certain veterans make co-payments in exchange for receiving health-care benefits.

Section 8012. Medical care cost recovery for nonservice-connected disabilities of service-connected veterans.

Section 8013. Department of Veterans Affairs medical-care receipts.

Section 8014. Income verification authority.

Section 8015. Limitation on pension for certain recipients of medicaid-covered nursing home care.

Section 8016. Home loan fees.

Section 8017. Procedures applicable to liquidation sales on defaulted home loans guaranteed by the Secretary of Veterans Affairs.

Section 8018. Enhanced loan asset sale authority.

Subtitle B—Other Matters

Section 8021. Rounding down of cost-of-living adjustments in compensation and DIC rates.

Section 8022. Withholding of payments and benefits.

SUMMARY OF RECOMMENDED MEASURES TO MEET RECONCILIATION TARGET OF THE COMMITTEE ON VETERANS' AFFAIRS

Section 8011. Authority to require that certain veterans make copayments in exchange for receiving health care benefits

Extends through 2002 existing VA authority to charge daily copayments for hospital and nursing home care required of higher-income (Category C) veterans. Also extends existing VA authority to collect \$2 copayment for each 30-day supply of prescription medication for treatment of nonservice-connected conditions. (Severely disabled service-connected veterans and veterans with very low incomes are exempt from this requirement.)

Section 8012. Medical care cost recovery authority with respect to nonservice-connected conditions of service-connected veterans

Extends through 2002 existing VA authority to collect from third parties for care provided for a nonservice-connected condition of a veteran with a service-connected disability.

Section 8013. Department of Veterans Affairs medical care receipts

Replaces the existing Medical Care Cost Recovery Fund with a new fund to be known as the Department of Veterans Affairs Medical Care Collections Fund. Monies recovered or collected for medical care after September 30, 1997, would be deposited in this fund and would be available to pay for the expenses associated with veterans' medical care. [The Department would be required to establish a policy to maximize collections and to distribute those funds to the medical centers which collected them.]

The Committee measure differs from the Administration proposal in three key respects:

The Committee provision would not make amounts collected subject to action by the Appropriations Committee, as proposed by the Administration;

The Committee would change existing law to allow VA to bill "reasonable charges" as most providers do today, instead of reasonable costs, as currently authorized; and

The Committee measure includes a provision authorizing additional funds in the event there is a shortfall in anticipated collections.

Section 8014. Income verification authority

Extends through 2002 existing VA authority to match income records with SSA and IRS for purposes of verifying income reported to qualify for needs-based veterans programs.

Section 8015. Limitation of monthly pension for certain recipients of Medicaid-covered nursing home care

Extends through 2002 existing authority to limit pension payments to \$90 for veterans with no dependents whose pension would otherwise be attached (except for \$30) to pay for their care in Medicaid-covered nursing homes.

Section 8016. Home loan fees

Extends through 2002 current fee rates and surcharges for users of the VA Home Loan Program, and raises the fee for vendee loans to 2.25 percent.

Section 8017. Procedures applicable to liquidation sales on defaulted home loans guaranteed by the Secretary of Veterans Affairs

Extends through 2002 current VA post-foreclosure procedures used to determine whether it is more cost effective for VA to pay the loan guaranty or to purchase the home for resale.

Section 8018. Enhanced loan asset sale authority

Extends through 2002 current VA authority to package home loans for secondary market resale.

Section 8021. Rounding down of compensation cost-of-living adjustments (COLA) in compensation and DIC rates

Provides that any COLA for compensation and DIC authorized in fiscal years 1998–2002 could not exceed the percentage increase applied to payments authorized for Social Security and would be “rounded down” to the next lower dollar.

Section 8022. Withholding of payments and benefits

Authorizes VA to refer a veteran’s (or surviving spouse’s) home loan guaranty debt to another Federal agency for offset under certain circumstances. Referrals would be allowed if (a) the debtor is given notice, in writing, of VA’s authority to waive debts under section 5302 of title 38; (b) VA makes an affirmative determination that the debtor should not be released from liability under section 3713(b) of title 38; (c) the debtor has been notified of procedures available to appeal a determination that a release of liability is not warranted. In effect, this provision allows VA to refer such debts to the Internal Revenue Service for offset against income tax refunds or, in the case of debtor who are Federal employees, to the debtor’s employing agency for offset against salary or wages.

PURPOSE AND BACKGROUND

SUBTITLE A—EXTENSION OF TEMPORARY AUTHORITIES

Section 8011. Health care copayments

Public Law 99–272 for the first time established copayment obligations for VA health care, requiring veterans with incomes exceeding so-called “category A and B” means test levels to agree to pay copayments as a condition of receiving VA care. (That law also provided that “category C” veterans were only eligible for care to the

extent resources and facilities are available.) Public Law 101–508, the Omnibus Budget Reconciliation Act of 1990 (OBRA 90), eliminated the distinction between veterans in income categories “B” and “C” and provided that in addition to the copayments established earlier, veterans in both so-called “B” and “C” income categories would be required to make per-diem payments of \$10 for VA-provided hospital care and \$5 for nursing home care. The per diem payment requirement, which would have expired under OBRA 90 on September 30, 1997, was extended through September 30, 1998, by Public Law 103–66 (OBRA 93).

Section 1722A of title 38, United States Code, requires a veteran (other than a veteran who has a service-connected disability rated 50% or greater, or a veteran whose income is at or below the maximum annual rate of VA pension) to pay \$2 for each 30-day supply of medication furnished on an outpatient basis. Congress, in OBRA 93, extended this provision through September 30, 1998.

Section 8011 of the bill would extend these expiring copayment authorities through September 30, 2002.

Section 8012. Medical care cost recover—Nonservice-connected care furnished to service-connected veterans

Section 1729 of title 38, United States Code, provides ongoing authority for the Department of Veterans Affairs to collect from a third party payer the reasonable cost of VA-furnished care and treatment rendered a nonservice-connected veteran. That section of law also authorizes VA to collect from a health care payment plan the reasonable cost of medical care furnished for a nonservice-connected disability of a veteran who has a service-connected disability and who, under the health plan, is entitled to care or to payment of the expenses of that care. VA’s authority to collect for nonservice-connected care furnished a service-connected veteran was initially established as section 8011 of OBRA 90. Congress, in OBRA 93, extended the expiration date of that provision (which is codified at section 1729(a)(2)(E) of title 38) to October 1, 1998.

Section 8012 of the bill would extend this date until October 1, 2002.

Section 8013. Retention of medical care

The Administration, in submitting its Fiscal Year 1998 medical care budget, advised the Congress that the Department of Veterans Affairs would require \$17.55 billion to operate a comprehensive, integrated health care system providing care to eligible veterans. Rather than requesting appropriations in that amount, the Administration presented the Congress with an unprecedented request. It proposed that the resources to support the needed funding level be comprised in part of funds which the Department collects from third parties and veterans’ copayments. Under current law, such funds are deposited as miscellaneous receipts in the Treasury. The Administration proposed that Congress enact legislation to authorize VA to retain its medical care cost recoveries.

This Committee has long supported legislation to permit VA to retain third party collections. Such support has been premised, however, on the view that collections should be retained, in whole or in part, to supplement medical care appropriations so as to ex-

pand and improve VA health care delivery. In its report to the Budget Committee on the Fiscal Year 1998 budget for the Department of Veterans Affairs, the Committee strongly recommended that VA medical care funding needs for Fiscal Year 1998 should be met through appropriations, in the amount of \$17.6 billion. In expressing that view, the Committee also highlighted its concern regarding the speculative nature of future VA collections.

As the Committee noted in its budget analysis, Medical Care Cost Recovery (MCCR) collections' projections for Fiscal Year 1998 and the outyears are uncertain. VA's own 1996 strategic plan for the MCCR program highlighted the troublesome path it is on, and warned:

Assumptions that (1) MCCR recoveries from third party payers should continue to rise and (2) operating costs associated with the recovery of this revenue should diminish as a result of efficiencies ignore two critical facts facing third party recovery. First VHA inpatient workload is diminishing while outpatient workload is increasing. Second * * * MCCR spends nearly five times the amount to collect a dollar from outpatient billing than it spends to collect a dollar from inpatient billing * * * MCCR must also generate approximately 20 outpatient bills to produce the equivalent recovery of a single inpatient bill.

Moreover, the VA's report acknowledges that "there is no methodology that can *accurately* estimate the 'full collection potential' of VA's MCCR program."

Factors beyond VA's control not only complicate accurate estimating but actually jeopardize VA's ability to increase its collections, the strategy on which VA's budget depends. Under laws governing eligibility for VA health care, the Department has little control over the number of patients it treats who have health insurance. As a group, veterans are aging and becoming eligible for Medicare. Most Medicare beneficiaries limit their insurance coverage to a Medicare supplemental plan, from which VA recoveries will be markedly lower because of the limited nature of that coverage. Under current law, of course, VA cannot recover any of the costs of a veteran's care from Medicare itself. Further impinging on collections' potential, the insurance market itself is changing rapidly with fee-for-service models, from which VA has obtained substantial payments, giving way to health maintenance organizations and preferred provider plans, from which VA generally cannot gain recoveries. The Committee has been gravely concerned that these uncontrollable factors may take a far greater toll on collections than can be offset through untested improvements in program administration.

Regrettably, the recent budget agreement appears not to have taken the Committee's concerns into account. That agreement adopted, in concept, the Administration's medical receipts-retention proposal and reflects the assumption that VA health care appropriations would be frozen or slightly reduced during the next five fiscal years at a level below the medical care appropriation level for the current fiscal year. This Committee does not accept, as a given, the assumption that VA medical care appropriations would be fro-

zen for any period of time. Indeed, the Committee notes that the Appropriations Committees are no more bound by such assumptions than are the health care needs presented by an aging veteran population which depends on VA care.

Freezing appropriations for veterans' medical care and making delivery of VA health care contingent on achieving third party collection goals could diminish substantially VA's capacity to provide veterans with benefits they have earned. Thus, in advancing legislation to provide for VA retention of medical care cost recoveries, the VA Committee specifically rejects that policy and reiterates its belief that third party collections should be available at least in part to augment rather than substitute for needed VA appropriations.

In that regard, the Committee rejects—as inadequate to protect veterans' health care benefits—the mechanism for funding VA medical care reflected in both the budget resolution and the Administration's draft legislation. The Committee finds that this mechanism fails to offer any safeguard to ensure against the risk that collections will fail to meet budget targets. Yet, as discussed above, VA's own strategic plan for its medical care cost recovery program warns that factors beyond its control threaten to diminish medical care collections at the very time that budget imperatives arbitrarily assume increased collections. To guard against the risk of a significant shortfall in anticipated collections, section 8013 would establish a contingency mechanism for funding veterans' medical care programs. Under that mechanism, which would be in effect for three years, funds would be deposited in the new Medical Care Collections Fund from unobligated amounts in the Treasury in the event that the Secretary of Veterans Affairs, on the basis of an estimate, determined (and certified to the Secretary of the Treasury) that recoveries for a fiscal year would fall more than \$25 million below the level of the Congressional Budget Office's estimates for that fiscal year. In that event, VA would receive an amount representing the difference between the amount of the estimated shortfall and the "trigger" amount. The measure also provides for payment from the Treasury in a future year under circumstances where the actual shortfall exceeded the Secretary's estimate. In the Committee's view, this contingency mechanism represents an important safeguard for veterans' health care for the critical transition period during which VA implements and refines this new and untested authority.

With other significant exceptions described below, section 8013 reflects the general policy regarding retention of medical care cost recoveries proposed in the Administration's budget and the budget resolution. The reported measure would terminate the Department of Veterans Affairs Medical Care Cost Recovery Fund and establish a new fund in the Treasury to be known as the Department of Veterans Affairs Medical Care Collections Fund. Monies recovered or collected under specified provisions of chapter 17 of title 38, United States Code, after September 30, 1997, would be deposited in the new fund. Such monies are no-year funds, available for furnishing medical care and services during any fiscal year and for collections-related expenses. While the measure does not explicitly draw limits on the use of funds for medical care and services, the Committee

intends that such funds be used for provision of care, and are not available for renovation of administrative offices, for example. Under the 1997 Budget Agreement, expenditures from the fund would not be subject to otherwise applicable pay-as-you-go rules. A provision of law directing that collections be deposited in miscellaneous receipts of the Treasury would be repealed.

In proposing that VA be given authority to retain third party collections, it is asserted that such authority would provide a strong incentive to maximize fully VA's collections potential. The Committee believes that the policies governing the allocation of funds from the new medical care collections fund will be critical to creating effective incentives. Accordingly, section 8013 would require that the Department establish a policy—which shall be designed to maximize collections, to the extent feasible—governing allocation of monies from the fund. The Committee believes that the policy must reflect the principle that monies should be distributed in such a manner as to permit facilities to benefit substantially from the success of their collection efforts. Moreover, facilities should incur measurable financial penalties where such efforts are deficient or conducted inefficiently. Consideration has been given to a proposal that would require a local facility retain in full the monies it recovers. Such a policy, however, may be inherently inequitable, potentially penalizing facilities in areas where factors beyond the Department's control artificially frustrate the most aggressive collections efforts, and providing a windfall to some others. (For example, the nature of the insurance market in certain regions of the country where managed care health plans represent a substantial sector for the insurance market could be such a factor, as could demographics.) In the Committee's view, VA's allocation policy should reflect a balance between local retention of funds to provide an incentive to maximize collections, and avoiding the imposition of financial penalties on facilities whose collections' potential is markedly limited by regional and other factors beyond the Department's control.

Section 8013 would also require the Department to refine its data capture and analysis to determine the extent to which variability in collections is due to the market in which the facilities operate, the level of effort expended in collections, and the efficiency of collections efforts. The Committee understands that, in the absence of such data, VA's allocation policy for fiscal year 1998 cannot achieve and will not reflect the level of sophistication that would be anticipated if such data were available. The Committee also understands that management considerations argue persuasively, at least for fiscal year 1998, that VA's networks, which control other VA health care resources, should manage the allocation of medical care cost recovery collections consistent with the principles discussed above. The Committee expects that, as soon as practicable after VA refines its understanding of the factors accounting for collections variability, VA will refine its allocation policies, accordingly, to take account of that data.

Section 8013 would require VA to submit quarterly report on its collections (accounting separately for collections under each of the authorities) to Congress as well as a separate report by January 1, 1999, detailing VA's collection experience for each of its 22 net-

works, and to the extent practicable, for each facility. In that report, VA would be required to analyze differences among the networks with respect to (1) the market in which the network operates (to include the extent to which managed care plans have penetrated the insurance market), (2) the effort expended to achieve collections, and (3) the efficiency of such effort. The Committee intends to oversee closely and aggressively VA's collections record and operations, and its efforts and actions to streamline and reduce costs of collection. The Committee is similarly concerned that the Department make every effort to refine its policies on dispersing collections to ensure that such policies maximize incentive and ensure equitable allocations in relation to collection effort and efficiency.

The Committee measure differs from the Administration proposal in two other key respects:

The Administration's draft bill limits the availability of third party collections to such amounts as are provided in advance in appropriations acts. The Committee provision would instead have VA retain its collections without prior action by the Appropriations Committee. One of the underpinnings of the Administration's proposal was that it would provide new incentives to increase collections. But the inclusion of a requirement making appropriations' action a precondition to VA's retaining collections—and, thus, introducing uncertainty as to whether those collections would in fact be returned in full to the Department—would inevitably diminish the very incentive the legislation is designed to instill.

Currently, VA bills insurers on the basis of its average cost. Accordingly, billings often fall markedly below VA's (or virtually any other provider's) costs and exceed such levels in other instances. (The Administration draft bill did not propose changing this concept.) The Committee measure aims to set a more appropriate billing level by providing that VA recover from insurers on the basis of reasonable charges for each case.

The Committee believes that the several policy changes it has adopted considerably strengthen the medical receipts retention concept. In the Committee's view, section 8013 offers a sound foundation for improved collections while safeguarding against the risk that factors beyond the Department's control could result in collections shortfalls and cutbacks in veteran's access to care.

Section 8014. Income verification authority

VA administers a needs-based pension program and provides some health care on a means-tested basis. Section 5317 of title 38 and section 6103 of title 26, the Internal Revenue Code, authorize VA to verify the eligibility of recipients of, or applicants for, VA needs-based benefits and VA means-tested medical care by gaining access to income records of the Department of Health and Human Services/Social Security Administration and the Internal Revenue Service. These provision were originally enacted as section 8051 of OBRA 90 and extended by section 12004 of OBRA 93 to September 30, 1998.

Section 8014 would extend VA's authority to verify this data through September 30, 2002.

Section 8015. Limitation of monthly pension for certain recipients of Medicaid-covered nursing home care

Section 5503(f) of title 38 limits to \$90 a month the maximum amount of VA nonservice-connected pension that may be paid to Medicaid-eligible veterans and surviving spouses who have no dependents and who are in nursing homes that participate in Medicaid. The payments may not be used to offset the costs of care. This section treats such individuals as if the care were being furnished at VA expense. This provision was originally enacted as section 8003 of OBRA 90, and extended by section 12005 of OBRA 93 to September 30, 1998.

Nonservice-connected pension is a needs-based program that seeks to provide a minimum level of income to wartime veterans who are permanently and totally disabled because of nonservice-connected causes. The minimum level of income is approximately equal to the poverty level, with additional amounts payable for dependents. Pension payments are offset dollar-for-dollar by any household income and can also be adjusted for unusual medical expenses. Today, the maximum pension for a single veteran with no dependents is \$8,486.

Section 8015 would extend the \$90 limitation to September 30, 2002.

Section 8016. Home loan fees

Section 3729 specifies that borrowers who obtain VA-guaranteed, insured or direct home loans will pay a fee. For first loans, the fees range from 0.5 percent to 2 percent, depending on the amount of down payment and the type of military or naval service (active duty or reserve). Purchasers of VA-owned foreclosed properties pay a fee of one percent. OBRA 93 added section 3729(a)(4) of title 38, to require a surcharge of .75 percent for all first-use loans. This provision expires on October 1, 1998.

There is no limitation to the number of times a veteran may use the VA home loan program. Section 3729 of title 38 requires a three percent fee for all second and subsequent home loans with less than a five percent down payment. This provision expires on October 1, 1998.

Section 8016 would extend the surcharge provision to September 30, 2002, and increase, from one percent to 2.25 percent, the fee paid by purchasers of VA-owned properties. The provision would also extend VA's authority to charge the 3 percent fee for second and subsequent use of the home loan program to October 1, 2002.

Section 8017. Procedures applicable to liquidation sales on defaulted home loans guaranteed by the Secretary of Veterans Affairs

Section 3732 of title 38 specifies that VA has two options when a property the financing of which is guaranteed under the VA Home Loan Guaranty Program, goes into foreclosure. VA may simply pay off the guaranty, or elect to purchase the property securing the loan in default and resell it. The decision on the course of action to take depends, generally, on VA calculations as to which action would be less costly and, therefore, more advantageous to the

government. The Secretary's authority to use the "no-bid" procedures expires on December 31, 1997.

Section 8017 would extend VA's authority to use the alternative "no-bid" formula to September 30, 2002.

Section 8018. Enhanced loan asset sale authority

Section 3720(h) of title 38 authorizes VA to guarantee the timely payment of principal and interest to purchasers of real estate mortgage investment conduits (REMICs). REMICs are used to "bundle" and market vendee loan notes. Such notes are made on direct loans made by VA to purchasers of VA-acquired real estate. Using this authority, VA guarantees to REMIC purchasers that principal and interest will be paid in a timely manner which in turn, enhances the value of the REMICs in the secondary market and increases the return to VA when such securities are sold. This provision expires on October 1, 1998.

Section 8018 would extend VA's authority to market REMICs through October 1, 2002.

SUBTITLE B—OTHER MATTERS

Section 8021. Rounding down of compensation cost-of-living adjustments in compensation and DIC rates

Compensation is paid to veterans with service-connected disabilities. Amounts of compensation are based on a rating schedule that uses 10 percent increments from zero percent to 100 percent. Fiscal year 1997 payments range from \$94 for a veteran rated as 10 percent disabled to \$1924 for a 100% disability rating.

Dependency and Indemnity Compensation (DIC) is paid to the surviving spouse of a veteran who dies of a service-connected disability. Prior to the passage of Public Law 102-568, payments were based on the rank of the deceased veteran. With the passage of Public Law 102-568, compensation for deaths occurring after January 1, 1993, were based on a flat rate. With the addition of subsequent cost-of-living adjustments (COLA), that rate is now \$794. However, survivors receiving payments in excess of the flat rate were "grandmothered" at the higher rates for deaths prior to January 1, 1993. The top rate for deaths prior to January 1, 1993, is now \$1,774.

Compensation and DIC payments are not indexed. Congress has, however, enacted legislation which, for a given year, has adjusted compensation and DIC benefits to reflect the percentage of change in the consumer price index (CPI) relative to the prior year. When such a COLA is enacted and new compensation and DIC rates are computed, the prior year's benefit—which is paid in "round dollar" amounts—is multiplied by a fraction which expresses the change in the CPI, and the product is then converted to a whole-dollar amount using "normal" rounding techniques. This is, if the product of the whole dollar amount multiplied by the CPI is a fractional dollar amount of \$0.50 or more, the compensation or DIC payment is rounded up; if it is a fractional amount of \$0.49 or less, it is rounded down. The projected 2.7 percent increase for 1998 is estimated to cost \$313,500,000.

Section 8021 would require that any increase authorized in the rates of compensation and DIC during fiscal years 1998–2002 could not exceed the percentage increase applied to payments under title II of the Social Security Act. The provision would also require that such increases be rounded down to the next lower whole dollar. For example, based on a projected 2.7 percent increase in the Social Security cost-of-living allowance, the current \$94 payment for a 10 percent disability would be multiplied by 2.7 percent. The result would be \$96.53, which would then be rounded down to \$96.

Section 8022. Withholding of payments and benefits

Section 3726 of title 38 prohibits the offset of federal payments other than veterans' or survivors' benefits, to recover losses incurred by VA arising from loans made to, assumed by, or guaranteed or insured on behalf of a veteran or surviving spouse. To offset losses through other federal payments such as salaries or federal tax refunds, the veteran or surviving spouse must consent in writing to the offset, or a court must determine the veteran or surviving spouse is liable.

Section 8022 would eliminate the consent and court determination requirements. Prior to referring the debt to another federal agency for offset, such as the IRS, the Secretary would be required to notify the veteran or surviving spouse by certified mail of the process by which the Secretary may waive indebtedness under section 5302(b) of title 38. If such a request is filed, the Secretary must determine whether the veteran or surviving spouse is responsible for some or all of the liability incurred by the Secretary, and that decision may be appealed.

HEARINGS

On February 13, 1997, the VA Committee held a hearing on the Administration's Fiscal Year 1998 Budget and its deficit reduction proposals;

On February 27, 1997, the VA Committee held a second hearing on the Administration's Fiscal Year 1998 Budget; and

On June 12, 1997, the VA Committee approved its reconciliation recommendations to the House Committee on the Budget by a vote of 18 to 4.

SECTION-BY-SECTION ANALYSIS

Section 8011(a) would amend section 1710(f)(2)(B) of title 38, United States Code, and extend for four years, through September 30, 2002, the per diem copayment requirements for hospital and nursing home care.

Section 8011(b) would amend section 1722A(c) of title 38, and extend for four years, through September 30, 2002, VA's authority to collect medication copayment from certain veterans.

Section 8012 would amend section 1729(a)(2)(E) of title 38, and extend for four years, through September 30, 2002, VA's authority to bill a health care payment plan on the basis of reasonable charges for each case of medical care furnished to a veteran who has a service-connected disability for treatment of a nonservice-connected disability.

Section 8013(a) would add a new section, section 1729A, to title 38, and establish the Department of Veteran Affairs Medical Care Collections Fund. The VA Medical Care Collections Fund replaces the existing Medical Care Cost Recovery Fund. Monies recovered or collected for medical care after September 30, 1997 would be deposited in the new fund and would be available to pay for expenses associated with veterans' medical care. This section would establish a contingency mechanism for funding VA medical care programs for three years, to guard against the risk of a shortfall in anticipated collections. Section 8013(a) would also require VA to establish a policy—which shall be designated to maximize collections, to the extent feasible—governing allocation of moies from the fund. This section would require VA to submit to Congress quarterly reports on the operation of section 8013 for fiscal years 1998–2000, and for the first quarter of fiscal year 2001.

Section 8013(b) would make conforming amendments to chapter 17 of title 38.

Section 8013(c) would eliminate the Medical Care Cost Recovery Fund, established by section 1729(g)(1) of title 38, and any unobligated balance remaining on September 30, 1997, would be deposited in the U.S. Treasury as miscellaneous receipts, not later than December 31, 1997.

Section 8013(d) would amend section 1729 of title 38, to allow VA to bill insurers on the basis of reasonable charges for each case.

Section 8013(e) would amend section 712(b)(2) of title 38, to make a technical change, which would eliminate the current law exemption of MCCR employers for purposes of determination of, and limitations on the number of full time equivalent positions at VA. Current law providers that person involved in MCCR activities are exempt from the determination of the number of statutorily mandated VA full-time employees.

Section 8013(f) would require that VA report to Congress by January 1, 1999, on the implementation of section 8013.

Section 8013(f) would establish October 1, 1997, as the effective date for section 8013, except that the amendments made by section 8013(d) would take effect on the date of enactment of this Act.

Section 8014 would amend section 5317(f) of title 38 and section 6103 of the Internal Revenue Code, and extend for four years, through September 30, 2002, VA's authority to verify income data furnished by VA by gaining access to relevant income records of the Internal Revenue Service and Social Security Administration.

Section 8015 would amend section 5503(f)(7), and extend for four years through September 30, 2002, the \$90 limitation on the maximum amount of VA pension which can be received by Medicaid-eligible veterans and surviving spouses who have no dependents and who are in nursing homes that participate in Medical.

Section 8016 would amend section 3729(a) of title 38, and extend for four years, through September 30, 2002, the loan fees currently applicable to borrowers who obtain home loans guaranteed, insured, or made by VA.

Section 8017 would amend section 3732(c)(11) of title 38, and extend for four years, through September 30, 2002, the procedures applicable to liquidation sales on defaulted home loans guaranteed by VA.

Section 8018 would amend section 3720(h)(2) of title 38, and extend through September 30, 2002, VA's authority to guarantee the timely payment of principal and interest to purchasers of real estate mortgage investment conduits.

Section 8021 would add new section 1103 (compensation) and 1303 (DIC) to title 38. Both sections would require that any cost-of-living (COLA) adjustments for compensation and DIC made during fiscal years 1998 through 2002 could not exceed the percentage increase applied to payments authorized for Social Security and would be "rounded down" to the next lower dollar.

Section 8022 would amend section 3726 of title 38 to authorize VA to refer a veteran's (or surviving spouse's) home loan guaranty debt to another Federal agency for offset under certain circumstances. Referrals would be allowed if (a) the debtor is given notice, in writing, of VA's authority to waive debts under section 5302 of title 38; (b) VA makes an affirmative determination that the debtor should not be released from liability under section 3713(b) of title 38; and (c) the debtor has been notified of procedures available to appeal a determination that a release of liability is not warranted. In effect, this provision allows VA to refer such debts to the Internal Revenue Service for offset against income tax refunds or, in the case of debtors who are Federal employees, to the debtor's employing agency for offset against salary or wages.

CHANGES IN EXISTING LAW MADE BY TITLE VIII OF THE BILL, AS REPORTED

In compliance with clause 3 of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

TITLE 38, UNITED STATES CODE

PART I—GENERAL PROVISIONS

* * * * *

CHAPTER 7—EMPLOYEES

* * * * *

§ 712. Full-time equivalent positions: limitation on reduction

(a) * * *

(b) In determining the number of full-time equivalent positions in the Department of Veterans Affairs during a fiscal year for purposes of ensuring under section 5(b) of the Federal Workforce Restructuring Act of 1994 (Public Law 103-226; 108 Stat. 115; 5 U.S.C. 3101 note) that the total number of full-time equivalent positions in all agencies of the Federal Government during a fiscal year covered by that section does not exceed the limit prescribed for that fiscal year under that section, the total number of full-time equivalent positions in the Department of Veterans Affairs during that fiscal year shall be the number equal to—

- (1) the number of such positions in the Department during that fiscal year, reduced by
- (2) the sum of the following:

(A) * * *

[(B) The number of such positions held during that fiscal year by persons involved in medical care cost recovery activities under section 1729 of this title.]

[(C)] (B) The number of such positions in the Department during that fiscal year held by persons involved in providing health-care resources under section 8111 or 8153 of this title or under section 201 of the Veterans Health Care Act of 1992 (Public Law 102-585; 106 Stat. 4949; 38 U.S.C. 8111 note).

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PART II—GENERAL BENEFITS

* * * * *

CHAPTER 11—COMPENSATION FOR SERVICE-CONNECTED DISABILITY OR DEATH

SUBCHAPTER I—GENERAL

- Sec.
- 1101. Definitions.
- 1102. Special provisions relating to surviving spouses.
- 1103. *Cost-of-living adjustments.*

* * * * *

SUBCHAPTER I—GENERAL

* * * * *

§ 1103. *Cost-of-living adjustments*

(a) *In the computation of cost-of-living adjustments for fiscal years 1998 through 2002 in the rates of, and dollar limitations applicable to, compensation payable under this chapter, such adjustments shall be made by a uniform percentage that is no more than the percentage equal to the social security increase for that fiscal year, with all increased monthly rates and limitations (other than increased rates or limitations equal to a whole dollar amount) rounded down to the next lower whole dollar amount.*

(b) *For purposes of this section, the term “social security increase” means the percentage by which benefit amounts payable under title II of the Social Security Act (42 U.S.C. 401 et seq.) are increased for any fiscal year as a result of a determination under section 215(i) of such Act (42 U.S.C. 415(i)).*

* * * * *

**CHAPTER 13—DEPENDENCY AND INDEMNITY
COMPENSATION FOR SERVICE-CONNECTED DEATHS**

SUBCHAPTER I—GENERAL

- Sec. 1301. Definitions.
 - * * * * *
- 1303. *Cost-of-living adjustments.*
 - * * * * *

SUBCHAPTER I—GENERAL

* * * * *

§ 1303. Cost-of-living adjustments

(a) *In the computation of cost-of-living adjustments for fiscal years 1998 through 2002 in the rates of dependency and indemnity compensation payable under this chapter, such adjustments shall be made by a uniform percentage that is no more than the percentage equal to the social security increase for that fiscal year, with all increased monthly rates (other than increased rates equal to a whole dollar amount) rounded down to the next lower whole dollar amount.*

(b) *For purposes of this section, the term “social security increase” means the percentage by which benefit amounts payable under title II of the Social Security Act (42 U.S.C. 401 et seq.) are increased for any fiscal year as a result of a determination under section 215(i) of such Act (42 U.S.C. 415(i)).*

* * * * *

**CHAPTER 17—HOSPITAL, NURSING HOME,
DOMICILIARY, AND MEDICAL CARE**

* * * * *

SUBCHAPTER III—MISCELLANEOUS PROVISIONS RELATING TO HOSPITAL AND NURSING HOME CARE AND MEDICAL TREATMENT OF VETERANS

- 1721. Power to make rules and regulations.
 - * * * * *
- 1729A. *Department of Veterans Affairs Medical Care Collections Fund.*
 - * * * * *

SUBCHAPTER II—HOSPITAL, NURSING HOME OR
DOMICILIARY CARE AND MEDICAL TREATMENT

§ 1710. Eligibility for hospital, nursing home, and domiciliary care

- (a) * * *
 - * * * * *

(f)(1) The Secretary may not furnish hospital care or nursing home care under this section to a veteran who is eligible for such care under subsection (a)(3) of this section unless the veteran agrees to pay to the United States the applicable amount determined under paragraph (2) of this subsection.

(2) A veteran who is furnished hospital care or nursing home care under this section and who is required under paragraph (1) of this subsection to agree to pay an amount to the United States in order to be furnished such care shall be liable to the United States for an amount equal to—

(A) * * *

(B) *before September 30, 2002*, an amount equal to \$10 for every day the veteran receives hospital care and \$5 for every day the veteran receives nursing home care.

* * * * *

[(4) Amounts collected or received on behalf of the United States under this subsection shall be deposited in the Treasury as miscellaneous receipts.]

[(5) (4) For the purposes of this subsection, the term “inpatient Medicare deductible” means the amount of the inpatient hospital deductible in effect under section 1813(b) of the Social Security Act (42 U.S.C. 1895e(b)) on the first day of the 365-day period applicable under paragraph (3) of this subsection.]

* * * * *

SUBCHAPTER III—MISCELLANEOUS PROVISIONS RELATING TO HOSPITAL AND NURSING HOME CARE AND MEDICAL TREATMENT OF VETERANS

§ 1722A. Copayment for medications

(a) * * *

(b) Amounts collected under this section shall be deposited in the [Department of Veterans Affairs Medical-Care Cost Recovery Fund] *Department of Veterans Affairs Medical Care Collections Fund*.

(c) The provisions of subsection (a) expire on September 30, [1998] 2002.

* * * * *

§ 1729. Recovery by the United States of the cost of certain care and services

(a)(1) Subject to the provisions of this section, in any case in which a veteran is furnished care or services under this chapter for a non-service-connected disability described in paragraph (2) of this subsection, the United States has the right to recover or collect [the reasonable cost of] *reasonable charges* for such care or services (as determined by the Secretary) from a third party to the extent that the veteran (or the provider of the care or services) would be eligible to receive payment for such care or services from such third party if the care or services had not been furnished by a department or agency of the United States.

(2) Paragraph (1) of this subsection applies to a non-service-connected disability—

(A) * * *

* * * * *

(E) for which care and services are furnished before October 1, [1998] 2002, under this chapter to a veteran who—

- (i) has a service-connected disability; and
- (ii) is entitled to care (or payment of the expenses of care) under a health-plan contract.

(c)(1) The Secretary may compromise, settle, or waive any claim which the United States has under this section.

(2)(A) The Secretary, after consultation with the Comptroller General of the United States, shall prescribe regulations for the purpose of determining **the reasonable cost of** *reasonable charges* for care or services under subsection (a)(1) of this section. Any determination of such **cost** *charges* shall be made in accordance with such regulations.

(B) Such regulations shall provide that **the reasonable cost of** *reasonable charges* for care or services sought to be recovered or collected from a third-party liable under a health-plan contract may not exceed the amount that such third party demonstrates to the satisfaction of the Secretary it would pay for the care or services if provided by facilities (other than facilities of departments or agencies of the United States) in the same geographic area.

* * * * *

[(g)(1) There is established in the Treasury a fund to be known as the Department of Veterans Affairs Medical-Care Cost Recovery Fund (hereafter referred to in this section as the "Fund").

[(2) Amounts recovered or collected under this section shall be deposited in the Fund.

[(3) Sums in the Fund shall be available to the Secretary for the following:

[(A) Payment of necessary expenses for the identification, billing, and collection of the cost of care and services furnished under this chapter, and for the administration and collection of payments required under subsection (f) or (g) of section 1710 of this title for hospital care, medical services, or nursing home care and under section 1722A of this title for medications, including—

[(i) the costs of computer hardware and software, word processing and telecommunications equipment, other equipment, supplies, and furniture;

[(ii) personnel training and travel costs;

[(iii) personnel and administrative costs for attorneys in the Office of General Counsel of the Department and for support personnel of such office;

[(iv) other personnel and administrative costs; and

[(v) the costs of any contract for identification, billing, or collection services.

[(B) Payment of the Secretary for reasonable charges, as determined by the Secretary, imposed for (i) services and utilities (including light, water, and heat) furnished by the Secretary, (ii) recovery and collection activities under this section, and (iii) administration of the Fund.

[(4) Not later than January 1 of each year, there shall be deposited into the Treasury as miscellaneous receipts an amount equal to the amount of the unobligated balance remaining in the Fund at the close of business on September 30 of the preceding year minus any part of such balance that the Secretary determines is necessary in order to enable the Secretary to defray, during the fis-

cal year in which the deposit is made, the expenses, payments, and costs described in paragraph (3).】

* * * * *

§ 1729A. Department of Veterans Affairs Medical Care Collections Fund

(a) *There is in the Treasury a fund to be known as the Department of Veterans Affairs Medical Care Collections Fund.*

(b) *Amounts recovered or collected after September 30, 1997, under any of the following provisions of law shall be deposited in the fund:*

(1) *Section 1710(f) of this title.*

(2) *Section 1710(g) of this title.*

(3) *Section 1711 of this title.*

(4) *Section 1722A of this title.*

(5) *Section 1729 of this title.*

(6) *Public Law 87-693, popularly known as the “Federal Medical Care Recovery Act” (42 U.S.C. 2651 et seq.), to the extent that a recovery or collection under that law is based on medical care or services furnished under this chapter.*

(c)(1) *Amounts in the fund are available to the Secretary for the following purposes:*

(A) *Furnishing medical care and services under this chapter, to be available during any fiscal year for the same purposes and subject to the same limitations as apply to amounts appropriated for that fiscal year for medical care.*

(B) *Expenses of the Department for the identification, billing, auditing, and collection of amounts owed the United States by reason of medical care and services furnished under this chapter.*

(2)(A) *If for fiscal year 1998, 1999, or 2000 the Secretary determines that the total amount to be recovered for that fiscal year under the provisions of law specified in subsection (b) will be less than the amount contained in the latest Congressional Budget Office baseline estimate (computed under section 257 of the Balanced Budget and Emergency Deficit Control Act of 1985) for the amount of such recoveries for that fiscal year by at least \$25,000,000, the Secretary shall promptly certify to the Secretary of the Treasury the amount of the shortfall (as estimated by the Secretary) that is in excess of \$25,000,000. Upon receipt of such a certification, the Secretary of the Treasury shall, not later than 30 days after receiving the certification, deposit in the fund, from any unobligated amounts in the Treasury, an amount equal to the amount certified by the Secretary.*

(B) *For a fiscal year for which a deposit is made under subparagraph (A), if the Secretary subsequently determines that the actual amount recovered for that fiscal year under the provisions of law specified in subsection (b) is greater than the amount estimated by the Secretary that was used for purposes of the certification by the Secretary under subparagraph (A), the Secretary shall pay into the general fund of the Treasury, from amounts available for medical care, an amount equal to the difference between the amount actually recovered and the amount so estimated (but not in excess of the*

amount of the deposit under subparagraph (A) pursuant to such certification).

(C) For a fiscal year for which a deposit is made under subparagraph (A), if the Secretary subsequently determines that the actual amount recovered for that fiscal year under the provisions of law specified in subsection (b) is less than the amount estimated by the Secretary that was used for purposes of the certification by the Secretary under subparagraph (A), the Secretary shall promptly certify to the Secretary of the Treasury the amount of the shortfall. Upon receipt of such a certification, the Secretary of the Treasury shall, not later than 30 days after receiving the certification, deposit in the fund, from any unobligated amounts in the Treasury, an amount equal to the amount certified by the Secretary.

(d)(1) The Secretary may allocate amounts available to the Secretary under subsection (c) among components of the Department in such manner as the Secretary considers appropriate.

(2) The Secretary shall establish a policy for the allocation under paragraph (1) of amounts in the fund. Such policy shall be designed so as to facilitate the realization of the maximum feasible collections under the provisions of law specified in subsection (b). In developing the policy, the Secretary shall take into account any factors beyond the control of the Secretary that the Secretary considers may impede such collections.

(e)(1) The Secretary shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives quarterly reports on the operation of this section for fiscal years 1998, 1999, and 2000 and for the first quarter of fiscal year 2001. Each such report shall specify the amount collected under each of the provisions specified in subsection (b) during the preceding quarter and the amount originally estimated to be collected under each such provision during such quarter.

(2) A report under paragraph (1) for a quarter shall be submitted not later than 45 days after the end of that quarter.

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PART III—READJUSTMENT AND RELATED BENEFITS

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CHAPTER 37—HOUSING AND SMALL BUSINESS LOANS

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SUBCHAPTER III—ADMINISTRATIVE PROVISIONS

* * * * *

§ 3720. Powers of Secretary

(a) * * *

* * * * *

(h)(1) The Secretary may, upon such terms and conditions as the Secretary considers appropriate, issue or approve the issuance of, and guarantee the timely payment of principal and interest on, cer-

tificates or other securities evidencing an interest in a pool of mortgage loans made in connection with the sale of properties acquired under this chapter.

(2) The Secretary may not under this subsection guarantee the payment of principal and interest on certificates or other securities issued or approved after [December 31, 1997] *September 30, 2002.*

* * * * *

§ 3726. Withholding of payments, benefits, etc.

No officer, employee, department, or agency of the United States shall set off against, or otherwise withhold from, any veteran or the surviving spouse of any veteran any payments (other than benefit payments under any law administered by the Department of Veterans Affairs) which such veteran or surviving spouse would otherwise be entitled to receive because of any liability to the Secretary allegedly arising out of any loan made to, assumed by, or guaranteed or insured on account of, such veteran or surviving spouse under this chapter, [unless (1) there is first received the consent in writing of such veteran or surviving spouse, as the case may be, or (2) such liability and the amount thereof was determined by a court of competent jurisdiction in a proceeding to which such veteran or surviving spouse was a party.] *unless the Secretary provides such veteran or surviving spouse with notice by certified mail with return receipt requested of the authority of the Secretary to waive the payment of indebtedness under section 5302(b) of this title. If the Secretary does not waive the entire amount of the liability, the Secretary shall then determine whether the veteran or surviving spouse should be released from liability under section 3713(b) of this title. If the Secretary determines that the veteran or surviving spouse should not be released from liability, the Secretary shall notify the veteran or surviving spouse of that determination and provide a notice of the procedure for appealing that determination, unless the Secretary has previously made such determination and notified the veteran or surviving spouse of the procedure for appealing the determination.*

* * * * *

§ 3729. Loan fee

(a)(1) * * *

(2) Except as provided in paragraphs (4) and (5) of this subsection, the amount of such fee shall be 1.25 percent of the total loan amount, except that—

(A) in the case of a loan made under section 3711 [or 3733(a)] of this title or for any purpose specified in section 3712 (other than section 3712(a)(1)(F)) of this title, the amount of such fee shall be one percent of the total loan amount;

* * * * *

(D) in the case of a loan made to, or guaranteed or insured on behalf of, a veteran described in section 3701(b)(5) of this title under this chapter, the amount of such fee shall be—

(i) * * *

* * * * *

(iii) in the case of a loan for a purchase (other than a purchase referred to in section 3712 of this title) or for construction with respect to which the veteran has made a downpayment of 5 percent or more of the total purchase price or construction cost—

(I) * * *

(II) 1.25 percent of the total loan amount if such downpayment is 10 percent or more of such price or cost; **[and]**

(E) in the case of a loan guaranteed under section 3710(a)(8), 3710(a)(9)(B)(i), 3710(a)(11), 3712(a)(1)(F), or 3762(h) of this title, the amount of such fee shall be 0.5 percent of the total loan amount**[.]**; *and*

(F) in the case of a loan made under section 3733(a) of this title, the amount of such fee shall be 2.25 percent of the total loan amount.

* * * * *

(4) With respect to a loan closed after September 30, 1993, and before October 1, **[1998] 2002**, for which a fee is collected under paragraph (1), the amount of such fee, as computed under paragraph (2), shall be increased by 0.75 percent of the total loan amount other than in the case of a loan described in subparagraph (A), (D)(ii), **[or (E)]** *(E) or (F)* of paragraph (2).

(5)(A) * * *

* * * * *

(C) This paragraph applies with respect to a loan closed after September 30, 1993, and before October 1, **[1998] 2002**.

* * * * *

§ 3732. Procedure on default

(a) * * *

* * * * *

(c)(1) For purposes of this subsection—

(A) * * *

* * * * *

(11) This subsection shall apply to loans closed before October 1, **[1998] 2002**.

* * * * *

PART IV—GENERAL ADMINISTRATIVE PROVISIONS

* * * * *

CHAPTER 53—SPECIAL PROVISIONS RELATING TO BENEFITS

* * * * *

§ 5302. Waiver of recovery of claims by the United States

(a) * * *

(b) With respect to any loan guaranteed, insured, or made under chapter 37 of this title, the Secretary shall, except as provided in subsection (c) of this section, waive payment of an indebtedness to the Department by the veteran (as defined in sections 101, 3701, and 3702(a)(2)(C)(ii) of this title), or the veteran's spouse, following default and loss of the property, where the Secretary determines that collection of such indebtedness would be against equity and good conscience. An application for relief under this subsection must be made within one year after the date on which the veteran receives notice by certified mail *with return receipt requested* from the Secretary of the indebtedness. The Secretary shall include in the notification a statement of the right of the veteran to submit an application for a waiver under this subsection and a description of the procedures for submitting the application.

* * * * *

§ 5317. Use of income information from other agencies: notice and verification

(a) * * *

* * * * *

(g) The authority of the Secretary to obtain information from the Secretary of the Treasury or the Secretary of Health and Human Services under section 6103(l)(7)(D)(viii) of the Internal Revenue Code of 1986 expires on September 30, **[1998]** 2002.

* * * * *

CHAPTER 55—MINORS, INCOMPETENTS, AND OTHER WARDS

§ 5503. Hospitalized veterans and estates of incompetent institutionalized veterans

(a) * * *

* * * * *

(f)(1) For the purposes of this subsection—

(A) * * *

* * * * *

(7) This subsection expires on September 30, **[1998]** 2002.

* * * * *

SECTION 8013 OF THE OMNIBUS BUDGET RECONCILIATION ACT OF 1990

SEC. 8013. MODIFICATION OF HEALTH-CARE CATEGORIES AND CO-PAYMENTS.

(a) * * *

* * * * *

[(e) SUNSET.—The amendments made by this section expire on September 30, 1991.]

SECTION 6103 OF THE INTERNAL REVENUE CODE OF 1986

SEC. 6103. CONFIDENTIALITY AND DISCLOSURE OF RETURNS AND RETURN INFORMATION.

(a) * * *

* * * * *

(1) DISCLOSURE OF RETURNS AND RETURN INFORMATION FOR PURPOSES OTHER THAN TAX ADMINISTRATION.—

(1) * * *

* * * * *

(7) Disclosure of return information to Federal, State, and local agencies administering certain programs under the Social Security Act, the Food Stamp Act of 1977, or title 38, United States Code or certain housing assistance programs.

(A) * * *

* * * * *

(D) PROGRAMS TO WHICH RULE APPLIES.—The programs to which this paragraph applies are:

(i) * * *

* * * * *

(viii)(I) * * *

Only return information from returns with respect to net earnings from self-employment and wages may be disclosed under this paragraph for use with respect to any program described in clause (viii)(IV), Clause (viii) shall not apply after September 30, [1998] 2002; and,

* * * * *

COMMITTEE OVERSIGHT FINDINGS

The Committee's oversight findings are generally contained in the Purpose and Background portion of the VA Committee's reconciliation recommendations.

OVERSIGHT FINDINGS OF THE COMMITTEE ON GOVERNMENT REFORM AND OVERSIGHT

No oversight findings have been submitted to the VA Committee by the Committee on Government Reform and Oversight.

ROLLCALL—MARKUP OF RECONCILIATION MEASURES AND H.R. 699

Name	Present	Absent	Yea	Nay	Not voting
Bob Stump, AZ, Chairman	X				
Christopher H. Smith, NJ, Vice Chairman	X				
Michael Bilirakis, FL		X			
Floyd Spence, SC	X				
Terry Everett, AL	X				
Steve Buyer, IN		X			
Jack Quinn, NY	X				
Spencer Bachus, AL		X			
Cliff Stearns, FL	X				
Dan Schaefer, CO		X			
Jerry Moran, KS	X				

ROLLCALL—MARKUP OF RECONCILIATION MEASURES AND H.R. 699—Continued

Name	Present	Absent	Yea	Nay	Not voting
John Cooksey, LA	X				
Asa Hutchinson, AR	X				
J.D. Hayworth, AZ	X				
Helen Chenoweth, ID		X			
Ray LaHood, IL	X				
Lane Evans, IL, Ranking	X				
Joseph P. Kennedy II, MA	X				
Bob Filner, CA	X				
Luis V. Gutierrez, IL	X				
James E. Clyburn, SC	X				
Corrine Brown, FL	X				
Mike Doyle, PA	X				
Frank Mascara, PA	X				
Collin Peterson, MN	X				
Julia Carson, IN		X			
Silvestre Reyes, TX	X				
Vic Snyder, AR	X				
Ciro Rodriguez	X				
Total	23	6			

ROLLCALL—KENNEDY AMENDMENT TO RECONCILIATION MEASURES TO STRIKE SEC. 8016 AND SEC. 8021

Name	Present	Absent	Yea	Nay	Not voting
Bob Stump, AZ, Chairman				X	
Christopher H. Smith, NJ, Vice Chairman				X	
Michael Bilirakis, FL					X
Floyd Spence, SC				X	
Terry Everett, AL				X	
Steve Buyer, IN					X
Jack Quinn, NY				X	
Spencer Bachus, AL					X
Cliff Stearns, FL				X	
Dan Schaffer, CO					X
Jerry Moran, KS					X
John Cooksey, LA				X	
Asa Hutchinson, AR				X	
J.D. Hayworth, AZ				X	
Helen Chenoweth, ID					X
Ray LaHood, ID				X	
Lane Evans, IL, Ranking				X	
Joseph P. Kennedy II, MA			X		
Bob Filner, CA			X		
Luis V. Gutierrez, IL				X	
James E. Clyburn, SC				X	
Corrine Brown, FL			X		
Mike Doyle, PA				X	
Frank Mascara, PA				X	
Collin Peterson, MN			X		
Julia Carson, IN					X
Silvestre Reyes, TX				X	
Vic Snyder, AR				X	
Ciro Rodriguez			X		
Total			5	17	7

ROLLCALL—RECONCILIATION MEASURES

Name	Present	Absent	Yea	Nay	Not voting
Bob Stump, AZ, Chairman			X		
Christopher H. Smith, NJ, Vice Chairman			X		
Michael Bilirakis, FL					X
Floyd Spence, SC			X		
Terry Everett, AL			X		
Steve Buyer, IN					X
Jack Quinn, NY			X		
Spencer Bachus, AL					X
Cliff Stearns, FL			X		
Dan Schaffer, CO					X
Jerry Moran, KS					X
John Cooksey, LA			X		
Asa Hutchinson, AR			X		
J.D. Hayworth, AZ			X		
Helen Chenoweth, ID					X
Ray LaHood, IL			X		
Lane Evans, IL, Ranking			X		
Joseph P. Kennedy II, MA				X	
Bob Filner, CA				X	
Luis V. Gutierrez, IL			X		
James E. Clyburn, SC			X		
Corrine Brown, FL				X	
Mike Doyle, PA			X		
Frank Mascara, PA			X		
Collin Peterson, MN				X	
Julia Carson, IN					X
Silvestre Reyes, TX			X		
Vic Snyder, AR			X		
Ciro Rodriguez			X		
Total			18	4	7

CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, June 16, 1997.

Hon. BOB STUMP,
Chairman, Committee on Veterans' Affairs, House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the enclosed cost estimate for the reconciliation recommendations approved by the House Committee on Veterans' Affairs on June 12, 1997.

The estimate shows the budgetary effects of the committee's proposals over the 1998–2007 period. CBO understands that the Committee on the Budget will be responsible for interpreting how these proposals compare with the reconciliation instructions in the budget resolution. This estimate assumes the reconciliation bill will be enacted by August 15, 1997; the estimate could change if the bill is enacted later.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contacts are Shawn Bishop, Sunita D'Monte, and Mary Helen Petrus.

Sincerely,

JUNE E. O'NEILL, *Director.*

Enclosure.

Reconciliation Recommendations of the House Committee on Veterans' Affairs (Title VIII)

Summary: Title VIII would extend through 2002 provisions of the Omnibus Reconciliation Act of 1990 (OBRA) that affect programs for veterans, allow the Department of Veterans Affairs to spend certain receipts, and round down cost-of-living adjustments (COLAs) for veterans' disability compensation. CBO estimates the recommendations would raise direct spending by \$322 million in 1998, but reduce it by about \$594 million over the 1998–2002 period. The recommendations contain no intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act of 1995 (UMRA), but they would significantly increase Medicaid costs for state governments beginning in fiscal year 1999.

Estimated cost to the Federal Government: The estimated budgetary impact of the committee's recommendations over the fiscal years 1998 through 2002 is shown in Table 1. The projected impact over 10 years is shown in Table 6, which appears at the end of this estimate.

Receipts for medical care

The committee's recommendations contain provisions that would extend the authority of the Department of Veterans Affairs (VA) to collect certain receipts and would provide new authority to spend the amounts it collects under title VIII and current law. The combined budgetary effects are shown in Table 2. In total, these provisions would increase direct spending by \$1.5 billion over the 1998–2002 period.

TABLE 1. ESTIMATED BUDGETARY IMPACT OF TITLE VIII, FISCAL YEARS 1998–2002

[By fiscal year, in millions of dollars]

	1997	1998	1999	2000	2001	2002
VETERANS PROGRAMS						
Spending Under Current Law for Veterans Programs: ¹						
Estimated Budget Authority	39,126	41,323	43,484	44,649	45,826	47,043
Estimated Outlays	39,445	41,793	43,378	46,287	43,920	46,971
Proposed Changes:						
Estimated Budget Authority	0	460	– 481	– 502	– 540	– 564
Estimated Outlays	0	322	– 448	– 546	– 495	– 564
Spending Under Title VIII for Veterans Programs:						
Estimated Budget Authority	39,126	41,783	43,003	44,147	45,286	46,479
Estimated Outlays	39,445	42,115	42,930	45,741	43,425	46,407
MEDICAID						
Spending Under Current Law for Medicaid:						
Estimated Budget Authority	98,599	105,308	113,619	122,861	132,792	143,783
Estimated Outlays	98,599	105,308	113,619	122,861	132,792	143,783
Proposed Changes:						
Estimated Budget Authority	0	0	282	280	283	292
Estimated Outlays	0	0	282	280	283	292
Spending Under Title VIII for Medicaid:						
Estimated Budget Authority	98,599	105,308	113,901	123,141	133,075	144,075
Estimated Outlays	98,599	105,308	113,901	123,141	133,075	144,075
TOTAL PROPOSED CHANGES IN DIRECT SPENDING						
Estimated Budget Authority	0	460	– 199	– 222	– 257	– 272

TABLE 1. ESTIMATED BUDGETARY IMPACT OF TITLE VIII, FISCAL YEARS 1998–2002—Continued
 [By fiscal year, in millions of dollars]

	1997	1998	1999	2000	2001	2002
Estimated Outlays	0	322	–166	–266	–212	–272

¹ CBO's baseline with adjustments for anticipated inflation.

Note: The budgetary impact of the recommendations would fall under budget function 700 (veterans' affairs) and 550 (health).

Hospital Per Diems and Medical Care Copayments.—Section 8011 would extend through September 30, 2002, VA's authority to collect per diem payments for inpatient hospitalizations and nursing home care, and other copayments for medical services provided to certain veterans. Under current law, veterans are subject to these copayments if they have no service-connected disability or a disability rated as less than 10 percent disabling, have high enough income, and are treated for a non-service-connected ailment. Extending these provisions of law, which expire on September 30, 1998, would result in collections of about \$2 million in 1999 and \$11 million over the 1999–2002 period.

In addition, this section would extend through September 30, 2002, VA's authority to collect copayments for outpatient medications that are prescribed for nonservice-connected conditions. The copayment would apply to all veterans, except those who have a service-connected disability rated at 50 percent or more or whose income falls below a certain threshold. CBO estimates that these collections would amount to about \$36 million in 1999 and \$152 million over the 1999–2002 period.

Medical Care Cost Recovery.—Section 8012 would extend through September 30, 2002, VA's authority to collect from third-party insurers the cost of treating veterans with a service-connected disability for nonservice-connected ailments. CBO estimates that collections would amount to about \$195 million in 1999 and \$829 million over five years, based on VA's recent experience and adjustments for anticipated inflation.

Medical Care Collections Fund.—Section 8013 would allow VA to spend all amounts that it collects, including copayments, per diems, and third-party recoveries. Under current law, VA will collect about \$486 million in 1998 and about \$1.5 billion over the 1998–2002 period. Sections 8011, 8012, and 8014 of the bill would add about \$1.1 billion over the five-year period to VA's collections that would be available for expenditure. Thus, this legislation would give VA additional spending authority totaling \$2.6 billion over the 1998–2002 period.

In addition, this section contains a provision that would allow VA to have direct spending authority if actual collections fall short of estimates. Specifically, Treasury funds would be made available to VA if the VA Secretary projects that its collections will fall \$25 million or more below the latest CBO baseline estimate. Under that provision VA would have permanent, indefinite authority to spend the difference between \$25 million and the amount of any shortfall greater than \$25 million during fiscal years 1998, 1999, and 2000.

This provision has potential costs but no potential savings. If recoveries are less than CBO projects by at least \$25 million, the deficit would be greater than under the baseline projection. If, on the other hand, recoveries are more than CBO projects, the additional

funds would be spent and the deficit would be unaffected. On average, therefore, this provision would increase the expected deficit in any year, an increase that CBO estimates would be about \$15 million a year for the three-year period.

Income Verification.—Section 8014 would allow VA to use data from the IRS to verify the incomes of veterans receiving benefits from VA, including medical care. Under current law, veterans whose income falls below a certain level qualify for free medical treatment. Veterans who receive free treatment, but are later found to be ineligible through income verification, could be charged the standard Medicare deductible (\$760) for the first 90 days of care, and a \$10 daily copayment. These payments revert to the Treasury as mandatory receipts. CBO estimates that VA would collect about \$17 million in 1999 and \$71 million over the 1999–2002 period as a result of this extension of its authority to verify incomes.

TABLE 2. BUDGETARY IMPACT OF PROPOSED CHANGES AFFECTING RECEIPTS FOR VETERANS MEDICAL CARE

[By fiscal year, in millions of dollars]

	1997	1998	1999	2000	2001	2002
DIRECT SPENDING						
Receipts Under Current Law from Medical Care:						
Estimated Budget Authority	– 580	– 604	– 365	– 380	– 395	– 412
Estimated Outlays	– 580	– 603	– 365	– 380	– 395	– 412
Proposed Changes:						
Estimated Budget Authority	0	501	257	267	262	273
Estimated Outlays	0	451	251	265	261	270
Receipts Under Title VIII from Medical Care:						
Estimated Budget Authority	– 580	– 103	– 108	– 113	– 133	– 139
Estimated Outlays	– 580	– 152	– 114	– 115	– 134	– 142

Housing

Veterans housing would be affected by four provisions. As shown in Table 3, these provisions would reduce direct spending by \$1.0 billion over the 1998–2002 period.

Home Loan Fees.—Section 8016 would raise the origination fee on direct loans and extend through 2002 two provisions of law pertaining to the veterans home loan program that expire on September 30, 1998. VA often acquires property when a guaranteed loan goes into foreclosure and issues a new direct loan (called a vendee loan) when the property is sold.

This section would raise the fee on vendee loans, from 1 percent to 2.25 percent of the loan amount, to match the premium charged by the Federal Housing Administration. CBO estimates that collections would rise by about \$13 million a year.

Under one provision that would be extended, VA must charge certain veterans a fee of 0.75 percent of the total loan amount. CBO estimates this provision would affect about 209,000 loans each year and raise collections by about \$150 million a year. Under current law, veterans can reuse their home loan guarantee benefit if their previous debt has been paid in full. The second provision of this section would require VA to collect a fee of 3 percent of the total loan amount from veterans who reuse this benefit. CBO esti-

mates this fee would apply to about 30,000 loans each year and raise collections by about \$57 million a year.

Withholding of Payments and Benefits.—Section 8022 would permit VA to collect certain loan guarantee debts by reducing any federal salary or federal income tax return refund due to a veteran or surviving spouse. Under current law, before VA could use these means, either it would have to obtain the written consent of the debtor or the debt would have to be due to a court determination. Based on information from VA, CBO estimates this provision would raise collections by \$90 million in 1998 from a stock of loans that originated several years ago. There would be no effect after 1998 because this provision does not apply to debts from the home loan program as it currently operates.

Liquidation Sales.—Section 8017 would extend from 1998 through 2002 a provision of law that requires VA to consider the losses it might incur when selling a property acquired through foreclosure. Under current law, VA follows a formula defined in statute to decide whether to acquire the property or pay off the loan guarantee instead. The formula requires appraisals that may be valid at the time they are made, but do not account for changes in market conditions that may occur while VA prepares to dispose of the property. This provision would require VA to take account of losses from changes in housing prices that the appraisal does not capture. Losses of this type might be prevalent when housing prices are particularly volatile or if appraisals were biased for other reasons. Since 1978, VA has suffered a resale loss every year except 1993 and 1994. Recent losses average about \$2,500 per home. Assuming this provision applies to approximately 2,000 homes each year, CBO estimates it would save \$5 million a year.

Enhanced Loan Asset Sales.—Section 8018 would extend from December 31, 1997, through fiscal year 2002 VA's authority to guarantee the real estate mortgage conduits (REMICs) that are used to market vendee loans. Vendee loans are issued to the buyers of properties that VA acquires through foreclosures. VA then sells these loans on the secondary mortgage market by using REMICs. By guaranteeing the certificates issued on a pool of loans, VA obtains a better price but also assumes some risk.

Because recent history indicates that receipts would increase by about 0.3 percent of sales, CBO estimates that this provision would save about \$5 million a year based on sales of \$1.6 billion. If this provision were not enacted, VA could market vendee loans under other provisions of law. Nevertheless, this provision would permit VA to realize a better price for a package of vendee loans than if it used a REMIC program of the Government National Mortgage Association

TABLE 3. BUDGETARY IMPACT OF PROPOSED CHANGES TO THE VETERANS HOME LOAN PROGRAM
[By fiscal year, in millions of dollars]

	1997	1998	1999	2000	2001	2002
DIRECT SPENDING						
Spending Under Current Law for Veterans Housing Programs:						
Estimated Budget Authority	– 627	145	296	310	311	308
Estimated Outlays	– 695	71	229	252	256	261

TABLE 3. BUDGETARY IMPACT OF PROPOSED CHANGES TO THE VETERANS HOME LOAN PROGRAM—Continued

[By fiscal year, in millions of dollars]

	1997	1998	1999	2000	2001	2002
Proposed Changes:						
Estimated Budget Authority	0	-16	-233	-232	-229	-224
Estimated Outlays	0	-106	-233	-232	-229	-224
Spending Under Title VIII for Veterans Housing Programs:						
Estimated Budget Authority	-627	129	63	78	82	84
Estimated Outlays	-695	-35	-4	20	27	37

Pensions

Veterans pensions would be affected by two provisions. As shown in Table 4, these provisions would reduce direct spending for veterans' pensions and increase spending for Medicaid, resulting in a net spending reduction of \$0.7 billion over the 1999–2002 period.

Pension Limitation for Medicaid-Eligible Veterans in Nursing Homes.—Section 8015 would extend from September 30, 1998, to September 30, 2002, the expiration date on a provision of law that sets a \$90 per month limit on pensions for any veteran without a spouse or child, or for any survivor of a veteran, who is receiving Medicaid coverage in a Medicaid-approved nursing home. It also allows the beneficiary to retain the pension instead of having to use it to defray nursing home costs.

Based on VA's experience under current law, this estimate assumes that the extension of the expiration date would affect approximately 16,000 veterans and 27,000 survivors. According to VA, average savings were about \$12,000 for veterans and \$8,000 for survivors in 1996. Higher Medicaid payments to nursing homes would offset some of the savings credited to VA. Net savings would increase from \$129 million in 1999 to \$174 million in 2002.

Income Verification. Current law authorizes VA to acquire information on income reported to the Internal Revenue Service (IRS) to verify income reported by recipients of VA pension benefits. This authorization expires on September 30, 1998. Section 8014 would extend the expiration date to September 30, 2002. This estimate is based on VA's recent experience, which has shown that about \$4 million in new savings is achieved annually through this income match. Savings would grow from \$4 million in 1999 to \$16 million in 2002 as each year a new cohort of veterans is subject to income verification.

TABLE 4. BUDGETARY IMPACT OF PROPOSED CHANGES TO VETERANS PENSIONS

[By fiscal year, in millions of dollars]

	1997	1998	1999	2000	2001	2002
VETERANS PENSIONS						
Spending Under Current Law for Veterans Pensions:						
Estimated Budget Authority	2,975	2,975	3,427	3,454	3,513	3,608
Estimated Outlays	2,975	2,989	3,399	3,751	3,203	3,604
Proposed Changes:						
Estimated Budget Authority	0	0	-452	-454	-463	-483
Estimated Outlays	0	0	-415	-491	-426	-482
Spending Under Title VIII for Veterans Pensions:						
Estimated Budget Authority	2,975	2,975	2,975	3,000	3,050	3,125

TABLE 4. BUDGETARY IMPACT OF PROPOSED CHANGES TO VETERANS PENSIONS—Continued
 [By fiscal year, in millions of dollars]

	1997	1998	1999	2000	2001	2002
Estimated Outlays	2,975	2,989	2,984	3,049	2,777	3,122
MEDICAID						
Spending Under Current Law for Medicaid:						
Estimated Budget Authority	98,599	105,308	113,619	122,861	132,792	143,783
Estimated Outlays	98,599	105,308	113,619	122,861	132,792	143,783
Proposed Changes:						
Estimated Budget Authority	0	0	282	280	283	292
Estimated Outlays	0	0	282	280	283	292
Spending Under Title VIII for Medicaid:						
Estimated Budget Authority	98,599	105,308	113,901	123,141	133,075	144,075
Estimated Outlays	98,599	105,308	113,901	123,141	133,075	144,075
TOTAL PROPOSED CHANGES IN DIRECT SPENDING						
Estimated Budget Authority	0	0	-170	-174	-180	-191
Estimated Outlays	0	0	-133	-211	-143	-190

Compensation

The budget resolution baseline assumes that monthly payments of disability compensation to veterans and monthly payments of dependency and indemnity compensation (DIC) to their survivors are increased by the same cost-of-living adjustment (COLA) payable to Social Security recipients. The results of the adjustments are rounded to the nearest dollar. Section 8021 would require VA to round down, to the next lower dollar, adjustments to disability compensation and DIC through 2002. CBO estimated the savings from this provision using the current table of monthly benefits and the number of beneficiaries assumed in the baseline. As shown in Table 5, savings from this section would be about \$23 million in 1998, growing to \$128 million in 2002.

Estimated impact on State, local, and tribal governments: This title contains no intergovernmental mandates as defined in UMRA. It would, however, significantly increase Medicaid costs for state governments. CBO estimates that states would spend an additional \$213 million for the Medicaid program in fiscal year 1999 and an additional \$857 million between 1999 and 2002. Under UMRA, these costs would not be considered mandate costs because states have the flexibility to offset them by reducing their programmatic or financial responsibilities elsewhere in the Medicaid program.

The proposal would extend until September 30, 2002, the limitation on the monthly pension that certain veterans in nursing homes could receive. Under current law, this limitation will expire on September 30, 1998. The effect of the extension would be to require the Medicaid program to continue covering 100 percent of the nursing home expenses of certain veterans after fiscal year 1998. The states' portion of these costs totals about \$213 million annually. Under current law, the Department of Veterans Affairs and the veterans themselves would have paid these costs.

TABLE 5. BUDGETARY IMPACT OF PROPOSED CHANGES TO VETERANS COMPENSATION

[By fiscal year, in millions of dollars]

	1997	1998	1999	2000	2001	2002
DIRECT SPENDING						
Spending Under Current Law for Veterans Compensation:						
Estimated Budget Authority	16,082	16,742	17,366	17,809	18,243	18,680
Estimated Outlays	15,942	16,687	17,314	19,257	16,723	18,643
Proposed Changes:						
Estimated Budget Authority	0	-25	-53	-83	-110	-130
Estimated Outlays	0	-23	-51	-88	-101	-128
Spending Under Title VIII for Veterans Compensation:						
Estimated Budget Authority	16,082	16,717	17,313	17,726	18,133	18,550
Estimated Outlays	15,942	16,664	17,263	19,169	16,622	18,515

Estimated impact on the private sector: This bill would impose no new private-sector mandates as defined UMRA.

Estimate prepared by—Federal Cost: Shawn Bishop (medical care), Sunita D'Monte (housing), and Mary Helen Petrus (compensation and pension); Impact on State, Local, and Tribal Governments: Marc Nicole; Impact on the Private Sector: Rachel Schmidt.

Estimate approved by: Robert A. Sunshine, Deputy Assistant Director for Budget Analysis.

TABLE 6.—ESTIMATED BUDGETARY EFFECTS OF TITLE VIII, FISCAL YEARS 1998–2007—RECONCILIATION RECOMMENDATIONS OF THE HOUSE COMMITTEE ON VETERANS' AFFAIRS

[In millions of dollars, by fiscal years]

	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	1998–2007 total
CHANGES IN VETERANS PROGRAMS											
Medical Care Receipts:											
Estimated Budget Authority	501	257	267	262	273	284	295	308	320	333	3,099
Estimated Outlays	451	251	265	261	270	311	297	306	319	332	3,063
Housing:											
Estimated Budget Authority	-16	-233	-232	-229	-224	0	0	0	0	0	-934
Estimated Outlays	-106	-233	-232	-229	-224	0	0	0	0	0	-1,024
Pensions:											
Estimated Budget Authority	0	-452	-454	-463	-483	0	0	0	0	0	-1,852
Estimated Outlays	0	-415	-491	-426	-482	0	0	0	0	0	-1,814
Compensation:											
Estimated Budget Authority	-25	-53	-83	-110	-130	0	0	0	0	0	-401
Estimated Outlays	-23	-51	-88	-101	-128	0	0	0	0	0	-391
Total Veterans Programs:											
Estimated Budget Authority	460	-481	-502	-540	-564	284	295	308	320	333	-88
Estimated Outlays	322	-448	-546	-495	-564	311	297	306	319	332	-166
CHANGES IN MEDICAID											
Estimated Budget Authority	0	282	280	283	292	0	0	0	0	0	1,137
Estimated Outlays	0	282	280	283	292	0	0	0	0	0	1,137
TOTAL CHANGE IN DIRECT SPENDING											
Estimated Budget Authority	460	-199	-222	-257	-272	284	295	308	320	333	1,049
Estimated Outlays	322	-166	-266	-212	-272	311	297	306	319	332	971

COMMITTEE ON WAYS AND MEANS,
HOUSE OF REPRESENTATIVES,
Washington, DC, June 13, 1997.

Hon. JOHN KASICH,
Chairman, Committee on the Budget,
Washington, DC.

DEAR MR. CHAIRMAN: On June 10, 1997, the Committee on Ways and Means, pursuant to H. Con. Res. 84, the Concurrent Resolution on the Budget of Fiscal Year 1998, ordered favorably reported, as amended, its budget reconciliation human resources recommendations to the Committee on Budget by a recorded vote of 21 to 18 with a quorum present. Accordingly, I am now transmitting these recommendations to you.

Pursuant to your letter dated May 30, enclosed are the legislative language and explanatory report language.

Please feel free to contact me or Pete Singleton if you have any questions. With best personal regards,

Sincerely,

BILL ARCHER, *Chairman.*

Enclosures.

SUMMARY TABLE—BY SUBTITLE, BY PROGRAM, FEDERAL BUDGETARY EFFECTS OF WAYS AND MEANS RECONCILIATION PROPOSALS—TITLE IX

[By fiscal year, in millions of dollars. Estimates based on draft legislative language and clarifications specified by Committee staff. Assumes enactment by August 15, 1997]

	1997	1998	1999	2000	2001	2002	1997-2002 total	1998-2002 total
DIRECT SPENDING								
Subtitle A: Temporary Assistance for needy Families Block Grant, ¹ Welfare to Work Grants:								
Budget Authority ..	0	750	1,250	1,000	0	0	3,000	3,000
Outlays	0	137	596	1,087	779	385	2,984	2,984
Subtitle B: Supplemental Security Income, ^{2 3} SSI:								
Budget Authority ..	0	(35)	(70)	(80)	(90)	(105)	(380)	(380)
Outlays	0	(35)	(70)	(80)	(90)	(105)	(380)	(380)
Subtitle D: Restricting Welfare and Public Benefits for Aliens; SSI:								
Budget Authority	200	1,900	1,650	1,525	1,150	1,175	7,600	7,400
Outlays	200	1,900	1,650	1,525	1,150	1,175	7,600	7,400
Food Stamp Program:								
Budget Authority	0	0	0	0	0	0	0	0

**SUMMARY TABLE—BY SUBTITLE, BY PROGRAM, FEDERAL BUDGETARY EFFECTS OF WAYS AND
MEANS RECONCILIATION PROPOSALS—TITLE IX—Continued**

[By fiscal year, in millions of dollars. Estimates based on draft legislative language and clarifications specified by
Committee staff. Assumes enactment by August 15, 1997]

	1997	1998	1999	2000	2001	2002	1997-2002 total	1998-2002 total
Outlays	0	0	0	0	0	0	0	0
Medicaid:								
Budget Au- thority	40	375	350	300	275	275	1,615	1,575
Outlays	40	375	350	300	275	275	1,615	1,575
Total Subtitle D:								
Budget Authority ..	240	2,275	2,000	1,825	1,425	1,450	9,215	8,975
Outlays	240	2,275	2,000	1,825	1,425	1,450	9,215	8,975
Subtitle: Unemployment Compensation: ⁴								
Budget Authority ..	0	(34)	(36)	(238)	(247)	(257)	(814)	(814)
Outlays	0	(34)	(36)	(238)	(247)	(257)	(814)	(814)
Total Direct Spending:								
Budget Authority ..	240	2,956	3,144	2,507	1,088	1,088	11,021	10,781
Outlays	240	2,343	2,490	2,594	1,867	1,473	11,005	10,765
REVENUES								
Subtitle: Unemployment C	0	0	(11)	488	495	410	1,380	1,380

¹This estimate assumes that states would use nearly all of the \$3 billion in welfare-to-work grants that would be established by the proposal. We are continuing to survey some states about their likelihood of using this money.

²The bill proposes to repeal the maintenance-of-effort requirement for state supplementation of federal SSI benefits found in section 1618 of the Social Security Act. That repeal would have no direct effect on the federal budget, but it could have indirect effects. Assuming that states reduce their supplements in response to this provision, the principal indirect effects on federal outlays would be an increase in Food Stamp costs (as some beneficiaries' Food Stamps would rise to offset a part of their lost supplements), and a decrease in Medicaid spending (as a few beneficiaries who gain coverage solely through state supplements lose that coverage). CBO's best estimate is that these effects would be roughly offsetting, so that no federal costs or savings are shown as a consequence of the repeal of Sec. 1618. The proposed legislation does not make clear whether the state of California's ability to "cash out" Food Stamp benefits for SSI recipients, which is now based on its relatively high supplements and its compliance with the maintenance-of-effort requirement, would end. ("Cashout" means that a small part of the supplement is simply regarded as a substitute for Food Stamp benefits.) However, CBO's conclusion about federal budgetary impacts from the repeal of the maintenance-of-effort requirement is not very sensitive to assumptions about the continuation of California's cashout status.

³The bill would permit the proceeds from extra fees for federal administration of state supplements to be appropriated to help cover the administrative expenses of the Social Security Administration. The bill does not, however, directly grant SSA authority to spend those proceeds.

⁴The unemployment benefit outlay savings shown assume an adjustment to the CBO March 1997 baseline to reflect increases due to the April 4, 1997 decision by the Seventh Circuit U.S. Court of Appeals, which affirmed the judgment of the district court in the case of Pennington v. Doherty.

Notes: Details may not add to totals because of rounding.

I. INTRODUCTION

A. PURPOSE AND SUMMARY

The budget agreement worked out between the Congress and the Administration included several issues under the jurisdiction of the Committee on Ways and Means. These items are items about which the Committee or its Subcommittee on Human Resources has held hearings and introduced legislation over the past two years (with one exception) are contained in the Committee's reconciliation recommendation to the Committee on the Budget.

Although the general purpose of this proposal is to balance the budget within 5 years, each of the 23 provisions in the Committee recommendation to the Committee on the Budget are good public policy and stand on their own merits. One set of proposals deals with issues raised by last year's welfare reform legislation. Here the Committee clarified work requirements and the number of hours certain workfare participants may work, given the amount of taxpayer-paid benefits they receive, while satisfying minimum wage requirements. The Committee also, in accord with the budget

agreement, creates a new \$3 billion welfare-to-work grant aimed at helping the most disadvantaged and least job ready welfare recipients obtain jobs.

Another set of proposals addresses the issue of welfare benefits for noncitizens. The Committee proposal includes about \$9 billion in welfare benefits for noncitizens who were receiving benefits when the welfare reform law, enacted last August, restricted welfare benefits for noncitizens. This policy will provide Supplemental Security Income (SSI) and Medicaid benefits to about 500,000 noncitizens who would otherwise lose them no later than October 1, 1997. The Committee proposal also extends from 5 years to 7 years the time during which refugees, asylees, and those whose deportation is being withheld can receive SSI and Medicaid, continues SSI benefits for permanent resident alien members of Indian tribes living along the U.S./Canada and U.S./Mexico border, and authorizes States and localities to require applicants for welfare benefits to provide proof of eligibility.

Since passage of the welfare reform law last year, the Committee has closely followed implementation of the stricter eligibility guidelines for children receiving SSI benefits. Because implementation fell behind schedule, the Committee proposal gives the Social Security Administration an additional 6 months to review cases in applying the new guidelines. The proposal also clarifies that regardless of when reviews are conducted, the new eligibility guidelines must be applied. In accordance with the budget agreement, the proposal requires the Social Security Administration to increase fees for including State SSI supplements in the Federal benefit check. It also would repeal the maintenance of effort requirement that States must maintain their State SSI supplement at 1983 levels.

Finally, the Committee proposal, in reaction to the *Pennington v. Doherty* court decision by the Federal district court in Illinois, contains a proposal clarifying that States have complete authority in setting the base period for determining eligibility for unemployment benefits. Consistent with the budget agreement, the proposal increases the ceilings for the Federal unemployment compensation trust funds, limits transfers from Federal to State accounts to \$100 million annually in the coming years, and authorizes specific amounts for unemployment compensation "integrity" activities designed to reduce overpayments. Given the recent concern with States' maintaining adequate reserves in their unemployment trust fund accounts, the proposal would reward States that reach a State-specific criterion for high trust fund levels by granting these States interest-free loans if the necessity for borrowing from the Federal loan account should occur. Other provisions exclude certain inmates, poll workers, and employers of religious schools from eligibility for UI benefits.

Taken together, the Committee proposal both fulfills the spending and savings terms of the budget agreement and reforms several of the important social programs under the Committee's jurisdiction.

B. LEGISLATIVE HISTORY

The Subcommittee on Human Resources of the Committee on Ways and Means held a hearing on February 13, 1997 on the

President's Fiscal Year 1998 Budget and heard testimony from the Honorable Lamar Smith (TX), representatives of the Clinton Administration, and other interested parties.

On June 6, 1997, the Subcommittee on Human Resources ordered favorably reported to the full Committee, as amended, budget reconciliation human resources recommendations by a recorded vote of 8 to 3 with a quorum present.

On June 10, 1997, the Committee on Ways and Means approved and reported to the Committee on the Budget, as amended, budget reconciliation human resources recommendations by a recorded vote of 21 to 18.

II. EXPLANATION OF PROVISIONS

SUBTITLE A—TANF BLOCK GRANTS

Section 9001. Welfare-to-work grants

Present law

The law combines recent Federal funding levels for three repealed programs (AFDC, Emergency Assistance, and JOBS) into a single block grant (\$16.5 billion annually through Fiscal Year 2002). Each State is entitled to the sum it received for these programs in a recent year, but no part of the TANF grant is earmarked for any program component, such as benefits or work programs. The law also provides an average of \$2.3 billion annually in a child care block grant.

Explanation of provision

After reserving 1 percent of each year's appropriation for Indian tribes and 0.5 percent for evaluation by the Secretary of HHS, the remainder of each year's appropriation is divided into two grant funds of \$1.478 billion each. The first fund is used for grants to States and localities and is allocated by a formula based equally on each State's share of the national poor population, unemployed workers, and adults receiving assistance under the Temporary Assistance for Needy Families block grant. Funds may also be used to help noncustodial parents of children receiving benefits under the Temporary Assistance for Needy Families program enter the labor force. The second fund is used to support proposals submitted by private industry councils (authorized by the Job Training Partnership Act) or political subdivisions of States that are determined by the Secretary of Labor, in consultation with the Secretaries of Health and Human Services and Housing and Urban Development, to hold promise for helping long-term welfare recipients enter the workforce.

Formula grants from the first fund are to be provided to States for the purpose of initiating projects that aim to place long-term welfare recipients in the workforce. Governors must distribute at least 85 percent of the State allotment to service delivery areas within the State. These funds must be distributed in accord with a formula devised by the governor that bases at least 50 percent of its allocation weight on poverty and may also include two additional factors, welfare recipients who have received benefits for 30 or more months and unemployment. Any service delivery area that,

under this formula, would be allocated less than \$100,000 will not receive any funds; these funds will instead revert to the governor. Governors may use up to 15 percent of the State allocation, plus any amounts remitted from service delivery areas that would be allotted less than \$100,000, to fund projects designed to help long-term recipients enter the workforce. Formula grant funds for service delivery areas must be passed through to private industry councils; these councils have sole authority to expend funds, but they cannot conduct programs themselves and the agency responsible for the TANF program must approve the grant proposal.

Competitive grants are awarded in FY 1998 and FY 2000, although approved projects can receive funds from the Secretary every year and have 3 years to spend funds once obligated, on the basis of the likelihood that program applicants can successfully make long-term placements of welfare-dependent individuals into the workforce. The Secretary must select projects that show promise in: (1) expanding the base of knowledge about welfare-to-work programs for the least job ready; (2) moving the least job ready recipients into the labor force; and (3) moving the least job ready recipients into the labor force even in labor markets that have a shortage of low-skill jobs. Other factors the Secretary, at her discretion, may use to select projects include: history of success in moving individuals with multiple barriers into work; evidence of ability to leverage private, State, and local resources; use of State and local resources that exceed the required match; plans to coordinate with other organizations at the local and State level; and use of current or former welfare recipients as mentors, case managers, or service providers. Private industry councils or any political subdivision of a State may apply for funds. The Secretary cannot award grants unless the TANF agency has approved the grant application. Further, the Secretary, in consultation with the Secretaries of Health and Human Services and Housing and Urban Development, must terminate funds for a project upon a determination that the private industry council and the TANF agency are not adhering to the agreement. The Secretary must ensure that at least 65 percent of each year's amount available for competitive grants is awarded for projects in the 100 cities in the U.S. that have the highest number of poor adults and that at least 25 percent is reserved for spending in rural areas. Awards to each project must be based on the Secretary's determination of the amount needed for the project to be successful. Allowable activities include job creation, on-the-job training, contracts with public or private providers of employment services, job vouchers, and job support services. The Secretary must include several required outcome measures in the evaluation study and must report to Congress on program outcomes in 1999 and 2001.

Funds under both the competitive grants and the formula grants can be spent only for job creation through public or private sector employment wage subsidies; on-the-job training; contracts with public or private providers of readiness, placement, and post-employment services; job vouchers for placement, readiness, and post-employment services; and job support services (not including child care) if such services are not otherwise available. Any entity receiving funds under either grant must expend at least 90 percent of the

money on recipients who possess a pattern of characteristics that include long-term receipt of welfare, school dropout, drug addiction, a poor work history, and imminent termination of welfare benefits.

Entitlement funds available under this program are \$0.75 billion for fiscal year 1998, \$1.25 billion for fiscal year 1999, and \$1.0 billion for fiscal year 2000. The Secretary would be provided with funds to evaluate the welfare-to-work projects and is required to include several specific measures, such as success in job placements, in her evaluation of the program.

The proposal also contains worker protections that would apply to work activities supported by funds from the new welfare-to-work grant. These protections would include worker displacement language, a prohibition on using recipients to violate collective bargaining contracts, health and safety standards, and a grievance procedure that includes financial sanctions against States that violate the grievance procedure.

Reason for change

After many years of research on welfare-to-work programs, there is now widespread agreement that good programs can help welfare recipients enter the workforce. However, it is also generally acknowledged that many welfare recipients, especially those with low education, low skills, and little job experience, have difficulty finding jobs and even more difficulty keeping jobs once they are found. In fact, the few programs that have made serious attempts to help the least job ready enter the labor force have found that extensive efforts are required to help these workers, both before and during the time they hold jobs, as well as after they have lost jobs.

However, so few programs have attempted to help the least job-ready recipients enter the labor force that we know far too little about the types of activities that will be most successful in helping them. This grant program should help States and local governments work with the private sector in finding new ways to help these welfare recipients—as well as the noncustodial parents of children on welfare—make the difficult transition into the work force while simultaneously helping hundreds of thousands of such recipients actually enter the workforce. For that reason, it is especially important that the State or local TANF agency be directly involved in planning for, and carrying out, these job creation activities. It is the TANF agency that will be held accountable for meeting the work requirements and time limits of the welfare law. It is also important for the TANF agency and the local private industry council to work together so that unnecessary duplication can be avoided. The Committee proposal strikes the right balance between these important considerations. This grant program will become increasingly important as the most job ready adults welfare and the State welfare caseloads come to have increasingly high proportions of seriously disadvantaged recipients.

Effective date

Date of enactment (funds are available beginning in fiscal year 1998).

Section 9002. Limitation on amount of Federal funds transferable to title XX programs

Present law

States may transfer up to 30 percent of their TANF funds to the Title XX block grant and the Child Care and Development Block Grant (CCDBG), but no more than one-third of the total transfer may go to the former. (For every \$1 transferred to Title XX, \$2 must go to the child care block grant.)

Explanation of provision

The 30 percent transfer provision is replaced with a provision allowing State to transfer up to 30 percent of their TANF funds to the child care block grant and up to 10 percent of the TANF funds to the Title XX block grant. States may transfer funds to both block grants, but the total amount transferred may not exceed 30 percent of TANF funds in any year. The provision that transfer to the Title XX block grant can be spent only on children and families below 200 percent of the poverty level is retained.

Reason for change

States have vast new responsibilities under last year's welfare reform law. Notably, they must not only provide benefits for destitute families, but they must now do so while helping these families get back on their feet and become self-sufficient. The mandatory work standards and time limits of the welfare reform legislation force States to mount effective programs in helping dependent families both during the time they are on welfare and once they enter the labor force. To achieve both the goal of providing welfare benefits and the goal of helping families become self-sufficient, States need flexible source of funding. The block grant structure of Temporary Assistance for Needy Families, Title XX, and the Child Care and Development Block grants is an important tool to help States achieve these difficult goals. These resources can be used by States even more effectively if they have the flexibility to transfer funds between these block grants so they can spend the money where it is needed most. This provision will make it easier for States to transfer money to the Title XX block grant while ensuring that the money must be spent on families with children.

Effective date

August 22, 1996.

Section 9003. Clarification of limitation on number of persons who may be treated as engaged in work by reason of participation in education activities

Present law

The law restricts to 20 percent the proportion of persons in all families and in 2-parent families who may be treated as engaged in work for a month by reason of participating in vocational education training or, if single teenage household heads without a high school diploma, by reason of satisfactory attendance at secondary school or participation in education directly related to employment.

Explanation of provision

Rather than restrict to 20 percent the proportion of persons in all families and in 2-parent families who may be treated as engaged in work by reason of vocational educational training, secondary education, or education related to employment, this provision adjusts the limitation so that no more than 30 percent of those who qualify as meeting the work standard may do so by participating in vocational educational, training, secondary education, and other education related to employment. Teen heads of household are exempted from this limitation.

Reason for change

One purpose of the welfare reform law is to help adults on welfare become self-sufficient by entering the labor force. Based on years of experience with welfare-to-work programs on a vast research literature on these programs, the legislation was based on the judgment that the most effective approach to helping welfare recipients enter the labor force is by requiring actual work or by providing help in searching for work. Thus, the legislation emphasized work and job search and allowed a more moderate role for education. The Committee provision closes a loophole in the original legislation that allowed States, in fulfilling their work requirement, to count 20 percent of their entire caseload if they were in education activities. The intent of the legislation was to allow States to count participants in educational activities up to 20 percent of those required to meet the work requirement, not 20 percent of the entire caseload. However, primarily because 40 percent of TANF adult recipients have not completed high school, the Committee wanted to allow States to count a reasonable number of people participating in educational activities toward the work participation rate. Thus, the Committee proposal allows States to meet 30 percent, rather than 20 percent, of their work requirement with recipients in vocational educational activities and also allows States to exempt teen heads-of-household attending school from the 30 percent limitation. This reinforces a provision of the underlying law which conditions the receipt of TANF benefits by a teen parent on satisfactory school attendance. Without this exemption, in some States, the limit on vocational education could accommodate only teen parents.

Effective date

August 21, 1996.

*Section 9004. Required hours of work and labor provisions**Present law*

The new welfare law is silent on the issue of coverage of TANF "workforce" participants by the Federal wage standards. TANF work activities include two workfare programs: work experience and community service. In these programs, recipients are required to perform services in exchange for their cash benefit. For single parents, required weekly hours of workfare (or other work activity) begin at 20 and, for those without a preschool child, rise to 30 in fiscal year 2000. For two-parent families, minimum average hours

are 35 weekly. Application of Federal wage standards to TANF workfare programs would require some States to increase TANF benefits, especially for smaller families, and/or to add Food Stamp benefits in order to meet Federal wage standards with half-time (or $\frac{3}{4}$ time) workfare assignments.

Explanation of provision

The portion of Committee action addressing hours of work and wages can be summarized in several points. First, no employment position in the private sector is affected by the Committee recommendation. Thus, current statutes and regulations that govern minimum wage and other labor protections for private sector jobs are unaffected by the Committee proposal. Second, welfare recipients in workfare and training placements in the public and nonprofit sectors are not defined as employees for purposes of Federal labor legislation. Third, even though recipients in these placements are not employees, States are nonetheless constrained in the number of hours they may require welfare recipients to serve in these placements. More specifically, States may not require recipients to be employed by a public agency or nonprofit organization for a number of hours greater than the welfare benefits package divided by the minimum wage (\$4.75 per hour until September 1, 1997, then \$5.15 per hour).

Fourth, the welfare benefits package used in the hours computation must include the dollar value of benefits provided under the Temporary Assistance for Needy Families (TANF) program plus the dollar value of benefits provided by the Food Stamp program. At State option, the welfare benefits package may also include the insurance value of Medicaid (as defined by the Secretary), the dollar value of child care benefits, and the dollar value of housing benefits. In conducting the hours of work computation, States may calculate the value of each benefit in the benefit package either by using the average value of each benefit in the State or by using the actual value of each benefit received by particular families.

Finally, if recipients are employed for at least the number of hours equal to the dollar value of TANF benefits plus the dollar value of Food Stamp benefits divided by the Federal minimum wage, then States may subtract from the hours of work required to meet the participation standard (20 hours per week in 1997 and 1998, 25 hours in 1999, and 30 hours in 2000 and thereafter) the number of hours recipients participate in various educational activities.

With regard to worker protections, all Federal and State health and safety standards apply to the working conditions of recipients engaged in any work activity under the TANF program. Workers' compensation must be provided to participants in work programs on the same basis as it is provided to other workers in the State in similar employment.

Reason for change

The Committee proposal applies minimum wage requirements to all welfare recipients while counting more taxpayer-provided benefits in determining the hours certain recipients can be required to work. A notable feature of the Committee approach is that posi-

tions in the private sector are treated exactly as they are under current law. The major goal of the welfare reform law was to help recipients leave welfare and establish their independence through work. Experience shows that most of these jobs will be in the private sector. Thus, the Committee provision leaves untouched all the current Federal protections for anyone who enters a private-sector job. The Committee provision also clarifies that work experience or community service positions in the public or nonprofit sectors are not considered employment for purposes of Federal legislation. Welfare recipients in such positions must participate for the number of hours equal to the value of their welfare benefits package divided by the Federal minimum wage. In order to promote flexibility for States in providing a minimum wage, States may also require participants to engage in educational activities if they have first worked for the number of hours equal to the value of TANF benefit plus Food Stamp benefit divided by the minimum wage.

The following example illustrates how a State can meet work participation rates, while at the same time not requiring recipients to be employed in a workfare program for a number of hours greater than the value of their welfare benefits divided by the minimum wage. Assume that in the year 2000 when the work requirement is 30 hours a State places a recipient in a workfare position with a government or non-profit agency. Assume further that the recipient receives cash and Food Stamp benefits worth \$412 dollars per month (the Committee proposal allows States also to count the value of Medicaid, child care and housing benefits as part of the welfare benefits package). This recipient could then be required to work for \$412 divided by the minimum wage of \$5.15 or 20 hours per week (80 hours per month). If the State wants to count this recipient as meeting the work requirement, the State could either supply additional benefits worth approximately \$206 per month, require the recipient to participate in educational activities for an additional 10 hours per week, or some combination of these two approaches. Thus, the Committee approach maintains the minimum wage and provides States with flexibility in meeting welfare reform work requirements. The Committee recommendation also applies health and safety standards and worker displacement protections to workfare positions held by TANF recipients.

Effective date

August 22, 1996.

Section 9005. Penalty for failure of state to reduce assistance for recipients refusing without good cause to work

Present law

States are required to reduce benefits pro rata (or more, at the option of the State) during any period in which recipients refuse to meet work requirements.

Explanation of provision

The Secretary is required to reduce the annual TANF grant amount by between 1 and 5 percent in the case of States that do not reduce assistance pro rata for missed work.

Reason for change

The welfare reform law required States to reduce benefit payments in proportion to the amount of work they choose to miss. However, in reviewing the welfare reform plans submitted to the Department of Health and Human Services by States, there is little indication that States are planning the administrative procedures necessary to ensure that benefits are reduced in proportion to missed work assignments. Thus, the Committee directed the Secretary to impose fines on States that refuse to comply with this important provision of the welfare reform legislation.

Effective date

August 22, 1996.

SUBTITLE B—SUPPLEMENTAL SECURITY INCOME

*Section 9101. Requirement to perform childhood disability redeterminations in missed cases**Present law*

By August 22, 1997 (one year after the date of enactment of P.L. 104–193), the Commissioner of the Social Security Administration (SSA) is expected to redetermine the eligibility of any child receiving SSI benefits on August 22, 1996, whose eligibility may be affected by changes in childhood disability eligibility criteria, including the new definition of childhood disability and the elimination of the individualized functional assessment. Benefits of current recipients will continue until the later of July 1, 1997 or a redetermination assessment. Should a child be found ineligible, benefits will end following redetermination. Within 1 year of attainment of age 18, SSA is expected to make a medical redetermination of current SSI childhood recipients using adult disability eligibility criteria. For low birth weight babies, a review must be conducted within 12 months after the birth of a child whose low birth weight is a contributing factor to his or her disability.

Explanation of provision

This provision extends from 1 year after the date of enactment to 18 months after the date of enactment the period by which SSA must redetermine the eligibility of any child receiving benefits on August 22, 1996 whose eligibility may be affected by changes in childhood disability. The provision also specifies that any child subject to an SSI redetermination under the terms of the welfare reform law whose redetermination does not occur during the 18-month period following enactment (that is, by February 22, 1998) is to be assessed as soon as practicable thereafter using the new eligibility standards applied to other children under the welfare reform law.

Reason for change

Due to delay in releasing implementing regulations, the Committee is extending from 12 months to 18 months the period of time for SSA to redetermine the eligibility of any child receiving SSI benefits on August 22, 1996 whose eligibility may be affected by

changes in the childhood eligibility criteria. In addition, Congress intended that all children affected by the changes in P.L. 104–193 would be redetermined using the new eligibility criteria and not the medical improvement standard.

Effective date

August 22, 1996.

Section 9102. Repeal of maintenance of effort requirements applicable to optional state programs for supplementation of SSI benefits

Present law

Since the beginning of the SSI program, States have had the option to supplement the Federal SSI payment with State funds. The purpose of section 1618 of the Social Security Act was to encourage States to pass along to SSI recipients the amount of any Federal SSI benefit increase. Under section 1618, a State that is found to be not in compliance with the “pass along/maintenance of effort” provision is subject to loss of its Medicaid reimbursements. Section 1618 allows States to comply with the “pass along/maintenance of effort” provision by either maintaining their State supplementary payment levels at or above 1983 levels or by maintaining total annual expenditures for supplementary payments (including any Federal cost-of-living adjustment) at a level at least equal to the prior 12-month period, provided that State was in compliance for that period. In effect, section 1618 requires that once a State elects to provide supplementary payments it must continue to do so.

Explanation of provision

The maintenance of effort requirements applicable to optional State programs for supplementation of SSI benefits are repealed.

Reason for change

In nearly every social program in which States pay a substantial portion of the benefits, States have the authority to establish benefit levels. However, in the Supplemental Security Income program, States that supplement the Federal benefit are required by Federal law to maintain benefits at or above their 1983 level. The Committee proposal, however, is based on the principle that States should be able to establish and to change benefits levels in accordance with the actions of elected State officials. Thus, the proposal overturns the Federal freeze on State supplemental payments and allows States complete control in setting their own benefits.

Effective date

Date of enactment.

Sec. 9103. Fees for Federal Administration of State Supplementary Payments

Present law

P.L. 103–66, the Omnibus Budget Reconciliation Act of 1993, stipulated that part of the administrative cost of the SSI program was to be funded through a user fee. Since fiscal year 1994, States

have been required to pay a fee of Federal administration of State supplementary SSI payments. Thus, States that choose to have their supplementary SSI payments administered by the Social Security Administration must pay the Commissioner or Social Security \$5 per payment for fiscal year 1996 and each succeeding year, or a different rate deemed appropriate for the State by the Commissioner (the rate per payment was \$1.67 in fiscal year 1994 and \$3.33 in fiscal year 1995).

Explanation of provision

The administrative fee charged by the Federal government for including State supplemental SSI payments with the Federal SSI check is increased as follows:

<i>Fiscal year</i>	<i>Adminis- trative fee</i>
1997	\$5.00
1998	6.20
1999	7.60
2000	7.80
2001	8.10
2002	8.50

For 2003 and subsequent years, the rate from the previous year is increased by the percentage by which the Consumer Price Index increased that year or a different amount established by the Commissioner. Revenue attributed to the increase in fees (i.e., amounts in excess of \$5.00) each year would, subject to the appropriation process, be available to defray the Social Security Administration's administrative costs.

Reason for change

The basis for the 1993 Congressional decision to charge administrative fees against States that include their State supplement in the Federal SSI check is that States are using Federal administrative resources to fulfill a State function. Given that the Federal government is absorbing the cost of providing a service to States, it is reasonable to ask States to defray the Federal costs. The Committee proposal simply extends this principle into the future by increasing the fee States must pay in rough correlation with inflation and other factors that cause Federal costs to increase.

Effective date

Date of enactment.

SUBTITLE C—CHILD SUPPORT ENFORCEMENT

Section 9201. Clarification of Authority to Permit Certain Disclosures of Wage and Claim Information

Present law

P.L. 104-193 gives the Department of Health and Human Services (HHS) the authority to obtain information about the wages and unemployment compensation paid to individuals from State unemployment compensation agencies for the State Directory of New Hires. The State Directory of New Hires is then to furnish this

wage and claim information, on a quarterly basis, to the National Directory of New Hires. P.L. 104–193 also requires State unemployment compensation agencies to establish such safeguards as the Secretary of Labor determines are necessary to insure that the information disclosed to the National Directory of New Hires is used only for the purpose of administering programs under State plans approved under the Child Support Enforcement program, the Temporary Assistance for Needy Families (TANF) block grant, and for other purposes authorized in section 453 of the Social Security Act (as amended by P.L. 104–193).

Explanation of provision

Although the welfare reform law allowed HHS to disclose information from the Directory of New Hires to the Social Security Administration and to the Internal Revenue Service, the wording of a provision in the child support title of the legislation could be interpreted to contradict this policy. This wording is amended to clarify that HHS is authorized to share information from the Directory of New Hires with the Social Security Administration and the Internal Revenue Service.

Reason for change

This purely technical proposal is necessary to clarify current law and allow the Office of Child Support Enforcement to share information collected from States with the Social Security Administration and the Internal Revenue Service.

Effective date

August 22, 1996.

SUBTITLE D—RESTRICTING WELFARE AND PUBLIC BENEFITS FOR ALIENS

Section 9301. Extension of eligibility period for refugees and certain other qualified aliens from 5 to 7 years for SSI and Medicaid

Present law

Current law provides a 5-year exemption from: (1) the bar against SSI and Food Stamps; and (2) the provision allowing States to deny “qualified aliens” access to Medicaid, TANF, and Social Services Block Grant for three groups of aliens admitted for humanitarian reasons. These groups are (1) refugees, for 5 years after entry; (2) asylees, for 5 years after being granted asylum; and (3) aliens whose deportation is withheld on the grounds of likely persecution upon return, for 5 years after such withholding.

Explanation of provision

This change would lengthen the period during which eligibility for SSI and Medicaid is guaranteed to three groups (refugees, asylees, and aliens whose deportation has been withheld) from 5 years to 7 years.

Reason for change

The 5-year exception in the welfare law was designed to allow refugees and asylees, who often arrive in the U.S. with few posses-

sions, time to adjust to life here. However, because of delays in adjusting to permanent resident status, mandatory residency requirements before applying for citizenship, and recent increases in waiting times in the naturalization process, under the 5-year eligibility period many would become ineligible for welfare benefits despite their attempting to naturalize at their earliest opportunity. By extending the exception to allow these groups 7 instead of 5 years of eligibility, these noncitizens would be given more time to naturalize while continuing to receive welfare benefits without interruption.

Effective date

August 22, 1996.

Section 9302. SSI eligibility for aliens receiving SSI on August 22, 1996

Present law

SSI. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193) bars most "qualified aliens" from Supplemental Security Income (SSI) (sec. 402(a)). Current recipients must be screened for continuing eligibility during a 1-year period after enactment of the welfare law (i.e., by Aug. 22, 1997). The pending fiscal year 1997 supplemental appropriations bill would extend this date until September 30, 1997.

Medicaid.—States may exclude "qualified aliens" who entered the United States before enactment of the welfare law (August 22, 1996) from Medicaid beginning January 1, 1997 (sec. 402(b)). Additionally, to the extent that legal immigrants' receipt of Medicaid is based only on their eligibility for SSI, some will lose Medicaid because of their ineligibility for SSI.

Definitions and exemptions.—"Qualified aliens" are defined by P.L. 104-193 (as amended by P.L. 104-208) as aliens admitted for legal permanent residence (i.e., immigrants), refugees, aliens paroled into the United States for at least 1 year, aliens granted asylum or related relief, and certain abused spouses and children.

Certain "qualified aliens" are exempted from the SSI ban and the State option to deny Medicaid, as well as from certain other restrictions. These groups include: (1) refugees for 5 years after admission and asylees 5 years after obtaining asylum; (2) aliens who have worked, or may be credited with, 40 "qualifying quarters." As defined by P.L. 104-193, a "qualifying quarter" is a 3-month work period with sufficient income to qualify as a social security quarter and, with respect to periods beginning after 1996, during which the worker did not receive Federal means-based assistance (sec. 435). The "qualifying quarter" test takes into account work performed by the alien, the alien's parent while the alien was under age 18, and the alien's spouse (provided the alien remains married to the spouse or the spouse is deceased); and (3) veterans, active duty members of the armed forces, and their spouses and unmarried dependent children.

Explanation of provision

Legal noncitizens who were receiving SSI benefits on August 22, 1996 (the date of enactment of the welfare reform law) would re-

main eligible for SSI, despite underlying restrictions in the Personal Responsibility and Work Opportunity Reconciliation Act. This section also specifies that Cuban and Haitian entrants and Amerasian immigrants are to be considered qualified aliens, thereby continuing the SSI and Medicaid eligibility of those who were receiving SSI benefits on August 22, 1996.

Reason for change

The new welfare law would restrict SSI and Food Stamp benefits for noncitizens, with the exception of those who have worked for at least 10 years or who have become naturalized citizens. However, to smooth the transition for those who were already receiving benefits, additional changes were sought to allow for continued cash and health care benefits. Under this change, Food Stamp benefits would remain generally restricted to noncitizens, and noncitizens not enrolled on SSI as of August 22, 1996 would remain ineligible for SSI benefits unless they naturalize or work for 10 or more years. For those in the U.S. when the President signed the new welfare law but who were not then on SSI, special exceptions in the naturalization process remain available to elderly noncitizens who have resided in the U.S. for a number of years and also for individuals with disabilities that prevent their passing the language or civics tests for naturalization. In addition, Medicaid is available at State option for all noncitizens residing in the U.S. on August 22, 1996.

Effective date

August 22, 1996.

Section 9303. SSI eligibility for permanent resident aliens who are members of an Indian tribe

Present law

With limited exceptions, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104–193) makes “qualified aliens,” including aliens lawfully admitted for permanent residence, ineligible for Supplemental Security Income (SSI). The limited exceptions to this bar do not include an exception based on membership in an Indian tribe.

Though the immigration status of foreign-born Indians can, like that of other aliens, vary from individual to individual, immigration law does accord certain Indians entry rights that facilitate their residing here as legal permanent residents. Section 289 of the Immigration and Nationality Act of 1952 (INA) preserves the right of free passage recognized in the Jay Treaty of 1794 by allowing “American Indians born in Canada” unimpeded entry and residency rights if they “possess at least 50 per centum of blood of the American Indian race.” By regulation, individuals who enter the U.S. and reside here under this provision are regarded as lawful permanent resident aliens.

Entirely separate from immigration law, the Indian Self-Determination and Education Assistance Act defines “Indian tribe” as a tribe, band, nation, or other organized group that is recognized as eligible for special Indian programs and services. Recognition may

be based on a treaty or statute, or may be drawn from the acknowledgment process. Not all Indian communities, nations, tribes, and other groups are Federally recognized.

Explanation of provision

Permanent resident Indians who are members of recognized tribes are eligible for SSI, despite restrictions in the welfare law on noncitizens' eligibility for benefits.

Reason for change

This change is made to protect the longstanding entry rights and access to benefits of members of certain Indian tribes residing in the U.S. as lawful permanent residents.

Effective date

August 22, 1996.

Section 9304. Verification of eligibility for State and local public benefits

Present law

Last year's welfare reform law requires the Attorney General, in consultation with the Secretary of Health and Human Services, to promulgate regulations requiring verification that persons applying for Federal public benefits are citizens or qualified aliens and eligible for the benefits (sec. 432(a)). The law also requires that States administering programs that provide a Federal benefit have a verification system that complies with the regulation (sec. 432(b)). However, the law does not provide authority for State and local governments to verify eligibility for State or local public benefits.

Explanation of provision

This provision authorizes States or political subdivisions to require an applicant for State or local public benefits (as defined in section 411(c) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996) to provide proof of eligibility.

Reason for change

This change will allow States and local governments to require proof of eligibility, including evidence pertaining to citizenship status, for individuals seeking welfare benefits. (See section 506 of House Report 104-828.)

Effective date

August 22, 1996.

Section 9305. Derivative eligibility for benefits

Present law

States may exclude "qualified aliens" who entered the United States before enactment of the welfare law (August 22, 1996) from Medicaid beginning January 1, 1997 (sec. 402(b)). Sec. 1902(a)(10) of the Social Security Act makes all individuals who are receiving SSI eligible for medical assistance under the Medicaid program. Under the welfare law, most "qualified aliens" are ineligible for

both SSI and Food Stamps. Under section 5(a) of the Food Stamp Act, households in which each member receives SSI benefits are also eligible for Food Stamps.

Explanation of provision

This section clarifies that legal noncitizens eligible for SSI under the provisions of this subtitle are also eligible for Medicaid benefits. In addition, individuals made ineligible for Food Stamp benefits as a result of the welfare reform law are not to have their eligibility for Food Stamps restored as a result of the renewed eligibility for SSI.

Reason for change

This section clarifies that individuals receiving SSI benefits on August 22, 1996 (who under section 9302 of this subtitle would maintain eligibility for SSI benefits) would also be assured of coverage under Medicaid, despite provisions in welfare reform law that allow States the option of restricting Medicaid benefits for qualified aliens in the U.S. on August 22, 1996. Food Stamp benefits would remain generally restricted for noncitizens, despite individuals' continued eligibility for SSI.

Effective date

August 22, 1996.

Section 9306. Effective date

Present law

No provision.

Explanation of provision

Except as otherwise provided, the amendments made by this subtitle shall be effective as if included in the enactment of title IV of the Personal Responsibility and Work Opportunity Act of 1996.

Reason for change

This section clarifies that all provisions in this subtitle are to apply as if included in the welfare reform law (whose effective date was August 22, 1996).

Effective date

August 22, 1996.

SUBTITLE E—UNEMPLOYMENT COMPENSATION

Section 9401. Clarifying provision relating to base periods

Present law

Federal law establishes broad guidelines for the operation of State unemployment insurance (UI) programs but leaves most of the details of eligibility and benefits to State determination. One of these general Federal guidelines calls for States to use administrative methods that ensure full payment of UI benefits "when due." All states meet this requirement with program rules that the U.S. Department of Labor has found to be in compliance. In com-

plying with the “when due” clause, States must decide what “base period” to use in measuring a claimant’s wage history for the purpose of determining individual eligibility and benefit entitlement. States have generally used a base period consisting of the first 4 of the last 5 completed calendar quarters. However, several States that use this base period also use an “alternative base period,” usually the last 4 completed calendar quarters. This alternative base period is used for claimants who are found to be ineligible because their earnings were too low in the regular base period. Although current State base periods have Department of Labor approval, a Federal court in Illinois, in the case of *Pennington v. Doherty*, ruled that the State of Illinois is not in compliance with the “when due” clause because it could use a more recent base period, which would benefit a significant number of claimants. This case may be appealed further. If left standing, it will apply only to three States: Illinois, Indiana, and Wisconsin. However, similar suits have been filed in other States, and they could lead to a de facto national rules change based on judicial action.

Explanation of provision

The Committee amendment reinforces current policy by affirming that States have complete authority to set their own base periods used in determining individuals’ eligibility for unemployment insurance benefits.

Reason for change

Since the inception of the UI program in the 1930s, there has been general agreement that each State has the right to set its own base period used to determine eligibility for unemployment benefits. This general assumption recently was called into question by the *Pennington* decision. If the decision stands, according to the Congressional Budget Office (CBO), 41 States could be required to adopt alternative base periods at a cost of \$400 million annually in added UI benefits plus increased administrative costs. CBO assumes that, without the Committee provision, States would increase their revenue collections (by raising payroll) to cover any increase in benefit outlays.

Effective date

This section shall apply for purposes of any period beginning before, on, or after the date of enactment of this Act.

Sections 9402 and 9403. Increase in federal unemployment account ceiling and special distribution to states from the unemployment trust fund

Present law

FUTA taxes are credited to Federal accounts in the Unemployment Trust Fund in proportions that are set by statute. Funds are held in reserve in these accounts to provide Federal spending authority for certain purposes. The Employment Security Administration Account (ESAA) funds Federal and State administration of the UI program. The Extended Unemployment Compensation Account (EUCA) finances the Federal share of extended UI benefits. The

Federal Unemployment Account (FUA) provides authority for loans to States with insolvent UI benefit accounts. Each of these accounts has a statutory ceiling. ESAA's balance after the end of a fiscal year is reduced to 40% of the prior-year appropriation from ESAA. Excess funds are transferred to EUCA and/or FUA. The ceilings on EUCA and FUA are set as a percent of total wages in employment covered by UI. The current ceilings are 0.5% of wages for EUCA and 0.25% of wages for FUA. If all three accounts reach their ceilings, excess funds are distributed among the 53 State benefit accounts in the Unemployment Trust Fund, after repayment of any outstanding general revenue advances to FUA and EUCA. These transfers to the State accounts are termed "Reed Act transfers" after the name of the legislation that authorized this use of excess FUTA funds. The Department of Labor projects that Reed Act transfers will be triggered beginning in fiscal year 2000 under present law.

Explanation of provision

This provision would double the Federal Unemployment Account ceiling from 0.25 percent to 0.50 percent of covered wages, effective at the beginning of fiscal year 2002. In addition, for each of fiscal years 2000, 2001, and 2002, if Federal account ceilings are reached, an annual total of more than \$100 million in Reed Act transfers are to be made from Federal UI accounts to State accounts for use by States in administering their UI programs. (Annual amounts in excess of \$100 million are to accrue to the Federal Unemployment Account, notwithstanding the ceiling). Funds are to be distributed among the States in the same manner as administrative funds from the Federal account are allocated.

Reason for change

This provision has two main effects: (1) raising the ceiling in the Federal Unemployment Account while limiting Reed Act transfers allows for further buildup of funds pending a future recession requiring increased administrative resources; and (2) allowing \$100 million in Reed Act transfers will assist States in the administration of their UI programs.

Effective date

The increase in the Federal Unemployment Account ceiling is to occur on October 1, 2001; special distributions are made beginning in fiscal year 2000, based on account balances at the end of the preceding fiscal year.

Section 9404. Interest-free advances to state accounts in unemployment trust fund restricted to states which meet funding goals

Present law

The Unemployment Trust Fund has 53 benefits accounts for the UI programs of each State, the District of Columbia, Puerto Rico, and the Virgin Islands. Each of these jurisdictions raises revenue from their own payroll taxes to finance the UI benefits they pay to their jobless workers. State UI revenue collections are deposited with the U.S. Treasury, which credits the individual State ac-

counts. Each State's benefit payments are reimbursed by the Federal government; these reimbursements are charged against their trust fund accounts. The balance in each account represents the amount available to a State for payment of UI benefits at any point in time. If a State account becomes insolvent, the State can receive an interest-bearing loan from the Federal government. Should a State account become insolvent during an economic downturn, adverse conditions can result for the State and its employers. Borrowing Federal funds imposes a cost on the State at a time when it may face other financial difficulties. The State may react by raising taxes on its employers, thereby discouraging economic activity during a period when its economy is already in decline. Thus, States strive to adopt financing policies that assure a positive balance will be maintained in their benefit accounts during all foreseeable circumstances, including economic downturns. However, account balances vary widely among the States in relation to the States' benefit payments and covered wages. As a result, some States find it necessary to borrow Federal funds more often than others. Congress has never applied Federal standards to State benefit account reserve levels.

Explanation of provision

States that maintain adequate reserves (defined as sufficient to cover, in 4 out of the 5 most recent calendar quarters, the average benefits paid during the 3 years out of the last 20 years in which the State paid the greatest UI benefits) would be allowed to receive interest-free, Federal loans for the operation of State UI program activities.

Reason for change

The provision would encourage States to maintain sufficient unemployment trust fund balances to cover the needs of unemployed workers in the event of a recession.

Effective date

Applies to calendar years beginning after the date of enactment.

Section 9405. Exemption of service performed by election workers from the federal unemployment tax

Present law

The Federal Unemployment Tax Act generally requires States to cover under their unemployment compensation laws work performed in the employment of a State or local government. Only certain enumerated exceptions are allowed.

Explanation of provision

The proposal would exempt from FUTA taxes and UI benefits work performed as an election official or election worker. This exemption would apply only if the annual wages received by the individual for such service is less than \$1,000.

Reason for change

The Committee believes that short-term employment as an election official or election worker should not be used as the basis for participation in the unemployment compensation system.

Effective date

Date of enactment.

*Section 9406. Treatment of certain services performed by inmates**Present law*

The Federal Unemployment Tax Act (FUTA) imposes a 6.2 percent gross tax rate on the first \$7,000 of wages paid annually by covered employers to each employee. Generally, wages are defined to include all remuneration for employment unless specifically exempted. There is no exemption for wages paid to persons committed to penal institutions. However, in the requirement of FUTA that States cover State and local employment, an exception is permitted for government wages paid to inmates.

Explanation of provision

The proposal would exempt wages paid to persons committed to penal institutions from the definition of wages for FUTA tax purposes. These persons would also be ineligible to claim unemployment benefits with respect to such wages.

Reason for change

The Committee provision prevents a person committed to a penal institution from qualifying for unemployment insurance benefits. The Committee also intends that if a State has denied unemployment benefits to a person because the person's qualifying wages were earned while the person was committed to a penal institution, before or after the effective date of this change, that such denial of unemployment benefits does not place that State's law out of conformity with Federal law and does not prevent certification of that State's law by the Secretary of Labor pursuant to section 3304 of the Internal Revenue Code of 1986.

Effective date

The proposal would be effective with respect to service performed after March 26, 1996.

*Section 9407. Exemption of service performed for an elementary or secondary school operated primarily for religious purposes from the federal unemployment tax**Present law*

The Federal Unemployment Tax Act requires States to cover under their unemployment compensation laws certain nonprofit organizations designated under FUTA. Specifically, FUTA exempts service performed in the employ of: (1) a church or convention or association of churches, or (2) an organization which is operated primarily for religious purposes and which is operated, supervised, controlled, or principally supported by a church or convention or

association of churches. Individuals who are in the employ of entities with a religious orientation which are not affiliated with a particular church, or convention or association of churches are not exempt.

Explanation of provision

The proposal would exempt from both the FUTA tax and UI benefits work performed in an elementary or secondary school which is operated primarily for religious purposes. This exemption would be available to such schools even though they are not operated, supervised, controlled, or principally supported by a church or convention or association of churches. Persons performing such service would also be ineligible to claim benefits with respect to such wages.

Reason for change

The Committee believes that employees of certain schools with a religious orientation should be treated similarly for FUTA tax purposes regardless of the school's affiliation, or lack thereof, with a particular church, or convention, or association of churches.

Effective date

Date of enactment.

Section 9408. State program integrity activities for unemployment compensation

Present law

Each State administers its UI program. Funding for administration is provided from FUTA. A portion of FUTA revenue is allocated to ESAA in the Unemployment Trust Fund. Congress makes annual appropriations from this account for UI administration. The Department of Labor decides how to allocate appropriated funds among the States based on its analysis of expected claims workloads in each State and each State's cost for personnel and non-personnel activities.

While the specific uses of these State grants generally are left to each State as it decides how to administer UI in compliance with the applicable Federal and State laws, Congress has created specific spending authority from time to time to assure that certain Federal objectives are funded. For example, "worker profiling" (the identification of claimants likely to experience long-term unemployment for the purpose of early intervention with employment services) has received earmarked funding in recent years.

There is no separate spending authority for "program integrity" activities. These activities include initial claims reviews, eligibility reviews, financial controls over benefit payments, and audits of employer tax liabilities. Such activities are undertaken by the States using funds from the general UI administrative grants allocated to them by the Department of Labor from annual appropriations.

Explanation of provision

The Committee amendment provides special funding for unemployment insurance program integrity activities designed to im-

prove the accuracy of benefit payments and employer tax collections through fiscal year 2002. The provision authorizes funding for integrity activities, defines integrity activities, and requires States to maintain integrity activity levels funded by the base grant for unemployment insurance administration.

Reason for change

Recent UI administrative funding has fallen below levels needed to maintain adequate State program integrity activities, including screening initial claims for separation issues to determine validity of claims, benefit payment control, tax field audits and eligibility reviews. Additional integrity activities paid for through these added funds would assist in assuring benefit payment accuracy, detection of overpayments (both fraud and non-fraud), collection of overpayments, and collection of under-reported taxes. Continued failure to adequately fund these activities will result in losses due to overpayment of benefits and undercollection of taxes, leading to higher taxes for employers and economic inefficiency.

Effective date

Date of enactment.

SUBTITLE F—INCREASE IN THE PUBLIC DEBT LIMIT

Present law

The statutory limit on the public debt currently is \$5.5 trillion. It was set at this level in P.L. 104–121, enacted into law on March 29, 1996.

Reasons for change

When the current debt limit is reached, the Treasury will be unable to meet the Federal Government's financial obligations and to manage the Federal debt effectively. Although the month of May 1997 ended with approximately \$5.26 trillion outstanding public debt that is subject to the current \$5.5 trillion limitation, the Treasury Department requested that the Committee increase the statutory limit. Current estimates forecast that a limit of \$5.95 trillion should be sufficient to cover Federal Government borrowing needs through December 14, 1999, as the Congress and Administration guide the Federal budget to balance in the year 2002.

The Committee believes it is imperative to increase the debt limit on a permanent basis to facilitate the smooth functioning of the Federal Government and to prevent any disruption of financial markets.

Explanation of provision

The bill increases the statutory limit on the public debt to \$5.95 trillion. The new debt limit has no expiration date.

Effective date

The provision is effective on the date of enactment.

III. VOTES OF THE COMMITTEE

In compliance with clause 2(1)(2)(B) of rule XI of the Rules of the House of Representatives, the following statements are made concerning the votes of the Committee on Ways and Means in its consideration of the Budget Reconciliation Human Resources Recommendations:

Motion to report Budget Reconciliation Human Resources Recommendations

The Committee on Ways and Means approved the reconciliation human resources provisions by a rollcall vote of 21 yeas to 18 nays (with a quorum being present). The vote was follows:

Representatives	Yea	Nay	Representatives	Yea	Nay
Mr. Archer	X	.....	Mr. Rangel .....	.....	X
Mr. Crane	X	.....	Mr. Stark .....	.....	X
Mr. Thomas	X	.....	Mr. Matsui .....	.....	X
Mr. Shaw	X	.....	Mrs. Kennelly .....	.....	X
Mrs. Johnson	X	.....	Mr. Coyne .....	.....	X
Mr. Bunning	X	.....	Mr. Levin .....	.....	X
Mr. Houghton	X	.....	Mr. Cardin .....	.....	X
Mr. Herger .....	.....	X	Mr. McDermott .....	.....	X
Mr. McCreery	X	.....	Mr. Kleczka .....	.....	X
Mr. Camp	X	.....	Mr. Lewis .....	.....	X
Mr. Ramstad	X	.....	Mr. Neal .....	.....	X
Mr. Nussle	X	.....	Mr. McNulty .....	.....	X
Mr. Johnson	X	.....	Mr. Jefferson .....	.....	X
Ms. Dunn	X	.....	Mr. Tanner .....	.....	X
Mr. Collins .....	.....	X	Mr. Becerra .....	.....	X
Mr. Portman	X	.....	Mrs. Thurman .....	.....	X
Mr. English	X	.....		
Mr. Ensign	X	.....		
Mr. Christensen	X	.....		
Mr. Watkins	X	.....		
Mr. Hayworth	X	.....		
Mr. Weller	X	.....		
Mr. Hulshof	X	.....		

Votes on amendments

Rollcall votes were conducted on the following amendments to the Chairman's amendment in the nature of a substitute:

An amendment by Mr. Tanner to Subtitle A, Section 9001, to award bonuses to States for meeting specific performance goals was defeated by a rollcall vote of 16 yeas to 19 nays. The vote was as follows:

Representatives	Yea	Nay	Representatives	Yea	Nay
Mr. Archer	X	Mr. Rangel	X	.....
Mr. Crane	X	Mr. Stark	X	.....
Mr. Thomas	Mr. Matsui	X	.....
Mr. Shaw	X	Mrs. Kennelly	X	.....
Mrs. Johnson	X	Mr. Coyne	X	.....
Mr. Bunning	X	Mr. Levin	X	.....
Mr. Houghton	X	Mr. Cardin	X	.....
Mr. Herger	X	Mr. McDermott	X	.....
Mr. McCreery	X	Mr. Kleczka	X	.....
Mr. Camp	X	Mr. Lewis	X	.....
Mr. Ramstad	X	Mr. Neal .....	.....	.....
Mr. Nussle	Mr. McNulty	X	.....
Mr. Johnson	Mr. Jefferson	X	.....

Representatives	Yea	Nay	Representatives	Yea	Nay
Ms. Dunn		X	Mr. Tanner	X	
Mr. Collins		X	Mr. Becerra	X	
Mr. Portman		X	Mrs. Thurman	X	
Mr. English		X			
Mr. Ensign	X				
Mr. Christensen		X			
Mr. Watkins		X			
Mr. Hayworth		X			
Mr. Weller		X			
Mr. Hulshof		X			

An amendment by Mr. Stark to strike Section 9003, Subtitle A, which limits to 30 percent the number of families participating in educational activities that may be counted towards the State's work participation rate was defeated by a rollcall vote of 16 yeas to 21 nays. The vote was as follows:

Representatives	Yea	Nay	Representatives	Yea	Nay
Mr. Archer		X	Mr. Rangel	X	
Mr. Crane		X	Mr. Stark	X	
Mr. Thomas			Mr. Matsui	X	
Mr. Shaw		X	Mrs. Kennelly	X	
Mrs. Johnson		X	Mr. Coyne	X	
Mr. Bunning		X	Mr. Levin	X	
Mr. Houghton		X	Mr. Cardin	X	
Mr. Herger		X	Mr. McDermott	X	
Mr. McCreery		X	Mr. Kleczka	X	
Mr. Camp		X	Mr. Lewis	X	
Mr. Ramstad			Mr. Neal	X	
Mr. Nussle		X	Mr. McNulty	X	
Mr. Johnson		X	Mr. Jefferson	X	
Ms. Dunn		X	Mr. Tanner	X	
Mr. Collins		X	Mr. Becerra	X	
Mr. Portman		X	Mrs. Thurman	X	
Mr. English		X			
Mr. Ensign		X			
Mr. Christensen		X			
Mr. Watkins		X			
Mr. Hayworth		X			
Mr. Weller		X			
Mr. Hulshof		X			

An amendment by Mrs. Kennelly to Subtitle A, Section 9003, to remove teen parents from the 30 percent limitation on persons engaged in educational activities counting towards the participation rate was agreed to by a rollcall vote of 20 yeas to 17 nays. The vote was as follows:

Representatives	Yea	Nay	Representatives	Yea	Nay
Mr. Archer		X	Mr. Rangel	X	
Mr. Crane		X	Mr. Stark	X	
Mr. Thomas			Mr. Matsui	X	
Mr. Shaw		X	Mrs. Kennelly	X	
Mrs. Johnson	X		Mr. Coyne	X	
Mr. Bunning	X		Mr. Levin	X	
Mr. Houghton	X		Mr. Cardin	X	
Mr. Herger		X	Mr. McDermott	X	
Mr. McCreery			Mr. Kleczka	X	
Mr. Camp		X	Mr. Lewis	X	
Mr. Ramstad		X	Mr. Neal	X	
Mr. Nussle		X	Mr. McNulty	X	
Mr. Johnson		X	Mr. Jefferson	X	

Representatives	Yea	Nay	Representatives	Yea	Nay
Ms. Dunn		X	Mr. Tanner	X	
Mr. Collins	X		Mr. Becerra	X	
Mr. Portman		X	Mrs. Thurman	X	
Mr. English		X			
Mr. Ensign		X			
Mr. Christensen		X			
Mr. Watkins		X			
Mr. Hayworth		X			
Mr. Weller		X			
Mr. Hulshof		X			

An amendment by Stark to strike Section 9004, Subtitle A, relating to the allowable hours of work was defeated by a rollcall vote of 16 yeas to 22 nays. The vote was as follows:

Representatives	Yea	Nay	Representatives	Yea	Nay
Mr. Archer			Mr. Rangel	X	
Mr. Crane		X	Mr. Stark	X	
Mr. Thomas		X	Mr. Matsui	X	
Mr. Shaw		X	Mrs. Kennelly	X	
Mrs. Johnson		X	Mr. Coyne	X	
Mr. Bunning		X	Mr. Levin	X	
Mr. Houghton		X	Mr. Cardin	X	
Mr. Herger		X	Mr. McDermott	X	
Mr. McCreery		X	Mr. Kleczka	X	
Mr. Camp		X	Mr. Lewis	X	
Mr. Ramstad		X	Mr. Neal	X	
Mr. Nussle		X	Mr. McNulty	X	
Mr. Johnson		X	Mr. Jefferson	X	
Ms. Dunn		X	Mr. Tanner	X	
Mr. Collins		X	Mr. Becerra	X	
Mr. Portman		X	Mrs. Thurman	X	
Mr. English		X			
Mr. Ensign		X			
Mr. Christensen		X			
Mr. Watkins		X			
Mr. Hayworth		X			
Mr. Weller		X			
Mr. Hulshof		X			

An amendment by Mr. Matsui to strike Section 9102, Subtitle B, on the repeal of the State SSI maintenance of effort requirement, was defeated by a rollcall vote of 16 yeas to 23 nays. The vote was as follows:

Representatives	Yea	Nay	Representatives	Yea	Nay
Mr. Archer		X	Mr. Rangel	X	
Mr. Crane		X	Mr. Stark	X	
Mr. Thomas		X	Mr. Matsui	X	
Mr. Shaw		X	Mrs. Kennelly	X	
Mrs. Johnson		X	Mr. Coyne	X	
Mr. Bunning		X	Mr. Levin	X	
Mr. Houghton		X	Mr. Cardin	X	
Mr. Herger		X	Mr. McDermott	X	
Mr. McCreery		X	Mr. Kleczka	X	
Mr. Camp		X	Mr. Lewis	X	
Mr. Ramstad		X	Mr. Neal	X	
Mr. Nussle		X	Mr. McNulty	X	
Mr. Johnson		X	Mr. Jefferson	X	
Ms. Dunn		X	Mr. Tanner	X	
Mr. Collins		X	Mr. Becerra	X	
Mr. Portman		X	Mrs. Thurman	X	
Mr. English		X			

Representatives	Yea	Nay	Representatives	Yea	Nay
Mr. Ensign		X			
Mr. Christensen		X			
Mr. Watkins		X			
Mr. Hayworth		X			
Mr. Weller		X			
Mr. Hulshof		X			

An amendment by Mr. Becerra to add a new Section 9305, Subtitle D, to allow legal immigrants present before August 22, 1996, but disabled after that date, to be eligible for SSI, was defeated by a rollcall vote of 19 yeas to 20 nays. The vote was as follows:

Representatives	Yea	Nay	Representatives	Yea	Nay
Mr. Archer		X	Mr. Rangel	X	
Mr. Crane		X	Mr. Stark	X	
Mr. Thomas	X		Mr. Matsui	X	
Mr. Shaw		X	Mrs. Kennelly	X	
Mrs. Johnson	X		Mr. Coyne	X	
Mr. Bunning		X	Mr. Levin	X	
Mr. Houghton		X	Mr. Cardin	X	
Mr. Herger		X	Mr. McDermott	X	
Mr. McCrery		X	Mr. Kleczka	X	
Mr. Camp		X	Mr. Lewis	X	
Mr. Ramstad		X	Mr. Neal	X	
Mr. Nussle		X	Mr. McNulty	X	
Mr. Johnson		X	Mr. Jefferson	X	
Ms. Dunn		X	Mr. Tanner	X	
Mr. Collins	X		Mr. Becerra	X	
Mr. Portman		X	Mr. Thurman	X	
Mr. English		X			
Mr. Ensign		X			
Mr. Christensen		X			
Mr. Watkins		X			
Mr. Hayworth		X			
Mr. Weller		X			
Mr. Hulshof		X			

An amendment by Mr. Coyne to strike Section 9401, Subtitle E, a provision clarifying State authority to determine base periods for determining eligibility for unemployment benefits was defeated by a rollcall vote of 17 yeas and 22 nays. The vote was as follows:

Representatives	Yea	Nay	Representatives	Yea	Nay
Mr. Archer		X	Mr. Rangel	X	
Mr. Crane		X	Mr. Stark	X	
Mr. Thomas		X	Mr. Matsui	X	
Mr. Shaw		X	Mrs. Kennelly	X	
Mrs. Johnson		X	Mr. Coyne	X	
Mr. Bunning		X	Mr. Levin	X	
Mr. Houghton		X	Mr. Cardin	X	
Mr. Herger		X	Mr. McDermott	X	
Mr. McCrery		X	Mr. Kleczka	X	
Mr. Camp		X	Mr. Lewis	X	
Mr. Ramstad		X	Mr. Neal	X	
Mr. Nussle		X	Mr. McNulty	X	
Mr. Johnson		X	Mr. Jefferson	X	
Ms. Dunn		X	Mr. Tanner	X	
Mr. Collins		X	Mr. Becerra	X	
Mr. Portman		X	Mrs. Thurman	X	
Mr. English	X				
Mr. Ensign		X			
Mr. Christensen		X			

Representatives	Yea	Nay	Representatives	Yea	Nay
Mr. Watkins	X			
Mr. Hayworth	X			
Mr. Weller	X			
Mr. Hulshof	X			

IV. BUDGET EFFECTS OF THE BILL

A. COMMITTEE ESTIMATE OF BUDGETARY EFFECTS

In compliance with clause 7(a) of Rule XIII of the Rules of the House of Representatives, the following statement is made:

The Committee agrees with the estimate prepared by the Congressional Budget Office (CBO) which is included below.

B. STATEMENT REGARDING NEW BUDGET AUTHORITY AND TAX EXPENDITURES

In compliance with clause 2(1)(3)(B) of Rule XI of the House of Representatives, the Committee states that the Committee recommendations result in increased budget authority for direct spending programs relative to current law, and increased revenues.

C. COST ESTIMATE PREPARED BY THE CONGRESSIONAL BUDGET OFFICE

In compliance with clause 2(1)(3)(C) of Rule XI of the Rules of the House of Representatives requiring a cost estimate prepared by the Congressional Budget Office, the following report prepared by CBO is provided.

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, June 16, 1997.

Hon. BILL ARCHER,
Chairman, Committee on Ways and Means, House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the enclosed cost estimate for Title IX of the proposed reconciliation bill, containing the non-Medicare spending recommendations of the Committee on Ways and Means.

The estimate shows the budgetary effects of the committee's proposals over the 1998–2007 period. CBO understands that the Committee on the Budget will be responsible for interpreting how these proposals compare with the reconciliation instructions in the budget resolution. The estimate assumes that the reconciliation bill will be enacted by August 15; the estimate could change if the bill is enacted later.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contacts are Sheila Dacey, Kathy Ruffing, and Christina Hawley Sadoti for federal costs, and Leo Lex and John Patterson, for state and local impacts.

Sincerely,

JUNE E. O'NEILL, *Director.*

ESTIMATED BUDGETARY IMPACT OF THE RECONCILIATION RECOMMENDATIONS OF THE COMMITTEE
ON WAYS AND MEANS

[Outlays by fiscal year, in millions of dollars]

	1997	1998	1999	2000	2001	2002
DIRECT SPENDING						
Spending Under Current Law						
Family Support ¹	20,121	21,825	22,194	22,767	22,836	22,889
Supplemental Security Income (fees)	-155	-140	-145	-150	-155	-160
Supplemental Security Income (spending) ²	27,458	26,135	28,001	32,593	29,733	34,638
Medicaid ²	98,639	105,308	113,619	122,861	132,792	143,783
Unemployment Compensation ³	22,958	24,489	26,418	28,085	29,588	30,751
Interest on UI loans to States	0	0	0	0	0	0
Proposed Changes						
Family Support	0	137	596	1,087	691	350
Supplemental Security Income (fees)	0	-35	-70	-80	-90	-105
Supplemental Security Income (spending) ...	0	1,900	1,650	1,525	1,150	1,175
Medicaid ⁴	0	375	350	300	275	275
Unemployment Compensation	0	-29	-31	-233	-242	-252
Interest on UI loans to States	0	-5	-5	-5	-5	-5
Total	0	2,343	2,490	2,594	1,779	1,438
Spending Under Title IX						
Family Support	20,121	21,962	22,790	23,854	23,527	23,239
Supplemental Security Income (fees)	-155	-175	-215	-230	-245	-265
Supplemental Security Income (spending) ...	27,458	28,035	29,651	34,118	30,883	35,813
Medicaid	98,639	105,683	113,969	123,161	133,067	144,058
Unemployment Compensation	22,958	24,460	26,387	27,852	29,346	30,499
Interest on UI loans to States	0	-5	-5	-5	-5	-5
REVENUES						
Unemployment Insurance Revenues	0	0	-11	488	495	410
DEFICIT						
Total	0	2,343	2,501	2,106	1,284	1,028

¹ Family support includes the Temporary Assistance for Needy Family block grant, federal administrative costs for child support enforcement, the Child Care block grant, certain research funding enacted in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), and residual outlays from several programs that were repealed by PRWORA.

² CBO's March 1997 baseline estimates for Supplemental Income and Medicaid have been adjusted upward by \$200 million and \$40 million, respectively, because of the supplemental appropriation signed by the President on June 12, 1997 (H.R. 1871).

³ CBO's Marcy 1997 baseline estimates for unemployment compensation have been adjusted to reflect increases due to the April 4, 1997, decision of the even Circuit United States Court of Appeals, which affirmed the judgment of the District Court in the case of Pennington v. Doherty.

⁴ Medicaid would also be affected by the reconciliation recommendations of the Committee on Commerce (Title III).

BASIS OF ESTIMATE

CBO's estimates assume that the bill would be enacted by August 15, 1997. The following sections describe only those sections of the bill that are estimated to have significant budgetary effects.

SUBTITLE A, TEMPORARY ASSISTANCE FOR NEEDY FAMILIES

Section 9001 would establish welfare-to-work grants for states and localities to help recipients of Temporary Assistance for Needy Families (TANF) find jobs. Grants totaling up to \$3 billion would be awarded—\$750 million in 1998, \$1.25 billion in 1999, and \$1 billion in 2000. A small amount of the grant money would be set aside for special purposes: 1 percent for Indian tribes and 0.5 percent for evaluation of welfare-to-work programs. The remaining money would be divided evenly between non-competitive grants to states and competitive grants to localities and private industry councils.

Non-competitive grants would be allocated to states based on a formula that equally considers states' shares of the nationwide number of poor individuals, unemployed individuals, and adult recipients of TANF. States must match the federal funds, spending one dollar of state money for every two dollars of federal money (a 67 percent federal match rate). To be eligible for federal matching, the state spending must be in addition to the maintenance of effort spending for the TANF program (80 percent of a state's historic spending on Aid to Families with Dependent Children and related programs.) States would be required to pass through 85 percent of the grant money to private industry councils and localities, which would have sole authority to spend the money after consulting with the state agency that administers the grant. The state could retain 15 percent of the money to fund welfare-to-work projects of the state's choice.

Competitive grants would be awarded directly to local governments and private industry councils and would not need to be matched by any state or local spending. The Secretary of Labor would be required to give at least 65 percent of the funds to cities that are among the 100 cities in the United States with the highest number of poor residents and at least 25 percent of the funds to rural areas.

Grantees could spend grant funds, either non-competitive or competitive, to help move recipients of TANF assistance into the workforce by means of job creation, on-the-job training, job placement, job vouchers or job retention, and support services. Any funds that were not obligated by a state or locality by the end of the fiscal year would be reallocated in the following year. Any funds that were not expended after 3 years would be returned.

Based on conversations with officials in half a dozen large states, CBO believes that states would draw down most of the non-competitive grant money. The officials indicated that the 67 percent match rate would be very attractive to their states and that spending on welfare-to-work programs is politically popular. CBO assumes most states would spend more than 80 percent of their historic level on benefit and work programs over this period under current law, and thus could draw down the federal grant without spending any additional state money.

However, not all the state officials were confident that their state would tap all the money available. Some states with particularly low spending relative to their historic level would need to expand state spending significantly in order to draw down the federal funds. Also, the requirement to pass much of the money through to private industry councils would make it less attractive for states to spend match money. The estimate assumes that 30 percent of the grant funds available in 1998 and 20 percent of these grant funds available in 1999 would not be used in those years but would be carried over to the immediately following years. The estimate assumes that 20 percent of the funds available in 2000 would not be used but would not be redistributed in 2001 because the bill does not allow grants to be made after 2000. States would spend the grant funds they draw down more slowly in the start-up years of the program than in the later years.

Because no match is required, CBO assumes that all of the competitive grant money would be spent. However, the competitive grant funds would be spent a little more slowly than the non-competitive grant money because the process of awarding the grants would delay spending.

Based on discussions with committee staff, the estimate assumes that the legislative language will be changed to clarify that state spending that is used to match welfare-to-work grant dollars cannot also be used to match contingency fund dollars.

CBO estimates that only \$137 million of the \$750 million available will be spent in 1998. This would increase to \$1.1 billion by 2000 and then decline to \$350 million by 2002. In total, all but \$139 million of the \$3 billion would be spent.

SUBTITLE B, SUPPLEMENTAL SECURITY INCOME

Subtitle B would reduce the deficit by an estimated \$0.4 billion over the 1998–2002 period by raising fees that the federal government charges some states in the Supplemental Security Income (SSI) program.

Increased Fees for Administration of State Supplements.—About 6 million people now receive federal SSI benefits, which may be as high as \$484 a month per person. Many states supplement that federal payment. As a convenience, states can request that the federal government administer the state supplement, so that beneficiaries receive a single check. About 2.7 million people get state supplements, of which 2.4 million are administered by the federal government and the rest by the states. Under a law enacted in 1993, the federal government charges states a fee of \$5 per month for administering state supplements. Section 9103 of this bill would raise that in steps to \$6.20 in fiscal year 1998 and to \$8.50 in 2002. After 2002, the fee would be increased for inflation.

CBO assumed that the number of beneficiaries receiving federally-administered state supplementation would inch up to about 2.7 million in 2002. Although states would be free under another provision of the bill to cease their supplementation entirely, CBO assumed that relatively few would do so. Many may choose to pay smaller supplements than they would under current law, but that choice would not affect the federal government's proceeds from the fee, which depend on the number of supplements rather than on their size. CBO also assumed that few states would switch to state-administered supplementation to avoid the fee, because of the administrative headaches that would entail. Multiplying the number of supplements by the additional fee yields estimated proceeds of \$35 million in 1998 and \$105 million in 2002.

Repeal of Maintenance-of-Effort Requirement. Section 9201 of the bill would repeal the requirement (Section 1618 of the Social Security Act) that states which supplement the incomes of SSI recipients keep up that effort. States can choose between two methods of compliance with Section 1618: a "maintenance of expenditures" method (spending at least as much on supplementation as in the previous year) or "maintenance of payments" (maintaining per-capita supplements at 1983 levels). Currently, a total of about \$3.6 billion in state supplements goes every year to approximately 2.7 million beneficiaries—figures that have changed little for several years.

The principal effect of repealing this requirement would be on state budgets. Potential effects on the federal budget would be small, and too speculative to estimate reliably. If states opt to trim their supplements, for example, the federal government would automatically pay larger Food Stamp benefits in most states (with the possible exception of California, as discussed below). On the other hand, a small number of people who participate in Medicaid solely because of state supplements might lose that coverage, leading to small savings in Medicaid.

California pays relatively generous supplements—accounting for more than half of the \$3.6 billion paid nationwide, even though it has only about one-sixth of the nation's SSI caseload—and has special permission to offer no food stamps to SSI recipients. Its supplements are decreed by federal law to represent a “cashout” of the small food stamp benefit that the recipient could otherwise get. By repealing section 1618, this title would leave the legal basis of that cashout status tenuous; the issue would be left for the executive branch and—very likely—the courts to decide. Even if California lost its cashout status, however, CBO believes that the effects on federal outlays would be fairly small. A large number of SSI beneficiaries in California would automatically become eligible for a small Food Stamp benefit; administrative costs in the Food Stamp program (which are split equally between the federal government and the state) would go up as a consequence; but a subset of recipients—those who live in households that include non-SSI recipients and whose income, for the first time, would begin to be counted with the other members’—would cause a fairly steep drop in household's food stamp benefit.

SUBTITLE D—NONCITIZENS

Last year's welfare reform law, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) ended the eligibility of most legal aliens for SSI benefits. Specifically, legal aliens could not receive SSI unless they fell in one of the exempted categories—chiefly refugees during their first 5 years in the United States, and aliens who had worked for 10 years or more in this country. (The same criteria were enacted for aliens seeking Food Stamp benefits.) The government stopped making new awards to legal aliens immediately after PRWORA's enactment. The approximately half-million legal aliens who were on the rolls at the PRWORA's enactment and who do not fall in one of the exempt categories faced the end of their SSI benefits in August or September, after a one-year grace period provided by PRWORA. The cutoff date was delayed to October 1, 1997, by the supplemental appropriation signed by the President on June 12, at an estimated cost in fiscal year 1997 of \$0.2 billion.

This bill would spare those aliens who were on the SSI rolls in August 1996 from losing their benefits after October 1. CBO estimates that the number who would benefit from this provision, who totaled about 500,000 in August 1996, would average about 375,000 in fiscal year 1998 and 210,000 in 2002. That number falls for two reasons. First, the number would shrink naturally due to death or (less frequently) financial improvement; second, many who lost benefits as a result of PRWORA were assumed by CBO to re-

turn to the rolls through naturalization. Multiplying the number of aliens retaining SSI eligibility by an average benefit—assumed to equal about \$425 in 1998 and \$475 in 2002—yields outlays of \$1.9 billion and \$1.2 billion in those two years. The extra outlays would total \$7.4 billion over the 1998–2002 period.

This bill would also extend the window of SSI eligibility for refugees from 5 years to 7 years after their arrival in the United States. (Since aliens generally must live here 5 years before they can become naturalized, this change would give more aged and disabled refugees a chance to complete the process without losing benefits.) Refugees; eligibility would remain at 5 years in the Food Stamp program. If the extension from 5 years to 7 years for refugees were enacted as a free-standing measure, it would cost approximately \$100 million a year in SSI. However, the extra cost from the extension in this bill is negligible. Most of its cost in the 1997–2002 period as associated with refugees already in the country, and who have been here for more than 5 years or will soon hit the 5-year mark; but most of those people would be spared by the proposed “grandfather” provision for aliens on the rolls in August 1996.

Legal aliens who lost SSI would not necessarily have lost Medicaid. PRWORA fundamentally left up to the states whether to provide Medicaid coverage for aliens who were in the United States legally in August 1996. (Much tougher rules, notably a ban on non-emergency Medicaid benefits for five years after entry, applied to immigrants other than refugees who enter the country after August 1996.) CBO assumed that, because most states provide Medicaid for the aged and disabled who are “medically needy,” only about one-quarter of aliens who lost SSI would have lost or stopped participating in Medicaid. Under this bill, they would retain Medicaid. Multiplying those participants by an assumed average Medicaid cost of about \$4,000 in 1998—reflecting the fact that aliens are clustered in states with lower-than-average federal matching rates and that, in the absence of regular Medicaid emergency Medicaid spending would have gone up—yields extra outlays of \$0.3 billion in 1998 and gradually diminishing amounts thereafter.

SUBTITLE E—UNEMPLOYMENT COMPENSATION

Subtitle E would clarify that state base period determinations are not administrative provisions, increase the federal unemployment account ceiling, provide for a special distribution of \$100 million to states in fiscal years 2000–2002, and restrict interest-free advances. In addition, Subtitle E would exempt from coverage under the federal unemployment tax act (FUTA) certain workers, including teachers at church-run schools, temporary election workers, and inmates who work in private businesses as part of a cooperative work program. The following table shows the budgetary effect of each of these provisions.

[By fiscal year in millions of dollars]

	1997	1998	1999	2000	2001	2002
DIRECT SPENDING						
Section 9401: Base Period Determination		-26	-28	-30	-31	-33
Section 9403: Special Distribution to States				-200	-208	-216

[By fiscal year in millions of dollars]

	1997	1998	1999	2000	2001	2002
Section 9404: Interest on Advances		-5	-5	-5	-5	-5
Sections 9405, 9406, and 9407: Exemption from FUTA coverage of Certain Workers		-3	-3	-3	-3	-3
Total Changes		-34	-36	-238	-247	-257
REVENUES						
Section 9401: Base Period Determination		0	-8	-30	-36	-37
Section 9403: Special Distribution to States				521	534	450
Sections 9405, 9406, and 9407: Exemption from FUTA coverage of Certain Workers			-3	-3	-3	-3
Total Changes			-11	488	495	410

Base Period Determination.—Section 9401 would clarify that base periods, as defined under state law, are not considered methods of administration for purposes of section 303(a)(1) of the Social Security Act. Enacting this section would reduce federal outlays for unemployment compensation by \$26 million for fiscal year 1998 and by \$148 million over the 1998–2002 period. Payroll taxes would be adjusted in order to compensate for these reductions. These payroll taxes are levied and collected by state governments but deposited with the federal government in the Unemployment Trust Fund (UTF). CBO estimates that revenue from payroll taxes would fall by \$111 million over the 1998–2002 period. As a result, the deficit would be reduced by a total of \$37 million over this five-year period. These savings assume that the CBO March 1997 baseline for unemployment benefit outlays and state deposit collections are adjusted to reflect increases due to the April 4, 1997, decision by the Seventh Circuit U.S. Court of Appeals, which affirmed the judgment in the District Court in the case of *Pennington v. Doherty*.

Increase the Federal Unemployment Account Ceiling.—Section 9402 would raise the statutory ceiling on the Federal Unemployment Account in the UTF from 0.25 percent of covered wages to 0.5 percent of covered wages beginning in fiscal year 2002. This change would increase the ceiling from about \$7 billion under current law to about \$14 billion. This increase would have no effect on revenues or outlays during fiscal years 1998–2002 but would have sizeable impacts on both outlays and revenues beginning in fiscal year 2003.

Special Distribution to States.—Section 9403 would eliminate certain transfers of UTF funds to states but allow for transfers of \$100 million to take place in fiscal years 2000, 2001, and 2002. Current provisions of the Social Security Act require that when all of the federal accounts within the UTF reach their statutory limits, excess federal income is transferred to the state benefits accounts. CBO estimates that the federal accounts would reach these limits at the end of fiscal year 1999 and that approximately \$0.9 billion would be transferred to the states and be available for expenditure beginning in fiscal year 2000. Similar transfers would continue throughout the baseline projection period. CBO estimated that states would spend about \$300 million of these transfers each year, with slight adjustments for inflation.

This section would effectively increase the ceiling, because it would require amounts in excess of the ceiling, minus \$100 million, to be held in the FUA regardless of the ceiling. This section would restrict transfers to \$300 million over fiscal years 2000–2002, thereby reducing net outlays by \$624 million compared to the current law. In contrast to CBO's baseline estimate, where state revenues would drop because of the transfer effected by the current FUA ceiling, CBO estimates that state tax rates would be maintained at levels that would yield roughly \$1.5 billion more in revenues than had been estimated under current law. Enacting this section would reduce the federal deficit by about \$2.1 billion over the 1998–2002 period.

Restriction on Interest-Free Advances to State Accounts.—Section 9404 would require states to meet certain criteria in order to be eligible to receive interest-free advances to their state benefit account in the UTF. Under current law, states are not charged interest on advances if they are repaid in full by September 30 of the calendar year the advances were made, and if no other advances were made during that calendar year. This proposal would further require that states meet certain funding goals in four of the last five quarters before the quarter in which the advance was required. U.S.C.

Currently, most states have sufficient balances in their benefit accounts and would not require advances in order to meet benefit payments. A few states, however, do not have balances that would meet the funding goal and could require advances within the projection period. Section 9404 would require that these states be charged interest on their advances, even if they are paid back by September 30.

In addition to intra-year borrowing due to timing of payroll tax receipts, states may require advances when economic conditions would cause outlays to increase or tax receipts to fall. Over the past five years (1992–1996), about \$140 million in interest on advances was paid by the states. If this new policy had applied, interest payments would have been \$20 million more than under current law. Assuming a 25 percent probability that similar conditions would recur, CBO estimates that additional interest payments of about \$5 million annually, on average, would be collected, for a net deficit reduction of \$25 million over fiscal years 1998–2002. These interest payments are shown in the offsetting receipts account of the UTF in function 900.

Exemption of Service Performed by Election Workers from the Federal Unemployment Tax Act (FUTA).—Section 9405 would exempt from FUTA coverage work performed by approximately 925,000 temporary election workers who staff polling places for one to two days during a local, state, or federal election. CBO estimates that enacting this provision would reduce benefit outlays and revenues by \$1 million a year.

Exemption of Service Performed for an Elementary or Secondary School Operated Primarily for Religious Purposes from the Federal Unemployment Tax.—Section 9406 would eliminate FUTA coverage for approximately 71,000 elementary and secondary school teachers employed by religious organizations. CBO estimates that enacting this provision would reduce benefit outlays and revenues by \$2 million a year.

Treatment of Certain Services Performed by Inmates.—Section 9407 would exempt from coverage under FUTA service performed by persons committed to penal institutions. Enactment of this section would reduce unemployment benefit outlays as well as FUTA and state employment tax revenues, but the amount is likely to be insignificant.

Estimated impact on State, local, and tribal governments: This title would impose no new intergovernmental mandates as defined under the Unfunded Mandates Reform Act of 1995 (UMRA) and would repeal an existing mandate under the Supplemental Security Income (SSI) program. In addition, the title includes other provisions that would have a significant effect the budgets of state, local, and tribal governments.

Repeal of mandatory SSI supplementation

Current law requires states to maintain their per-capita SSI supplements at 1983 levels or maintain their total expenditures at the level from the previous year. Once a state elects to supplement SSI, federal law requires it to continue in order to remain eligible for Medicaid payments. Title IX would repeal this mandate.

States currently supplement SSI annually with about \$3.6 billion of their own funds. Although some states supplement SSI beyond what is required, most of the \$3.6 billion can be attributed to the mandate to maintain spending levels. However, under the welfare reform law, most legal aliens will no longer be eligible for SSI or state supplements after August 1997. (This title would allow many of these legal aliens to remain eligible for SSI and supplements.) Based on data from the Social Security Administration, CBO estimates that the annual cost of the mandate will decrease to about \$3.0 billion after August 1997 as a result of welfare reform. Even though this mandate would be repealed, CBO does not expect that states would cut their supplement programs significantly.

If the repeal of the maintenance-of-effort requirement results in California losing its cashout status, a large number of SSI beneficiaries in California would automatically become eligible for Food Stamps, and the state's share of the program's annual administrative costs would increase by \$25 million to \$50 million.

Other significant impacts

Welfare to Work.—The title would provide states and tribal governments with between \$750 million and \$1.25 billion annually for fiscal years 1998 through 2000 to move welfare recipients to work. In order to receive these funds, states would have to match each federal dollar with 50 cents of its own funds and also meet the 80 percent maintenance of effort requirement under the Temporary Assistance for Needy Families (TANF) program.

TANF Work Requirement.—The TANF work requirement (which specifies percentages of TANF families that must have a member engaged in work activities) would be modified in ways that CBO estimates would likely increase the net costs of meeting the work requirement. Such costs would not constitute a mandate as defined under UMRA because under TANF states have the flexibility to offset additional costs by tightening eligibility or reducing benefit levels.

Fees for Administering SSI Supplements.—CBO estimates that states would spend an additional \$105 million annually by 2002 because of the increase in fees charged by the federal government to administer SSI supplements. The higher fees do not constitute a mandate because states contract voluntarily with the federal government to provide these services.

Welfare and Public Benefits for Aliens.—Subtitle D would grandfather the eligibility of aliens receiving SSI on August 22, 1996, enabling those aliens to continue receiving benefits. Assuming states continue to supplement SSI payments, the costs of these supplements would be approximately \$400 million in 1998. Because Section 9102 of the subtitle eliminates the requirement for states to comply with maintenance-of-effort requirements in the SSI program, continuing supplemental benefits for these aliens would not constitute a mandate under UMRA.

The increased SSI eligibility that results from this subtitle would also lead to an increase in state costs for their share of Medicaid payments. These costs are estimated to total approximately \$325 million in 1998, decreasing to \$250 million in 2002. Because states have the authority to make programmatic changes in the Medicaid program to offset these costs, they would not be considered mandates under UMRA.

Unemployment Compensation.—This title contains a number of provisions that would affect states' costs under the federal Unemployment Compensation program. Because state participation in this program is not required by federal law, the changes made by this subtitle would not be considered mandates as defined by UMRA.

The provision clarifying the base period for determining the eligibility of an applicant for unemployment would preserve the ability of states to define certain eligibility standards. The court decision that this provision would modify now applies to only three states (Illinois, Wisconsin, and Indiana). In the absence of this provision, however, 41 states could be required to adopt alternative base periods at a cost of \$400 million annually in additional unemployment compensation benefits, as well as administrative costs.

Provisions raising the FUA ceiling would reduce transfers to state unemployment accounts by a total of about \$2.5 billion from fiscal year 2000 to fiscal year 2002.

Under current law, states may receive interest-free advances to their state unemployment benefit accounts. Additional restrictions imposed by this title would result in fewer states qualifying for such loans. In total, CBO estimates that these restrictions would result in additional costs to state governments totaling approximately \$5 million annually beginning in fiscal year 1998.

Estimated impact on the private sector: This title contains no private-sector mandates as defined in the Unfunded Mandates Reform Act of 1995.

Estimate prepared by: Federal Costs: Sheila Dacey, Kathy Ruffing, Christina Hawley Sadoti; Impact on State, Local, and Tribal Governments: Leo Lex and John Patterson; Impact on the Private Sector: Ralph Smith.

Estimate approved by: Paul N. Van de Water, Assistant Director for Budget Analysis.

APPENDIX TABLE: FEDERAL BUDGETARY EFFECTS OF TITLE IX BY SUBTITLE

[By fiscal year, in millions of dollars]

	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	1998- 2007 total	1998- 2007 total
DIRECT SPENDING												
Subtitle A: temporary assistance for needy families block grant, welfare to work grants												
Budget Authority	750	1,250	1,000	0	0	0	0	0	0	0	3,000	3,000
Outlays	137	596	1,087	691	350	0	0	0	0	0	2,861	2,881
Subtitle B: supplemental security income, SSI												
Budget Authority	-35	-70	-80	-90	-105	-115	-130	-140	-155	-165	-380	-1,085
Outlays	-35	-70	-80	-90	-105	-115	-130	-140	-155	-165	-380	-1,085
Subtitle D: restricting welfare and public benefits for aliens												
SSI												
Budget Authority	1,900	1,650	1,525	1,150	1,175	1,150	1,025	950	725	525	7,400	11,775
Outlays	1,900	1,650	1,525	1,150	1,175	1,150	1,025	950	725	525	7,400	11,775
Medicaid												
Budget Authority	375	350	300	275	275	275	250	226	200	160	1,675	2,675
Outlays	375	350	300	275	275	275	250	226	200	150	1,575	2,675
Subtotal												
Budget Authority	2,275	2,000	1,825	1,425	1,450	1,425	1,275	1,175	925	675	8,975	14,450
Outlays	2,275	2,000	1,825	1,425	1,450	1,425	1,275	1,175	925	675	8,975	14,450
Subtitle E: unemployment compensation												
Budget Authority	-34	-36	-238	-247	-267	-367	-377	-388	-398	-410	-813	-2,752
Outlays	-34	-36	-238	-247	-267	-367	-377	-388	-398	-410	-813	-2,752
Total												
Budget Authority	2,956	3,144	2,507	1,088	1,088	943	768	647	372	100	10,782	13,613
Outlays	2,343	2,490	2,594	1,779	1,438	943	768	647	372	100	10,643	13,474
SUBTITLE E: UNEMPLOYMENT COMPENSATION	0	-11	488	495	410	358	292	209	143	59	1,380	2,442

Note: Details may not add to totals because of rounding.

V. OTHER MATTERS REQUIRED TO BE DISCUSSED UNDER THE RULES OF THE HOUSE

A. COMMITTEE OVERSIGHT FINDINGS AND RECOMMENDATIONS

In compliance with clause 2(1)(3)(A) of Rule XI of the Rules of the House of Representatives, the Committee concludes that the actions taken in this legislation are appropriate given its oversight activities related to the human resources programs within its jurisdiction.

B. SUMMARY OF FINDINGS AND RECOMMENDATIONS OF THE GOVERNMENT REFORM AND OVERSIGHT COMMITTEE

In compliance with clause 2(1)(3)(D) of Rule XI of the Rules of the House of Representatives, the Committee states that no oversight findings and recommendations have been submitted to this Committee by the Committee on Government Operations with respect to the provisions contained in this legislation.

C. CONSTITUTIONAL AUTHORITY STATEMENT

With respect to clause 2(1)(4) of rule XI of the Rules of the House of Representatives, relating to Constitutional Authority, the Committee states that the Committee's action in reporting the bill is derived from Article I of the Constitution, Section 8 ("The Congress shall have power to lay and collect taxes, duties, imposts and excises to pay the debts and to provide for * * * the general Welfare of the United States * * *").

CHANGES IN EXISTING LAW MADE BY TITLE IX OF THE BILL, AS REPORTED

In compliance with clause 3 of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

SOCIAL SECURITY ACT

* * * * *

TITLE III—GRANTS TO STATES FOR UNEMPLOYMENT COMPENSATION ADMINISTRATION

* * * * *

PROVISIONS OF STATE LAW

SEC. 303. (a) * * *

* * * * *

(h)(1) The State agency charged with the administration of the State law shall, on a reimbursable basis—

(A) * * *

* * * * *

(C) establish such safeguards as the Secretary of Labor determines are necessary to insure that information disclosed

under subparagraph (A) is used only for purposes of section [453(i)(1) in carrying out the child support enforcement program under title IV] subsections (i)(1), (i)(3), and (j) of section 453.

* * * * *

TITLE IV—GRANTS TO STATES FOR AID AND SERVICES TO NEEDY FAMILIES WITH CHILDREN AND FOR CHILD-WELFARE SERVICES

* * * * *

PART A—AID TO FAMILIES WITH DEPENDENT CHILDREN

* * * * *

SEC. 403. GRANTS TO STATES.

(a) GRANTS.—

(1) * * *

* * * * *

(5) WELFARE-TO-WORK GRANTS.—

(A) NONCOMPETITIVE GRANTS.—

(i) ENTITLEMENT.—A State shall be entitled to receive from the Secretary a grant for each fiscal year specified in subparagraph (H) of this paragraph for which the State is a welfare-to-work State, in an amount that does not exceed the lesser of—

(I) 2 times the total of the expenditures by the State (excluding qualified State expenditures (as defined in section 409(a)(7)(B)(i)) and any expenditure described in subclause (I), (II), or (IV) of section 409(a)(7)(B)(iv)) during the fiscal year for activities described in subparagraph (C)(i) of this paragraph; or

(II) the allotment of the State under clause (iii) of this subparagraph for the fiscal year.

(ii) WELFARE-TO-WORK STATE.—A State shall be considered a welfare-to-work State for a fiscal year for purposes of this subparagraph if the Secretary, after consultation (and the sharing of any plan or amendment thereto submitted under this clause) with the Secretary of Health and Human Services and the Secretary of Housing and Urban Development, determines that the State meets the following requirements:

(I) The State has submitted to the Secretary (in the form of an addendum to the State plan submitted under section 402) a plan which—

(aa) describes how, consistent with this subparagraph, the State will use any funds provided under this subparagraph during the fiscal year;

(bb) specifies the formula to be used pursuant to clause (vi) to distribute funds in the State, and describes the process by which the formula was developed;

(cc) contains evidence that the plan was developed in consultation and coordination with sub-State areas; and

(dd) is approved by the agency administering the State program funded under this part.

(II) The State has provided the Secretary with an estimate of the amount that the State intends to expend during the fiscal year (excluding expenditures described in section 409(a)(7)(B)(iv)) for activities described in subparagraph (C)(i) of this paragraph.

(III) The State has agreed to negotiate in good faith with the Secretary of Health and Human Services with respect to the substance of any evaluation under section 413(j), and to cooperate with the conduct of any such evaluation.

(IV) The State is an eligible State for the fiscal year.

(V) Qualified State expenditures (within the meaning of section 409(a)(7)) are at least 80 percent of historic State expenditures (within the meaning of such section), with respect to the fiscal year or the immediately preceding fiscal year.

(iii) ALLOTMENTS TO WELFARE-TO-WORK STATES.—The allotment of a welfare-to-work State for a fiscal year shall be the available amount for the fiscal year multiplied by the State percentage for the fiscal year.

(iv) AVAILABLE AMOUNT.—As used in this subparagraph, the term “available amount” means, for a fiscal year, the sum of—

(I) 50 percent of the sum of—

(aa) the amount specified in subparagraph (H) for the fiscal year, minus the total of the amounts reserved pursuant to subparagraphs (F) and (G) for the fiscal year; and

(bb) any amount reserved pursuant to subparagraph (F) for the immediately preceding fiscal year that has not been obligated; and

(II) any available amount for the immediately preceding fiscal year that has not been obligated by a State or sub-State entity.

(v) STATE PERCENTAGE.—As used in clause (iii), the term “State percentage” means, with respect to a fiscal year, $\frac{1}{3}$ of the sum of—

(aa) the percentage represented by the number of individuals in the State whose income is less than the poverty line divided by the number of such individuals in the United States;

(bb) the percentage represented by the number of unemployed individuals in the State divided by the number of such individuals in the United States; and

(cc) the percentage represented by the number of individuals who are adult recipients of

assistance under the State program funded under this part divided by the number of individuals in the United States who are adult recipients of assistance under any State program funded under this part.

(vi) DISTRIBUTION OF FUNDS WITHIN STATES.—

(I) IN GENERAL.—A State to which a grant is made under this subparagraph shall distribute not less than 85 percent of the grant funds among the service delivery areas in the State, in accordance with a formula which—

(aa) determines the amount to be distributed for the benefit of a service delivery area in proportion to the number (if any) by which the number of individuals residing in the service delivery area with an income that is less than the poverty line exceeds 5 percent of the population of the service delivery area, relative to such number for the other service delivery areas in the State, and accords a weight of not less than 50 percent to this factor;

(bb) may determine the amount to be distributed for the benefit of a service delivery area in proportion to the number of adults residing in the service delivery area who are recipients of assistance under the State program funded under this part (whether in effect before or after the amendments made by section 103(a) of the Personal Responsibility and Work Opportunity Reconciliation Act first applied to the State) for at least 30 months (whether or not consecutive) relative to the number of such adults residing in the other service delivery areas in the State; and

(cc) may determine the amount to be distributed for the benefit of a service delivery area in proportion to the number of unemployed individuals residing in the service delivery area relative to the number of such individuals residing in the other service delivery areas in the State.

(II) SPECIAL RULE.—Notwithstanding subclause (I), if the formula used pursuant to subclause (I) would result in the distribution of less than \$100,000 during a fiscal year for the benefit of a service delivery area, then in lieu of distributing such sum in accordance with the formula, such sum shall be available for distribution under subclause (III) during the fiscal year.

(III) PROJECTS TO HELP LONG-TERM RECIPIENTS OF ASSISTANCE INTO THE WORK FORCE.—The Governor of a State to which a grant is made under this subparagraph may distribute not more than 15 percent of the grant funds (plus any amount re-

quired to be distributed under this subclause by reason of subclause (II) to projects that appear likely to help long-term recipients of assistance under the State program funded under this part (whether in effect before or after the amendments made by section 103(a) of the Personal Responsibility and Work Opportunity Reconciliation Act first applied to the State) enter the work force.

(vii) ADMINISTRATION.—

(I) IN GENERAL.—A grant made under this subparagraph to a State shall be administered by the State agency that is administering, or supervising the administration of, the State program funded under this part, or by another State agency designated by the Governor of the State.

(II) SPENDING BY PRIVATE INDUSTRY COUNCILS.—The private industry council for a service delivery area shall have sole authority to expend the amounts provided for the benefit of a service delivery area under subparagraph (vi)(I), pursuant to an agreement with the agency that is administering the State program funded under this part in the service delivery area.

(B) COMPETITIVE GRANTS.—

(i) IN GENERAL.—The Secretary, in consultation with the Secretary of Health and Human Services and the Secretary of Housing and Urban Development, shall award grants in accordance with this subparagraph, in fiscal years 1998 and 2000, for projects proposed by eligible applicants, based on the following:

(I) The effectiveness of the proposal in—

(aa) expanding the base of knowledge about programs aimed at moving recipients of assistance under State programs funded under this part who are least job ready into the work force.

(bb) moving recipients of assistance under State programs funded under this part who are least job ready into the work force; and

(cc) moving recipients of assistance under State programs funded under this part who are least job ready into the work force, even in labor markets that have a shortage of low-skill jobs.

(II) At the discretion of the Secretary, any of the following:

(aa) The history of success of the applicant in moving individuals with multiple barriers into work.

(bb) Evidence of the applicant's ability to leverage private, State, and local resources.

(cc) Use by the applicant of State and local resources beyond those required by subparagraph (A).

(dd) *Plans of the applicant to coordinate with other organizations at the local and State level.*

(ee) *Use by the applicant of current or former recipients of assistance under a State program funded under this part as mentors, case managers, or service providers.*

(ii) **ELIGIBLE APPLICANTS.**—*As used in clause (i), the term “eligible applicant” means a private industry council or a political subdivision of a State that submits a proposal that is approved by the agency administering the State program funded under this part.*

(iii) **DETERMINATION OF GRANT AMOUNT.**—*In determining the amount of a grant to be made under this subparagraph for a project proposed by an applicant, the Secretary shall provide the applicant with an amount sufficient to ensure that the project has a reasonable opportunity to be successful, taking into account the number of long-term recipients of assistance under a State program funded under this part, the level of unemployment, the job opportunities and job growth, the poverty rate, and such other factors as the Secretary deems appropriate, in the area to be served by the project.*

(iv) **TARGETING OF FUNDS TO CERTAIN AREAS.**—

(I) **CITIES WITH GREATEST NUMBER OF PERSONS WITH INCOME LESS THAN THE POVERTY LINE.**—*The Secretary shall use not less than 65 percent of the funds available for grants under this subparagraph for a fiscal year to award grants for expenditures in cities that are among the 100 cities in the United States with the highest number of residents with an income that is less than the poverty line.*

(II) **RURAL AREAS.**—

(aa) **IN GENERAL.**—*The Secretary shall use not less than 25 percent of the funds available for grants under this subparagraph for a fiscal year to award grants for expenditures in rural areas.*

(bb) **RURAL AREA DEFINED.**—*As used in item (aa), the term “rural area” means a city, town, or unincorporated area that has a population of 50,000 or fewer inhabitants and that is not an urbanized area immediately adjacent to a city, town, or unincorporated area that has a population of more than 50,000 inhabitants.*

(v) **FUNDING.**—*For grants under this subparagraph for each fiscal year specified in subparagraph (H), there shall be available to the Secretary an amount equal to the sum of—*

(I) *50 percent of the sum of—*

(aa) *the amount specified in subparagraph (H) for the fiscal year, minus the total of the*

amounts reserved pursuant to subparagraphs (F) and (G) for the fiscal year; and

(bb) any amount reserved pursuant to subparagraph (F) for the immediately preceding fiscal year that has not been obligated; and

(II) any amount available for grants under this subparagraph for the immediately preceding fiscal year that has not been obligated.

(C) *LIMITATIONS ON USE OF FUNDS.—*

(i) *ALLOWABLE ACTIVITIES.—An entity to which funds are provided under this paragraph may use the funds to move into the work force recipients of assistance under the program funded under this part of the State in which the entity is located and the noncustodial parent of any minor who is such a recipient, by means of any of the following:*

(I) *Job creation through public or private sector employment wage subsidies.*

(II) *On-the-job training.*

(III) *Contracts with public or private providers of readiness, placement, and post-employment services.*

(IV) *Job vouchers for placement, readiness, and postemployment services.*

(V) *Job support services (excluding child care services) if such services are not otherwise available.*

(ii) *REQUIRED BENEFICIARIES.—An entity that operates a project with funds provided under this paragraph shall expend at least 90 percent of all funds provided to the project for the benefit of recipients of assistance under the program funded under this part of the State in which the entity is located who meet the requirements of each of the following subclauses:*

(I) *At least 2 of the following apply to the recipient:*

(aa) *The individual has not completed secondary school or obtained a certificate of general equivalency, and has low skills in reading and mathematics.*

(bb) *The individual requires substance abuse treatment for employment.*

(cc) *The individual has a poor work history.*

The Secretary shall prescribe such regulations as may be necessary to interpret this subclause.

(II) *The individual—*

(aa) *has received assistance under the State program funded under this part (whether in effect before or after the amendments made by section 103 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 first apply to the State) for at least 30 months (whether or not consecutive); or*

(bb) *within 12 months, will become ineligible for assistance under the State program funded under this part by reason of a durational limit on such assistance, without regard to any exemption provided pursuant to section 408(a)(7)(C) that may apply to the individual.*

(iii) **LIMITATION ON APPLICABILITY OF SECTION 404.**—*The rules of section 404, other than subsections (b), (f), and (h) of section 404, shall not apply to a grant made under this paragraph.*

(iv) **LIMITATIONS RELATING TO PRIVATE INDUSTRY COUNCILS.**—

(I) **NO DIRECT PROVISION OF SERVICES.**—*A private industry council may not directly provide services using funds provided under this paragraph.*

(II) **COOPERATION WITH TANF AGENCY.**—*On a determination by the Secretary, in consultation with the Secretary of Health and Human Services and the Secretary of Housing and Urban Development, that the private industry council for a service delivery area in a State for which funds are provided under this paragraph and the agency administering the State program funded under this part are not adhering to the agreement referred to in subparagraph (A)(vii)(II) to implement any plan or project for which the funds are provided, the recipient of the funds shall remit the funds to the Secretary.*

(v) **PROHIBITION AGAINST USE OF GRANT FUNDS FOR ANY OTHER FUND MATCHING REQUIREMENT.**—*An entity to which funds are provided under this paragraph shall not use any part of the funds to fulfill any obligation of any State, political subdivision, or private industry council to contribute funds under other Federal law.*

(vi) **DEADLINE FOR EXPENDITURE.**—*An entity to which funds are provided under this paragraph shall remit to the Secretary any part of the funds that are not expended within 3 years after the date the funds are so provided.*

(D) **INDIVIDUALS WITH INCOME LESS THAN THE POVERTY LINE.**—*For purposes of this paragraph, the number of individuals with an income that is less than the poverty line shall be determined based on the methodology used by the Bureau of the Census to produce and publish intercensal poverty data for 1993 for States and counties.*

(E) **DEFINITIONS.**—*As used in this paragraph:*

(i) **PRIVATE INDUSTRY COUNCIL.**—*The term “private industry council” means, with respect to a service delivery area, the private industry council (or successor entity) established for the service delivery area pursuant to the Job Training Partnership Act.*

(ii) *SECRETARY*.—The term “Secretary” means the Secretary of Labor, except as otherwise expressly provided.

(iii) *SERVICE DELIVERY AREA*.—The term “service delivery area” shall have the meaning given such term for purposes of the Job Training Partnership Act.

(F) *SET-ASIDE FOR INDIAN TRIBES*.—1 percent of the amount specified in subparagraph (H) for each fiscal year shall be reserved for grants to Indian tribes under section 412(a)(3).

(G) *SET-ASIDE FOR EVALUATIONS*.—0.5 percent of the amount specified in subparagraph (H) for each fiscal year shall be reserved for use by the Secretary of Health and Human Services to carry out section 413(j).

(H) *FUNDING*.—The amount specified in this subparagraph is—

- (i) \$750,000,000 for fiscal year 1998;
- (ii) \$1,250,000,000 for fiscal year 1999; and
- (iii) \$1,000,000,000 for fiscal year 2000.

(I) *AVAILABILITY OF FUNDS*.—Amounts appropriated pursuant to this paragraph shall remain available through fiscal year 2002.

(J) *BUDGET SCORING*.—Notwithstanding section 457(b)(2) of the Balanced Budget and Emergency Deficit Control Act of 1985, the baseline shall assume that no grant shall be awarded under this paragraph or under section 412(a)(3) after fiscal year 2000.

(K) *WORKER PROTECTIONS*.—

(i) *LABOR STANDARDS*.—

(I) *DISPLACEMENT*.—

(aa) *PROHIBITION*.—A participant in an activity under this paragraph shall not displace (including a partial displacement, such as a reduction in the hours of nonovertime work, wages, or employment benefits) any currently employed employee (as of the date of the participation).

(bb) *PROHIBITION ON IMPAIRMENT OF CONTRACTS*.—An activity under this paragraph shall not impair an existing contract for services or collective bargaining agreement, and no such activity that would be inconsistent with the terms of a collective bargaining agreement shall be undertaken without the written concurrence of the labor organization and employer concerned.

(II) *OTHER PROHIBITIONS*.—A participant in an activity under this paragraph shall not be employed in a job—

(aa) when any other individual is on layoff from the same or any substantially equivalent job;

(bb) when the employer has terminated the employment of any regular employee or other-

wise reduced the workforce of the employer with the intention of filling the vacancy so created with the participant; or

(cc) which is created in a promotional line that will infringe in any way upon the promotional opportunities of currently employed individuals.

(III) *HEALTH AND SAFETY.*—Health and safety standards established under Federal and State law otherwise applicable to working conditions of employees shall be equally applicable to working conditions of participants engaged in activities under this paragraph. To the extent that a State workers' compensation law applies, workers' compensation shall be provided to participants on the same basis as the compensation is provided to other individuals in the State in similar employment.

(IV) *EMPLOYMENT CONDITIONS.*—Individuals in on-the-job training or individuals employed in activities under this paragraph shall be provided benefits and working conditions at the same level and to the same extent as other trainees or employees working a similar length of time and doing the same type of work.

(V) *OPPORTUNITY TO SUBMIT COMMENTS.*—Interested parties shall be provided an opportunity to submit comments with respect to training programs proposed to be funded under this paragraph.

(ii) *GRIEVANCE PROCEDURE.*—

(I) *IN GENERAL.*—A State to which funds are provided under this paragraph shall establish and maintain a procedure for addressing grievances or complaints alleging violations of this paragraph from participants and other interested or affected parties. The procedure shall include an opportunity for a hearing and be completed within 60 days of filing the grievance or complaint.

(II) *INVESTIGATION.*—

(aa) *IN GENERAL.*—The Secretary shall investigate an allegation of a violation of this paragraph if a decision relating to the allegation is made within 60 days after the date of the filing of the grievance or complaint and either party appeals to the Secretary, or if a decision relating to the allegation is made within the 60-day period and the party to which the decision is adverse appeals the decision to the Secretary.

(bb) *ADDITIONAL REQUIREMENT.*—The Secretary shall make a final determination relating to an appeal made under item (aa) no later than 120 days after receiving the appeal.

(III) *REMEDIES.*—*Remedies shall be limited to—*
 (aa) *suspension or termination of payments under this paragraph;*
 (bb) *prohibition of placement of a participant with an employer who has violated this subparagraph;*
 (cc) *where applicable, reinstatement of an employee, payment of lost wages and benefits, and reestablishment of other relevant terms, conditions and privileges of employment; and*
 (dd) *where appropriate, other equitable relief.*

* * * * *

SEC. 404. USE OF GRANTS.

(a) * * *

* * * * *

(d) **AUTHORITY TO USE PORTION OF GRANT FOR OTHER PURPOSES.**—

(1) **IN GENERAL.**—**[A State may]** *Subject to paragraph (2), a State may use not more than 30 percent of the amount of any grant made to the State under section 403(a) for a fiscal year to carry out a State program pursuant to any or all of the following provisions of law:*

(A) *Title XX of this Act.*

(B) *The Child Care and Development Block Grant Act of 1990.*

[(2) LIMITATION ON AMOUNT TRANSFERABLE TO TITLE XX PROGRAMS.—*Notwithstanding paragraph (1), not more than 1/3 of the total amount paid to a State under this part for a fiscal year that is used to carry out State programs pursuant to provisions of law specified in paragraph (1) may be used to carry out State programs pursuant to title XX.]*

(2) LIMITATION ON AMOUNT TRANSFERABLE TO TITLE XX PROGRAMS.—A State may use not more than 10 percent of the amount of any grant made to the State under section 403(a) for a fiscal year to carry out State programs pursuant to title XX.

* * * * *

SEC. 407. MANDATORY WORK REQUIREMENTS.

(a) * * *

* * * * *

(c) **ENGAGED IN WORK.**—

(1) * * *

(2) **LIMITATIONS AND SPECIAL RULES.**—

(A) * * *

* * * * *

[(D) NUMBER OF PERSONS THAT MAY BE TREATED AS ENGAGED IN WORK BY VIRTUE OF PARTICIPATION IN VOCATIONAL EDUCATION ACTIVITIES OR BEING A TEEN HEAD OF HOUSEHOLD WHO MAINTAINS SATISFACTORY SCHOOL ATTENDANCE.—*For purposes of determining monthly participation rates under paragraphs (1)(B)(i) and (2)(B) of sub-*

section (b), not more than 20 percent of individuals in all families and in 2-parent families may be determined to be engaged in work in the State for a month by reason of participation in vocational educational training or deemed to be engaged in work by reason of subparagraph (C) of this paragraph.】

(D) *LIMITATION ON NUMBER OF PERSONS WHO MAY BE TREATED AS ENGAGED IN WORK BY REASON OF PARTICIPATION IN VOCATIONAL EDUCATIONAL TRAINING.*—*For purposes of determining monthly participation rates under paragraphs (1)(B)(i) and (2)(B) of subsection (b), not more than 30 percent of the number of individuals in all families and in 2-parent families, respectively, in a State who are treated as engaged in work for a month may consist of individuals who are determined to be engaged in work for the month by reason of participation in vocational educational training.*

* * * * *

(j) *LIMITATION ON NUMBER OF HOURS PER MONTH THAT A RECIPIENT OF ASSISTANCE MAY BE REQUIRED TO WORK FOR A PUBLIC AGENCY OR NONPROFIT ORGANIZATION.*—

(1) *IN GENERAL.*—*A State to which a grant is made under section 403 may not require a recipient of assistance under the State program funded under this part to be assigned to a work experience, on-the-job training, or community service position with a public agency or nonprofit organization during a month for more than the allowable number of hours determined for the month under paragraph (2).*

(2) *ALLOWABLE NUMBER OF HOURS.*—

(A) *GENERAL METHOD.*—*Subject to this paragraph, the allowable number of hours determined for a month under this paragraph—*

(i) *for a recipient to whom the benefit described in paragraph (3)(A) is provided during the month is—*

(I) *the average value of the benefit provided by the State during the month to families that the State determines are similarly situated to the family of the recipient, or (at the option of the State) the value of the benefit provided by the State to the recipient during the month; divided by*

(II) *the minimum wage rate in effect during the month under section 6 of the Fair Labor Standards Act of 1938;*

(ii) *for a recipient to whom the benefits described in subparagraphs (A) and (B) of paragraph (3) are provided during the month is—*

(I) *the average value of such benefits provided by the State during the month to families that the State determines are similarly situated to the family of the recipient, or (at the option of the State) the value of such benefits provided by the State to the recipient during the month; divided by*

(II) the minimum wage rate in effect during the month under section 6 of the Fair Labor Standards Act of 1938;

(iii) for a recipient to whom the benefits described in subparagraphs (A), (B), and (C) of paragraph (3) are provided during the month is—

(I) the average value of such benefits provided by the State during the month to families that the State determines are similarly situated to the family of the recipient, or (at the option of the State) the value of such benefits provided by the State to the recipient during the month; divided by

(II) the minimum wage rate in effect during the month under section 6 of the Fair Labor Standards Act of 1938;

(iv) for a recipient to whom the benefits described in subparagraphs (A), (B), (C), and (D) of paragraph (3) are provided during the month is—

(I) the average value of such benefits provided by the State during the month to families that the State determines are similarly situated to the family of the recipient, or (at the option of the State) the value of such benefits provided by the State to the recipient during the month; divided by

(II) the minimum wage rate in effect during the month under section 6 of the Fair Labor Standards Act of 1938; and

(v) for a recipient to whom the benefits described in subparagraphs (A), (B), (C), (D), and (E) of paragraph (3) are provided during the month is—

(I) the average value of such benefits provided by the State during the month to families that the State determines are similarly situated to the family of the recipient, or (at the option of the State) the value of such benefits provided by the State to the recipient during the month; divided by

(II) the minimum wage rate in effect during the month under section 6 of the Fair Labor Standards Act of 1938.

(B) STATE OPTION TO TAKE ACCOUNT OF CERTAIN WORK ACTIVITIES.—

(i) **IN GENERAL.**—In determining the number of hours for a month for which a sufficiently employed recipient may be determined to be engaged in work under subsection (c)(1), the State may, notwithstanding subsection (c)(2), count the number of hours during the month for which the recipient participates in a work activity described in paragraph (6), (8), (9), (10), or (11) of subsection (d).

(ii) **SUFFICIENTLY EMPLOYED RECIPIENT.**—As used in clause (i), the term “sufficiently employed recipient” means, with respect to a month, a recipient who is in a position described in paragraph (1) during the month for a number of hours that is not less than—

(I) the sum of the dollar value of any assistance provided to the recipient during the month under the State program funded under this part, and the dollar value equivalent of any benefits provided to the recipient during the month under the food stamp program under the Food Stamp Act of 1977; divided by

(II) the minimum wage rate in effect during the month under section 6 of the Fair Labor Standards Act of 1938.

(3) *BENEFITS.*—As used in paragraph (2)(A), the term “value of the benefits” means—

(A) in the case of assistance under the State program funded under this part, the dollar value of such assistance;

(B) in the case of food stamp benefits under the food stamp program under the Food Stamp Act of 1977, the dollar value equivalent of such benefits;

(C) at the option of the State, in the case of medical assistance benefits provided under the State plan approved under title XIX, the dollar value of such benefits, as determined in accordance with paragraph (4);

(D) at the option of the State, in the case of child care assistance, the dollar value of such assistance; and

(E) at the option of the State, in the case of housing benefits, the dollar value of such benefits.

(4) *VALUATION OF MEDICAID BENEFITS.*—Annually, the Secretary shall publish a table that specifies the dollar value of the insurance coverage provided under title XIX to a family of each size, which may take account of geographical variations or other factors identified by the Secretary.

(5) *TREATMENT OF RECIPIENTS ASSIGNED TO CERTAIN POSITIONS WITH A PUBLIC AGENCY OR NONPROFIT ORGANIZATION.*—A recipient of assistance under a State program funded under this part who is engaged in work experience or community service with a public agency or nonprofit organization shall not be considered an employee of the public agency or the nonprofit organization.

(k) *HEALTH AND SAFETY.*—Health and safety standards established under Federal and State law otherwise applicable to working conditions of employees shall be equally applicable to working conditions of participants engaged in a work activity. To the extent that a State workers’ compensation law applies, workers’ compensation shall be provided to participants on the same basis as the compensation is provided to other individuals in the State in similar employment.

* * * * *

SEC. 408. PROHIBITIONS; REQUIREMENTS.

(a) *IN GENERAL.*—

(1) * * *

* * * * *

(7) *NO ASSISTANCE FOR MORE THAN 5 YEARS.*—

(A) * * *

* * * * *

(G) *INAPPLICABILITY TO WELFARE-TO-WORK GRANTS AND ASSISTANCE.—For purposes of subparagraph (A) of this paragraph, a grant made under section 403(a)(5) shall not be considered a grant made under section 403, and assistance from funds provided under section 403(a)(5) shall not be considered assistance.*

* * * * *

SEC. 409. PENALTIES.

(a) **IN GENERAL.**—Subject to this section:

(1) * * *

* * * * *

(7) **FAILURE OF ANY STATE TO MAINTAIN CERTAIN LEVEL OF HISTORIC EFFORT.**—

(A) * * *

(B) **DEFINITIONS.**—As used in this paragraph:

(i) * * *

* * * * *

[(iv) EXPENDITURES BY THE STATE.—The term “expenditures by the State” does not include—

[(I) any expenditures from amounts made available by the Federal Government;

[(II) any State funds expended for the medicaid program under title XIX;

[(III) any State funds which are used to match Federal funds; or

[(IV) any State funds which are expended as a condition of receiving Federal funds under Federal programs other than under this part.

Notwithstanding subclause (IV) of the preceding sentence, such term includes expenditures by a State for child care in a fiscal year to the extent that the total amount of such expenditures does not exceed an amount equal to the amount of State expenditures in fiscal year 1994 or 1995 (whichever is greater) that equal the non-Federal share for the programs described in section 418(a)(1)(A).]

(iv) EXPENDITURES BY THE STATE.—The term “expenditures by the State” does not include—

(I) any expenditure from amounts made available by the Federal Government;

(II) any State funds expended for the medicaid program under title XIX;

(III) any State funds which are used to match Federal funds provided under section 403(a)(5); or

(IV) any State funds which are expended as a condition of receiving Federal funds other than under this part.

Notwithstanding subclause (IV) of the preceding sentence, such term includes expenditures by a State for

child care in a fiscal year to the extent that the total amount of the expenditures does not exceed the amount of State expenditures in fiscal year 1994 or 1995 (whichever is the greater) that equal the non-Federal share for the programs described in section 418(a)(1)(A).

* * * * *

(13) *PENALTY FOR FAILURE TO REDUCE ASSISTANCE FOR RECIPIENTS REFUSING WITHOUT GOOD CAUSE TO WORK.—*

(A) *IN GENERAL.—*If the Secretary determines that a State to which a grant is made under section 403 in a fiscal year has violated section 407(e) during the fiscal year, the Secretary shall reduce the grant payable to the State under section 403(a)(1) for the immediately succeeding fiscal year by an amount equal to not less than 1 percent and not more than 5 percent of the State family assistance grant.

(B) *PENALTY BASED ON SEVERITY OF FAILURE.—*The Secretary shall impose reductions under subparagraph (A) with respect to a fiscal year based on the degree of non-compliance.

* * * * *

(j) *EVALUATION OF WELFARE-TO-WORK PROGRAMS.—*

(1) *EVALUATION.—*The Secretary—

(A) shall, in consultation with the Secretary of Labor, develop a plan to evaluate how grants made under sections 403(a)(5) and 412(a)(3) have been used;

(B) may evaluate the use of such grants by such grantees as the Secretary deems appropriate, in accordance with an agreement entered into with the grantees after good-faith negotiations; and

(C) is urged to include the following outcome measures in the plan developed under subparagraph (A):

(i) Placements in the labor force and placements in the labor force that last for at least 6 months.

(ii) Placements in the private and public sectors.

(iii) Earnings of individuals who obtain employment.

(iv) Average expenditures per placement.

(2) *REPORTS TO THE CONGRESS.—*

(A) *IN GENERAL.—*Subject to subparagraphs (B) and (C), the Secretary, in consultation with the Secretary of Labor and the Secretary of Housing and Urban Development, shall submit to the Congress reports on the projects funded under section 403(a)(5) and 412(a)(3) and on the evaluations of the projects.

(B) *INTERIM REPORT.—*Not later than January 1, 1999, the Secretary shall submit an interim report on the matter described in subparagraph (A).

(C) *FINAL REPORT.—*Not later than January 1, 2001, (or at a later date, if the Secretary informs the Committees of the Congress with jurisdiction over the subject matter of the report) the Secretary shall submit a final report on the matter described in subparagraph (A).

TITLE IX—MISCELLANEOUS PROVISIONS RELATING TO
EMPLOYMENT SECURITY

EMPLOYMENT SECURITY ADMINISTRATION ACCOUNT

Establishment of Account

SEC. 901. (a) * * *

* * * * *

Administrative Expenditures

(c)(1) * * *

* * * * *

(5)(A) *There are authorized to be appropriated out of the employment security administration account to carry out program integrity activities, in addition to any amounts available under paragraph (1)(A)(i)—*

- (i) \$89,000,000 for fiscal year 1998;
- (ii) \$91,000,000 for fiscal year 1999;
- (iii) \$93,000,000 fiscal year 2000;
- (iv) \$96,000,000 for fiscal year 2001; and
- (v) \$98,000,000 for fiscal year 2002.

(B) *In any fiscal year in which a State receives funds appropriated pursuant to this paragraph, the State shall expend a proportion of the funds appropriated pursuant to paragraph (1)(A)(i) to carry out program integrity activities that is not less than the proportion of the funds appropriated under such paragraph that was expended by the State to carry out program integrity activities in fiscal year 1997.*

(C) *For purposes of this paragraph, the term "program integrity activities" means initial claims review activities, eligibility review activities, benefit payments control activities, and employer liability auditing activities.*

* * * * *

TRANSFERS TO FEDERAL UNEMPLOYMENT ACCOUNT AND REPORT TO
CONGRESS

TRANSFERS TO FEDERAL UNEMPLOYMENT ACCOUNT

SEC. 902. (a) Whenever the Secretary of the Treasury determines pursuant to section 901(f) that there is an excess in the employment security administration account as of the close of any fiscal year and the entire amount of such excess is not retained in the employment security administration account or transferred to the extended unemployment compensation account as provided in section 901(f)(3), there shall be transferred (as of the beginning of the succeeding fiscal year) to the Federal unemployment account the balance of such excess or so much thereof as is required to increase the amount in the Federal unemployment account to whichever of the following is the greater:

- (1) \$550 million, or
- (2) the amount (determined by the Secretary of Labor and certified by him to the Secretary of the Treasury) equal to

【0.25 percent】 *0.5 percent* of the total wages subject (determined without any limitation on amount) to contributions under all State unemployment compensation laws for the calendar year ending during the fiscal year for which the excess is determined.

* * * * *

AMOUNTS TRANSFERRED TO STATE ACCOUNTS

In General

SEC. 903. (a)(1) * * *

* * * * *

(3)(A) *Notwithstanding any other provision of this section, for purposes of carrying out this subsection with respect to any excess amount (referred to in paragraph (1)) remaining in the employment security administration account as of the close of fiscal year 1999, 2000, or 2001, such amount shall—*

(i) to the extent of any amounts not in excess of \$100,000,000, be subject to subparagraph (B), and

(ii) to the extent of any amounts in excess of \$100,000,000, be subject to subparagraph (C).

(B) *Paragraphs (1) and (2) shall apply with respect to any amounts described in subparagraph (A)(i), except that—*

(i) in carrying out the provisions of paragraph (2)(B) with respect to such amounts (to determine the portion of such amounts which is to be allocated to a State for a succeeding fiscal year), the ratio to be applied under such provisions shall be the same as the ratio that—

(I) the amount of funds to be allocated to such State for such fiscal year pursuant to title III, bears to

(II) the total amount of funds to be allocated to all States for such fiscal year pursuant to title III, as determined by the Secretary of Labor, and

(ii) the amounts allocated to a State pursuant to this subparagraph shall be available to such State, subject to the last sentence of subsection (c)(2).

Nothing in this paragraph shall preclude the application of subsection (b) with respect to any allocation determined under this subparagraph.

(C) *Any amounts described in clause (ii) of subparagraph (A) (remaining in the employment security administration account as of the close of any fiscal year specified in such subparagraph) shall, as of the beginning of the succeeding fiscal year, accrue to the Federal unemployment account, without regard to the limit provided in section 902(a).*

* * * * *

USE OF TRANSFERRED AMOUNTS

(c)(1) Except as provided in paragraph (2), amounts transferred to the account of a State pursuant to subsections (a) and (b) shall be used only in the payment of cash benefits to individuals with

respect to their unemployment, exclusive of expenses of administration.

(2) A State may, pursuant to a specific appropriation made by the legislative body of the State, use money withdrawn from its account in the payment of expenses incurred by it for the administration of its unemployment compensation law and public employment offices if and only if—

(A) * * *

* * * * *

Any amount allocated to a State under this section for fiscal year 2000, 2001, or 2002 may be used by such State only to pay expenses incurred by it for the administration of its unemployment compensation law, and may be so used by it without regard to any of the conditions prescribed in any of the preceding provisions of this paragraph.

* * * * *

TITLE XI—GENERAL PROVISIONS, PEER REVIEW, AND ADMINISTRATIVE SIMPLIFICATION

* * * * *

SEC. 1108. **ADDITIONAL GRANTS TO PUERTO RICO, THE VIRGIN ISLANDS, GUAM, AND AMERICAN SAMOA; LIMITATION ON TOTAL PAYMENTS.**

(a) LIMITATION ON TOTAL PAYMENTS TO EACH TERRITORY.—Notwithstanding any other provision of this Act, the total amount certified by the Secretary of Health and Human Services under titles I, X, XIV, and XVI, under parts A and E of title IV (except section 403(a)(5)), and under subsection (b) of this section, for payment to any territory for a fiscal year shall not exceed the ceiling amount for the territory for the fiscal year.

* * * * *

TITLE XII—ADVANCES TO STATE UNEMPLOYMENT FUNDS

* * * * *

REPAYMENT BY STATES OF ADVANCES TO STATE UNEMPLOYMENT FUNDS

SEC. 1202. (a) * * *

(b)(1) Except as otherwise provided in this subsection, each State shall pay interest on any advance made to such State under section 1201. Interest so payable with respect to periods during any calendar year shall be at the rate determined under paragraph (4) for such calendar year.

(2) No interest shall be required to be paid under paragraph (1) with respect to any advance or advances made during any calendar year if—

(A) such advances are repaid in full before the close of September 30 of the calendar year in which the advances were made, [and]

(B) no other advance was made to such State under section 1201 during such calendar year and after the date on which the repayment of the advances was completed[.], and

(C) the average daily balance in the account of such State in the Unemployment Trust Fund for each of 4 of the 5 calendar quarters preceding the calendar quarter in which such advances were made exceeds the funding goal of such State (as defined in subsection (d)).

* * * * *

(d) For purposes of subsection (b)(2)(C), the term “funding goal” means, for any State for any calendar quarter, the average of the unemployment insurance benefits paid by such State during each of the 3 years, in the 20-year period ending with the calendar year containing such calendar quarter, during which the State paid the greatest amount of unemployment benefits.

* * * * *

TITLE XVI—SUPPLEMENTAL SECURITY INCOME FOR THE AGED, BLIND, AND DISABLED

* * * * *

OPTIONAL STATE SUPPLEMENTATION

SEC. 1616. (a) * * *

* * * * *

(d)(1) Any State which has entered into an agreement with the Commissioner of Social Security under this section which provides that the Commissioner of Social Security will, on behalf of the State (or political subdivision), make the supplementary payments to individuals who are receiving benefits under this title (or who would but for their income be eligible to receive such benefits), shall, at such times and in such installments as may be agreed upon between the Commissioner of Social Security and such State, pay to the Commissioner of Social Security an amount equal to the expenditures made by the Commissioner of Social Security as such supplementary payments, plus an administration fee assessed in accordance with paragraph (2) and any additional services fee charged in accordance with paragraph (3).

(2)(A) The Commissioner of Social Security shall assess each State an administration fee in an amount equal to—

(i) * * *

(B) As used in subparagraph (A), the term “applicable rate” means—

(i) for fiscal year 1994, \$1.67;

(ii) for fiscal year 1995, \$3.33;

(iii) for fiscal year 1996, \$5.00; **[and]**

[(iv) for fiscal year 1997 and each succeeding fiscal year, \$5.00, or such different rate as the Commissioner of Social Security determines is appropriate for the State.]

(iv) for fiscal year 1997, \$5.00;

(v) for fiscal year 1998, \$6.20;

(vi) for fiscal year 1999, \$7.60;

(vii) for fiscal year 2000, \$7.80;

(viii) for fiscal year 2001, \$8.10;

(ix) for fiscal year 2002, \$8.50; and

(x) for fiscal year 2003 and each succeeding fiscal year—

(I) the applicable rate in the preceding fiscal year, increased by the percentage, if any, by which the Consumer Price Index for the month of June of the calendar year of the increase exceeds the Consumer Price Index for the month of June of the calendar year preceding the calendar year of the increase, and rounded to the nearest whole cent; or

(II) such different rate as the Commissioner determines is appropriate for the State.

(C) Upon making a determination under subparagraph [(B)(iv)] (B)(x)(II), the Commissioner of Social Security shall promulgate the determination in regulations, which may take into account the complexity of administering the State's supplementary payment program.

* * * * *

(d)(1) * * * * *

* * * * *

[(4) All administration fees and additional services fees collected pursuant to this subsection shall be deposited in the general fund of the Treasury of the United States as miscellaneous receipts.]

(4)(A) *The first \$5 of each administration fee assessed pursuant to paragraph (2), upon collection, shall be deposited in the general fund of the Treasury of the United States as miscellaneous receipts.*

(B) *That portion of each administration fee in excess of \$5, and 100 percent of each additional services fee charged pursuant to paragraph (3), upon collection for fiscal year 1998 and each subsequent fiscal year, shall be credited to a special fund established in the Treasury of the United States for State supplementary payment fees. The amounts so credited, to the extent and in the amounts provided in advance in appropriations Acts, shall be available to defray expenses incurred in carrying out this title and related laws.*

* * * * *

[OPERATION OF STATE SUPPLEMENTATION PROGRAMS

[SEC. 1618. (a) In order for any State which makes supplementary payments of the type described in section 1616(a) (including payments pursuant to an agreement entered into under section 212(a) of Public Law 93-66), on or after June 30, 1977, to be eligible for payments pursuant to title XIX with respect to expenditures for any calendar quarter which begins—

[(1) after June 30, 1977, or, if later,

[(2) after the calendar quarter in which it first makes such supplementary payments,

such State must have in effect an agreement with the Commissioner of Social Security whereby the State will—

[(3) continue to make such supplementary payments, and

[(4) maintain such supplementary payments at levels which are not lower than the levels of such payments in effect in December 1976, or, if no such payments were made in that month, the levels for the first subsequent month in which such payments were made.

[(b)(1) The Commissioner of Social Security shall not find that a State has failed to meet the requirements imposed by paragraph (4) of subsection (a) with respect to the levels of its supplementary payments for a particular month or months if the State's expenditures for such payments in the twelve-month period (within which such month or months fall) beginning on the effective date of any increase in the level of supplemental security income benefits pursuant to section 1617 are not less than its expenditures for such payments in the preceding twelve-month period.

[(2) For purposes of determining under paragraph (1) whether a State's expenditures for supplementary payments in the 12-month period beginning on the effective date of any increase in the level of supplemental security income benefits are not less than the State's expenditures for such payments in the preceding 12-month period, the Commissioner of Social Security, in computing the State's expenditures, shall disregard, pursuant to a 1-time election of the State, all expenditures by the State for retroactive supplementary payments that are required to be made in connection with the retroactive supplemental security income benefits referred to in section 5041 of the Omnibus Budget Reconciliation Act of 1990.

[(c) Any State which satisfies the requirements of this section solely by reason of subsection (b) for a particular month or months in any 12-month period (described in such subsection) ending on or after June 30, 1982, may elect, with respect to any month in any subsequent 12-month period (so described), to apply subsection (a)(4) as though the reference to December 1976 in such subsection were a reference to the month of December which occurred in the 12-month period immediately preceding such subsequent period.

[(d) The Commissioner of Social Security shall not find that a State has failed to meet the requirements imposed by paragraph (4) of subsection (a) with respect to the levels of its supplementary payments for any portion of the period July 1, 1980, through June 30, 1981, if the State's expenditures for such payments in that twelve-month period were not less than its expenditures for such payments for the period July 1, 1976, through June 30, 1977 (or, if the State made no supplementary payments in the period July 1, 1976, through June 30, 1977, the expenditures for the first twelve-month period extending from July 1 through June 30 in which the State made such payments).

[(e)(1) For any particular month after March 1983, a State which is not treated as meeting the requirements imposed by paragraph (4) of subsection (a) by reason of subsection (b) shall be treated as meeting such requirements if and only if—

[(A) the combined level of its supplementary payments (to recipients of the type involved) and the amounts payable (to or on behalf of such recipients) under section 1611(b) of this Act and section 211(a)(1)(A) of Public Law 93-66, for that particular month,

is not less than—

[(B) the combined level of its supplementary payments (to recipients of the type involved) and the amounts payable (to or on behalf of such recipients) under section 1611(b) of this Act and section 211(a)(1)(A) of Public Law 93-66, for March 1983, increased by the amount of all cost-of-living adjustments under

section 1617 (and any other benefit increases under this title) which have occurred after March 1983 and before that particular month.

[(2) In determining the amount of any increase in the combined level involved under paragraph (1)(B) of this subsection, any portion of such amount which would otherwise be attributable to the increase under section 1617(c) shall be deemed instead to be equal to the amount of the cost-of-living adjustment which would have occurred in July 1983 (without regard to the 3-percent limitation contained in section 215(i)(1)(B)) if section 111 of the Social Security Amendments of 1983 had not been enacted.

[(f) The Commissioner of Social Security shall not find that a State has failed to meet the requirements imposed by subsection (a) with respect to the levels of its supplementary payments for the period January 1, 1984, through December 31, 1985, if in the period January 1, 1986, through December 31, 1986, its supplementary payment levels (other than to recipients of benefits determined under section 1611(e)(1)(B)) are not less than those in effect in December 1976, increased by a percentage equal to the percentage by which payments under section 1611(b) of this Act and section 211(a)(1)(A) of Public Law 93-66 have been increased as a result of all adjustments under section 1617(a) and (c) which have occurred after December 1976 and before February 1986.

[(g) In order for any State which makes supplementary payments of the type described in section 1616(a) (including payments pursuant to an agreement entered into under section 212(a) of Public Law 93-66) to recipients of benefits determined under section 1611(e)(1)(B), on or after October 1, 1987, to be eligible for payments pursuant to title XIX with respect to any calendar quarter which begins—

[(1) after October 1, 1987, or, if later

[(2) after the calendar quarter in which it first makes such supplementary payments to recipients of benefits so determined,

such State must have in effect an agreement with the Commissioner of Social Security whereby the State will—

[(3) continue to make such supplementary payments to recipients of benefits so determined, and

[(4) maintain such supplementary payments to recipients of benefits so determined at levels which assure (with respect to any particular month beginning with the month in which this subsection is first effective) that—

[(A) the combined level of such supplementary payments and the amounts payable to or on behalf of such recipients under section 1611(e)(1)(B) for that particular month,

is not less than—

[(B) the combined level of such supplementary payments and the amounts payable to or on behalf of such recipients under section 1611(e)(1)(B) for October 1987 (or, if no such supplementary payments were made for that month, the combined level for the first subsequent month for which such payments were made), increased—

[(i) in a case to which clause (i) of such section 1611(e)(1)(B) applies or (with respect to the individual

or spouse who is in the hospital, home, or facility involved) to which clause (ii) of such section applies, by \$5, and [(ii) in a case to which clause (iii) of such section 1611(e)(1)(B) applies, by \$10.]

* * * * *

PERSONAL RESPONSIBILITY AND WORK OPPORTUNITY RECONCILIATION ACT OF 1996

SEC. 2. TABLE OF CONTENTS.

The table of contents for this Act is as follows:

* * * * *

TITLE IV—RESTRICTING WELFARE AND PUBLIC BENEFITS FOR ALIENS

* * * * *

Subtitle B—Eligibility for State and Local Public Benefits Programs

Sec. 411. Aliens who are not qualified aliens or nonimmigrants ineligible for State and local public benefits.

* * * * *

Sec. 413. Authorization for verification of eligibility for state and local public benefits.

* * * * *

Subtitle D—General Provisions

Sec. 431. Definitions.

* * * * *

Sec. 436. Derivative eligibility for benefits.

* * * * *

TITLE II—SUPPLEMENTAL SECURITY INCOME

SEC. 200. REFERENCE TO SOCIAL SECURITY ACT.

Except as otherwise specifically provided, wherever 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.

* * * * *

Subtitle B—Benefits for Disabled Children

SEC. 211. DEFINITION AND ELIGIBILITY RULES.

(a) * * *

* * * * *

(d) EFFECTIVE DATES, ETC.—

(1) * * *

(2) APPLICATION TO CURRENT RECIPIENTS.—

(A) ELIGIBILITY REDETERMINATIONS.—During the period beginning on the date of the enactment of this Act and ending on the date which is [1 year] 18 months after such date of enactment, the Commissioner of Social Security shall redetermine the eligibility of any individual under age 18 who is eligible for supplemental security income benefits by reason of disability under title XVI of the Social Security Act as of the date of the enactment of this Act and whose eligibility for such benefits may terminate by reason of the provisions of, or amendments made by, subsections (a) and (b) of this section. Any redetermination required by the preceding sentence that is not performed before the end of the period described in the preceding sentence shall be performed as soon as is practicable thereafter. With respect to any redetermination under this subparagraph—

(i) * * *

* * * * *

(C) NOTICE.—Not later than January 1, 1997, the Commissioner of Social Security shall notify an individual described in subparagraph (A) of the provisions of this paragraph. Before commencing a redetermination under the 2nd sentence of subparagraph (A), in any case in which the individual involved has not already been notified of the provisions of this paragraph, the Commissioner of Social Security shall notify the individual involved of the provisions of this paragraph.

* * * * *

TITLE IV—RESTRICTING WELFARE AND PUBLIC BENEFITS FOR ALIENS

* * * * *

Subtitle A—Eligibility for Federal Benefits

* * * * *

SEC. 402. LIMITED ELIGIBILITY OF QUALIFIED ALIENS FOR CERTAIN FEDERAL PROGRAMS.

(a) LIMITED ELIGIBILITY FOR SPECIFIED FEDERAL PROGRAMS.—

(1) * * *

(2) EXCEPTIONS.—

[(A) TIME-LIMITED EXCEPTION FOR REFUGEES AND ASYLEES.—Paragraph (1) shall not apply to an alien until 5 years after the date—

[(i) an alien is admitted to the United States as a refugee under section 207 of the Immigration and Nationality Act;

[(ii) an alien is granted asylum under section 208 of such Act; or

[(iii) an alien's deportation is withheld under section 243(h) of such Act.]

(A) *TIME-LIMITED EXCEPTION FOR REFUGEES AND ASYLEES.*—

(i) *SSI.*—*With respect to the specified Federal program described in paragraph (3)(A) paragraph 1 shall not apply to an alien until 7 years after the date—*

(I) *an alien is admitted to the United States as a refugee under section 207 of the Immigration and Nationality Act;*

(II) *an alien is granted asylum under section 208 of such Act; or*

(III) *an alien's deportation is withheld under section 243(h) of such Act.*

(ii) *FOOD STAMPS.*—*With respect to the specified Federal program described in paragraph (3)(B), paragraph 1 shall not apply to an alien until 5 years after the date—*

(I) *an alien is admitted to the United States as a refugee under section 207 of the Immigration and Nationality Act;*

(II) *an alien is granted asylum under section 208 of such Act; or*

(III) *an alien's deportation is withheld under section 243(h) of such Act.*

* * * * *

(D) *TRANSITION FOR ALIENS CURRENTLY RECEIVING [BENEFITS] FOOD STAMPS.*—

[(i) *SSI.*—

[(I) *IN GENERAL.*—*With respect to the specified Federal program described in paragraph (3)(A), during the period beginning on the date of the enactment of this Act and ending on the date which is 1 year after such date of enactment, the Commissioner of Social Security shall redetermine the eligibility of any individual who is receiving benefits under such program as of the date of the enactment of this Act and whose eligibility for such benefits may terminate by reason of the provisions of this subsection.*

[(II) *REDETERMINATION CRITERIA.*—*With respect to any redetermination under subclause (I), the Commissioner of Social Security shall apply the eligibility criteria for new applicants for benefits under such program.*

[(III) *GRANDFATHER PROVISION.*—*The provisions of this subsection and the redetermination under subclause (I), shall only apply with respect to the benefits of an individual described in subclause (I) for months beginning on or after the date of the redetermination with respect to such individual.*

[(IV) NOTICE.—Not later than March 31, 1997, the Commissioner of Social Security shall notify an individual described in subclause (I) of the provisions of this clause.]

[(ii) FOOD STAMPS.—]

[(I)] (i) IN GENERAL.—With respect to the specified Federal program described in paragraph (3)(B), ineligibility under paragraph (1) shall not apply until April 1, 1997, to an alien who received benefits under such program on the date of enactment of this Act, unless such alien is determined to be ineligible to receive such benefits under the Food Stamp Act of 1977. The State agency shall recertify the eligibility of all such aliens during the period beginning April 1, 1997, and ending August 22, 1997.

[(II)] (ii) RECERTIFICATION CRITERIA.—With respect to any recertification under subclause (I), the State agency shall apply the eligibility criteria for applicants for benefits under such program.

[(III)] (iii) GRANDFATHER PROVISION.—The provisions of this subsection and the recertification under subclause (I) shall only apply with respect to the eligibility of an alien for a program for months beginning on or after the date of recertification, if on the date of enactment of this Act the alien is lawfully residing in any State and is receiving benefits under such program on such date of enactment.

(E) ALIENS RECEIVING SSI ON AUGUST 22, 1996.—With respect to eligibility for benefits for the program defined in paragraph (3)(A) (relating to the supplemental security income program), paragraph (1) shall not apply to an alien who was receiving such benefits on August 22, 1996.

(F) PERMANENT RESIDENT ALIENS WHO ARE MEMBERS OF AN INDIAN TRIBE.—With respect to eligibility for benefits for the program defined in paragraph (3)(A) (relating to the supplemental security income program), paragraph (1) shall not apply to an alien who—

(i) is lawfully admitted for permanent residence under the Immigration and Nationality Act; and

(ii) is a member of an Indian tribe (as defined in section 4(e) of the Indian Self-Determination and Education Assistance Act).

* * * * *
(b) LIMITED ELIGIBILITY FOR DESIGNATED FEDERAL PROGRAMS.—

(1) * * *

(2) EXCEPTIONS.—Qualified aliens under this paragraph shall be eligible for any designated Federal program.

[(A) TIME-LIMITED EXCEPTION FOR REFUGEES AND ASYLEES.—

[(i) An alien who is admitted to the United States as a refugee under section 207 of the Immigration and Nationality Act until 5 years after the date of an alien's entry into the United States.

[(ii) An alien who is granted asylum under section 208 of such Act until 5 years after the date of such grant of asylum.

[(iii) An alien whose deportation is being withheld under section 243(h) of such Act until 5 years after such withholding.]

(A) TIME-LIMITED EXCEPTION FOR REFUGEES AND ASYLEES.—

(i) MEDICAID.—With respect to the designated Federal program described in paragraph (3)(C), paragraph 1 shall not apply to an alien until 7 years after the date—

(I) an alien is admitted to the United States as a refugee under section 207 of the Immigration and Nationality Act;

(II) an alien is granted asylum under section 208 of such Act; or

(III) an alien's deportation is withheld under section 243(h) of such Act.

(ii) OTHER DESIGNATED FEDERAL PROGRAMS.—With respect to the designated Federal programs under paragraph (3) (other than subparagraph (C)), paragraph 1 shall not apply to an alien until 5 years after the date—

(I) an alien is admitted to the United States as a refugee under section 207 of the Immigration and Nationality Act;

(II) an alien is granted asylum under section 208 of such Act; or

(III) an alien's deportation is withheld under section 243(h) of such Act.

* * * * *

Subtitle B—Eligibility for State and Local Public Benefits Programs

* * * * *

SEC. 413. AUTHORIZATION FOR VERIFICATION OF ELIGIBILITY FOR STATE AND LOCAL PUBLIC BENEFITS.

A State or political subdivision of a State is authorized to require an applicant for State and local public benefits (as defined in section 411(c)) to provide proof of eligibility.

* * * * *

Subtitle D—General Provisions

* * * * *

SEC. 436. DERIVATIVE ELIGIBILITY FOR BENEFITS.

(a) FOOD STAMPS.—Notwithstanding any other provision of law, an alien who under the provisions of this title is ineligible for benefits under the food stamp program (as defined in section

402(a)(3)(A) shall not be eligible for such benefits because the alien receives benefits under the supplemental security income program (as defined in section 402(a)(3)(B)).

(b) *MEDICAID.*—Notwithstanding any other provision of this title, an alien who under the provisions of this title is ineligible for benefits under the medicaid program (as defined in section 402(b)(3)(C)) shall be eligible for such benefits if the alien is receiving benefits under the supplemental security income program and title XIX of the Social Security Act provides for such derivative eligibility.

* * * * *

SECTION 212 OF THE ACT OF JULY 9, 1973

AN ACT To extend the Renegotiation Act of 1951 for one year, and for other purposes.

MANDATORY MINIMUM STATE SUPPLEMENTATION OF SSI BENEFITS PROGRAM

SEC. 212. (a) * * *
(b)(1) * * *

* * * * *

(3)(A) * * *

(B)(i) The Secretary shall assess each State an administration fee in an amount equal to—

(I) the number of supplementary payments made by the Secretary on behalf of the State under this subsection for any month in a fiscal year; multiplied by

(II) the applicable rate for the fiscal year.

(ii) As used in clause (i), the term “applicable rate” means—

(I) for fiscal year 1994, \$1.67;

(II) for fiscal year 1995, \$3.33;

(III) for fiscal year 1996, \$5.00; [and]

[(IV) for fiscal year 1997 and each succeeding fiscal year, \$5.00, or such different rate as the Secretary determines is appropriate for the State, taking into account the complexity of administering the State’s supplementary payment program.]

(IV) for fiscal year 1997, \$5.00;

(V) for fiscal year 1998, \$6.20;

(VI) for fiscal year 1999, \$7.60;

(VII) for fiscal year 2000, \$7.80;

(VIII) for fiscal year 2001, \$8.10;

(IX) for fiscal year 2002, \$8.50; and

(X) for fiscal year 2003 and each succeeding fiscal year—

(aa) the applicable rate in the preceding fiscal year, increased by the percentage, if any, by which the Consumer Price Index for the month of June of the calendar year of the increase exceeds the Consumer Price Index for the month of June of the calendar year preceding the calendar year of the increase, and rounded to the nearest whole cent;

or

(bb) such different rate as the Commissioner determines is appropriate for the State.

(iii) Upon making a determination under clause [(ii)(IV)] (ii)(X)(bb), the Secretary shall promulgate the determination in regulations, which may take into account the complexity of administering the State's supplementary payment program.

(iv) All fees assessed pursuant to this subparagraph shall be transferred to the Secretary at the same time that amounts for such supplementary payments are required to be so transferred.

* * * * *

[(D) All administration fees and additional services fees collected pursuant to this paragraph shall be deposited in the general fund of the Treasury of the United States as miscellaneous receipts.]

(D)(i) *The first \$5 of each administration fee assessed pursuant to subparagraph (B), upon collection, shall be deposited in the general fund of the Treasury of the United States as miscellaneous receipts.*

(ii) *The portion of each administration fee in excess of \$5, and 100 percent of each additional services fee charged pursuant to subparagraph (C), upon collection for fiscal year 1998 and each subsequent fiscal year, shall be credited to a special fund established in the Treasury of the United States for State supplementary payment fees. The amounts so credited, to the extent and in the amounts provided in advance in appropriations Acts, shall be available to defray expenses incurred in carrying out this section and title XVI of the Social Security Act and related laws.*

* * * * *

INTERNAL REVENUE CODE OF 1986

Subtitle C—Employment Taxes

* * * * *

CHAPTER 23—FEDERAL UNEMPLOYMENT TAX ACT

* * * * *

SEC. 3306. DEFINITIONS

(a) * * *

* * * * *

(c) EMPLOYMENT.—For purposes of this chapter, the term “employment” means any service performed prior to 1955, which was employment for purposes of subchapter C of chapter 9 of the Internal Revenue Code of 1939 under the law applicable to the period in which such service was performed, and (A) any service, of whatever nature, performed after 1954 by an employee for the person employing him, irrespective of the citizenship or residence of either, (i) within the United States, or (ii) on or in connection with an American vessel or American aircraft under a contract of service which is entered into within the United States or during the performance of which and while the employee is employed on the vessel or aircraft it touches at a port in the United States, if the em-

ployee is employed on and in connection with such vessel or aircraft when outside the United States, and (B) any service, of whatever nature, performed after 1971 outside the United States (except in a contiguous country with which the United States has an agreement relating to unemployment compensation) by a citizen of the United States as an employee of an American employer (as defined in subsection (j)(3)), except—

(1) * * *

* * * * *

(19) service which is performed by a nonresident alien individual for the period he is temporarily present in the United States as a nonimmigrant under subparagraph (F), (J), (M), or (Q) of section 101(a)(15) of the Immigration and Nationality Act, as amended (8 U.S.C. 1101(a)(15)(F), (J), (M), or (Q)), and which is performed to carry out the purpose specified in subparagraph (F), (J), (M), or (Q), as the case may be; **[or]**

(20) service performed by a full time student (as defined in subsection (q)) in the employ of an organized camp—

(A) if such camp—

(i) did not operate for more than 7 months in the calendar year and did not operate for more than 7 months in the preceding calendar year, or

(ii) had average gross receipts for any 6 months in the preceding calendar year which were not more than $33\frac{1}{3}$ percent of its average gross receipts for the other 6 months in the preceding calendar year; and

(B) if such full time student performed services in the employ of such camp for less than 13 calendar weeks in such calendar year~~].~~; or

(21) *service performed by a person committed to a penal institution.*

* * * * *

SEC. 3309. STATE LAW COVERAGE OF SERVICES PERFORMED FOR NONPROFIT ORGANIZATIONS OR GOVERNMENTAL ENTITIES.

(a) * * *

(b) SECTION NOT TO APPLY TO CERTAIN SERVICE.—This section shall not apply to service performed—

(1) in the employ of (A) a church or convention or association of churches, **[or]** (B) an organization which is operated primarily for religious purposes and which is operated, supervised, controlled, or principally supported by a church or convention or association of churches, or (C) *an elementary or secondary school which is operated primarily for religious purposes, which is described in section 501(c)(3), and which is exempt from tax under section 501(a)*;

(2) by a duly ordained, commissioned, or licensed minister of a church in the exercise of his ministry or by a member of a religious order in the exercise of duties required by such order;

(3) in the employ of a governmental entity referred to in paragraph (7) of section 3306(c), if such service is performed by an individual in the exercise of his duties—

(A) * * *

* * * * *

(D) as an employee serving on a temporary basis in case of fire, storm, snow, earthquake, flood, or similar emergency; **[or]**

(E) in a position which, under or pursuant to the State law, is designated as (i) a major nontenured policymaking or advisory position, or (ii) a policymaking or advisory position the performance of the duties of which ordinarily does not require more than 8 hours per week; *or*

(F) as an election official or election worker if the amount of remuneration received by the individual during the calendar year for services as an election official or election worker is less than \$1,000;

* * * * *

COMMITTEE ON WAYS AND MEANS,
U.S. HOUSE OF REPRESENTATIVES,
Washington, DC, June 13, 1997.

Hon. JOHN R. KASICH,
*Chairman, Committee on the Budget, U.S. House of Representatives,
Washington, DC.*

DEAR MR. CHAIRMAN: On June 9, 1997, the Committee on Ways and Means, pursuant to H. Con. Res. 84, the Concurrent Resolution on the Budget for fiscal Year 1998, ordered favorably reported, as amended, its budget reconciliation recommendations on health items, to the Committee on Budget by a recorded vote of 36 to 3. Accordingly, I am now transmitting these recommendations to you.

Enclosed are the legislative language, explanatory report language, estimates of the Congressional Budget Office and Joint Committee on Taxation and additional views. Under separate covers, I am transmitting the Committee's recommendations on human resources items and revenue items.

Please feel free to contact me or Pete Singleton if you have any questions. With best personal regards,

Sincerely,

BILL ARCHER, *Chairman.*

Enclosures

I. INTRODUCTION

A. PURPOSE AND SUMMARY

The goal of this legislation is to extend the financial life of the Medicare trust funds, to expand the private health plan choices available to Medicare beneficiaries, and improve the quality of Medicare coverage.

The Board of Trustees of the Medicare Hospital Insurance and Supplementary Medical Insurance trust funds have urged the Congress for many years to take action to curb the significant financial imbalance in the trust funds both in the short and long terms. In response to these recommendations, the House of Representatives passed the Medicare Preservation Act of 1995 in the 104th Congress, and included that bill in the Balanced Budget Act of 1995 which was passed by the Congress. This legislation would have kept the Medicare Hospital Insurance trust in balance to the advent of the retirement of the baby boomer generation and stemmed the unsustainable growth in the Supplementary Medical Insurance trust fund. It would also have greatly expanded the private health plan choices available to Medicare beneficiaries. Unfortunately, the Act was vetoed by the President. So, no substantive action regarding the challenges facing Medicare was taken in the 104th Congress.

This legislation would extend the life of the Medicare Hospital Insurance trust fund to 2007. More importantly, with the great increase in program cost that will accompany the retirement of the baby boomer generation after 2010, this measure makes the structural changes in the program that will provide a platform for meeting the longer term financial issues facing Medicare.

The legislation expands the private health plan options available to beneficiaries, and will allow them to choose the type of coverage available to them during their working lives. The increased use of private health plans by beneficiaries will both improve coverage for most of those on Medicare, while offering them quality, cost-effective health care.

Further, the legislation modernizes Medicare payment on the fee-for-service side of the program. Today, 89% of Medicare beneficiaries choose to remain in fee-for-service Medicare. Over time that number will decline, but there will always be beneficiaries who prefer traditional Medicare coverage. To keep that option cost-effective, it is critical that payment for services give providers the incentive to offer quality care at the best price for the program. This legislation achieves this objective by expanding the use of prospective payment in Medicare to home health, skilled nursing, outpatient hospital department, and other services.

Also, to help control costs, the legislation expands on the anti-fraud and abuse initiatives in the Health Insurance Portability and Accountability Act of 1996. The legislation gives the power to Medicare to bar providers from the program who have been convicted of health care fraud, and requires certain new providers to post a \$50,000 surety bond to assure that they will meet their obligations in offering Medicare services.

The legislation further begins the process of improving the Medicare benefit package through its prevention initiatives. It will encourage more preventative screening and empower beneficiaries with diabetes to better treat their disease.

This legislation achieves its objectives by improving the program and expanding opportunities for beneficiaries to seek and for providers to give more cost effective, quality health care without increasing current costs of health to Medicare beneficiaries.

B. BACKGROUND AND NEED FOR LEGISLATION

As in past years, the Board of Trustees of the Medicare Federal Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) trust funds have called for action on the financial crisis facing the Medicare program. The HI trust fund now spends more money than it receives in revenues from the payroll tax, and will run out of reserves in 2001 according to the intermediate assumptions of the Trustees report.

In the report for this year, the Board of Trustees urge action on the HI trust fund:

“As we reported for the last several years, one of the Medicare trust funds, the Hospital Insurance fund, would be exhausted in four years without legislation that addresses its financial imbalance. Any trust fund exhaustion can and should be avoided, as it has been in the past.”

Additionally, they note the need to attend to the unsustainable costs of the SMI trust fund:

“Costs of the Medical Supplementary Medical Insurance Program are rising rapidly and need to be addressed in the near term.”

The short term imbalance in the Medicare Health Insurance trust fund and the excessive growth in the Supplementary Medical Insurance trust fund are fueled primarily by increasing health care costs. This cost growth, depending on the service, is due to ever-increasing prices, use of services, intensity of care, and new technologies. Once the baby boomer generation starts to retire, the rising proportion of Americans entitled to Medicare will present a new challenge and level of concern.

The Ways and Means Committee believes that the short term cost inflation problem faced by Medicare, as well as this longer term demographic problem the retirement of the baby boomers, requires the attention of the Congress.

The Committee has undertaken an effort to meet this challenge with a legislative program that contends with the short term cost inflation for both the HI and SMI trust funds. This program keeps the HI trust fund in balance to 2007. Further, the Committee takes steps to prepare the way for keeping Medicare in financial balance when it confronts the challenge of the baby boomer generation through the development of cost effective, private health plan options under MedicarePlus and the development of payment reform in costly areas of the Medicare fee- for-service program.

Additionally, the Medicare benefits have not been changed significantly since the inception of the program in 1965. Over the last thirty years, priorities in medical care have changed. There is now more emphasis given to disease prevention and health promotion, and most benefits packages in the private sector reflect these trends. Medicare still does not.

The Committee recognizes the need to modernize Medicare. Clearly life-extending and improving medical treatment is likely to be more effective the earlier a disease can be discovered, and better understanding of disease can empower beneficiaries with chronic illnesses to help take care of themselves.

Finally, the Committee continues to have concern with fraud and abuse of the Medicare program. The General Accounting Office has reported over the years that as much as 10 percent of Medicare expenditures are lost to fraud and abuse. In the last Congress, the Health Insurance Portability and Accountability Act took action to curb these costs. The Act stiffened penalties and appropriated additional funds to root out health care crime. However, more can be done, and this legislation recognizes this need and provides further steps to get the “bad apples” among the health care providers out of Medicare and to keep them out.

The Committee is committed to preserving and protecting Medicare as well as modernizing the program to expand the choices of coverage available to beneficiaries. This legislation has been developed to assure all Americans that the Medicare program will continue to improve with time and will be there for all those who expect it in their retirement years or if they become disabled.

C. LEGISLATIVE HISTORY

Committee recommendations

The Committee's budget reconciliation health recommendations to the House Committee on Budget were ordered favorably reported by the Committee on June 9, 1997, by a vote of 36 ayes and 3 nays. These recommendations were initially developed by the Subcommittee on Health, which favorably reported them by a unanimous roll call vote of 13–0 on June 4, 1997.

These recommendations includes nine subtitles. Subtitle A provides for the Medicare Plus program which will provide beneficiaries greater choice of health coverage. Subtitle B expands Medicare coverage to increase health promotion and disease prevention. Subtitle C improves payment for certain rural hospitals. Subtitle D includes initiatives to reduce health care fraud and abuse. Subtitle E modernizes Medicare payment by placing many services under a perspective payment system. Subtitle F provides for refinements in payment under Part A of Medicare and Subtitle G provides for refinements in payment under Part B of Medicare. Subtitle H concerns matter related to both Parts A and B of Medicare. Subtitle I provides for medical liability reform.

Committee action

The Subcommittee on Health of the Committee on Ways and Means held the following hearings in the 105th Congress related to the Subcommittee's 1997 Budget Reconciliation proposals:

February 13—Medicare Provisions in the President's Budget

February 25—Medicare HMO Payment Policies

March 4—Medicare Home Health Care, Skilled Nursing Facility, and other Post-Acute Care Payment Policies

March 6—Medicare HMO Regulation and Quality

March 11—Teaching Hospitals and Medicare Disproportionate

March 13—H.R. 15, the "Medicare Preventive Benefit Improvement Act of 1997"

March 20—Recommendations Regarding Medicare Hospital and Physician Payment Policies

April 10—Rehabilitation and Long-Term Care Hospitals Payments

April 17—Medicare's Coverage Policy

April 24—Medicare Provider-Sponsored Organizations

April 29—Coordinated Care Options for Seniors

On June 4, 1997 the Subcommittee on Health of the Committee on Ways and Means favorably reported to the full Committee as amended, budget reconciliation health recommendations by a recorded vote of 13 to 0 with a quorum present.

On June 9, 1997 the Committee on Ways and Means approved, as amended, budget reconciliation health recommendations by a recorded vote of 36 to 3.

On June 13, 1997 the Committee on Ways and Means forwarded to the Committee on the Budget its budget reconciliation health recommendations.

II. EXPLANATION OF PROVISIONS

SUBTITLE A—MEDICAREPLUS PROGRAM

Chapter 1: Medicare Plus

*Section 10001. Establishment of Program**New Section 1851 of the Social Security Act. Eligibility, election, and enrollment*

Current Law.—Persons enrolling in Medicare have two basic coverage options. They may elect to obtain services through the traditional fee-for-service system under which program payments are made for each service rendered. Under section 1876 of the Social Security Act, they may also elect to enroll with a managed care organization which has entered into a payment agreement with Medicare. Three types of managed care organizations are authorized to contract with Medicare: an entity that has a risk contract with Medicare, an entity that has a cost contract with Medicare, or a health care prepayment plan (HCPP) that has a cost contract to provide Medicare Part B services. Risk-contracts are frequently referred to as TEFRA risk contracts and cost contracts are frequently referred to as TEFRA cost contracts. TEFRA refers to the 1982 legislation, the Tax Equity and Fiscal Responsibility Act of 1982, which established the rules governing these types of contracts.

A beneficiary in an area served by a health maintenance organization (HMO) or competitive medical plan (CMP) with a Medicare risk contract may voluntarily choose to enroll in the organization. (A CMP is a health plan that is not a federally qualified HMO but that meets specific Medicare requirements.) Medicare makes a single monthly capitation payment for each of its enrollees. In return, the entity agrees to provide or arrange for the full range of Medicare services through an organized system of affiliated physicians, hospitals and other providers. The beneficiary must obtain all covered services through the HMO or CMP, except in emergencies. The beneficiary may be charged the usual cost-sharing charges or pay the equivalent in the form of a monthly premium to the organization. Beneficiaries are expected to share in any of the HMO's/CMP's projected cost savings between Medicare's capitation payment and what it would cost the organization to provide Medicare benefits to its commercial enrollees through the provision of additional benefits. (It could also return the "savings" to Medicare.)

Beneficiaries may also enroll in organizations with TEFRA cost contracts. These entities must meet essentially the same conditions of participation as risk contractors; however they may have as few as 1,500 enrollees (rather than 5,000) to qualify. Under a cost contract, Medicare pays the actual cost the entity incurs in furnishing covered services (less the estimated value of beneficiary cost-sharing). Enrollees obtain supplemental benefits by paying a monthly premium. The entity must offer a basic package (which covers all or a portion of Medicare cost-sharing charges); any additional benefits must be priced separately. (Conversely, a risk-contractor may offer just one package.) Enrollees in TEFRA cost-contract entities may obtain services outside the entity's network; however, the en-

tity has no obligation to cover the beneficiary's cost-sharing in this case.

A third type of managed care arrangement is the HCPP. A HCPP arrangement is similar to a TEFRA cost-contract except that it provides only Part B services. Further, there are no specific statutory conditions to qualify for a HCPP contract. Some HCPPs are private market HMOs, while others are union or employer plans. HCPPs have no minimum enrollment requirements, no requirement that the plan have non-Medicare enrollees, or a requirement for an open enrollment period. Unlike TEFRA cost contractors (but like risk contractors), HCPPs may offer a single supplemental package that includes both Part B cost-sharing and other benefits; cost-sharing benefits need not be priced separately.

Any Medicare beneficiary residing in the area served by an HMO/CMP may enroll, with two exceptions. The first exception applies to beneficiaries not enrolled in Part B. The second exception applies to persons qualifying for Medicare on the basis of end-stage renal disease (ESRD); however, persons already enrolled who later develop ESRD may remain enrolled in the entity.

The HMO/CMP must have an annual open enrollment period of at least 30 days duration. During this period, it must accept beneficiaries in the order in which they apply up to the limits of its capacity, unless to do so would lead to violation of the 50 percent Medicare-Medicaid maximum or to an enrolled population unrepresentative of the population in the area served by the HMO.

TEFRA risk contractors are required to hold an additional open enrollment period if any other risk-based entity serving part of the same geographic area does not renew its Medicare contract, has its contract terminated, or has reduced its service area to exclude any portion of the service area previously served by both contractors. In such cases, the Secretary must establish a single coordinated open enrollment period for the remaining contractors. These remaining HMOs/CMPs must then accept its enrollees during an enrollment period of 30 days.

An enrollee may request termination of his or her enrollment at any time. An individual may file disenrollment requests directly with the HMO or at the local social security office. Disenrollment takes effect on the first day of the month following the month during which the request is filed. The HMO may not disenroll or refuse to re-enroll a beneficiary on the basis of health status or need for health services.

The requirement for an open enrollment period does not apply to HCPPs. These entities may deny enrollment or terminate enrollment on medical or other grounds, if in doing so they use the same criteria for Medicare and non-Medicare enrollees. As a result, employer or union plans may restrict enrollment to covered retirees.

The Secretary is authorized to prescribe procedures and conditions under which eligible organizations contracting with Medicare may inform beneficiaries about the organization. Brochures, applications forms, or other promotional or informational material may be distributed only after review and approval by the Secretary of the Department of Health and Human Services (HHS). HMOs may not disenroll or refuse to re-enroll a beneficiary because of health status or need for health care services. HMOs must provide enroll-

ees, at the time of enrollment and annually thereafter, an explanation of rights to benefits, restrictions on services provided through nonaffiliated providers, out-of-area coverage, coverage of emergency and urgently needed services, and appeal rights. A terminating HMO must arrange for supplementary coverage for Medicare enrollees for the duration of any preexisting condition exclusion under their successor coverage for the lesser of 6 months or the duration of the exclusion period.

Explanation of Provision. The Social Security Act would be amended to insert a new Part C, MedicarePlus Program. New section 1851 of Part C of the Social Security Act would specify requirements related to eligibility, election of coverage, and enrollment.

a. Types of Choices. Under the provision, every individual entitled to Medicare Part A and enrolled under Part B could elect to receive benefits through two options: (i) the existing Medicare fee-for-service program (Medicare FFS) or (ii) through a MedicarePlus plan. The exception to this would be individuals medically determined to have ESRD. They would not be able to elect MedicarePlus. Individuals who developed ESRD while enrolled in a plan could continue in that plan. A MedicarePlus plan could be offered by: (i) a coordinated care plan (including an HMO or preferred provider organization (PPO)), (ii) a provider sponsored organization (PSO); and (iii) a combination of a medical savings account (MSA) and contributions to a MedicarePlus MSA.

b. Special Rules. In general, an individual would be eligible to elect a MedicarePlus plan offered by a MedicarePlus organization only if the organization served the geographic area in which the individual resided. Enrollment could continue if the plan provided benefits for enrollees located in the area to which the individual moved. An individual eligible for an annuity under the Federal Employee Health Benefits Program would not be eligible for an MSA plan until the Office of Management and Budget adopted policies to ensure that such enrollment did not result in increased expenditures for the federal government to FEHBP plans. The Secretary could apply similar rules in the case of individuals who are eligible for Departments of Defense or Veterans' Affairs health care. An individual who is a qualified Medicare beneficiary (QMB), a qualified disabled and working individual, a specified low-income Medicare beneficiary (SLMB), or otherwise entitled to Medicare cost-sharing assistance under a state Medicaid program, would not be eligible to enroll in an MSA plan.

In addition, individuals would not be eligible to enroll in an MSA plan on or after January 1, 2003, or as of any date if the number of individuals enrolled in MSA plans reached 500,000. Individuals enrolling in MSA plans prior to either of those two events would be allowed to continue such enrollment. The Secretary is required to regularly evaluate and report to Congress on the impact of permitting enrollment of MSA plans on selection, adverse selection, use of preventive care, access to care, and the financial status of the Trust Funds. In addition, the Secretary is required to submit to Congress periodic reports on the number of individuals enrolled in MSA plans and to submit a report to Congress by no later than March 1, 2002 on whether the four-year time limitation should be

extended or removed, and whether any change should be made to the number of individuals permitted to enroll in Medicare MSAs.

c. Process for Exercising Choice. The Secretary would be required to establish a process for elections (and changing elections) of Medicare FFS and MedicarePlus options. Elections would be made (or changed) only during specified coverage election periods. An individual who wished to elect a MedicarePlus plan could do so by filing an election form with the organization, disenrollment would be accomplished the same way. An individual failing to make an election during the initial election period would be deemed to have chosen the Medicare FFS option. The Secretary would be required to establish procedures under which individuals enrolled with a MedicarePlus organization at the time of the initial election period and who failed to elect to receive coverage other than through the organization would be deemed to have elected the MedicarePlus plan offered by the organization (or, if the organization offered more than one such plan, such plan as the Secretary provided for under such procedures). An individual who made (or was deemed to have made) an election would be considered to have continued such election until the individual changed the election or the plan was discontinued.

d. Providing Information to Promote Informed Choice. The Secretary would provide for activities to disseminate broadly information to current and prospective Medicare beneficiaries on the coverage options available in order to promote an active, informed selection among such options. At least 30 days before each annual, coordinated election period, the Secretary would send to each MedicarePlus eligible person a notice containing the information specified below in order to assist the individual in making an election. This would include general information, a list of plan options and comparative plan option information, the MedicarePlus monthly capitation rate, and other information determined by the Secretary to be helpful in making elections. This information would have to be written in language easily understood by Medicare beneficiaries. The Secretary would be required to coordinate the mailing of this information with annual mailing of other Medicare information required under current law. To the extent practicable, the Secretary would provide such information to new MedicarePlus individuals at least two months prior to their initial enrollment period.

The required general election information would include information on: (i) services covered and not covered by Medicare FFS (including benefits, cost-sharing, and beneficiary liability for balance billing); (ii) the Part B premium amount, (iii) election procedures, (iv) rights including grievance and appeals procedures and the right to be protected against discrimination, (v) information on Medigap and Medicare Select policies, and (vi) the right of the organization to terminate the contract and what this would mean for enrollees.

Comparative plan option information would have to include: (i) a description of benefits including any benefits covered beyond Medicare FFS, any reductions in cost-sharing and any maximum limits on out-of-pocket costs, and in the case of MSA plans, the differences in their cost sharing compared to other MedicarePlus plans; (ii) the monthly premium (and net monthly premium) for the

plan; (iii) to the extent available, quality indicators (compared with indicators for Medicare FFS) including disenrollment rates, enrollee satisfaction and health outcomes, and whether the plan is out of compliance with any federal requirements; and (iv) information on any supplemental coverage. The required information would be updated at least annually.

The Secretary would be required to maintain a toll-free number and Internet site for inquiries regarding MedicarePlus options and plans. A MedicarePlus organization would be required to provide the Secretary with such information on the organization and its plans as the Secretary needed to prepare the information described above for Medicare beneficiaries. The Secretary could enter into contracts with appropriate non-Federal entities to carry out these information activities.

e. Coverage Election Periods. Individuals would first have a choice ("initial election") between Medicare FFS and MedicarePlus plans (if there were one or more MedicarePlus plans to choose from in their area) upon eligibility for Medicare. The Secretary would designate a time for the election such that coverage would become effective when the individual was eligible to begin coverage.

From 1998 through 2000, there would be continuous open enrollment and disenrollment, under which eligible individuals could switch MedicarePlus plans or move into or out of the Medicare FFS program option. For the first 6 months during 2001, there would also be continuous open enrollment and disenrollment, but individuals could change their election only once during 2001 (except during the annual coordinated open enrollment period or a special enrollment period (as described below)). During subsequent years, individuals would be able to enroll in a MedicarePlus option or disenroll from it at any time during the first 3 months of a year (or during the first 3 months after an individual became eligible to enroll in a MedicarePlus plan). Such changes could be made only once a year except during annual coordinated election and special enrollment periods.

Beginning in October, 2000, there would be an annual, coordinated election period during which individuals could change elections for the following calendar year. The Secretary would be required to hold MedicarePlus health fairs in October of each year, beginning with 1998. Such fairs would provide for nationally, coordinated educational and publicity campaigns to inform MedicarePlus eligibles about MedicarePlus plans and the election process, including the annual, coordinated election periods.

Starting January 1, 2001, special election periods would be provided in which an individual could discontinue an election of a MedicarePlus plan and make a new election if: (i) the organization's or plan's certification were terminated or the organization terminated or otherwise discontinued providing the plan; (ii) the person who elected a MedicarePlus plan were no longer eligible because of a change in residence or certain other changes in circumstances; (iii) the individual demonstrated that the organization offering the plan violated its contract with Medicare (including the failure to provide the enrollee on a timely basis medically necessary care or to provide such care in accordance with applicable quality standards), or misrepresented the plan in its marketing; or

(4) the individual encountered other exceptional conditions specified by the Secretary.

Special rules would apply for MSA plans. Individuals could elect a MSA plan only during: (i) an initial open enrollment period; (ii) an annual, coordinated election period, or (iii) October 1998 and October 1999. Such individuals could not discontinue an election of an MSA plan except during an annual, coordinated election period, October 1998 and October 1999, or if the MSA plan had been decertified or terminated.

f. Effectiveness of Elections. An election made during the initial election period would become effective when the individual became entitled to Medicare benefits, except as the Secretary might provide in order to prevent retroactive coverage. During continuous open enrollment periods, an election or change of elections would take effect with the first calendar month after the election was made. An election or change of coverage made during a coordinated election period would take effect as of the first day of the following year. Elections during other periods would take effect in the manner specified by the Secretary to protect continuity of coverage.

g. Guaranteed Issue and Renewal. MedicarePlus organizations would be required to accept MedicarePlus eligibles without restriction during election periods. If the organization had a capacity limit, it could limit enrollment but only if priority were given to those who had already elected the plan and then to other persons in a manner that did not discriminate on the basis of health-status related factors (which include health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence) and disability). These restrictions would not apply if they would result in enrollment substantially misrepresentative of the Medicare population in the service area.

MedicarePlus organizations could not terminate an enrollee's election except for failure to pay premiums on a timely basis, disruptive behavior, or because of plan termination of all MedicarePlus individuals. Individuals terminated for cause would be deemed to have elected Medicare FFS. An individual whose plan was terminated would have a special election period to change into another MedicarePlus plan. If the individual failed to make an election, he or she would be deemed to be Medicare FFS. Plans would have to transmit to the Secretary a copy of each enrollee's election form.

h. Approval of marketing material. The provision would require MedicarePlus plans to submit marketing material to the Secretary at least 45 days before distribution. The material could then be distributed if not disapproved by the Secretary. Medicare's new standards for plans (established as described below) would have to include guidelines for the review of all marketing material submitted. Under these guidelines, the Secretary would have to disapprove marketing materials if they were materially inaccurate or misleading.

Each MedicarePlus organization would have to conform to fair marketing standards, including a prohibition on a MedicarePlus or-

ganization (or its agent) completing any portion of any election form on behalf of any individual.

i. Effect of Election of MedicarePlus Plan Option. Payments under a contract with a MedicarePlus organization with respect to an individual electing a MedicarePlus plan offered by an organization would be instead of the amounts which otherwise would have been payable under Medicare Parts A and B.

Reason for Change. Except for the addition of HMOs, modest benefit changes, and episodic reforms in provider payment methods, the Medicare program has remained essentially unchanged since the program's inception in 1965. This contrasts starkly with the health benefit design, delivery, and cost containment innovations that have occurred in the private sector and, to a great extent, have been captured by the Federal Employee Health Benefit Program. The creation of MedicarePlus will allow beneficiaries to have access to a wide array of private health plan choices in addition to traditional fee-for-service Medicare. In addition, it will enable the Medicare program to utilize innovations that have helped the private market contain costs and expand health care delivery options.

One of the most significant innovations is the Medical Savings Account (MSA). Building upon the private market MSA demonstration program available to small employers and the self-employed under the recently-enacted bipartisan Health Insurance Portability and Accountability Act (HIPAA), the provision would authorize a demonstration of Medicare MSAs available to 500,000 of the 33 million senior citizens eligible for Medicare. The Committee notes that this demonstration is smaller relative to the size of the eligible population than the HIPAA demonstration program, reaching less than 2 percent of Medicare beneficiaries.

There are several additional, critical components of the new MedicarePlus system. First, beneficiaries will for the first time have access to accurate information, including comparative information, about health plan choices. According to the 1990 Census, nearly 4 million people living in America over the age of 65 report that a language other than English is spoken in their home. The Committee believed that all beneficiaries, including those who are limited in their English proficiency, should have access to accurate and timely information about the array of private health plan options available under MedicarePlus. Therefore, the Committee intended that the language requiring the Secretary to promote "active, informed selection among" MedicarePlus plans and to provide information "using language that is easily understandable by Medicare beneficiaries" include such information as may be necessary to help all individuals eligible to enroll in MedicarePlus plans, including those with limited English proficiency.

In addition, for the risk adjustment methods authorized by the Act to work to their full potential and to provide organizations offering MedicarePlus plans with incentives to keep beneficiaries healthy, the Committee believed that it was important to move away from a system where beneficiaries can enroll and disenroll from HMOs at virtually any time. Therefore, the provision provides a transition to a system of annual open enrollment periods based on the FEHBP choice model. This model balances promotion of ac-

tive competition with protections for beneficiaries who wish to test the broad array of private health plan choices made available by the Act without losing their right to return to fee-for-service Medicare.

Effective Date. Unless otherwise provided, the provision is generally effective upon enactment.

New section 1852. Benefits and beneficiary protections

Current Law. Section 1876 provides for requirements relating to benefits, payment to the plans by Medicare, and payments to the plans by beneficiaries. In addition, it specifies standards for patient protection and quality assurance.

A Medicare beneficiary enrolled in an HMO/CMP is entitled to receive all services and supplies covered under Medicare Parts A and B (or Part B only, if only enrolled in Part B). These services must be provided directly by the organization or under arrangements with the organization. Enrollees in risk-based organizations are required to receive all services from the HMO/CMP except in emergencies.

In general, HMOs/CMPs offer benefits in addition to those provided under Medicare's benefit package. In certain cases, the beneficiary has the option of selecting the additional benefits, while in other cases some or all of the supplementary benefits are mandatory.

Some entities may require members to accept additional benefits (and pay extra for them in some cases). These required additional services may be approved by the Secretary if it is determined that the provision of such additional services will not discourage enrollment in the organization by other Medicare beneficiaries.

Medicare HMOs/CMPs must provide enrollees, at the time of enrollment and annually thereafter, an explanation of: rights to benefits, restrictions on services provided through nonaffiliated providers, out-of-area coverage, coverage of emergency and urgently needed services, and appeal rights.

Medicare HMOs/CMPs must make all Medicare covered services and all other services contracted for available and accessible within its service area, with reasonable promptness and in a manner that assures continuity of care. Urgent care must be available and accessible 24 hours a day and 7 days a week. HMOs must also pay for services provided by nonaffiliated providers when services are medically necessary and immediately required because of an unforeseen illness, injury, or condition and it is not reasonable, given the circumstances, to obtain the services through the HMO.

HMOs/CMPs are required to have arrangements for an ongoing quality assurance program that stresses health outcomes and provides review by physicians and other health care professionals of the process followed in the provision of health services. External review is conducted by a peer review organization (PRO), one of the groups that has contracted with the Secretary for review of the quality and appropriateness of hospital services. PRO reviews of HMOs/CMPs covers both inpatient and outpatient care. The Secretary also has the right to inspect or otherwise evaluate the quality, appropriateness, and timeliness of services provided and the fa-

cilities of the organization when there is reasonable evidence of some need for inspection.

In up to 25 States, the Secretary is authorized to designate another external agency, known as a quality review organization or QRO to perform reviews. QROs must meet many of the same standards as PROs, but have not contracted with the Department of HHS for the review of services other than those provided by an HMO/CMP.

HMOs/CMPs must have meaningful grievance procedures for the resolution of individual enrollee complaints, about such problems as failure to receive covered services or unpaid bills. In addition, an enrollee who believes that the HMO has improperly denied a service or imposed an excessive charge has the right to a hearing before the Secretary if the amount involved is greater than \$100. If the amount is greater than \$1,000, either the enrollee or the HMO may seek judicial review. On April 30, 1997, the Health Care Financing Administration (HCFA) issued final rules for establishing an expedited review process for Medicare beneficiaries enrolled in HMOs and CMPs.

Hospitals and other providers are required under Medicare as a condition of participation to ask whether an individual has an advance directive and make a notice of such in the patient's record. Such hospitals and other providers also have to provide upon admission and at other specified times written information to adult patients: on applicable advance directive laws of the relevant state and of the advance directive policies of the provider.

Payments to Medicare HMOs/CMPs include amounts that reflect Medicare's fee-for-service payments to hospitals in an area for indirect and direct medical education costs and disproportionate share adjustments.

Penalties apply for violations of limits on the use of "physician incentive plans," i.e., compensation arrangements between HMOs and physicians that might induce physicians to withhold services. An HMO may not make a specific payment to a physician as an inducement to reduce or limit services to a specific enrollee. In addition, if physicians or physician groups are placed at substantial financial risk for services other than their own, the HMO must provide adequate stop-loss protection to limit the physicians' potential liability and must periodically survey enrollee satisfaction.

There are no provisions in current law for provider protections. In addition, there is no provision in current law for medical savings account plans for Medicare beneficiaries.

Explanation of Provision. The provision establishes a new section 1852 specifying federal requirements related to MedicarePlus plan benefits and beneficiary protections.

a. Basic Benefits. Each MedicarePlus plan, except an MSA plan, would be required to provide benefits for at least the items and services for which benefits are available under parts A and B of Medicare and any additional health services as the Secretary may approve. A MedicarePlus plan would meet this requirement if:

- (i) in the case of benefits furnished through providers with a contract with the organization (i.e., plan providers), the individual's liability for payment for items and services did not exceed (after taking into account any deductible which did not

exceed any deductible under Medicare FFS) the lesser of: (a) the amount of liability that the individual would have had (based on the provider being a participating provider) if the individual had not elected coverage under MedicarePlus, or (b) the applicable coinsurance or copayment amounts that would have applied under Medicare FFS provided under the contract, and

(ii) in the case of benefits furnished through providers without contracts with the organization (i.e., out-of-plan providers), the MedicarePlus plan provided for at least the dollar amount of payment for such items and services as would otherwise have been provided under Medicare FFS. Such providers could not bill any more than they could under the balance billing limits applicable under Medicare FFS.

These cost-sharing limitations would not apply to an individual enrolled under an MSA plan.

MedicarePlus organizations could offer, with the Secretary's approval, under their MedicarePlus plans supplemental benefits. If the supplemental benefits were offered only to MedicarePlus enrollees, the additional premium would have to be the same for all enrollees in the area. The benefits could be marketed and sold outside of the enrollment process described above. A MedicarePlus plan could seek payment from other payers, such as insurers or employer plans, in circumstances where secondary payer rules apply.

The provision would establish a policy relating to a national coverage determination made between the annual announcements of MedicarePlus payment rates. The application of the determination would be delayed if the determination would result in a significant change in costs to the MedicarePlus plan, and such change were not incorporated into the MedicarePlus payment rate established for that period. In such cases, the national coverage determination would apply to the first contract year beginning after such period. If the determination provided for coverage of additional benefits or benefits under additional circumstances, it would also apply to the first contract year beginning after such period, unless otherwise required by law.

b. Antidiscrimination. A MedicarePlus organization could not deny, limit, or condition the coverage or provision of benefits under this part based on any health-status related factor (health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence) and disability). This requirement should not be construed to mean that a MedicarePlus organization had to enroll individuals determined to have ESRD.

c. Detailed Description of Plan Provisions. The provision would require each MedicarePlus plan to disclose in clear, accurate and standardized form to each enrollee at the time of enrollment and annually thereafter, the following information about the plan: (i) its service area; (ii) its benefits and exclusions from coverage (and, in the case of an MSA plan, a comparison with other MedicarePlus plans); (iii) the number, mix, and distribution of participating providers; (iv) permitted out-of-area coverage; (v) coverage of and procedures for obtaining emergency services (including the appropriate

use of 911 or local equivalent); (vi) any optional supplemental coverage, including the benefits and premium price; (vii) any prior authorization or other rules that could result in nonpayment; (viii) any plan-specific grievance and appeals procedures; and (ix) its quality assurance program.

d. Access to services. The provision would permit a MedicarePlus organization offering a MedicarePlus plan to restrict the providers from whom benefits could be provided so long as: (i) the organization makes the benefits available and accessible to each individual electing the plan within the service area with reasonable promptness and in a manner that assures continuity in the provision of benefits; (ii) when medically necessary, the organization makes benefits available and accessible 24 hours a day, 7 days a week; (iii) the plan provides reimbursement for out-of-network services if the services are medically necessary and immediately required because of unforeseen illness, injury, or condition and it is not reasonable to provide the services through the organization or met other conditions; (iv) the organization provides access to appropriate providers, including credentialed specialists, for medically necessary treatment and services; and (v) coverage is provided for emergency services without regard to either prior authorization requirements or the emergency care entity's contractual relationship with the organization.

The provision specifies that in the case of emergency services furnished to a MedicarePlus enrollee by a Medicare participating physician or provider, the applicable participation agreement is deemed to provide that the physician or provider accept as payment in full the amount that would have been paid under Medicare part B (including beneficiary cost-sharing). In the event services are furnished by a physician or health care professional not participating in Medicare, the Medicare part B limitation on actual charges would apply. Emergency services described in this paragraph mean covered inpatient and outpatient services that are furnished to an enrollee of a MedicarePlus organization by a provider qualified to provide services under Medicare.

A MedicarePlus organization would be required to comply with such guidelines as the Secretary may prescribe relating to promoting efficiency and timely coordination of appropriate maintenance and post-stabilization care provided to an enrollee determined to be stable by a medical screening examination required under the Examination and Treatment under Emergency Medical Conditions and Women in Labor requirements of the Social Security Act (section 1867).

An emergency medical condition is one manifesting itself by acute symptoms of sufficient severity such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (i) placing the health of the individual in serious jeopardy (and in case of a pregnant woman, her health or that of her unborn child); (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part. While the definition does not include an express reference to the term "severe pain," the Committee did not intend for the omission to give rise to the inference that severe pain is not an indication of an emer-

gency medical condition. Instead, it was the sense of the Committee that an express reference to “pain” was unnecessary because term “sufficient severity” used in the definition was broad enough to encompass indications including severe pain.

e. Quality assurance program. The provision would require a MedicarePlus organization to have arrangements (established in accordance with regulations of the Secretary) for an ongoing quality assurance program for services provided to its MedicarePlus enrollees. The program has to: (i) stress health outcomes and provide for the collection, analysis, and reporting of data that will permit measurement of outcomes and other indices of MedicarePlus plans and organizations; (ii) provide for written protocols for utilization review; (iii) provide review by physicians and other health care professionals of the process followed in the provision of health services; (iv) monitor and evaluate high volume and high risk services and the care of acute and chronic conditions; (v) evaluate the continuity and coordination of care; (vi) have mechanisms in place to detect both underutilization and overutilization; (vii) after identifying areas for improvement, establish or alter practice parameters; (viii) take actions to improve quality and assess effectiveness of such actions; (ix) make available information on quality and outcomes measures to facilitate beneficiary comparison and choice; (x) be evaluated on an ongoing basis; (xi) include measures of consumer satisfaction; and (xii) provide the Secretary with such access to information collected as may be appropriate to monitor and ensure quality.

Each organization would be required to have an agreement with an independent quality review and improvement organization, approved by the Secretary, for each plan it operates, to perform functions such as quality review, review for the appropriateness of setting of care, adequacy of access, beneficiary outreach, and review of complaints about poor quality of care. A MedicarePlus organization would be deemed to meet the requirements for quality assurance external review if it is accredited by a private organization under a process that the Secretary has determined assures that the organization applies and enforces standards that are no less stringent than those specified under the plan standards requirements established by this provision (see new section 1856 as described below).

f. Coverage Determinations. A MedicarePlus organization would be required to make determinations regarding authorization requests for nonemergency care on a timely basis. Appeals of denials would generally have to be decided within 30 days of receiving medical information, but not later than 60 days after the coverage determination. Physicians would be the only individuals permitted to make decisions to deny coverage based on medical necessity. Appeals of determinations involving a life-threatening or emergency situation would have to be made on an expedited basis.

g. Grievances and Appeals. The provision would require each MedicarePlus organization to provide meaningful procedures for hearing and resolving grievances. An enrollee dissatisfied by reason of the enrollee’s failure to receive health services would be entitled, if the amount in controversy was \$100 or more, to a hearing before the Secretary. If the amount in controversy was \$1,000 or

more, the individual or organization, upon notifying the other party, would be entitled to judicial review. The Secretary would be required to contract with an independent, outside entity to review and resolve appeals of denials of coverage related to urgent or emergency services.

An enrollee in a MedicarePlus plan could request an expedited determination by the organization regarding an appeal. Such requests could also come from physicians. The organization would have to maintain procedures for expediting organization determinations when, upon request of an enrollee, the organization determined that the application of a normal time frame for making a determination or a reconsideration could seriously jeopardize the life or health of an enrollee or the enrollee's ability to regain maximum function. In an urgent case, the organization would have to notify the enrollee (and physician involved) of the determination as expeditiously as the enrollee's condition requires, but not later than 72 hours (or 24 hours in the case of a reconsideration), or such longer period as the Secretary may permit in specified cases.

h. Confidentiality and Accuracy of Enrollee Records. Each MedicarePlus organization would be required to establish procedures to safeguard the privacy of individually identifiable enrollee information, to maintain accurate and timely medical records and other health information, and to assure timely access of enrollees to their medical records.

i. Information on Advance Directives. Each MedicarePlus organization would be required to maintain written policies and procedures respecting advance directives.

j. Rules Regarding Physician Participation. Each MedicarePlus organization would be required to establish reasonable procedures relating to the participation of physicians under a MedicarePlus plan offered by the organization. The procedures would include: (i) providing notice of the rules regarding participation; (ii) providing written notice of adverse participation decisions; and (iii) providing a process for appealing adverse decisions. The organization would be required to consult with physicians who have entered into participation agreements regarding the organization's medical policy, quality, and medical management procedures.

The provision would prohibit interference with physician advice to enrollees. A MedicarePlus organization could not prohibit a covered health professional from advising a patient about the patient's health status or about medical care or treatment for the patient's condition or disease, regardless of whether benefits for such care or treatment are provided under the plan if the professional is acting within the lawful scope of practice. "Health care provider" is defined to include physicians and other health care professionals (as specified). This provision should not be construed as requiring a MedicarePlus plan to provide, reimburse for, or provide coverage of a counseling or referral service if the MedicarePlus organization offering the plan objects to the provision of such service on moral or religious grounds, and, in the manner and through the written instrumentalities the MedicarePlus organization deems appropriate, makes available information on its policies regarding such service to prospective enrollees before or during enrollment. For those beneficiaries enrolled in the plan at any time a policy is adopted

by the MedicarePlus organization or MedicarePlus plan regarding coverage of a counseling or referral service, the MedicarePlus organization offering such plan must notify enrollees of such policy within 90 days.

The provision permits organizations offering MedicarePlus plans that object to the coverage or provision of counseling or referral services on moral or religious grounds to make information on these policies available in the manner and through the written instrumentalities the organization deems appropriate. This limitation was included primarily to remove discretion from the Secretary or other governmental entities that may seek to impose burdensome regulatory, legal, or stylistic requirements with respect to this notice requirement. This limitation is not intended to allow MedicarePlus organizations to intentionally obfuscate or seek to deceive prospective or current enrollees about their coverage policies. Rather, the Committee intends for such notice to be provided in a manner that would be meaningful to beneficiaries and reasonably inform them of any plan restrictions.

The provision also would limit the use of physician incentive plans. The provision would define a physician incentive plan as any compensation arrangement between a MedicarePlus organization and a physician group that has the effect, directly or indirectly, of reducing or limiting services provided. The provision would prohibit MedicarePlus plans from operating such a physician incentive plan unless the following conditions were met. No specific payment could be made, directly or indirectly, to a physician group as an inducement to reduce or limit medically necessary services provided with respect to a specific individual. If the plan placed a physician or physician group at substantial financial risk, the organization would be required to provide adequate and appropriate stop-loss protection and to conduct periodic surveys of currently and previously enrolled individuals to determine the degree of access to and satisfaction with the quality of services. Further, the organization would be required to provide the Secretary with sufficient descriptive information for the Secretary to determine compliance with these requirements.

A MedicarePlus organization would not be able to provide (directly or indirectly) for a provider (or group of providers) to indemnify the organization against any liability resulting from a civil action brought by or on behalf of an enrollee for any damage caused to the enrollee by the organization's denial of medically necessary care.

Each MedicarePlus organization would have to provide the Secretary with information on (i) the extent to which it provides inpatient and outpatient hospital benefits under MedicarePlus through the use of hospitals that are eligible for disproportionate share hospital adjustments or through the use of teaching hospitals that receive indirect and direct graduate medical education payments, and (ii) the extent to which differences between payment rates to different hospitals reflect the disproportionate share percentage of low-income patients and the presence of medical residency training programs in those hospitals.

Reason for Change. The provision contains significant new consumer protections for beneficiaries who choose to enroll in

MedicarePlus plans. In many cases, these requirements either codify or expand upon existing regulations or practices and, in most instances, they go well beyond State consumer protection requirements. For example, the provision requires all MedicarePlus plans to clearly and accurately notify beneficiaries of their rights under the plan. Because of some of the unique features of MSA Plans, additional notification requirements were provided. In addition, the provision incorporates provisions prohibiting MedicarePlus plans from restricting providers' advice to beneficiaries about medical care or treatment, requires MedicarePlus plans to guarantee access to appropriate providers, including specialists, for medically necessary treatment and services, and restricts the use of physician incentive plans in certain situations.

Finally, the Act codifies requirements for emergency coverage and resolution of urgent grievances and appeals. In both situations, the provision attempts to codify existing policy and regulation, while at the same time providing sufficient flexibility for the Secretary to modify such policies as circumstances may require. For example, the Committee believed that the coordination of health care services between emergency health care providers and MedicarePlus plans was critical. However, it chose not to specify rigid requirements for post-stabilization medical services in the legislative language. Instead, the Committee believed that the Secretary should be provided flexibility to determine such conditions, after extensive consultation with affected parties.

Effective Date. Unless otherwise provided, the provision is generally applicable to contracts entered into or renewed on or after January 1, 1999.

New section 1853. Payments to MedicarePlus organizations

Current Law. Under a Medicare risk contract, an HMO agrees to provide or arrange for the full scope of covered Medicare services in return for a single monthly capitation payment issued by Medicare for each enrolled beneficiary. One of the numbers used to determine this payment is the adjusted average per capita cost, or AAPCC. The other, the adjusted community rate or ACR, is discussed below (see new section 1854).

The AAPCC is Medicare's estimate of the average per capita amount it would spend for a given beneficiary (classified by certain demographic characteristics and county of residence) who was not enrolled in an HMO and who obtained services on the usual fee-for-service basis. Separate AAPCCs are established for enrollees on the basis of age, sex, whether they are in a nursing home or other institution, whether they are also eligible for Medicaid, whether they are working and being covered under an employer plan, and the county of their residence. These AAPCC values are calculated in three basic steps:

Medicare national average calendar year per capita costs are projected for the future year under consideration. These numbers are known as the U.S. per capita costs (USPCCs) and are estimated average incurred benefit costs per Medicare enrollee and adjusted to include program administration costs. USPCCs are developed separately for Parts A and B of Medicare, and

for costs incurred by the aged, disabled, and those with ESRD in those two parts of the program.

Geographic adjustment factors that reflect the historical relationships between the county's and the Nation's per capita costs are used to convert the national average per capita costs to the county level. Expected Medicare per capita costs for the county are calculated only for fee-for-service beneficiaries by removing both reimbursement and enrollment attributable to Medicare beneficiaries in prepaid plans.

Once the county AAPCC is calculated, it is then adjusted for the demographic variables described above, such as age, sex, and Medicaid status.

For each Medicare beneficiary enrolled under a risk contract, Medicare will pay the HMO 95 percent of the rate corresponding to the demographic class to which the beneficiary is assigned.

Explanation of Provision. The provision would establish a new section 1853 specifying the methodology for determining payment to MedicarePlus plans and the procedures for announcing rates and paying plans.

a. In General. Under a MedicarePlus contract, the Secretary would be required to make monthly payments in advance to each MedicarePlus organization for each covered individual in a payment area in an amount equal to $\frac{1}{12}$ of the annual MedicarePlus capitation rate with respect to that individual for that area. The payment would be adjusted for such risk factors as age, disability status, gender, institutional status, and other such factors as the Secretary determined to be appropriate, so as to ensure actuarial equivalence. The Secretary could add to, modify, or substitute for such factors, if such changes would improve the determination of actuarial equivalence. The Secretary would be required to establish separate rates of payment with respect to individuals with end stage renal disease (ESRD). Payments to organizations could be retroactively adjusted for (i) actual versus the estimated enrollment used to determine the amount of advance payment; and (ii) individuals' change of enrollment from a MedicarePlus organization sponsored or contributed to by an employer to a MedicarePlus organization.

Risk Adjustment: The Secretary would be required to develop and submit to Congress by no later than October 1, 1999, a report on a method of risk adjustment of payment rates that accounts for variations in per capita costs based on health status. This report would have to include an evaluation of the proposal by an independent actuary of the actuarial soundness of the proposal. The Secretary would have to require MedicarePlus organizations (and risk-contract plans) to submit, for periods beginning on or after January 1, 1998, data regarding inpatient hospital and other services and other information the Secretary deems necessary. The Secretary would have to provide for implementation of a risk adjustment methodology that accounts for variations in per capita costs based on health status by no later than January 1, 2000.

b. Annual Announcement of Payment Rates. Payments to plans would be calculated based on the annual MedicarePlus capitation rate. The Secretary would be required to annually determine, and announce no later than August 1 before the calendar year con-

cerned: (i) the annual MedicarePlus capitation rate for each MedicarePlus payment area for the year, and (ii) the risk and other factors to be used in adjusting such rates for payments for months in that year. An explanation of the assumptions and changes in methodology would have to be included in sufficient detail so that organizations could compute monthly adjusted MedicarePlus capitation rates. The Secretary would be required to provide advance notice (at least 45 days prior to the announcement) of the proposed changes in the methodology and assumptions used to develop the rates, and give organizations an opportunity to comment.

c. Calculation of Annual MedicarePlus Capitation Rates. The annual MedicarePlus capitation rate, for a payment area (for a contract for a calendar year) would be equal to the greatest of the following:

(A) A blended capitation rate, defined as the sum of:

(1) the area-specific percentage (as defined below) of the annual area-specific MedicarePlus capitation rate for the year for the payment area, and

(2) the national percentage (as defined below) of the input-price adjusted annual national MedicarePlus capitation rate for the year. (This sum is multiplied by the budget neutrality adjustment factors (described below);

(B) A minimum (i.e. "floor") monthly payment amount set at \$350 for 1998 (but not to exceed, in the case of an area outside the 50 states and the District of Columbia, 150% of the 1997 AAPCC). For a subsequent year, this payment amount would be increased by the national per capita MedicarePlus growth percentage for that year.

(C) A minimum percentage increase. In 1998, the payment area would receive a rate that is 102% of its 1997 AAPCC. For a subsequent year, it would be 102% of the annual MedicarePlus capitation rate for the previous year.

There are four elements in the blended capitation rate referred to in "A" above: First, the area-specific and national percentages are as follows:

1998—the area-specific percentage is 90% and the national percentage is 10%.

1999—the area-specific percentage is 80% and the national percentage is 20%.

2000—the area-specific percentage is 70% and the national percentage is 30%

2001—the area-specific percentage is 60% and the national percentage is 40%

After 2001—the area-specific percentage is 50% and the national percentage is 50%.

Second, the annual area-specific MedicarePlus capitation rate for a MedicarePlus payment area would be:

For 1998—the annual per capita rate of payment for 1997 (as determined under the current law calculation to derive the AAPCC), increased by the national average per capita growth percentage for 1998 (as defined below), or

For a subsequent year—the annual area-specific MedicarePlus capitation rate for the previous year, increased

by the national per capita MedicarePlus growth percentage for such subsequent year.

Third, the input-price-adjusted annual national MedicarePlus capitation rate for a MedicarePlus payment area for a year would be equal to the sum, for all types of Medicare services, of the product of three amounts: (i) the national standardized annual MedicarePlus capitation rate for the year (defined as the weighted average of area-specific MedicarePlus capitation rates), (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 service) the relative input price of such services in the area as compared to the national average input price of such services. (In applying (iii), the Secretary would use those indices that are used in applying (or updating) national payment rates for specific areas and localities.) Special rules specified in the provision would apply for 1998 (and optionally for 1999) in providing for the input price adjustment.

Fourth, in calculating the payment rates, the Secretary would be required to apply a budget neutrality adjustment to the blended rate payments. This adjustment would ensure that the aggregate of payments equals that which would have been made if the payment was based on 100% of the area-specific MedicarePlus capitation rates for each payment area. In doing this, the budget neutral amount for each county would be equal to the sum of the area-specific rates used to compute the blended rates multiplied by the product of the update factor and the number of enrollees in that county.

With respect to the blended and the minimum payment rate categories described in "A" and "B" above, the national per capita MedicarePlus growth percentage is the percentage determined by the Secretary, by April 30th before the beginning of the year involved, to reflect the Secretary's estimate of the projected per capita rate of growth in expenditures under Medicare parts A and B, reduced by 0.5 percentage points for 1998-2002, and by 0 percentage points for years thereafter. Separate determinations would have to be made for aged enrollees, disabled enrollees, and enrollees with ESRD. The percentage adjustment would have to reflect an adjustment for over or under projecting in the growth percentage for previous years.

d. MedicarePlus Payment Area. The provision defines a MedicarePlus payment area as a county or equivalent area specified by the Secretary. In the case of individuals determined to have ESRD, the MedicarePlus payment area would be each state, or other payment areas as the Secretary specifies.

Upon request of a state for a contract year (beginning after 1998) made at least 7 months before the beginning of the year, the Secretary would redefine MedicarePlus payment areas in the state to: (1) a single statewide MedicarePlus payment area; (2) a metropolitan system (described in the provision); or (3) a single MedicarePlus payment area consolidating noncontiguous counties (or equivalent areas) within a state. This adjustment would be effective for payments for months beginning with January of the year following the year in which the request was received. The Secretary

would be required to make an adjustment to payment areas in the state to ensure budget neutrality.

e. Special Rules for Individuals Electing MSA Plans. If the monthly premium for an MSA plan for a MedicarePlus payment area was less than $\frac{1}{12}$ of the annual MedicarePlus capitation rate for the area and year involved, the Secretary would deposit the difference in a MedicarePlus MSA established by the individual. No payment would be made unless the individual had established the MedicarePlus MSA before the beginning of the month or by such other deadline the Secretary specifies. If the individual had more than one account, he or she would designate one to receive the payment. The payment for the first month for which a MSA plan was effective for a year would also include amounts for successive months in the year. For cases when an MSA election was terminated before the end of the year, the Secretary would establish a procedure to recover deposits attributable to the remaining months.

f. Payments from Trust Funds. Payments to MedicarePlus organizations and payments to MedicarePlus MSAs, would be made from the HI and SMI trust funds in such proportion as the Secretary determined reflected the relative weights that benefits under Parts A and B represented Medicare's actuarial value of the total benefits.

g. Special Rule for Certain Inpatient Hospital Stays. In the case of an individual receiving inpatient hospital services from a hospital covered under Medicare's prospective payment system as of the effective date of the (1) individual's election of a MedicarePlus plan: (a) payment for such services until the date of the individual's discharge would be made as if the individual did not elect coverage under the MedicarePlus plan; (b) the elected organization would not be financially responsible for payment for such services until the date of the individual's discharge; and (c) the organization would nevertheless be paid the full amount otherwise payable to the organization; or (2) termination of enrollment with a MedicarePlus organization: (a) the organization would be financially responsible for payment for such services after the date of termination and until the date of discharge; (b) payment for such services during the stay would not be made under Medicare's PPS system; and (c) the terminated organization would not receive any payment with respect to the individual during the period in which the individual was not enrolled.

Reason for change. The current methodology for calculating capitation payments for managed care plans under the Medicare program has resulted in highly variable payment levels even in areas of close geographic proximity, and has generated volatile changes in payment levels in particular markets from year to year. In addition, contribution levels tend to be lower in rural areas and are excessive in certain urban areas, relative to what is necessary to encourage or induce private plans to participate in these markets.

The Committee believes that it is important to take steps to narrow these differences over a several year transition period. Contribution levels for each area are calculated so as to improve contribution levels in low average service utilization markets and to moderate the growth in contribution levels in high average service utilization markets.

The Committee is also very concerned about the inadequacy of Medicare's current risk adjustment methods and feels that the first step to improving risk adjustment is to collect additional clinical and financial data from managed care plans. Therefore, the Secretary is instructed to collect these data and to develop a risk adjuster that more adequately reflects the variation in health status among beneficiaries.

Effective date. These provisions are effective upon enactment and would be applied for contracting periods beginning on or after January 1, 1998.

New section 1854. Premiums

Current Law. Section 1876 provides for requirements relating to benefits, payments to the plans by Medicare, and payments to the plans by beneficiaries. A Medicare beneficiary enrolled in an HMO/CMP is entitled to receive all services and supplies covered under Medicare Parts A and B (or Part B only, if only enrolled in Part B). These services must be provided directly by the organization or under arrangements with the organization. Enrollees in risk-based organizations are required to receive all services from the HMO/CMP except in emergencies.

In general, HMOs/CMPs offer benefits in addition to those provided under Medicare's benefit package. In certain cases, the beneficiary has the option of selecting the additional benefits, while in other cases some or all of the supplementary benefits are mandatory.

Some entities may require members to accept additional benefits (and pay extra for them in some cases). These required additional services may be approved by the Secretary if it is determined that the provision of such additional services will not discourage enrollment in the organization by other Medicare beneficiaries.

The amount an HMO/CMP may charge for additional benefits is based on a comparison of the entity's adjusted community rate (ACR, essentially the estimated market price) for the Medicare package and the average of the Medicare per capita payment rate. A risk-based organization is required to offer "additional benefits" at no additional charge if the organization achieves a savings from Medicare. This "savings" occurs if the ACR for the Medicare package is less than the average of the per capita Medicare payment rates. The difference between the two is the amount available to pay additional benefits to enrollees. These may include types of services not covered, such as outpatient prescription drugs, or waivers of coverage limits, such as Medicare's lifetime limit on reserve days for inpatient hospital care. The organization might also waive some or all of the Medicare's cost-sharing requirements.

The entity may elect to have a portion of its "savings" placed in a benefit stabilization fund. The purpose of this fund is to permit the entity to continue to offer the same set of benefits in future years even if the revenues available to finance those benefits diminish. Any amounts not provided as additional benefits or placed in a stabilization fund would be offset by a reduction in Medicare's payment rate.

If the difference between the average Medicare payment rate and the adjusted ACR is insufficient to cover the cost of additional ben-

efits, the HMO/CMP may charge a supplemental premium or impose additional cost-sharing charges. If, on the other hand, the HMO does not offer additional benefits equal in value to the difference between the ACR and the average Medicare payment, the Medicare payments are reduced until the average payment is equal to the sum of the ACR and the value of the additional benefits.

For the basic Medicare covered services, premiums and the projected average amount of any other cost-sharing may not exceed what would have been paid by the average enrollee under Medicare rules if she or he had not joined the HMO. For supplementary services, premiums and projected average cost-sharing may not exceed what the HMO would have charged for the same set of services in the private market.

Explanation of Provision. The provision creates a new section 1854 specifying requirements for the determination of premiums charged by MedicarePlus organizations to MedicarePlus enrollees.

a. Submission and Charging of Premiums. Each MedicarePlus organization would be required annually to file with the Secretary the amount of the monthly premium for coverage under each of the plans it would be offering in each payment area, and the enrollment capacity in relation to the plan in each such area.

b. Net Monthly Premium. The monthly premium charged for a plan offered in a payment area would equal $\frac{1}{12}$ of the amount (if any) by which the premium exceeded the MedicarePlus capitation rate.

c. Uniform Premium. Premiums could not vary among individuals who resided in the same payment area.

d. Terms and Conditions of Imposing Premiums. Each MedicarePlus organization would have to permit monthly payment of premiums. An organization could terminate election of individuals for a MedicarePlus plan for failure to make premium payments but only under specified conditions. A MedicarePlus organization could not provide for cash or other monetary rebates as an inducement for enrollment or otherwise.

e. Limitation on Enrollee Cost-Sharing. In no case could the actuarial value of the deductibles, coinsurance, and copayments applicable on average to individuals enrolled with a MedicarePlus plan with respect to required benefits exceed the actuarial value of the premium rate, deductibles, coinsurance, and copayments applicable in Medicare FFS. This provision would not apply to an MSA plan. If the Secretary determined that adequate data were not available to determine the actuarial value of the cost-sharing elements of the plan, the Secretary could determine the amount.

f. Requirement for Additional Benefits. The extent to which a MedicarePlus plan (other than a MSA plan) would have to provide additional benefits would depend on whether the plan's adjusted community rate (ACR) was lower than its average capitation payments. The ACR would mean, at the election of the MedicarePlus organization, either: (i) the rate of payment for services which the Secretary annually determined would apply to the individuals electing a MedicarePlus plan if the payment were determined under a community rating system, or (ii) the portion of the weighted aggregate premium which the Secretary annually estimated would apply to the individual but adjusted for differences between

the utilization of individuals under Medicare and the utilization of other enrollees (or through another specified manner). For PSOs, the ACR could be computed using data in the general commercial marketplace (during a transition period) or based on the costs incurred by the organization in providing such a plan.

If the actuarial value of the benefits under the MedicarePlus plan (as determined based upon the ACR) for individuals was less than the average of the capitation payments made to the organization for the plan at the beginning of a contract year, the organization would have to provide additional benefits in a value which was at least as much as the amount by which the capitation payment exceeded the ACR. These benefits would have to be uniform for all enrollees in a plan area. (The excess amount could, however, be lower if the organization elected to withhold some of it for a stabilization fund.) A MedicarePlus organization could provide additional benefits (over and above those required to be added as a result of the excess payment), and could impose a premium for such additional benefits.

g. Periodic Auditing. The Secretary would be required to provide annually for the auditing of the financial records (including data relating to utilization and computation of the ACR) of at least one-third of the MedicarePlus organizations offering MedicarePlus plans. The General Accounting Office would be required to monitor such auditing activities.

h. Prohibition of State Imposition of Premium Taxes. No state could impose a premium tax or similar tax on the premiums of MedicarePlus plans or the offering of such plans.

Reason for Change. The Committee believes it is important to continue to allow beneficiaries to share in the efficiency gains of private managed care plans by receiving extra benefits. To assure that these benefits are provided at the appropriate levels, the Secretary is instructed to perform periodic auditing of the financial records of the MedicarePlus organizations.

Because States may not impose taxes on the traditional Medicare fee-for-service program, the Committee believes it is appropriate to limit the imposition of State premium taxes and similar premium charges on MedicarePlus plans. A similar rule applies to health plans offered to federal government employees and dependents through the FEHBP.

New section 1855. Organizational and financial requirements for MedicarePlus organizations; provider-sponsored organizations

Current Law. Under section 1876 of the Social Security Act, Medicare specifies requirements to be met by an organization seeking to become a managed care contractor with Medicare. In general, these include the following: (1) the entity must be organized under the laws of the State and be a Federally qualified HMO or a competitive medical plan (CMP) which is an organization that meets specified requirements (it provides physician, inpatient, laboratory, and other services, and provides out-of-area coverage); (2) the organization is paid a predetermined amount without regard to the frequency, extent, or kind of services actually delivered to a member; (3) the entity provides physicians' services primarily through physi-

cians who are either employees or partners of the organization or through contracts with individual physicians or physician groups; (4) the entity assumes full financial risk on a prospective basis for the provision of covered services, except that it may obtain stop-loss coverage and other insurance for catastrophic and other specified costs; and (5) the entity has made adequate protection against the risk of insolvency.

Provider Sponsored Organizations (PSOs) that are not organized under the laws of a state and are neither a federally qualified HMO or CMP are not eligible to contract with Medicare under the risk contract program. A PSO is a term generally used to describe a cooperative venture of a group of providers who control its health service delivery and financial arrangements.

Explanation of Provision. The provision adds a new section 1855 to the Social Security Act providing organizational and financial requirements for MedicarePlus organizations, including PSOs.

a. Organized and Licensed under State Law. In general, a MedicarePlus organization would have to be organized and licensed under state law as a risk-bearing entity eligible to offer health insurance or health benefits coverage in each state in which it offers a MedicarePlus plan. Special rules would apply for PSOs. In general, a PSO seeking to offer a MedicarePlus plan could apply to the Secretary for a waiver of the state licensing requirement. The Secretary would be required to grant or deny a waiver application within 60 days of a completed application.

The Secretary would grant a waiver of the state licensing requirement for an organization that is a PSO if the Secretary determined that: (i) the state had failed to substantially complete action on a licensing application within 90 days of the receipt of a completed application (not including any period before the date of enactment), or (ii) the state denied such a licensing application and (a) the state had imposed documentation or information requirements not related to solvency requirements that are not generally applicable to other entities engaged in substantially similar business, or (b) the state's standards or review process imposed any material requirements, procedures, or standards (other than requirements relating to solvency) on such organizations that were not generally applicable to other entities engaged in substantially similar business; or (iii) the state used its own solvency requirements which were not the same as the federal requirements to deny the licensing application, or the state had imposed as a condition of licensure approval any documentation requirements relating to solvency or other material requirements, procedures, or standards that were different from the requirements, procedures, or standards applied by the Secretary.

In the case of a waiver granted under this paragraph for a PSO: (i) the waiver would be effective for a 36-month period, except it could be renewed based on a subsequent application filed during the last 6 months of such period; and (ii) any provision of State law related to the licensing of the organization which prohibited the organization from providing coverage pursuant to a MedicarePlus contract would be preempted. Waivers could be renewed more than once.

This requirement would not apply to a MedicarePlus organization in a state if the state required the organization, as a condition of licensure, to offer any plan other than a MedicarePlus plan. The fact that an organization was licensed under state law would not substitute for or constitute certification.

b. Prepaid Payment. A MedicarePlus organization would have to be compensated (except for deductibles, coinsurance, and copayments) by a fixed payment paid on a periodic basis and without regard to the frequency, extent, or kind of health care services actually provided to an enrollee.

c. Assumption of Full Financial Risk. The MedicarePlus organization would have to assume full financial risk on a prospective basis for the provision of health services (other than hospice care) except the organization could obtain insurance or make other arrangements for costs in excess of \$5,000, services needing to be provided other than through the organization; and obtain insurance or make other arrangements for not more than 90 percent of the amount by which its fiscal year costs exceed 115 percent of its income for such year. It could also make arrangements with providers or health institutions to assume all or part of the risk on a prospective basis for the provision of basic services.

d. Certification of Provision Against Risk of Insolvency for Unlicensed PSOs. Each MedicarePlus PSO that is not licensed by a state and for which a waiver of state law has been approved by the Secretary would be required to meet federal financial solvency and capital adequacy standards (see new section 1856 as described below). These standards would have to ensure that enrollees would not be held financially liable in the event of a plan sponsor's insolvency. The Secretary would be required to establish a process for the receipt and approval of applications of entities for certification (and periodic recertification) of a PSO as meeting the federal solvency standards. The Secretary would be required to act upon the PSO's certification application within 60 days of its receipt.

e. Provider-Sponsored Organization (PSO) Defined. A PSO is a public or private entity that is a provider or group of affiliated providers that provides a substantial portion of the required services under the contract directly through the provider or affiliated group of providers, and with respect to those affiliated providers that share, directly or indirectly, substantial financial risk, have at least a majority interest in the entity. In defining substantial proportion, the Secretary would be required to consider the need for such an organization to assume responsibility for a substantial portion of required services in order to assure financial stability and other factors. "Affiliation," "control," and "health care provider" are specifically defined. The Secretary would be required to issue regulations to carry out this provision.

Reason for Change. This provision is intended to increase available MedicarePlus plan options by creating a mechanism to remove regulatory obstacles to the development of health plans organized and offered to beneficiaries directly by health care providers. Since certain states currently do not recognize in their regulatory processes the advantageous and unique features of PSOs, the provision would authorize the waiver of State licensing requirements and provide Federal certification of PSOs under certain circumstances.

Effective Date. Unless otherwise provided, the provision is generally effective January 1, 1999.

New section 1856. Establishment of standards; certification of organizations and plans

Current Law. Under section 1876 of the Social Security Act, Medicare specifies requirements to be met by an organization seeking to become a managed care contractor with Medicare. There is no provision for Provider Sponsored Organizations (PSOs).

Explanation of Provision. The provision would add a new section 1856 providing for the establishment of federal standards for MedicarePlus plans, including solvency standards for PSOs.

a. Establishment of Solvency Standards for PSOs. The provision would require the Secretary of HHS to establish, on an expedited basis and using a negotiated rule-making process, final standards related to financial solvency and capital adequacy of organizations seeking to qualify as PSOs. The target date for publication of the resulting rules would be April 1, 1998. The Secretary would be required to consult with interested parties and to take into account: (i) the delivery system assets of such an organization and ability of it to provide services directly to enrollees through affiliated providers, and (ii) alternative means of protection against insolvency, including reinsurance, unrestricted surplus, letters of credit, guarantees, organizational insurance coverage, etc. The negotiated rule-making committee would be appointed by the Secretary. If the committee reported by January 1, 1998 that it had failed to make significant progress towards consensus or was unlikely to reach consensus by a target date, the Secretary could terminate the process and provide for the publication of a rule. If the committee was not terminated, it would have to report with the proposed rule by March 1, 1998. The Secretary would then publish the rule on a final, interim basis, but it would be subject to change after public notice and comment. In connection with the rule, the Secretary would specify the process for timely review and approval of applications of entities to be certified as PSOs consistent with this subsection. The Secretary would be required to provide for consideration of such comments and republication of the rule within one year of its publication.

b. Establishment of Other Standards. The Secretary would be required to establish by regulation other standards (not included in (a)) for MedicarePlus organizations and plans consistent with, and to carry out, this part. By June 1, 1998, the Secretary would be required to issue interim standards based on currently applicable standards for Medicare HMOs/CMPs. The new standards established under this provision would supersede any state law or regulation with respect to MedicarePlus plans offered by Medicare contractors to the extent that such state law or regulations was inconsistent with such standards.

Reason for Change. Because the Committee believes that some States will not approve licenses for PSOs, the provision would authorize the development of federal solvency standards to be used by the Secretary to determine whether to certify PSOs in certain circumstances where the Secretary has determined that State licensing requirements should be waived. In developing solvency stand-

ards under this section through the negotiated rulemaking process, the Committee intends for the Secretary to consider the risk-based capital model recently developed by the National Association of Insurance Commissioners.

Standards developed under this provision relating to requirements for certification other than solvency would apply to all MedicarePlus plans. Because of the breadth of the requirements in the legislation relating to MedicarePlus plans, the Committee believes it would be extremely difficult to craft an individual rule regarding preemption for each of these requirements, or to anticipate the myriad of interactions of such requirements with 50 different State laws.

Therefore, the provision contained in the legislation preempting State laws and regulations that are inconsistent with the requirements of the Act provides a functional standard that would be subject to case-by-case determinations. In applying this standard, fact-finders should be guided primarily by the Committee's intent with respect to these provisions of the Act. The Committee intended for the requirements relating to MedicarePlus plans to accomplish two primary goals: (1) to encourage the development of a broad array of private health plan choices for beneficiaries; and (2) to ensure that beneficiaries choosing to enroll in such plans have protections available to ensure that they receive medically necessary and appropriate care in a timely manner.

The Committee did not intend to preempt the entire field of State regulation relating to standards for MedicarePlus plans. On the other hand, the Committee did not intend to save all State laws. Therefore, State laws are not preempted simply because they differ from the standards relating to MedicarePlus plans outlined in this provision or because they impose additional requirements on such plans. However, State laws which would interfere with the application of these federal standards or would be inconsistent with the Committee's intent to make a broad array of private health plans available to beneficiaries, or to protect those beneficiaries, would be preempted.

Effective Date. Unless otherwise provided, the provision is generally effective upon enactment.

New section 1857. Contracts with MedicarePlus organizations

Current Law. Contracts with HMOs are for 1 year, and may be made automatically renewable. However, the contract may be terminated by the Secretary at any time (after reasonable notice and opportunity for a hearing) in the event that the organization fails substantially to carry out the contract, carries out the contract in a manner inconsistent with the efficient and effective administration of Medicare HMO law, or no longer meets the requirements specified for Medicare HMOs. The Secretary also has authority to impose lesser sanctions, including suspension of enrollment or payment and imposition of civil monetary penalties. These sanctions may be applied for denial of medically necessary services, overcharging, enrollment violations, misrepresentation, failure to pay promptly for services, or employment of providers barred from Medicare participation.

To be eligible as a risk contractor, HMOs/CMPs generally must have at least 5,000 members. However, if HMOs/CMPs primarily serve members outside urbanized areas, they may have fewer members (regulations specify at least 1,500). Organizations eligible for Medicare cost contracts also may have fewer than 5,000 members (regulations specify at least 1,500).

No more than 50 percent of the organization's enrollees may be Medicare or Medicaid beneficiaries. This rule may be waived, however, for an organization that serves a geographic area where Medicare and Medicaid beneficiaries make up more than 50 percent of the population or (for 3 years) for an HMO that is owned and operated by a governmental entity.

During its annual open enrollment period of at least 30 days duration, HMOs must accept beneficiaries in the order in which they apply, up to the limits of its capacity, unless doing so would lead to violation of the 50 percent Medicare-Medicaid maximum or to an enrolled population unrepresentative of the population in the area served by the HMO. If an HMO chooses to limit enrollment because of its capacity, regulation provides that it must notify HCFA at least 90 days before the beginning of its open enrollment period and, at that time, provide HCFA with its reasons for limiting enrollment.

In areas where Medicare has risk contracts with more than one HMO and an HMO's contract is not renewed or is terminated, the other HMOs serving the area must have an open enrollment period of 30 days for persons enrolled under the terminated contract.

Explanation of Provision. The provision establishes a new section 1857 specifying requirements for organizations to become MedicarePlus contractors with the Medicare program.

a. In General. The Secretary would not permit the election of a MedicarePlus plan and no payment would be made to an organization unless the Secretary had entered into a contract with the organization with respect to the plan. A contract with an organization could cover more than one MedicarePlus plan. Contracts would provide that organizations agree to comply with applicable requirements and standards.

b. Minimum Enrollment Requirements. The Secretary would be prohibited from entering into a contract with a MedicarePlus organization unless the organization had at least 5,000 individuals (or 1,500 individuals in the case of a PSO) who were receiving health benefits through the organization. An exception would apply if the MedicarePlus standards (as established in new section 1856 described above) permitted the organization to have a lesser number of beneficiaries (but not less than 500 for a PSO) if the organization primarily served individuals residing outside of urbanized areas. These lower minimum enrollment requirements relating to PSOs are effective January 1, 1998. In addition, the Secretary could waive this requirement during an organization's first 3 contract years. Minimum enrollment requirements would not apply to a contract that related only to an MSA plan.

c. Contract Period and Effectiveness. Contracts would be for at least one year, and could be made automatically renewable in the absence of notice by either party of intention to terminate. The Secretary could terminate a contract at any time or impose intermedi-

ate sanctions described below if the Secretary determined that the organization: (i) had failed substantially to carry out the contract; (ii) was carrying it out in a manner substantially inconsistent with the efficient and effective administration of MedicarePlus; or (iii) no longer substantially met MedicarePlus conditions. Contracts would specify their effective date, but contracts providing coverage under an MSA plan could not take effect before January 1999. The Secretary would not contract with an organization that had terminated its MedicarePlus contract within the previous 5 years, except in special circumstances as determined by the Secretary. The authority of the Secretary with respect to MedicarePlus plans could be performed without regard to laws or regulations relating to contracts of the United States that the Secretary determined were inconsistent with the purposes of Medicare.

d. Protections Against Fraud and Beneficiary Protections. Contracts would provide that the Secretary would have the right to inspect or otherwise evaluate the quality, appropriateness and timeliness of services, as well as the organization's facilities if there were reasonable evidence of need for such inspection; in addition, the Secretary would have the right to audit and inspect any books and records that pertain either to the ability of the organization to bear the risk of potential financial loss or to services performed or determinations of amounts payable under the contract. Contracts would also require the organization to provide and pay for advance written notice to each enrollee of a termination, along with a description of alternatives for obtaining benefits. They would also require that organizations notify the Secretary of loans and other special financial arrangements made with subcontractors, affiliates, and related parties.

MedicarePlus organizations would be required to report financial information to the Secretary, including information demonstrating that the organization was fiscally sound, a copy of the financial report filed with HCFA containing information required under section 1124 of the Social Security Act, and a description of transactions between the organization and parties in interest. These transactions would include: (i) any sale, exchange, or leasing of property; (ii) any furnishing for consideration of goods, services, and facilities (but generally not including employees' salaries or health services provided to members); and (iii) any lending of money or other extension of credit. Financial information would be available to enrollees upon reasonable request. Consolidated financial statements could be required when the organization controls, is controlled by, or is under common control with another entity.

With respect to financial information, the term "party in interest" means: (i) any director, officer, partner, or employee responsible for management or administration of a MedicarePlus organization; any person who directly or indirectly is a beneficial owner of more than 5 percent of its equity; 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 nonprofit MedicarePlus organization, an incorporator or member of such corporation; (ii) any entity in which a person described in (i) is an officer or director; a partner; has directly or indirectly a beneficial interest in more than 5 percent of the equity;

or has a mortgage, deed of trust, note, or other interest valuing more than 5 percent of the assets of the 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 (i).

e. Additional Contract Terms. Contracts would contain other terms and conditions (including requirements for information) as the Secretary found necessary and appropriate. Contracts would require payments to the Secretary for the organization's pro rata share of the estimated costs to be incurred by the Secretary relating to enrollment and dissemination of information. These payments would be appropriated to defray such costs and would remain available until expended. If a contract with a MedicarePlus organization was terminated, the organization would notify each enrollee.

f. Prompt Payment by MedicarePlus Organization. Contracts would require a MedicarePlus organization to provide prompt payment of claims submitted for services and supplies furnished to individuals pursuant to the contract, if they are not furnished under a contract between the organization and the provider or supplier. If the Secretary determined (after notice and opportunity for a hearing) that the organization had failed to pay claims promptly, the Secretary could provide for direct payment of the amounts owed providers and suppliers. In these cases, the Secretary would reduce MedicarePlus payments otherwise made to the organization to reflect the amount of the payments and the Secretary's cost in making them.

g. Intermediate Sanctions. The Secretary would be authorized to carry out specific remedies in the event that a MedicarePlus organization: (i) failed substantially to provide medically necessary items and services required to be provided, if the failure adversely affected (or had the substantial likelihood of adversely affecting) the individual; (ii) imposed net monthly premiums on individuals that were in excess of the net monthly premiums permitted; (iii) acted to expel or refused to re-enroll an individual in violation of MedicarePlus requirements; (iv) engaged in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment (except as permitted by MedicarePlus) of eligible individuals whose medical condition or history indicates a need for substantial future medical services; (v) misrepresented or falsified information to the Secretary or others; (vi) failed to comply with rules regarding physician participation; or (vii) employed or contracted with any individual or entity that was excluded from participation in Medicare under section 1128 or 1128A of the Social Security Act (relating to sanctions for program violations) for the provision of health care, utilization review, medical social work, or administrative services, or employed or contracted with any entity for the provision (directly or indirectly) through such an excluded individual or entity.

The remedies would include civil money penalties of not more than \$25,000 for each determination of a failure described above or not more than \$100,000 with respect to misrepresenting information furnished to the Secretary or denying enrollment to persons with a preexisting medical condition. In cases of the latter failure,

the Secretary could also levy a \$15,000 fine for each individual not enrolled. In cases of excess premium charges, the Secretary could also recover twice the excess amount and return the excess amount to the affected individual. In addition, the Secretary could suspend enrollment of individuals and payment for them after notifying the organization of an adverse determination, until the Secretary was satisfied that the failure had been corrected and would not likely recur.

Other intermediate sanctions could be imposed if the Secretary determined that a failure had occurred other than those described above. These include: (i) civil money penalties up to \$25,000 if the deficiency directly adversely affected (or had the likelihood of adversely affecting) an individual under the organization's contract; (ii) civil money penalties of not more than \$10,000 for each week after the Secretary initiated procedures for imposing sanctions; and (iii) suspension of enrollment until the Secretary is satisfied the deficiency had been corrected and would not likely recur.

h. Procedures for Imposing Sanctions. The Secretary could terminate a contract or impose the sanctions described above in accordance with formal investigation and compliance procedures under which (i) the Secretary provides the organization with an opportunity to develop and implement a corrective action plan, (ii) the Secretary imposes more severe sanctions on organizations that have a history of deficiencies or have not taken steps to correct those the Secretary brought to their attention, (iii) there are no unreasonable or unnecessary delays between finding a deficiency and imposing sanctions, and (iv) the Secretary provides reasonable notice and opportunity for a hearing, including the right to appeal an initial decision, before imposing any sanction or terminating the contract. The provisions of section 1128A (other than subsections (a) and (b)) would apply to a civil money penalty in the same manner as they apply to a civil money penalty or proceeding under that section.

Reason for Change. The contracting and sanction provisions in this section of the Act were intended to largely mirror existing requirements applicable to Medicare risk plans. One major change from existing law is the modification of the minimum enrollment requirements, effective on January 1, 1998, for PSOs. This modification was intended to reduce barriers to the formation of PSOs and to help make PSOs available to Medicare beneficiaries as soon as possible.

Effective Date. The provision is generally effective January 1, 1999. However, the enrollment requirements relating to PSOs are effective January 1, 1998.

New section 1859. Definitions and miscellaneous provisions

Current Law. No provision.

Explanation of Provision. The provision establishes a new section 1859 including definitions and other provisions.

Definition of MedicarePlus Organization. A MedicarePlus organization is a public or private entity that is certified under section 1856 as meeting the MedicarePlus requirements and standards for such an organization (described above).

Definition of MedicarePlus Plan. A MedicarePlus plan is health benefits coverage offered under a policy, contract, or plan by a MedicarePlus organization pursuant to and in accordance with a contract under section 1857 (described above).

Definition of MSA Plan. A MSA plan is a MedicarePlus plan that (i) provides reimbursement for at least the items and services for which benefits are available under Medicare parts A and B to individuals residing in the area served by the plan and additional health services the Secretary may approve, but only after the enrollee incurs countable expenses (as specified in the plan) equal to the amount of the annual deductible; (ii) counts as such expenses at least all amounts that would have been payable under parts A and B or by the enrollee as deductibles, coinsurance, or copayments if the enrollee had elected to receive benefits through those parts; and (iii) provides, after the deductible is met for a year (and for all subsequent expenses referred to in (i) in the year) for a level of reimbursement that is not less than the lesser of (A) 100 percent of such expenses, or (B) 100 percent of the amount that would have been paid (without regard to any deductibles or coinsurance) under Medicare parts A and B. For contract year 1999, the annual deductible under a MSA plan could not be more than \$6,000. For a subsequent contract year, the annual deductible could not be more than the maximum amount for the previous contract year increased by the national per capita MedicarePlus growth percentage and rounded to the nearest multiple of \$50.

Coordinated Acute and Long-Term Care Benefits under a MedicarePlus Plan. A state would not be prevented from coordinating benefits under a Medicaid plan and a MedicarePlus plan 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 Medicare benefits under a MedicarePlus plan.

Restrictions on Enrollment for Certain MedicarePlus Plans. A MedicarePlus religious fraternal benefit society plan could restrict enrollment to individuals who are members of the church, convention, or group with which the society is affiliated. A MedicarePlus religious fraternal benefit society plan would be a MedicarePlus plan that (i) is offered by a religious fraternal benefit society only to members of the church, convention, or affiliated group, and (ii) permits all members to enroll without regard to health status-related factors. This provision could not be construed as waiving plan requirements for financial solvency. In developing solvency standards, the Secretary would take into account open contract and assessment features characteristic of fraternal insurance certificates. Under regulations, the Secretary would provide for adjustments to payment amounts under section 1854 to assure an appropriate payment level, taking account of the actuarial characteristics of the individuals enrolled in such a plan.

A religious fraternal benefit society is an organization that (i) is exempt from Federal income taxation under section 501(c)(8) of the Internal Revenue Code; (ii) is affiliated with, carries out the tenets of, and shares a religious bond with, a church or convention or association of churches or an affiliated group of churches; (iii) offers, in addition to a MedicarePlus religious fraternal benefit society plan, at least the same level of health coverage to individuals enti-

tled to Medicare benefits who are members of such church, convention, or group; and (iv) does not impose any limitation on membership in the society based on any health status-related factor.

Reports. (1) The Secretary would provide for a study on the feasibility and impact of removing the restriction on beneficiaries with end-stage renal disease from enrolling in a MSA MedicarePlus plan. No later than October 1, 1998, the Secretary would submit to Congress a report on this study and include recommendations regarding removing or restricting the limitation as may be appropriate. (2) No later than October 1, 1999, the Secretary would submit to Congress a report on the extent to which MedicarePlus organizations are providing payments to disproportionate share hospitals and teaching hospitals. The report would be based on information provided to the Secretary under section 1852(k) and other information, such as hospital claims data, the Secretary obtains.

Reason for Change. This provision contains definitions and other provisions necessary to ensure expanded health plan choices for Medicare beneficiaries.

The Committee included two reports by the Secretary. The first addresses the end stage renal disease population. The Committee believes that it was important to examine the special needs of individuals with ESRD and the impact of allowing them to enroll in MedicarePlus plans. In particular, the Committee would like the Secretary to examine whether it is appropriate to have a special set of requirements for plans that want to enroll these beneficiaries. Specific requirements might include certain personnel requirements (nephrologists, nephrology nurses, and renal nutritionists), evidence of access to dialysis facilities, and evidence of a contract or agreement with at least one transplant provider. In addition, the Committee is very concerned by the MedicarePlus payment rate that combines four very different types of patients into a single State-wide rate. These groups are: (1) patients who are unable to receive a transplant and receive dialysis services, (2) pre-transplant dialysis patients, (3) transplant patients, and (4) those who have received a transplant and are receiving immunosuppressive agents. The Committee would like the Secretary to develop a more refined method for determining payment rates for ESRD beneficiaries.

The Committee also believes that it is important to review the inclusion of Medicare teaching and disproportionate share hospital payments in the calculation of the MedicarePlus rates. There currently is limited data regarding the use of both teaching and disproportionate share hospitals by TEFRA risk plan enrollees or the rates health plans pay those hospitals. By collecting data regarding the use of these hospitals and the graduate medical programs operated by or in cooperation with health plans, the Secretary will be able to determine the extent to which health plans are using Medicare special payments included in their rates to fund these activities that Medicare subsidizes through its prospective payment system for fee for service Medicare beneficiaries. In addition, this information may provide evidence as to whether or not the Medicare program should redefine the settings in which it pays for the costs of these activities.

Section 10002. Transitional rules for current Medicare HMO program

Current Law. No provision for transition rules. Current law requires that to be a risk contractor, no more than 50 percent of the organization's enrollees may be Medicare or Medicaid beneficiaries. The rule may be waived, however, for an organization that serves a geographic area where Medicare and Medicaid beneficiaries make up more than 50 percent of the population or (for 3 years) for an HMO that is owned and operated by a governmental entity.

Explanation of Provision. Effective for contract periods beginning after December 31, 1996, the Secretary could waive or modify the 50:50 rule to the extent the Secretary finds the waiver is in the public interest.

The Secretary would be prohibited from entering into, renewing, or continuing any risk-sharing contract under section 1876 for any contract year beginning on or after the date MedicarePlus standards are first established for MedicarePlus organizations that are insurers or HMOs. If the organization had a contract in effect on that date, the prohibition would be effective one year later. The Secretary could not enter into, renew, or continue a risk-sharing contract for any contract year beginning on or after January 1, 2000. An individual who is enrolled in Medicare part B only and also in an organization with a risk-sharing contract on December 31, 1998 could continue enrollment in accordance with regulations issued not later than July 1, 1998.

For individuals enrolled under both Medicare part A and part B, payments for risk-sharing contracts for months beginning with January 1998 would be computed by substituting the MedicarePlus payment rates specified in this bill. For individuals enrolled only under part B, the substitution would be based upon the proportion of those rates that reflects the proportion of payments under title XVIII of the Social Security Act (i.e., Medicare) attributable to part B. With respect to months in 1998, the Secretary would compute, announce, and apply the MedicarePlus payment rates in as timely manner as possible (notwithstanding deadlines in section 1853(a) as described above) and could provide for retroactive adjustments in risk-sharing contract payments not in accordance with those rates.

An individual who is enrolled on December 31, 1998 with an organization having a section 1876 contract would be considered to be enrolled with that organization under MedicarePlus if the organization has a MedicarePlus contract for providing services on January 1, 1999, unless the individual had disenrolled effective that date.

Hospitals would accept Medicare payment rates as payment in full for inpatient emergency services covered under Medicare that an out-of-plan provider furnishes enrollees in a MedicarePlus plan which does not have a contract establishing such payment amounts.

Any reference in law in effect before the date of enactment of this legislation to part C of Medicare would be deemed a reference to part D as in effect after such date.

Not later than 90 days after enactment of this legislation, the Secretary would submit to Congress a legislative proposal provid-

ing for technical and conforming amendments as the MedicarePlus provisions require.

Required MedicarePlus organization contributions for costs related to enrollment and dissemination of information would apply to demonstrations if their enrollment were effected or coordinated under section 1851.

In order to carry out the MedicarePlus provisions in a timely manner, the Secretary could (after notice and opportunity for public comment) promulgate regulations that take effect on an interim basis.

Reason for Change. The Ways and Means Committee received testimony, including testimony during an April 17, 1997 hearing from the Chair of the Physician Payment Review Commission (PPRC), that the 50:50 rule is an arbitrary and outdated method for assuring health plan quality. Testimony at the hearing indicated in some instances, can be detrimental to beneficiaries. HCFA currently is collecting enhanced data on health plan quality, outcomes, and consumer satisfaction through measurement tools developed by the National Committee on Quality Assurance, the Foundation for Accountability, and others. In addition, the Act authorizes the collection of additional information relating to the quality of MedicarePlus plans. Therefore, Committee believes it was unnecessary to continue in effect the 50:50 rule after January 1, 1999. Between the date of enactment and January 1, 1999, the provision grants the Secretary broad authority to waive the 50:50 rule when the public interest requires. The Committee expects that the Secretary would use this authority, among other things, to provide extensions of existing waivers. In particular, the Committee intends that the Secretary grant waivers to the Wellness Plan in Southeastern Michigan and the Watts Health Foundation providing care in medically-underserved inner city areas.

Section 10003. Changes in Medigap program

Current law. Current law contains rules regarding the sale of Medicare supplement policies (generally referred to as "Medigap" policies). Included are prohibitions governing the sale of duplicative policies and exceptions to the general prohibitions.

Explanation of Provision. The provision would include conforming language to the duplication provisions for persons electing a MedicarePlus plan. Included in the general prohibitions would be a general prohibition against selling to a person electing a MedicarePlus plan a Medicare supplemental policy with the knowledge that it duplicated benefits to which the individual was otherwise entitled to under Medicare or another supplemental policy. The provision would further specify that a MedicarePlus policy is not included within the definition of a Medicare supplementary policy.

The provision would prohibit the sale of certain policies to a person electing a high deductible plan. Specifically, the prohibition would apply to the sale of policies providing coverage for expenses that are otherwise required to be counted toward meeting the annual deductible amount provided under a medical savings account (MSA) plan.

Reason for Change. The provision is necessary to conform existing law requirements relating to duplication to the MedicarePlus program.

Effective Date. The provision generally would become effective January 1, 1999.

SUBCHAPTER B. SPECIAL RULES FOR MEDICAREPLUS MEDICAL SAVINGS ACCOUNTS

Section 10006. Description of taxation of MedicarePlus medical savings accounts

Current Law. Under present law, the value of Medicare coverage and benefits is not includable in taxable income.

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

Within limits, contributions to a medical savings account ("MSA") are deductible in determining AGI if made by an eligible individual and are excludable from gross income and wages for employment tax purposes if made by the employer of an eligible individual.¹ Individuals covered under Medicare are not eligible to have an MSA.

Earnings on amounts in an MSA are not currently includable in income. Distributions from an MSA for medical expenses of the MSA account holder and his or her spouse or dependents are not includable in income. For this purpose, medical expenses are defined as under the itemized deduction for medical expenses, except that medical expenses do not include any insurance premiums other than premiums for long-term care insurance, continuation coverage (so-called "COBRA coverage"), or premiums for coverage while an individual is receiving unemployment compensation. Distributions not used for medical expenses are subject to an additional 15-percent tax unless the distribution is made after age 65, death, or disability.

Under present law, there are no tax provisions for MedicarePlus medical savings accounts ("MedicarePlus MSAs").

Explanation of Provision. Under the bill, individuals who are eligible for Medicare are permitted to choose either the traditional Medicare program or a MedicarePlus MSA plan. To the extent an individual chooses such a plan, the Secretary of Health and Human Services makes a specified contribution directly into a MedicarePlus MSA designated by such individual. Only contributions by the Secretary of Health and Human Services can be made to a MedicarePlus MSA and such contributions are not included in the taxable income of the MedicarePlus MSA holder. Income earned on amounts held in a MedicarePlus MSA are not currently includable in taxable income. Withdrawals from a MedicarePlus MSA are excludable from taxable income if used for the qualified medical expenses of the MedicarePlus MSA holder. Withdrawals from a MedicarePlus MSA that are not used for the qualified medi-

¹The number of MSAs which can be established is subject to a cap.

cal expenses of the account holder are includable in income and may be subject to an additional tax (described below).

Definition of MedicarePlus MSAs. In general, a MedicarePlus MSA is an MSA that is designated as MedicarePlus MSA and to which the only contributions that can be made are those by the Secretary of Health and Human Services.² Thus, a MedicarePlus MSA is a tax-exempt trust (or a custodial account) created exclusively for the purpose of paying the qualified medical expenses of the account holder that meets requirements similar to those applicable to individual retirement arrangements (“IRAs”).³ The trustee of a MedicarePlus MSA can be a bank, insurance company, or other person that demonstrates to the satisfaction of the Secretary of the Treasury that the manner in which such person will administer the trust will be consistent with applicable requirements.

A MedicarePlus MSA trustee would be required to make such reports as may be required by the Secretary of the Treasury. A \$50 penalty would be imposed for each failure to file without reasonable cause.

Taxation of distributions from a MedicarePlus MSA Distributions from a MedicarePlus MSA that are used to pay the qualified medical expenses of the account holder would be excludable from taxable income regardless of whether the account holder is enrolled in the MedicarePlus MSA plan at the time of the distribution.⁴ Qualified medical expenses are defined as under the rules relating to the itemized deduction for medical expenses. However, for this purpose, qualified medical expenses would not include any insurance premiums other than premiums for long-term care insurance, continuation insurance (so-called “COBRA coverage”), or premium for coverage while an individual is receiving unemployment compensation. Distributions from a MedicarePlus MSA that are excludable from gross income under the provision can not be taken into account for purposes of the itemized deduction for medical expenses.

Distributions for purposes other than qualified medical expenses are includable in taxable income. An additional tax of 50 percent applies to the extent the total distributions for purposes other than qualified medical expenses in a taxable year exceed the amount by which the value of the MedicarePlus MSA as of December 31, of the preceding taxable year exceeds 60 percent of the deductible of the plan under which the individual is covered. The additional tax does not apply to distributions on account of the disability or death of the account holder.

Following is an example of how the amount available to be withdrawn from a MedicarePlus MSA without penalty is calculated.

² MedicarePlus MSAs are not taken into account for purposes of the cap on non-MedicarePlus MSAs, nor are they subject to that cap.

³ For example, no MedicarePlus MSA assets could be invested in life insurance contracts, MedicarePlus MSA assets could not be commingled with other property except in a common trust fund or common investment fund, and an account holder's interest in a MedicarePlus MSA would be nonforfeitable. In addition, if an account holder engages in a prohibited transaction with respect to a MedicarePlus MSA or pledges assets in a MedicarePlus MSA, rules similar to those for IRAs would apply, and any amounts treated as distrusted to the account holder under such rules would be treated as not used for qualified medical expenses.

⁴ Under the provision, medical expenses of the account holder's spouse or dependents would not be treated as qualified medical expenses:

	Year 1	Year 2	Year 3	Year 4
Deductible	3,000	3,000	3,000	3,000
60 percent of deductible	1,800	1,800	1,800	1,800
Contribution	1,300	1,300	1,300	1,300
Opening Account ¹	1,300	2,130	3,030	4,030
Withdrawals for medical expenses	600	600	600	600
Closing Account	830	1,730	2,730	3,830
Amount available for non-medical withdrawal without penalties (4.-2., or 0 if less than 0)	0	330	1,230	2,230
Interest Income	130	200	300	400

¹ Opening account is calculated by adding closing amount from prior year to contribution amount for the year.

Direct trustee-to-trustee transfers could be made from one MedicarePlus MSA to another MedicarePlus MSA without income inclusion.

The provision includes a correction mechanism so that if contributions for a year are erroneously made by the Secretary of Health and Human Services, such erroneous contributions can be returned to the Secretary of Health and Human Services (along with any attributable earnings) from the MedicarePlus MSA without tax consequence to the account holder.

Treatment of MedicarePlus MSA at death. If the beneficiary of a MedicarePlus MSA is not the account holder's spouse, the MedicarePlus MSA is no longer treated as a MedicarePlus MSA and the value of the MedicarePlus MSA on the account holder's date of death is included in the taxable income of the beneficiary for the taxable year in which the death occurred (under the rules applicable to MSAs generally). If the account holder fails to name a beneficiary, the value of the MedicarePlus MSA on the account holder's date of death is to be included in the taxable income of the account holder's final income tax return (under the rules applicable to MSAs generally).

In all cases, the value of the MedicarePlus MSA is included in the account holder's gross estate for estate tax purposes.

Reason for Change. The Committee believes that introduction of significant innovations from the private sector, coupled with the full transfer of responsibility for health care choices to enrollees who choose to participate in private sector health plans will be effective in tempering the growth of Medicare spending while providing opportunities for certain beneficiaries to improve upon the traditional government-defined Medicare benefit package. In addition, the Committee believes that senior citizens should be provided with greater power over their own health care choices and expenses.

Effective Date. The provision is effective with respect to taxable years beginning after December 31, 1998.

Chapter 2.—Integrated Long-Term Care Programs

SUBCHAPTER A—PROGRAMS OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)

Section 10011–10014. Coverage of PACE under the Medicare Program

Current Law. OBRA 86 required the Secretary to grant waivers of certain Medicare and Medicaid requirements to up to 10 public or non-profit private community-based organizations to provide health and long-term care services on a capitated basis to frail el-

derly persons at risk of institutionalization. These projects, known as the Programs of All Inclusive Care for the Elderly, or PACE projects, were intended to determine whether an earlier demonstration program, On Lok, could be replicated across the country. OBRA 90 expanded the number of organizations eligible for waivers to 15.

Explanation of Provision. The provision would establish PACE as a permanent benefit category eligible for coverage and reimbursement under the Medicare program and as an optional benefit under the Medicaid program. PACE providers would offer comprehensive health care services to eligible individuals in accordance with regulations and program agreements between the providers, the Secretary, and state administering agency. In general, PACE providers would be public or private nonprofit entities, except for entities (up to 10) participating in a demonstration to test the operation of a PACE program by private, for-profit entities.

Eligible individuals would be 55 years of age or older requiring nursing facility level of care, reside in the service area of the program, and meet such other conditions as may be required under the program agreement. Enrollees would be required to receive all covered benefits through the program.

Eligibility would be determined by the State agency responsible for administering PACE program agreements. An individual's health status would have to be comparable to that of persons who participate in the PACE demonstration. Enrollees would be re-evaluated annually to determine continued qualification for nursing facility level of care, except where the State determines there would be no reasonable expectation of improvement or significant change in an individual's condition because of advanced age, severity of chronic condition or degree of impairment. A person could continue to be considered a PACE eligible individual, even though that person no longer requires nursing facility level of care, if in the absence of continued coverage, the individual reasonably would be expected to meet the requirement within the succeeding 6-month period. Enrollment and disenrollment in a PACE program would be done according to regulation and enrollees would be permitted to voluntarily disenroll without cause at any time.

At a minimum, a PACE provider would be required to provide to eligible persons, regardless of source of payment and directly or under contracts with other entities, all items and services covered under Medicare and Medicaid without any limitation as to amount, duration, or scope and without application of deductibles, copayments, coinsurance, or other cost-sharing provisions. PACE providers would be required to provide enrollees access to necessary covered items and services on a continuous basis, 24 hours per day, 365 days a year. Services would be provided through a comprehensive, multidisciplinary team that integrates acute and long-term care services. Providers also would specify covered items and services that would not be provided directly, and arrange for delivery of these services through contracts meeting regulatory requirements.

Under the regulation, a provider would be required to have a written plan of quality assurance and improvement and imple-

menting procedures as well as written safeguards of the enrollee rights.

The Secretary would be required to make prospective monthly capitation payments for each PACE program enrollee in the same manner and from the same sources as payments are made to a MedicarePlus organization. The amount would be adjusted to take into account the comparative frailty of PACE enrollees and such other factors as the Secretary determines to be appropriate. The total payment level for all PACE program enrollees would be required to be less than the projected payment under Medicare for a comparable population not enrolled under PACE.

The Secretary, in cooperation with the State agency, would establish procedures for entering into, extending, and terminating PACE agreements. The Secretary could not enter into more than 40 agreements (including those in effect as the result of demonstration waivers) as of enactment, and 20 additional agreements upon each succeeding anniversary date (without regard to the actual number of agreements in effect as of a previous anniversary date). The numeric limitation would not apply to a provider operating under the for-profit demonstration or which subsequently qualifies for PACE provider status.

A PACE agreement would designate its service area and could include additional eligibility requirements for individuals. The Secretary (in consultation with the State) could exclude an area already covered under another agreement, so as to avoid unnecessary duplication of services and/or impairing the financial and service viability of an existing program. Agreements would be effective for a year, and could be extended in the absence of notice to terminate, but would be subject to termination by the Secretary or the State at any time for cause.

Under an agreement, providers would be required to collect and maintain data, provide the Secretary and State access to records relating to the program, including pertinent financial, medical and personnel records; and make reports to the Secretary and the State necessary to monitor operation, cost, and effectiveness. During a provider's first 3 years of operation, it would be required to provide such additional data as the Secretary might specify for comprehensive annual review. Subsequently, the Secretary would continue to conduct reviews of PACE providers as might be appropriate, to evaluate performance levels and compliance with regulations.

During the 3-year period beginning with enactment, the Secretary would give priority, in processing applications to: (1) entities that are operating a PACE demonstration waiver program; and, (2) entities that applied to operate a program as of May 1, 1997. In awarding additional waivers under the original demonstration authority, the Secretary would also be required to give priority to entities which applied for waivers as of May 1, 1997, and to entities that as of May 1, 1997, have formally contracted with States to provide services on a capitation basis with an understanding that they were seeking to become PACE providers. The Secretary would give special consideration, in the processing of PACE applications for provider status and demonstration waivers, to entities which as of May 1, 1997, indicated through formal activities (such as entering into contracts for feasibility studies) a specific intent to become

PACE providers. Repeal of waiver demonstration authority would not apply to waivers granted before the initial effective date of regulations. Repeals would apply to waivers granted before this date only after allowing organizations a transition period (of up to 24 months) in order to permit sufficient time for orderly transition from demonstration to general authority.

The Secretary (in close consultation with States) would be required to conduct a study of the quality and cost of providing PACE services under Medicare and Medicaid. This study would specifically compare cost, quality, and access to services offered by private for-profit entities operating under the new demonstration described above with the costs, quality, and access to services of other PACE providers. The Secretary would report to Congress on findings of the study (including specific findings on private for-profit providers), together with any recommendations for changes, not later than 4 years after enactment. The Medicare Payment Evaluation Commission would include in its annual report to Congress recommendations on the methodology and level of payments made to PACE providers and on the treatment of private for-profit PACE providers.

Reason for Change. Today, twelve PACE programs sponsored by public and nonprofit community-based organizations care for more than 3,300 frail older adults across the country who might otherwise be institutionalized. PACE programs enroll individuals and assume full financial risk for comprehensive benefits without limit as to dollars or duration. PACE programs focus only on the needs of frail elderly individuals eligible for both Medicare and Medicaid who have chronic illness(es) so severe as to qualify them for nursing facility levels of care. The frail elderly. Since the PACE demonstration was initially authorized by Congress in 1986, projects have proven they can effectively meet the needs of these beneficiaries through comprehensive, community-based active care designed to enhance independence and function as a substitute for high-cost institutional care.

Analyses of PACE have found that the programs yield significant savings to the federal and state governments relative to their costs for comparable individuals not enrolled in PACE. Careful expansion of this proved program will make this high-quality, cost-effective alternative available to eligible elderly individuals throughout the country. The Committee believes that PACE should not necessarily be limited exclusively to public, nonprofit entities. However, since the complex mix of services offered under PACE has only been demonstrated by non-profit social welfare organizations, pilots are needed to determine how well for-profit entities can meet the needs of the frail elderly. The proposal would test the PACE program through a four-year demonstration of for-profit entities with full participation after the Secretary of Health and Human Services determines that quality of care remains high while Medicare costs have not increased.

Effective date. The provision would be effective upon enactment.

SUBCHAPTER B—SOCIAL HEALTH MAINTENANCE ORGANIZATIONS
(SHMOS)*Section 10015. Social health maintenance organizations (SHMOs)*

Current Law. The Deficit Reduction Act of 1984 required the Secretary to grant 3-year waivers for demonstrations of social health maintenance organizations (SHMOs) which provide integrated health and long-term care services on a prepaid capitation basis. The waivers have been extended on several occasions since then and a second generation of projects was authorized by OBRA 90.

Explanation of Provision. The provision would require the Secretary to extend waivers for SHMOs through December 31, 2000, and to submit a final report on the projects by March 31, 2001. The limit on the number of persons served per site would be expanded from 12,000 to 24,000. The Secretary also would be required to submit to Congress by January 1, 1999, a plan, including an appropriate transition, for the integration of health plans offered by first and second generation SHMOs and similar plans into the MedicarePlus program. The report on the plan would be required to include recommendations on appropriate payment levels for SHMO plans, including an analysis of the extent to which it is appropriate to apply the MedicarePlus risk adjustment factors to SHMO populations.

Reason for Change. The demonstration waivers for the SHMO program would have expired effective December 31, 1997. At the same time, the Committee believed that this should be the last such waiver extension and that all HCFA efforts previously focused on “testing” the SHMO concept during the last 13 years should be shifted immediately toward efforts to make SHMOs a permanent option available for beneficiaries under the MedicarePlus program.

Effective Date. The provision would be effective upon enactment.

Under regulations, procedures for termination of PACE agreements, the Secretary or State could terminate for, among other reasons, significant deficiencies in the quality of care, failure to comply substantially with conditions of participation, or failure to develop and successfully initiate within 30 days of notice a plan to correct deficiencies.

If the Secretary determines (after consultation with the State) that a provider fails substantially to comply with program requirements, the Secretary and State could take any or all of the following actions: (1) condition continuation upon timely execution of a corrective action plan; (2) withhold some or all payments until the deficiencies were corrected; or, (3) terminate the agreement. The Secretary could provide for the application of intermediate sanctions for certain deficiencies. Procedures for termination and sanctions of PACE programs would be the same as those that apply to Medicare managed care entities.

The Secretary would issue interim and final regulations to carry out the statutory provisions for PACE. The Secretary would incorporate the requirements applied to PACE demonstration waiver programs under the PACE Protocol, to the extent consistent with this section. The Secretary (in close consultation with States) could modify or waive provisions of the PACE Protocol to provide reasonable flexibility in adapting the PACE service delivery model to the

needs of particular organizations (such as those in rural areas or those that may wish to use non-staff physicians) where flexibility is not inconsistent with and would not impair the essential elements, objectives, and requirements of the PACE program. The Secretary could also apply to PACE requirements which apply to managed care plans, taking into account differences in populations served and not including requirements restricting the proportion of enrollees eligible for Medicare and Medicaid.

Certain Medicare requirements would be waived for PACE, including those pertaining to limits on coverage of institutional services, rules for payment for benefits, limits on coverage of SNF and home health services, the 3-day prior hospitalization requirement for SNF care, and other coverage rules.

The Secretary would be required to promulgate regulations for PACE in a timely manner so that entities may establish and operate PACE programs beginning not later than 1 year after enactment.

During the transition from demonstration waiver authority to permanent provider status, applications for waivers (subject to the numerical limitation) would be deemed approved unless the Secretary, within 90 days after the date of submission, either denies the request in writing or informs the applicant in writing that additional information is needed. After the date the Secretary receives the additional information, the application would be deemed approved unless the Secretary, within 90 days, denies the request. The same time frames would be applicable to non-waiver applications for PACE.

SUBCHAPTER C—OTHER PROGRAMS

Section 10018. Orderly transition of municipal health service demonstration projects

Current Law. Under a general demonstration authority, the Health Care Financing Administration began waiving in the late 1970s certain Medicare requirements to conduct the Municipal Health Services Demonstration. This project has been conducted in four cities—Baltimore, Cincinnati, Milwaukee, and San Jose. As originally conceived, the project was intended to encourage the use of municipal health centers, in place of more costly hospital emergency rooms and outpatient departments, by eliminating coinsurance and deductibles, expanding the range of covered services, and paying the cities the full cost of delivering services at the clinics. Waivers have been extended several times since the inception of the project by budget reconciliation bills.

Explanation of Provision. The provision would extend the demonstration through December 31, 2000, but only with respect to persons enrolled in the projects before January 1, 1998. The Secretary would be required to work with each demonstration project to develop a plan, to be submitted to the House Ways and Means and Senate Finance Committees by March 31, 1998, for the orderly transition of projects and project enrollees to a non-demonstration health plan, such as a Medicaid managed care or MedicarePlus plan. A demonstration project which does not develop and submit a transition plan by March 31, 1998 or within 6 months after en-

actment of the Act, whichever is later, would be discontinued as of December 31, 1998. The Secretary would be required to provide appropriate technical assistance to assist in the transition so that disruption of medical services to project enrollees would be minimized.

Reason for Change. The Committee recognizes that the Municipal Health Services Program has brought enhanced benefits to inner-city beneficiaries for many years. However, with the increased availability of Medicare HMOs and other MedicarePlus plans made possible by this Act, the Committee believes it is not longer necessary or cost-effective to continue this program in its current form.

Effective Date. The provision would be effective upon enactment.

Section 10019. Community Nursing Organization Demonstration Projects

Current Law. OBRA 87 required the Secretary to conduct demonstration projects to test a prepaid capitated, nurse-managed system of care. Covered services include home health care, durable medical equipment, and certain ambulatory care services. Four sites (Mahomet, Illinois; Tucson, Arizona; New York, New York; and St. Paul, Minnesota) were awarded contracts in September, 1992, and represent a mix of urban and rural sites and different types of health provider, including a home health agency, a hospital-based system, and a large multi-specialty clinic. The community nursing organization (CNO) sites completed development activities and implemented the demonstration in January 1994, with service delivery beginning February 1994.

Explanation of Provision. The provision would extend the CNO demonstration for an additional period of 2 years, and the deadline for the report on the results of the demonstration would be not later than 6 months before the end of the extension.

Reason for Change. Current demonstration provides innovative care options and home- and community-based services for the elderly and individuals with disabilities. CNOs offer extra benefits without increasing Medicare costs because their emphasis on primary and preventive care and coordinated management of patient care. The Committee was interested in further analysis on whether the combination of capitated payments and nurse case management will promote timely and appropriate use of community nursing and ambulatory care services and reduce the use of costly acute care services.

Effective Date. The provision would be effective upon enactment.

CHAPTER 3—MEDICARE PAYMENT ADVISORY COMMISSION

Section 10021. Medicare payment advisory commission

Current Law. The Prospective Payment Assessment Commission (ProPAC) was established by Congress through the Social Security Act Amendments of 1983 (P.L. 98-21). The Commission is charged with reporting each year its recommendation of an update factor for PPS payment rates and for other changes in reimbursement policy. It is also required each year to submit a report to Congress which provides background information on trends in health care delivery and financing. The Physician Payment Review Commission (PPRC) was established by the Congress through the Consoli-

dated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272). It was charged with advising and making recommendations to the Congress on methods to reform payment to physicians under the Medicare program. In subsequent laws, Congress mandated additional responsibilities relating to the Medicare and Medicaid programs as well as the health care system more generally.

The law specified that both Commissions were to be appointed by the Director of the Office of Technology Assessment and funded through appropriations from the Medicare trust funds. In 1995, the Office of Technology Assessment was abolished. In May 1997, P.L. 105-13 was enacted; this legislation extended the terms of those Commission members whose terms were slated to expire in 1997 to May 1, 1998.

Explanation of Provision. The provision would establish the Medicare Payment Advisory Commission (hereafter referred to as the Commission) to review and make recommendations to Congress concerning payment policies under Medicare. The Commission would be required to submit a report to Congress by March 1 of each year (beginning in 1998) containing the results of its reviews of payment policies and its recommendations concerning such policies and an examination of issues affecting the Medicare program.

The Commission would be charged with the following specific review responsibilities with respect to the MedicarePlus program: (1) the methodology for making payments to the plans, including the making of differential payments and the distribution of differential updates among different payment areas; (2) the risk adjustment mechanisms and the need to adjust such mechanisms to take into account health status; (3) the implications of risk selection among MedicarePlus organizations and between the MedicarePlus option and the Medicare fee-for-service option; (4) in relation to payment under MedicarePlus, the development and implementation of quality assurance mechanisms for those enrolled with MedicarePlus organizations; (5) the impact of the MedicarePlus program on beneficiary access to care; and (6) other major issues in implementation and further development of the MedicarePlus program.

In addition, the Commission would be required to review payment policies under Medicare parts A and B fee-for-service system, including: (1) factors affecting expenditures in different sectors, including the process for updating hospital, skilled nursing facility, physician, and other fees; (2) payment methodologies; and (3) the relationship of payment policies to access and quality of care. It would also review the effect of Medicare payment policies on the delivery of health care services not provided under Medicare and assess the implications of changes in the health services market on Medicare.

The Commission would be required to evaluate required reports on payment policies submitted by the Secretary to Congress (or a committee of Congress). The Commission would be required to submit a report on the evaluation within six months of the Secretary's report. The commission would also be required to consult with the chairmen and ranking members of the appropriate committees of Congress (House Ways and Means, House Commerce, and Senate Finance) regarding its agenda. The Commission would be authorized to submit from time to time other reports as requested by such

chairman and members and as it is deemed appropriate. The reports would be made public.

The Commission would be composed of 19 members appointed by the Comptroller General, with the first appointments being made by September 30, 1997. These members would have to meet specific qualifications (such as national recognition for their expertise). Commission membership would consist of a broad mix of different professionals, a broad geographic representation, and a balance between urban and rural representatives. It would include representatives of consumers and the elderly. Health care providers could not constitute a majority of the membership. Commissioners would serve for 3-year staggered terms. The provision would include a mechanism for filling vacancies, compensating commissioners, appointing a chair and vice chair; convening meetings; and providing for the executive director and other staff, experts, and consultants. The Commission would be authorized to secure directly from any department or agency information to carry out these provisions. It would be required to collect and assess information (which would be available on an unrestricted basis to GAO). The Commission would be subject to periodic audit by GAO.

The provision would require the Commission to submit appropriations requests in the same manner as the Comptroller General does; however, the amounts appropriated for each would be separate. It would authorize such sums as may be necessary to be appropriated from the Medicare trust funds (60 percent from part A and 40 percent from part B).

The Commission would require that the Comptroller first provide for appointment of members of the Commission (to be known as MedPAC) by not later than September 30, 1997. As quickly as possible after they were first appointed, the Comptroller General (in consultation with ProPac and PPRC) would provide for termination of these entities. As of that date, ProPAC and PPRC would be abolished. To the extent possible, the Comptroller General would be required to provide for the transfer to the new commission assets and staff of the former commissions without any loss of benefits or seniority by virtue of such transfers. Fund balances available to the former commissions would be transferred to the new commission. MedPAC would be responsible for the preparation and submission of reports required by law to be submitted (and which had not been submitted by the time it was established) by the former commissions.

Reason for Change. Both the ProPAC, which is responsible for hospital and health facilities payment policy, and the PPRC, which is responsible for physician payment policy and other Part B issues, have assumed critically important roles in assisting Congress with oversight and policy making for the Medicare program. However, with fee-for-service payment policy becoming relatively mature after years of refinement, Congress will require guidance in the future primarily in the MedicarePlus area. This area will require evaluation and oversight best suited for a single commission which can view the Medicare program in terms of an integrated totality between Parts A and B.

The Committee is concerned with the impact of the Part A proposals on Medicare dependent hospitals, defined as those which

treat more than 60 percent Medicare patients and do not receive indirect medical education or disproportionate share payments. The Committee is assigning MedPAC to include in its March 1 report analysis on the financial performance of hospitals with high Medicare shares.

Effective date. These provisions are effective upon enactment.

Section 10031. Medigap protections

Current Law. Medigap is the term used to describe individually-purchased Medicare supplement policies. In 1990, Congress provided for a standardization of Medigap policies; the intention was to enable consumers to better understand policy choices. Implementing regulations generally limit the number of different types of Medigap plans that can be sold in a state to no more than 10 standard benefit plans; these are known as Plans A through J. The Plan A standardized package covers a basic benefits package. Each of the other 9 plans includes the basic benefits plus a different combination of additional benefits.

All insurers offering Medigap policies are required to offer a 6-month open enrollment period for persons turning age 65. This is known as guaranteed open enrollment. There is no guaranteed open enrollment provision for the under-65 disabled population.

At the time insurers sell a Medigap policy, whether or not during an open enrollment period, they are permitted to limit or exclude coverage for services related to a preexisting health condition; such exclusions cannot be imposed for more than 6 months. An individual who has met the preexisting condition limitation in one Medigap policy does not have to meet the requirement under a new policy for previously covered benefits. However, an insurer could impose exclusions for newly covered benefits.

Federal requirements for open enrollment and limits on preexisting condition exclusions are designed to insure beneficiaries have access to Medigap protection. However, persons who disenroll (or wish to disenroll) from managed care plans and move back into fee-for-service Medicare may not have the same access to Medigap coverage as those who join during the open enrollment period.

Explanation of Provision. The provision would guarantee issuance of a Medigap "A", "B", "C", or "F" policy without a pre-existing condition exclusion for certain continuously covered individuals. The insurer also would be prohibited from discriminating in the pricing of such policy on the basis of the individual's health status, medical condition, claims experience, and receipt of health care.

The provision would specify those persons covered under the guaranteed issuance provision. The provision would apply to an individual enrolled under an employee welfare benefit plan that provides benefits supplementing Medicare and the plan terminates or ceases to provide such benefits.

The provision would apply to persons enrolled with a MedicarePlus organization and there are circumstances permitting discontinuance of the individual's election of the plan under section 1851(e)(4). It would also apply to individuals enrolled in a risk or cost contract HMO, a similar organization operating under demonstration project authority, or a Medicare SELECT policy who encounter circumstances permitting discontinuance of the individual's

election of the plan under section 1851(e)(4) and there is no provision under applicable State law for the continuation of coverage under such policy. In addition, the provision would apply to individuals enrolled in a Medicare supplemental policy whose enrollment ceases because (1) the issuer becomes bankrupt or insolvent and there is not provision under applicable State law for the continuance of such coverage; (2) the issuer substantially violates a material provision of the policy; or (3) the issuer materially misrepresented the policy's provisions during marketing.

The provision would also apply to an individual who: (1) was enrolled under a Medigap policy; (2) subsequently terminates such enrollment and enrolls with a MedicarePlus organization, a risk or cost contract HMO, a similar organization operating under a demonstration project authority, or a Medicare SELECT policy; and (3) terminates such enrollment within 6 months (or within 3 months beginning in 2003), but only if the individual was never previously enrolled with such an entity. Such individuals could also return to the Medigap policy in which they were previously enrolled if such policy is still available from the same issuer. At the time of the event which results in the cessation of enrollment or loss of coverage, the organization, insurer, or plan administrator (whichever is appropriate) would notify the individual of his or her rights and the obligations of issuers of Medigap policies. The individual must seek to enroll under the applicable Medigap policy not later than 63 days after termination of other enrollment and provide evidence of the date of termination or disenrollment along with the application for such Medicare supplemental policy.

The provision would limit the application of a preexisting condition exclusion during the initial 6-month open enrollment period. Specifically, such an exclusion could not be imposed on an individual who, on the date of application, had a continuous period of at least 6 months of health insurance coverage defined as "creditable coverage" under the Health Insurance Portability and Accountability Act (HIPAA). If the individual had less than 6 months coverage, the policy would reduce the period of any pre-existing exclusion by the aggregate of periods of "creditable coverage" applicable to the individual as of the enrollment date. The rules used to determine the reduction would be based on rules used under HIPAA.

The provision would give the National Association of Insurance Commissioners (NAIC) nine months to modify its regulations to conform to the new requirements. If the NAIC, did not make the changes within this time, the Secretary would make the appropriate modification in the regulations.

The provision would be effective July 1, 1998. In general, a state would not be deemed out of compliance due solely to failure to make changes before one year after the date the NAIC or Secretary made changes in its regulations. A longer time may be permitted if a state requires legislation.

Reasons for change. The provision is intended to extend basic protections, similar to those provided in the recently enacted Health Insurance Portability and Accountability Act, to certain Medicare beneficiaries who may lose coverage under a Medicare Plus or Medigap plan for reasons largely outside of their control. The Committee notes that, currently, the "A", "B", "C", and "F"

plans account for nearly 80 percent of total Medigap enrollment. With regard to MedicarePlus, the provision also is intended to work in conjunction with the plan election procedures specified in the Act in order to facilitate private health plan choices. At the same time, the provision attempts to protect against adverse risk selection and limit price increases for the significant number of beneficiaries already enrolled in Medicare supplemental policies that could have resulted from more expansive requirements.

The provision was not intended to require organizations that do not offer an "A," "B," "C," or "F" Medicare supplemental policy to offer those types of policies to beneficiaries who may become eligible for such coverage as a result of this provision.

Effective date. Unless otherwise provided, the provision is generally effective July 1, 1998.

Section 10032. Medicare Prepaid Competitive Pricing Demonstration Project

Current law. Under section 402 of the Social Security Amendments of 1967 (P.L. 90-248, 42 U.S.C. 1395b-1), the Secretary is authorized to develop and engage in experiments and demonstration projects for specified purposes, including to determine whether, and if so, which changes in methods of payment or reimbursement for Medicare services, including a change to methods based on negotiated rates, would have the effect of increasing the efficiency and economy of such health services. Under this authority, HCFA is seeking to demonstrate the application of competitive bidding as a method for establishing payments for risk contract HMOs in the Denver area. HCFA's actions have been challenged in the courts.

Explanation of provision. The provision requires the Secretary of HHS to provide for a demonstration of competitive pricing for private health plans participating in Medicare.

a. Establishment of project. The Secretary would be required to provide, no later than one year after enactment, for implementation of a project to demonstrate the application of, and the consequences of applying, a market-oriented pricing system for the provision of a full range of Medicare benefits in several geographic areas.

b. Research design advisory committee. Before implementing the project, the Secretary would be required to appoint a national advisory committee, including independent actuaries and individuals with expertise in competitive health plan pricing, to recommend to the Secretary the appropriate research design for implementing the project, including the method for area selection, benefit design among plans offered, structuring choice among health plans offered, methods for setting the price to be paid to plans, collection of plan information, information dissemination, and methods of evaluating the results of the project. Upon implementation of the project, the Committee would continue to advise the Secretary on the application of the design in different areas and changes in the project based on experience with its operations.

c. Area selection. Taking into account the national advisory committee's recommendations, the Secretary would be required to designate demonstration areas. Upon such designation, the Secretary

would be required to appoint an area advisory committee, composed of representatives of health plans, providers, and beneficiaries in each demonstration area. The committee could advise the Secretary on marketing and pricing of plans in the area, and other relevant factors.

d. Monitoring and report. Taking into considerations the recommendations of the advisory committee (established under (b)), the Secretary would be required to closely monitor the impact of projects in areas on the price and quality of, and access to, Medicare covered services, choice of plans, changes in enrollment, and other relevant factors. The Secretary would be required to periodically report to Congress on project progress.

e. Waiver authority. The provision authorizes the Secretary to waive such requirements of section 1876 (relating to Medicare risk, cost, and HCPP plans) and of MedicarePlus as may be needed to carry out the demonstration project.

Reason for change. The Health Care Financing Administration (HCFA) recently has encountered difficulty implementing a competitive pricing demonstration project for risk contractors in two different regions of the country. The Committee believed that one reason HCFA experienced difficulties was the failure to develop appropriate demonstration models, sensitive to differences in market areas. Another reason was the failure to appropriately consult with persons with expertise in health plan pricing, and local health plans and beneficiaries with a keen interest in the impact of such a demonstration project on the Medicare market in their areas. While providing clear authority to carry out such demonstration projects in the future, the provision requires HCFA to address perceived shortcomings in its previous attempts at this type of demonstration.

Effective date. The provision is effective upon enactment.

Section 10041. Tax treatment of hospitals which participate in provider-sponsored organizations

Current law. To qualify as a charitable tax-exempt organization described in Internal Revenue Code (the "Code") section 501(c)(3), an organization must be organized and operated exclusively for religious, charitable, scientific, testing for public safety, literary, or educational purposes, or to foster international sports competition, or for the prevention of cruelty to children or animals. Although section 501(c)(3) does not specifically mention furnishing medical care and operating a nonprofit hospital, such activities have long been considered to further charitable purposes, provided that the organization benefits the community as a whole.

No part of the net earnings of a 501(c)(3) organization may inure to the benefit of any private shareholder or individual. No substantial part of the activities of a 501(c)(3) organization may consist of carrying on propaganda, or otherwise attempting to influence legislation, and such organization may not participate in, or intervene in, any political campaign on behalf of (or in opposition to) any candidate for public office. In addition, under section 501(m), an organization described in section 501(c)(3) or 501(c)(4) is exempt from tax only if no substantial part of its activities consists of providing commercial-type insurance.

A tax-exempt organization may, subject to certain limitations, enter into a joint venture or partnership with a for-profit organization without affecting its tax-exempt status. Under current ruling practice, the IRS examines the facts and circumstances of each arrangement to determine (1) whether the venture itself and the participation of the tax-exempt organization therein furthers a charitable purpose, and (2) whether the sharing of profits and losses or other aspects of the arrangement entail improper private inurement or more than incidental private benefit.¹

Explanation of provision. The provision provides that an organization does not fail to be treated as organized and operated exclusively for a charitable purpose for purposes of Code section 501(c)(3) solely because a hospital which is owned and operated by such organization participates in a provider-sponsored organization ("PSO") (as defined in section 1845(a)(1) of the Social Security Act), whether or not such PSO is exempt from tax. Thus, participation by a hospital in a PSO (whether taxable or tax-exempt) is deemed to satisfy the first part of the inquiry under current IRS ruling practice.²

The provision does not change present-law restrictions on private inurement and private benefit. However, the provision provides that any person with a material financial interest in such a PSO shall be treated as a private shareholder or individual with respect to the hospital for purposes of applying the private inurement prohibition in Code section 501(c)(3). Accordingly, the facts and circumstances of each PSO arrangement are evaluated to determine whether the arrangement entails impermissible private inurement or more than incidental private benefit (e.g., where there is a disproportionate allocation of profits and losses to the non-exempt partners, the tax-exempt partner makes loans to the joint venture that are commercially unreasonable, the tax-exempt partner provides property or services to the joint venture at less than fair market value, or a non-exempt partner receives more than reasonable compensation for the sale of property or services to the joint venture).

The provision does not change present-law restrictions on lobbying and political activities. In addition, the restrictions of Code section 501(m) on the provision of commercial-type insurance continue to apply.

Reason for change. The provision is necessary to ensure that certain providers not lose tax-exempt status simply because they join or form a PSO.

Effective date. The provision is effective on the date of enactment.

¹ See IRS General Counsel Memorandum 39862; Announcement 92-83, 1992-22 I.R.B. 59 (IRS Audit Guidelines for Hospitals). Even where no prohibited private inurement exists, however, more than incidental private benefits conferred on individuals may result in the organization not being operated "exclusively" for an exempt purpose. See, e.g., *American Campaign Academy v. Commissioner*, 92 T.C. 1053 (1989).

² The qualification of a hospital as a tax-exempt charitable organization under section 501(c)(3) is determined as under present law. See Rev. Rul. 69-545, 1969-2 C.B. 117.

SUBTITLE B—PREVENTION INITIATIVES

Section 10101. Screening mammography

Current law. Medicare provides coverage for screening mammograms. Frequency of coverage is dependent on the age and risk factors of the woman. For women ages 35–39, one test is authorized. For women ages 40–49, a test is covered every 24 months, except, an annual test is authorized for women at high risk. Annual tests are covered for women ages 50–64. For women aged 65 and over, the program covers one test every 24 months. Medicare's Part B deductible and coinsurance apply for these services.

Explanation of provision. The proposal would authorize coverage for annual mammograms for all women ages 40 and over. It would also waive the deductible for screening mammograms. These provisions would be effective January 1, 1998.

Reason for change. One in every eight American women are affected by breast cancer during their lifetime and over 40,000 women die from breast cancer each year. Both the National Cancer Institute (NCI) and the American Cancer Society (ACS) recently recommended that women age 40 and over receive annual mammograms. According to NCI, annual mammograms can reduce the death rate from breast cancer by 17 percent among these women. In addition, there are currently 40 States that require private health insurance companies to pay for mammograms for women in their 40s.

The application of the Part B deductible to annual screening mammography is waived because research indicates that out of pocket costs of screening present a barrier to certain beneficiaries seeking preventative mammograms, particularly low income beneficiaries. Although Medicare coverage of screening mammography began in 1991, only 14 percent of eligible beneficiaries without supplemental insurance received a mammogram during the first two years of the benefit.

Effective date. The provision is effective January 1, 1998.

Section 10102. Screening pap smear and pelvic exams

Medicare covers a screening Pap smear once every 3 years. The Secretary is permitted to specify a shorter time period in the case of women at high risk of developing cancer.

Explanation of provision. The provision would authorize coverage, every 3 years, for a screening pelvic exam which would include a clinical breast examination. The provision would specify that for both Pap smears and screening pelvic exams, coverage would be authorized on a yearly basis for women at high risk of developing cancer (as determined pursuant to factors identified by the Secretary). Coverage would also be authorized on a yearly basis for a woman of childbearing age who had not had a test in each of the preceding three years that did not indicate the presence of cancer.

The provision would waive the deductible for screening Pap smears and screening pelvic exams.

Reason for change. An estimated 15,700 new cases of cervical cancer are diagnosed each year, and 4,900 women die from this disease annually. The incidence of invasive cervical cancer has de-

creased significantly over the last 40 years, due in large part to organized early detection programs. According to the Guide to Clinical Preventive Services published by the United States Preventive Services Task Force, routine screening for cervical cancer with Pap testing is recommended for all women who are or have been sexually active and who have a cervix. As with mammograms, the provision waives the application of the Part B deductible to these services because there is evidence that out of pocket cost reduce Pap screenings, especially for low-income women.

Effective date. The provision is effective January 1, 1998.

Section 10103. Prostate cancer screening tests

Current law. Medicare does not cover prostate cancer screening tests.

Explanation of provision. The provision would authorize an annual prostate cancer screening test for men over age 50. The test could consist of any (or all) of the following procedures: (1) a digital rectal exam; (2) a prostate-specific antigen blood test; and (3) after 2001, other procedures as the Secretary finds appropriate for the purpose of early detection of prostate cancer, taking into account such factors as changes in technology and standards of medical practice, availability, effectiveness, and costs.

The provision would specify that payment for prostate-specific antigen blood tests would be made under the clinical laboratory fee schedule.

Reason for change. Prostate cancer is the most common non-cutaneous cancer in American men. After lung cancer, it accounts for more cancer deaths in men than any other single cancer, accounting for nearly 250,000 new cases and over 40,000 deaths in the United States in 1995. Risk increases with age, beginning at age 50, and is also higher among African American men. Early detection may be extremely important because ten-year survival rates are 75 percent when the cancer is confined to the prostate and five-year survival rates for early-stage disease are extremely high.

Effective date. The provision is effective January 1, 1998.

Section 10104. Coverage of colorectal screening

Current law. Medicare does not cover preventive colorectal screening procedures. Such services are covered only as diagnostic services.

Explanation of provision. The provision would authorize coverage of colorectal cancer screening tests. A test covered under the provision would be any of the following procedures furnished for the purpose of early detection of colorectal cancer: (1) screening fecal-occult blood test; (2) screening flexible sigmoidoscopy; (3) screening colonoscopy for a high-risk individual; (4) screening barium enema, if found by the Secretary to be an appropriate alternative to screening flexible sigmoidoscopy or screening colonoscopy; and (5) after 2002, other procedures as the Secretary finds appropriate for the purpose of early detection of colorectal cancer, taking into account such factors as changes in technology and standards of medical practice, availability, effectiveness, and costs. A high-risk individual (for purposes of coverage for screening colonoscopy) would be defined as one who faces a high risk for colorectal cancer because

of family history, prior experience of cancer or precursor neoplastic polyps, a history of chronic digestive disease condition (including inflammatory bowel disease, Crohn's disease or ulcerative colitis), the presence of any appropriate recognized gene markers, or other predisposing factors. The Secretary would be required to make a decision with respect to coverage of screening barium enema tests within two years of enactment; the determination would be published.

The provision would establish frequency and payment limits for the tests. For screening fecal-occult blood tests, payment would be made under the lab fee schedule. In 1998, the payment amount could not exceed \$5; in future years the update would be limited to the update applicable under the fee schedule. Medicare could not make payments if the test were performed on an individual under age 50 or within 11 months of a previous screening fecal-occult blood test.

The provision would require the Secretary to establish a payment amount under the physician fee schedule for screening flexible sigmoidoscopies that is consistent with payment amounts for similar or related services. The payment amount could not exceed the amount the Secretary specifies, based upon the rates recognized for diagnostic flexible sigmoidoscopy services. For services performed in ambulatory surgical centers or hospital outpatient departments, the payment amount could not exceed the lesser of the payment rate that would apply to such services if they were performed at either site. Medicare could not make payments for a screening flexible sigmoidoscopy if the test were performed on an individual under age 50 or within 47 months of a previous screening flexible sigmoidoscopy.

The provision would require the Secretary to establish a payment amount under the physician fee schedule for screening colonoscopy for high risk individuals that is consistent with payment amounts for similar or related services. The payment amount could not exceed the amount the Secretary specifies, based upon the rates recognized for diagnostic colonoscopy services. For services performed in ambulatory surgical centers or hospital outpatient departments, the payment amount could not exceed the lesser of the payment rate that would apply to such services if they were performed at either site. Medicare could not make payments if the test were performed on a high-risk individual within 23 months of a previous screening colonoscopy.

The provision would establish special payment rules, in the case of both a screening flexible sigmoidoscopy or screening colonoscopy, if a lesion or growth is discovered during the procedure which results in a biopsy or removal of the lesion or growth during the procedure. In these cases, payment would be made for the procedure classified as either a flexible sigmoidoscopy with such biopsy or removal or screening colonoscopy with such biopsy or removal.

The provision would require the Secretary to review from time to time the appropriateness of the amount of the payment limit for fecal-occult blood tests. The Secretary could, beginning after 2000, reduce the amount of the limit as it applies nationally or in a given area to the amount the Secretary estimates is required to assure

that such tests of an appropriate quality are readily and conveniently available.

The provision would require the Secretary to review periodically the appropriate frequency for performing colorectal cancer screening tests based on age and other factors the Secretary believes to be pertinent. The Secretary may revise from time to time the frequency limitations, but no revisions could occur before January 1, 2001.

Nonparticipating physicians providing screening flexible sigmoidoscopies or screening colonoscopies for high risk individuals would be subject to limiting charge provisions applicable for physicians services. The Secretary could impose sanctions if a physician or supplier knowingly and willfully imposed a charge in violation of this requirement.

The provision would require the Secretary to establish payment limits and frequency limits for screening barium enema tests if the Secretary issues a determination that such tests should be covered. Payment limits would be consistent with those established for diagnostic barium enema procedures.

Reason for change. Colorectal cancer is the third most common form of cancer for both men and women and the United States. It is the second-leading cause of cancer deaths, accounting for nearly 55,000 deaths annually. Early screening and detection is extremely important because estimated five-year survival rates are 91 percent in persons with localized disease and 60 percent in persons with regional spread. Numerous experts, including Dr. Michael McGinnis, testified before the Health Subcommittee that the screening regimen authorized for coverage under legislation forming the basis of this provision was consistent with available studies and recommendations of the U.S. Preventive Services Task Force.

In addition, Dr. Louis Sullivan, former Secretary of Health and Human Services wrote the Chairman of the Committee in a May 5 letter that the colorectal screening provisions embodied in this provision "prescribes the most economical, most responsible package it would do the most good possible within the fiscal restraints that are the reality of modern government."

While there has been some disagreement between experts about whether or not barium enema screenings should be covered, the testimony before the Ways and Means Health Subcommittee demonstrated that the efficacy of barium enema as a screening device has not been definitively established. In the only true screening study of barium enema x-ray, published by the Mayo Clinic in 1996, single contrast barium enema x-ray detected polyps in only 3 percent of asymptomatic average-risk persons. In addition, the National Polyp Study found in 1994 that barium enema x-ray detected only 44 percent of polyps larger than one centimeter. Because there is not sufficient scientific evidence of the effectiveness of barium enema screening at this time, the provision authorizes coverage for that procedure only after the Secretary determines that barium screening is an appropriate alternative to screening flexible sigmoidoscopy or screening colonoscopy. The Committee emphasizes, however, that the Secretary could make this decision at any time following the effective date of the provision, as long as

such decision were made no later than two years after January 1, 1998.

Effective date. Unless otherwise provided, the provision would be effective January 1, 1998.

Section 10105. Diabetes Screening Tests

Current law. In general, Medicare covers only those items and services which are medically reasonable and necessary for the diagnosis or treatment of illness or injury. In addition, Medicare covers home blood glucose monitors and associated testing strips for certain diabetes patients. Home blood glucose monitors enable diabetics to measure their blood glucose levels and then alter their diets or insulin dosages to ensure that they are maintaining an adequate blood glucose level. Home glucose monitors and testing strips are covered under Medicare's durable medical equipment benefit. Coverage of home blood glucose monitors is currently limited to certain diabetics, formerly referred to as Type I diabetics, if: (1) the patient is an insulin-treated diabetic; (2) the patient is capable of being trained to use the monitor in an appropriate manner, or, in some cases, another responsible person is capable of being trained to use the equipment and monitor the patient to assure that the intended effect is achieved; and (3) the device is designed for home rather than clinical use.

Explanation of provision. Effective January 1, 1998, the provision would include among Medicare's covered benefits diabetes outpatient self-management training services. These services would include educational and training services furnished to an individual with diabetes by a certified provider in an outpatient setting meeting certain quality standards. They would be covered only if the physician who is managing the individual's diabetic condition certifies that the services are needed under a comprehensive plan of care 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. Certified providers for these purposes would be defined as physicians or other individuals or entities that, in addition to providing diabetes outpatient self-management training services, provide other items or services reimbursed by Medicare. Providers would have to meet quality standards established by the Secretary. They would be deemed to have met the Secretary's standards if they meet standards originally established by the National Diabetes Advisory Board and subsequently revised by organizations who participated in the establishment of standards of the Board, or if they are recognized by an organization representing persons with diabetes as meeting standards for furnishing such services. In establishing payment amounts for diabetes outpatient self-management training provided by physicians and determining the relative value for these services, the Secretary would be required to consult with appropriate organizations, including organizations representing persons or Medicare beneficiaries with diabetes.

In addition, beginning January 1, 1998, the provision would extend Medicare coverage of blood glucose monitors and testing strips to Type II diabetics and without regard to a person's use of insulin (as determined under standards established by the Secretary in

consultation with appropriate organization). The provision would also reduce the national payment limit used by Medicare for testing strips by 10% beginning in 1998.

The Secretary, in consultation with appropriate organizations, would be required to establish outcome measures, including glycosylated hemoglobin (past 90-day average blood sugar levels), for purposes of evaluating the improvement of the health status of Medicare beneficiaries with diabetes. The Secretary would also be required to submit recommendations to Congress from time to time on modifications to coverage of services for these beneficiaries.

Reasons for change. This provision is intended to empower Medicare beneficiaries with diabetes to better manage and control their condition. The Committee believes that this provision significant savings; we believe this provision will, provide significant Medicare savings over time due to reduced hospitalizations and complications arising from diabetes.

Nearly 20 percent of Americans over age 65 have diabetes, although less than half of these cases remain undiagnosed. Despite that fact that only 9 percent of Medicare beneficiaries are diagnosed with diabetes, \$28.6 billion is spent annually to treat these beneficiaries for diabetes and complications arising from the disease. With early detection, education, self-monitoring, and proper treatment, many of the complications that result from diabetes, such as kidney failure, amputation, blindness, nerve damage, heart disease, strokes, and lengthy hospitalizations, can be avoided. To better analyze and evaluate the improvements in health status that may result from this new disease management benefit, the provision authorizes the Secretary, in consultation with appropriate organizations, to establish and continually update diabetes outcome measures.

The provision would allow reimbursement for physicians, as well as other providers designated by the Secretary who currently are reimbursed by Medicare. The Committee intends that these additional classes of providers have expertise in diabetes self-management training and, consistent with the standards set forth in the provision, demonstrate the ability to provide counseling and training in a cost-effective way to beneficiaries.

Finally, to help keep the costs of this new benefit reasonable and because of the increased utilization of test strips which will result from this new benefit, the provision includes the Administration's proposal to reduce the Medicare national payment limit for testing strips by 10 percent.

The Committee is aware that there are a wealth of innovative disease management programs that are not now covered by Medicare. However, there is not sufficient evidence at this time that indicates these programs will be cost-effective for Medicare.

Effective date. The provision would be effective January 1, 1998.

Section 10106. Standardization of medicare coverage of bone mass measurements

Current law. There is no national coverage rule under Medicare regarding bone mass measurement screenings. Currently, approximately half of the carriers reimburse for bone mass measurement

for certain Medicare eligible women who are at high-risk for osteoporosis.

Explanation of provision. The provision would authorize Medicare coverage on a national basis regarding coverage for bone mass measurement for the following Medicare beneficiaries: (i) beneficiaries determined to be estrogen-deficient; (ii) beneficiaries who have vertebral abnormalities; (iii) beneficiaries receiving long-term glucocorticoid steroid therapy; (iv) beneficiaries with primary hyperparathyroidism; or (v) beneficiaries being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy. Bone mass measurement is defined as a radiologic or radioisotopic procedure, or other procedure approved by the Food and Drug Administration, for the purpose of identifying bone mass or detecting bone loss or determining bone quality. Payments for bone mass measurement with respect to qualified beneficiaries would be made under the Medicare physician fee schedule.

Reason for change. Because Medicare coverage decisions are made locally by individual carriers, there are no consistent national policies regarding payment for most bone mass measurement. Many women at risk for developing osteoporosis do not have access to coverage for early detection.

Effective date. The provision would be effective July 1, 1998.

Section 10107. Vaccines outreach expansion

Current law. The Health Care Financing Administration, in conjunction with the Centers for Disease Control and the National Coalition for Adult Immunization, conducts an Influenza and Pneumococcal Vaccination Campaign. The Campaign is scheduled to cease operations in 2000.

Explanation of provision. The provision would authorize the extension of the campaign through the end of FY 2002. In addition, the provision would authorize the appropriation of \$8 million for each fiscal year 1998—2002 to the Campaign.

Reason for change. There is evidence that education and outreach efforts alone can increase utilization. For example, pneumonia and influenza vaccination rates have increased 8 percent during the past few years due largely to educational outreach efforts. Therefore, this provision would nearly double the \$9 million annual budget of the Health Care Financing Administration's Influenza and Pneumococcal Vaccination Campaign through 2000, and extend the program for two additional years through 2002.

Effective date. The provision would be effective upon enactment.

Section 10108. Study on preventive benefits

Current law. No provision

Explanation of provision. The provision would require the Secretary to request the National Academy of Sciences, in conjunction with the United States Preventive Services Task Force, to analyze the expansion or modification of preventive services covered under Medicare. The study would consider both the short term and long term benefits and costs to Medicare. The study would have to include specific findings with respect to the following: (1) nutrition therapy, including parenteral and enteral nutrition; (2) medically necessary dental care; (3) routine patient care costs for bene-

ficiaries enrolled in approved clinical trial programs; and (4) elimination of time limitation for coverage of immunosuppressive drugs for transplant patients. The Secretary would be required to provide such funding as may be necessary in FY 1998 and FY 1999.

Reason for change. Because of widespread interest in expanding and updating Medicare's current benefit package to focus more attention on prevention, this provision is intended to signal the interest of the Committee in continuing to reexamine Medicare's benefits in light of evolving scientific evidence about the costs and benefits of various prevention initiatives.

Effective date. The provision would be effective upon enactment.

SUBTITLE C—RURAL INITIATIVES

Section 10201. Rural primary care hospital program

Current law. Under the Essential Access Community Hospital (EACH) demonstration program, seven states received grants to develop rural health networks consisting of essential access community hospitals (EACHs) and rural primary care hospitals (RPCHs). In order to have been designated by a State as a RPCH, a facility was required to meet certain criteria, including a requirement that inpatient stays not exceed 72 hours.

Montana also has a limited hospital program called the Medical Assistance Facility (MAF).

Explanation of provision. The provision would expand the Medicare Rural Primary Care Hospital Program under which a state could designate one or more facilities as a rural primary care hospital (RPCH). A facility could be designated as an RPCH if it was a nonprofit or public hospital located in a county in a rural area that is located at a distance that corresponds to travel time of more than 30 minutes from another hospital or RPCH, or is certified by the state as being a necessary provider of health care services. An RPCH would be required to provide 24-hour emergency care services, provide not more than 15 acute care inpatient beds and a total of 25 swing beds for providing inpatient care for a period not to exceed 96 hours (except under certain conditions), and would not have to meet all the staffing requirements that apply to hospitals under Medicare.

RPCHs would be required to have agreements with at least one hospital for patient referral and transfer, the development and use of communication systems including telemetry systems and systems for electronic sharing of patient data, and the provision of emergency and non-emergency transportation between the facility and the hospital. Each RPCH would also be required to have an agreement concerning credentialing and quality assurance with at least one hospital, peer review organization or equivalent entity, or other appropriate and qualified entity identified by the state.

Payment for inpatient and outpatient services provided at RPCHs would be made on the basis of reasonable costs of providing such services. Such payment would also continue for designated EACH hospitals as well as for the MAF demonstration program.

Reason for change. This new category of hospitals will enhance access to health care services for rural residents by assisting hospitals to convert to outpatient, emergency and limited inpatient

service facilities. These facilities will also assist rural areas to recruit physicians and other health care practitioners to that community.

The Committee intends that RPCHs could have swing beds either through a swing bed agreement when the hospital initially became a RPCH, or through a swing bed agreement under Section 1820(f)(3). With regard to the number of beds, the Committee intends that RPCHs will only use 15 beds for delivering acute care inpatient services. However, if the RPCH has a swing bed agreement, then it may have 15 swing beds plus up to an additional 10 beds for extended care services. These standards are intended to provide flexibility to facilities that deliver primarily acute care services but occasionally, in response to changes in patient needs, must use most or all of their beds for extended care services.

Effective date. The provision would be effective upon enactment.

Section 10202. Prohibiting denial of request by rural referral centers for reclassification on basis of comparability of wages

Current law. Rural Referral Centers are defined as:

- (1) rural hospitals having 275 or more beds;
- (2) hospitals having at least 50 percent of their Medicare patients referred from other hospitals or from physicians not on the hospital's staff, at least 60 percent of their Medicare patients residing more than 25 miles from the hospital, and at least 60 percent of the services furnished to Medicare beneficiaries living 25 miles or more from the hospital; or
- (3) rural hospitals meeting the following criteria for hospital cost reporting periods beginning on or after October 1, 1985:
 - (a) a case mix index equal to or greater than the median case mix for all urban hospitals (the national standard), or the median case mix for urban hospitals located in the same census region, excluding hospitals with approved teaching programs;
 - (b) a minimum of 5,000 discharges, the national discharge criterion (3,000 in the case of osteopathic hospitals), or the median number of discharges in urban hospitals for the region in which the hospital is located; and
 - (c) at least one of the following three criteria: more than 50 percent of the hospital's medical staff are specialists, at least 60 percent of discharges are for inpatients who reside more than 25 miles from the hospital, or at least 40 percent of inpatients treated at the hospital have been referred either from physicians not on the hospital's staff or from other hospitals.

Under Section 1886(d)(10)(d), RRCs are allowed to apply to the Medicare Geographic Classification Review Board (MGCRB) to be reclassified for purposes of wage index adjustment. (A wage index adjustment translates to higher prospective payment system reimbursement for the reclassified hospitals.) To be reclassified, RRCs must meet two thresholds: (1) the hospital's average hourly wage must be at least 108 percent of the statewide rural hourly wage; and, (2) the hospital's average hourly wage must be at least 84 percent of the average hourly wage of the target urban area to which the RRC is applying.

RRCs were paid prospective payments based on the applicable urban payment amount rather than the rural payment amount, as

adjusted by the hospital's area wage index, until FY1995 when the standardized payment amount for "other urban" and "rural" were combined into a single payment category, "other areas."

OBRA 93 extended the classification through FY1994 for those referral centers classified as of September 30, 1992.

Explanation of provision. The provision would prohibit the MGCRB from rejecting a hospital's request for reclassification on the basis of any comparison between the average hourly wage of any hospital ever classified as a RRC and the average hourly wage of hospitals in the area in which the RRC is located. The provision would also permanently grandfather RRC status for any hospitals designated since 1991.

Reason for change. RRCs compete with urban hospitals for specialty professionals and often must pay higher salaries to attract such professionals to rural areas. Moreover, RRCs rely on the increased income provided by the wage index adjustment for their unique recruiting needs. Lastly, RRCs have difficulty satisfying the 108 percent threshold because their average hourly wages are disproportionately weighted down by their non-specialized labor.

Effective date. The provision would be effective upon enactment.

Section 10203. Hospital geographic reclassification permitted for purposes of disproportionate share payment adjustments

Current law. The Medicare Geographic Classification Review Board is required to consider the applications from PPS hospitals requesting that the Secretary change the hospital's geographic classification for purposes of determining for a fiscal year the hospital's average standardized amount and the wage index used to adjust the DRG payment to reflect area differences in hospital wage levels.

Explanation of the provision. The provision would permit hospitals to request geographic reclassification for the purposes of receiving additional disproportionate share hospital (DSH) payment amounts provided to hospitals that treat a disproportionate share of low-income patients. The provision would require the Board to apply the guidelines established for reclassification for the standardized amount to applications for DSH payments until the Secretary promulgates separate guidelines for reclassification for DSH.

Reason for change. In September 1995, HCFA no longer allowed rural hospitals to be reclassified from "rural" to "other urban" areas for purposes of the standardized amount. By eliminating the availability of standardized amount reclassification, HCFA also eliminated other important benefits that accompanied standardized amount reclassification, such as DSH payment adjustments.

Effective date. The provision would be effective upon enactment.

Section 10204. Medicare-Dependent Small Rural Hospital Payment Extension

Current law. Medicare-dependent small rural hospitals are hospitals located in a rural area, with 100 beds or less, that are not classified as a sole community provider, and for which not less than 60 percent of inpatient days or discharges in the hospital cost reporting period are attributable to Medicare. These hospitals were reimbursed on the same basis as sole community hospitals. The

designation for Medicare-dependent small rural hospitals expired on October 1, 1994.

Explanation of provision. The provision would reinstate and extend the classification, and extend the target amount through October 1, 2001. The provision would also permit hospitals to decline reclassification.

Reason for change. The program would provide needed financial resources to rural hospitals faced with financial problems. ProPAC estimates show that both aggregate Medicare PPS and total margins for these hospitals are significantly lower than other comparable hospitals.

Effective date. The provision would be effective upon enactment.

Section 10205. Floor on area wage index

Current law. As part of the methodology for determining prospective payments to hospitals under PPS, the Secretary is required to adjust a portion of the standardized amounts for area differences in hospital wage levels by a factor reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level.

Explanation of provision. For discharges occurring on or after October 1, 1997, the area wage index applicable for any hospital which was not located in a rural area could not be less than the area wage indices applicable to hospitals located in rural areas in the state in which the hospital was located. The Secretary would be required to make any adjustments in the wage index in a budget neutral manner.

Reason for change: An anomaly that exists with the way area wage indexes are applied has resulted in some urban hospitals being paid less than the average rural hospital in their states.

Effective date. The provision would be effective upon enactment.

Section 10206. Geographic reclassification for certain disproportionately large hospitals

Current law. OBRA 1989 created the five member panel and set forth criteria for the Medicare Geographic Classification Review Board (MGCRB) to use in issuing its decisions concerning geographic reclassification of hospitals as rural or urban for prospective payment purposes of Medicare's hospital reimbursement. In 1992, HCFA issued guidelines requiring that hospitals seeking reclassification for years beginning with FY 1994 to have an average hourly wage of at least 108 percent of the average hourly wage of hospitals in its home region.

Explanation of provision. The provision would allow certain relatively large hospitals to be reclassified by the MGCRB if the hospital has 40 percent of the wages in a region and its wages are 108 percent or higher than the other hospitals in the region.

Reason for change: The current hospital geographic classification system does not work well for a certain class of leading hospitals in a small MSA, which have significantly higher wages than the other hospitals in the MSA because of the extra specialty, trauma, and other services they provide. While these large hospitals materially influence the average hourly wage in the MSA, they do not dominate it. Thus the way the formula works, a small MSA's major

hospital may have wages much larger than the other hospitals in the region, but when its wages are averaged with the others, it falls below the 108% threshold—thus suffering major Medicare payment reductions and a reduced ability to provide advanced medical services in that region. The provision allows certain large hospitals in this situation to be eligible for reclassification.

Effective date. The provision would be effective for fiscal year 1998.

Section 10207. Informatics, telemedicine, and education demonstration project

Current law. No provision.

Explanation of Provision. The provision would require the Secretary to conduct, no later than 9 months after enactment, a 4-year demonstration project designed to use eligible health care provider telemedicine networks to apply high-capacity computing and advanced networks for the provision of health care to Medicare beneficiaries who are residents of medically underserved rural and inner-city areas. The project would focus on improvements in primary care and prevention of complications for those residents with diabetes mellitus. The objectives of the project would include: (1) improving patient access to and compliance with appropriate care guidelines for chronic diseases through direct telecommunications links with information networks; (2) developing a curriculum to train, and provide standards for credentialing and licensure of, health professionals (particularly primary care) in the use of medical informatics and telecommunications; (3) demonstrating the application of advanced technologies to assist primary care providers in assisting patients with chronic illnesses in a home setting; (4) applying medical informatics to residents with limited English language skills; (5) developing standards in the application of telemedicine and medical informatics; and (6) developing a model for the cost-effective delivery of primary and related care both in a managed care and fee-for-service environment.

The provision defines an eligible health care provider telemedicine network as a consortium that includes at least one tertiary care hospital (but no more than two such hospitals), at least one medical school, and at least one regional telecommunications provider, no more than four facilities in rural or urban areas, and meets certain additional requirements. The provision would define those services to be covered under Part B for the purposes of this demonstration project. Medicare payment for covered Part B services would be made at a rate of 50% of the reasonable costs of providing such services. The Secretary would be required to recognize the following project costs as permissible costs for covered under Part B: (1) the acquisition of telemedicine equipment for use in patient homes; (2) curriculum development and training of health professionals in medical informatics and telemedicine, (3) payment of certain telecommunications costs, including costs of telecommunications between patients' homes and the eligible network and between the network and other entities under the arrangements described in the bill; and (4) payments to practitioners and providers under Medicare. Costs not covered under Part B would include: (1) purchase or installation of transmission equipment, (2)

the establishment or operation of a telecommunications common carrier network, (3) the costs of construction (except for minor renovations related to the installation of reimbursable equipment), or (4) the acquisition or building of real property.

The total amount of Medicare payments permitted under the project would be \$30 million. The project would be prohibited from imposing cost sharing on a Medicare beneficiary for the receipt of services under the project of more than 20% of the recognized costs of the project attributable to these services. The Secretary would be required to submit to the House Committees on Ways and Means and Commerce and the Senate Committee on Finance interim reports on the project and a final report on the project within 6 months of the conclusion of the project. The final report would be required to include an evaluation of the impact of the use of telemedicine and medical informatics on improving the access of Medicare beneficiaries to health care services, on reducing the costs of such services, and on improving the quality of life of such beneficiaries.

Reason for change. Americans living in rural and poor inner city areas have less access to specialty medical care and receive a disproportionate level of primary care by visiting hospital emergency rooms. Telemedicine may prove to be a promising tool to reach these individuals quickly. The Committee believes that while there are currently several ongoing telemedicine demonstrations, none exist in Medicare which examine chronic management issues related to diabetes mellitus. The Committee is concerned however that more information is needed on how to develop methodology for Part B payment purposes so that Medicare is not paying double for these services, and continues to urge HCFA to submit its recommendations on how to implement telemedicine methodology as described in the Health Insurance Portability and Accountability Act of 1996.

Effective date. The provision would be effective upon enactment.

SUBTITLE D—ANTI-FRAUD AND ABUSE PROVISIONS AND ADMINISTRATIVE EFFICIENCIES

Chapter 1.—Fraud and Abuse Related Provisions

Section 10301. Permanent exclusion for those convicted of 3 health care related crimes

Current law. Section 1128(a) of the Social Security Act directs the Secretary of Health and Human Services to mandatorily exclude individuals and entities from participation in the Medicare program and state health care programs (Medicaid, Title V Maternal and Child Health Block Grants, and Title XX Social Services Block Grants) upon conviction of certain criminal offenses including Medicare and Medicaid program-related crimes, patient abuse crimes, health care fraud felonies, and felonies relating to controlled substances. Such mandatory exclusions are, in most cases, for a minimum period of 5 years.

Explanation of provision. The provision would specify that if an individual is excluded by the Secretary of Health and Human Services from participation in federal health care programs, as defined

in Section 1128b(f) of the Social Security Act, or state health care programs because of a conviction relating to Medicare and Medicaid program-related crimes, patient abuse, or felonies related to health care fraud or controlled substances, then the exclusion would be for a period of 10 years if the individual had been convicted on one previous occasion of one or more offenses for which such an exclusion may be imposed. If an individual had been convicted on two or more previous occasions of an offense for which an exclusion may be imposed, the exclusion would be permanent. The provision would apply to exclusions based on a conviction occurring on or after the date of enactment of this section where the individual has had prior convictions occurring before, on, or after the date of enactment of this section.

Reason for change. Like all the provisions of Subtitle D, this provision builds on the historic anti-fraud and abuse provisions in the Health Insurance Portability and Accountability Act (HIPAA), which created new classes of health care crimes, increased civil penalties for health care fraud, and established a national health care fraud and abuse control program to coordinate federal, State and local law enforcement efforts. In addition, the Secretary and Attorney General were required to provide guidance to health care providers through the issuance of safe harbors, advisory opinions and special fraud alerts.

According to the Inspector General of the Department of Health and Human Services, “even after conviction and a subsequent program exclusion, there are instances where individuals and entities continue to engage in health care fraud and abuse.” Letter of June 3, 1997 from June Gibbs Brown, Inspector General, to Chairman William M. Thomas (“Brown letter”) of the Ways and Means Health Subcommittee. The Inspector General believes that “continuing misconduct poses ongoing risk to both federal health care programs and beneficiaries.” See Brown letter. This “three strikes, you’re out” provision will act as a strong deterrent to providers and health plans, helping to ensure the integrity of our federal health care programs.

There is precedent for this type of federal punishment. The Violent Crime and Law Enforcement Act of 1994 was introduced to require a sentence of life imprisonment for a third conviction for certain violent or drug offenses. The Committee believes that Medicare beneficiaries deserve the same type of protection.

Effective date. The provision is effective upon enactment.

Section 10302. Authority to refuse to enter into Medicare agreements with individuals or entities convicted of felonies

Current law. Section 1866 of the Social Security Act sets forth certain conditions under which providers may become qualified to participate in the Medicare program. The Secretary may refuse to enter into an agreement with a provider, or may refuse to renew or may terminate such an agreement, if the Secretary determines that the provider has failed to comply with provisions of the agreement, other applicable Medicare requirements and regulations, or if the provider has been excluded from participation in a health care program under section 1128 or 1128A of the Social Security Act. Section 1842 of the Social Security Act permits physicians and

suppliers to enter into agreements with the Secretary under which they become “participating” physicians or suppliers under the Medicare program.

Explanation of provision. The provision would allow the Secretary to refuse to enter into an agreement, or refuse to renew or terminate an agreement with a provider if the provider has been convicted of a felony under federal or state law for an offense which the Secretary determines is inconsistent with the best interests of program beneficiaries. This authority would extend to the Secretary’s agreements with physicians or suppliers who become “participating” physicians or suppliers under the Medicare program. Similar provisions would apply to the Medicaid program.

Reason for change. This is an important measure that will help to protect beneficiaries from potential harm. At the same time, however, the Committee recognizes that this recommendation could be read to provide broad authority to the Secretary. Therefore, it is the intent of the Committee that the Secretary exercise considerable discretion in utilizing this authority and weigh extremely carefully any decision to refuse to enter into an agreement, or to non-renew or terminate an agreement only where there is clear evidence that beneficiaries will be harmed by entering into a relationship or renewing a relationship with a provider, physician or supplier.

Effective date. The provision would take effect as of the date of enactment of this Act, and apply to new and renewed contracts on or after that date.

Sec. 10303. Inclusion of toll-free number to report Medicare waste, fraud, and abuse in explanation of benefits forms

Current law. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) required the Secretary to establish a program to encourage individuals to report information on individuals and entities who have engaged in acts or omissions which would constitute grounds for the imposition of a sanction under sections 1128, 1128A, or 1128B of the Social Security Act, or who otherwise have engaged in fraud and abuse against the Medicare program. The Secretary was authorized by HIPAA to pay a portion of amounts collected as a result of these reports to the individual making such report.

Explanation of provision. The provision would require the Inspector General of the Department of Health and Human Services to maintain a toll-free telephone number for the receipt of complaints and information about waste, fraud, and abuse in the provision or billing of Medicare services. It also would the Secretary to include in each Medicare beneficiary’s explanation of benefits form this toll-free telephone number so that beneficiaries can report instances of waste, fraud, and abuse in the Medicare program.

Reason for change. Over 90 percent of Medicare beneficiaries use their benefits at the same time during the year and receive an explanation of benefits form at least once each year. Medicare beneficiaries often detect billing irregularities and over-charges at the time they examine their explanation of benefits forms. This provision is intended to augment government enforcement efforts by empowering beneficiaries with easy, direct access to persons author-

ized to enforce penalties against fraud and abuse in the Medicare program.

Section 10304. Liability of Medicare carriers and fiscal intermediaries for claims submitted by excluded persons

Current law. Carriers and fiscal intermediaries are the entities which process claims for Medicare. Intermediaries process claims submitted by Part A providers of services and carriers process claims submitted by Part B providers.

Explanation of provision. The provision would specify that agreements with fiscal intermediaries or carriers require that such organizations reimburse the Secretary for any amounts paid for services under Medicare which have been furnished, directed, or prescribed by an individual or entity during any period in which the individual or entity has been excluded from participation under Medicare, if the amounts have been paid after the fiscal intermediary or carrier has received notice of the exclusion. Similar restrictions would be imposed upon states under the Medicaid program.

Reason for change. This provision is intended to ensure that Medicare contractors and State Medicaid agencies are vigilant in checking the eligibility of health care providers for reimbursement. Currently, when erroneous payments are made to excluded individuals, the Medicare and Medicaid programs incur the damages.

Effective date. These provisions would apply to contracts and agreements entered into, renewed, or extended after the date of enactment of this Act, but only with respect to claims submitted on or after either January 1, 1998, or the effective date of the contract, whichever is later.

Section 10305. Exclusion of entity controlled by family member of a sanctioned individual

Current law. Section 1128 of the Social Security Act authorizes the Secretary of HHS to impose mandatory and permissive exclusions of individuals and entities from participation in the Medicare program, Medicaid program and programs receiving funds under the Title V Maternal and Child Health Services Block Grant, or the Title XX Social Services Block Grant. The Secretary may exclude any entity which the Secretary determines has a person with a direct or indirect ownership or control interest of 5 percent or more in the entity or who is an officer, director, agent, or managing employee of the entity, where that person has been convicted of a specified criminal offense, or against whom a civil monetary penalty has been assessed, or who has been excluded from participation under Medicare or a state health care program.

Explanation of provision. The provision would specify that if a person transfers an ownership or control interest in an entity to an immediate family member or to a member of the household of the person in anticipation of, or following, a conviction, assessment or exclusion against the person, that the entity may be excluded from participation in Federal health care programs (see Section X309 of this bill) on the basis of that transfer. The terms "immediate family member" and "member of the household" are defined in this section.

Reason for change. According to the HHS Office of Inspector General, some excluded health care providers have been able to escape the impact of their sanction by transferring ownership and control interests in health care entities to family or household members. These individuals are then able to retain silent control of health care businesses that participate in Medicare and State health care programs despite exclusion from these programs. This provision will enable the OIG to prevent this scam.

Effective date. The provision would effective 45 days after enactment.

Section 10306. Imposition of civil money penalties

Current law. Section 1128A of the Social Security Act sets forth a list of fraudulent activities relating to claims submitted for payments for items of services under a Federal health care program. Civil money penalties of up to \$10,000 for each item or service may be assessed. In addition, the Secretary of HHS (or head of the department or agency for the Federal health care program involved) may also exclude the person involved in the fraudulent activity from participation in a Federal health care program, defined as any program providing health benefits, whether directly or otherwise, which is funded directly, in whole or in part, by the United States Government (other than the Federal Employees Health Benefits Program).

Explanation of provision. The provision would add a new civil money penalty for cases in which a person contracts with an excluded provider for the provision of health care items or services, where the person knows or should know that the provider has been excluded from participation in a Federal health care program. A civil money penalty is also added for cases in which a person provides a service ordered or prescribed by an excluded provider, where that person knows or should know that the provider has been excluded from participation in a Federal health care program.

Reason for change. This provision is intended to ensure that Medicare contractors are vigilant in checking the eligibility of health care providers for reimbursement. Currently, when erroneous payments are made to excluded individuals, the Medicare and Medicaid programs incur the damages.

Effective date. The provision would apply to arrangements and contracts entered into after the date of enactment of the Act.

Section 10307. Disclosure of information and surety bonds

Current law. Section 1834(a) of the Social Security Act establishes requirements for payments under Medicare for covered items defined as durable medical equipment. Home health agencies are required, under Section 1861(o) of the Social Security Act, to meet specified conditions in order to provide health care services under Medicare, including requirements, set by the Secretary, relating to bonding or establishing of escrow accounts, as the Secretary finds necessary for the effective and efficient operation of the Medicare program.

Explanation of provision. The provision would require that suppliers of durable medical equipment provide the Secretary with full and complete information as to persons with an ownership or con-

trol interest in the supplier, or in any subcontractor in which the supplier has a direct or indirect 5 percent or more ownership interest, other information concerning such ownership or control, and a surety bond for at least \$50,000. Home health agencies, comprehensive outpatient rehabilitation facilities, and rehabilitation agencies would also be required to provide a surety bond for at least \$50,000. The Secretary may impose the surety bond requirement which applies to durable medical equipment suppliers to suppliers of ambulance services and certain clinics that furnish medical and other health services (other than physicians' services).

The amendments with respect to suppliers of durable medical equipment would apply to equipment furnished on or after January 1, 1998. The amendments with respect to home health agencies would apply to services furnished on or after such date, and the Secretary of HHS is directed to modify participation agreements with home health agencies to provide for implementation of these amendments on a timely basis. The amendments with respect to ambulance services, certain clinics, comprehensive outpatient rehabilitation facilities and rehabilitation agencies would take effect on the date of enactment of this Act.

Reason for change. This provision is intended to protect Medicare and the integrity of the Medicare program from "fly-by-night operators" who can quickly and inexpensively set up sham businesses in order to fraudulently collect Medicare reimbursement. It is modeled after a successful program instituted by the State of Florida.

Effective date. The provision would apply with respect to items and services furnished on or after January 1, 1998.

Section 10308. Provision of Certain Identification Numbers

Current law. Section 1124 of the Social Security Act requires that entities participating in Medicare, Medicaid and the Maternal and Child Health Block Grant programs (including providers, clinical laboratories, renal disease facilities, health maintenance organizations, carriers and fiscal intermediaries), provide certain information regarding the identity of each person with an ownership or control interest in the entity, or in any subcontractor in which the entity has a direct or indirect 5 percent or more ownership interest. Section 1124A of the Social Security Act requires that providers under Part B of Medicare also provide information regarding persons with ownership or control interest in a provider, or in any subcontractor in which the provider has a direct or indirect 5 percent or more ownership interest.

Explanation of provision. The provision would require that all Medicare providers supply the Secretary with both the employer identification number and social security account number of each disclosing entity, each person with an ownership or control interest, and any subcontractor in which the entity has a direct or indirect 5 percent or more ownership interest. The Secretary of HHS is directed to transmit to the Commissioner of Social Security information concerning each Social Security number and to the Secretary of the Treasury information concerning each employer identification number supplied to the Secretary for verification of such information. The Secretary would reimburse the Commissioner and the Secretary of the Treasury for costs incurred in performing the

verification services required by this provision. The Secretary of HHS would report to Congress on the steps taken to assure confidentiality of Social Security numbers to be provided to the Secretary of HHS under this section. This section's reporting requirements would then become effective 90 days after submission of the Secretary's report to Congress on confidentiality of Social Security numbers.

Reason for change. This provision is intended to provide the Secretary of HHS with additional information necessary to determine whether giving a provider number to a provider, physician, or supplier is in the best interest of beneficiaries. It also is intended to serve as a deterrent to individuals with past records of fraud and abuse who seek to provide services through the Medicare program. Because the Committee believes it is extremely important to protect the privacy and confidentiality of physicians, the provision does not take effect until the Administration provides a report to the relevant committees of Congress to provide assurance that there are adequate measures in place to protect the privacy of physicians.

Effective date. The reporting requirements of this provision are applicable to conditions of participation, entering and renewal of contracts, and payments for items and services furnished more than 90 days after the submission of the report described above.

Section 10309. Advisory opinions regarding certain physician self-referral provisions

Current law. Section 1877 of the Social Security Act establishes a ban on certain financial arrangements between a referring physician and an entity. Specifically, if a physician (or immediate family member) has an ownership or investment interest in or a compensation arrangement with an entity, the physician is prohibited from making referrals to certain entities for services for which Medicare would otherwise pay.

Explanation of provision. The provision would require the Secretary of HHS to issue written advisory opinions concerning whether a physician referral relating to designated health services (other than clinical laboratory services) is prohibited under Section 1877 of the Social Security Act. Such opinions would be binding as to the Secretary and the party requesting the opinion. To the extent practicable, the Secretary is to apply the regulations issued under the advisory opinion provisions of Section 1128D of the Social Security Act to the issuance of advisory opinions under this provision.

Reasons for change. The so-called Stark II amendments of 1993 include a series of prohibitions designed to regulate the structure and operation of physician practices in ways that could interfere with the integration of physician practices and improved patient access. Despite the fact that the law was passed four years ago, regulations have not yet been issued because of the law's complexity. This provision is intended to provide some guidance to physicians seeking to comply with Stark II by extending the application of the binding advisory opinion structure authorized under HIPAA.

Effective date. The provision is effective upon enactment.

Section 10310. Other fraud and abuse related provisions

Current law. Section 1128D provides for safe harbors, advisory opinions, and fraud alerts as guidance regarding application of health care fraud and abuse sanctions. Section 1128E of the Social Security Act directs the Secretary of HHS to establish a national health care fraud and abuse data collection program for the reporting of final adverse actions against health care providers, suppliers, or practitioners.

Explanation of provision. The provision would make certain technical changes in provisions added by HIPAA. The provision would also provide that mandatory and permissive exclusions under Section 1128 apply to any Federal health care program, defined as any program providing health benefits, whether directly or otherwise, which is funded directly, in whole or in part, by the United States Government (other than the Federal Employees Health Benefits Program). A new provision is added to the health care fraud and abuse data collection program to provide a civil money penalty of up to \$25,000 to be imposed against a health plan that fails to report information on an adverse action required to be reported under this program. The Secretary would also publicize those government agencies which fail to report information on adverse actions as required.

The change in the federal programs under which a person may be excluded under Section 1128 of the Social Security Act would be effective on the date of enactment of this Act. The sanction provision for failure to report adverse action information as required under Section 1128E of the Social Security Act would apply to failures occurring on or after the date of the enactment of this Act.

Reasons for change. Because it is often difficult to track providers and physicians who move from one State to another, it is possible under current law for individuals and entities to avoid civil monetary penalties and continue providing services through Medicaid even after they have been excluded from the Medicare program. This provision would address that situation by extending the exclusion authority of the HHS Office of Inspector General to any federal health care program, other than the Federal Employee Health Benefit Program.

The provision instituting monetary penalties for failure by private entities to report adverse actions to the health care fraud and abuse data collection program and publicizing failures by public entities to report such adverse actions is intended to improve coordination of fraud and abuse control efforts through the Medicare Integrity Program established by HIPAA.

Effective date. The amendments made by this section generally would be effective as if included in the enactment of HIPAA.

SUBTITLE E—PROSPECTIVE PAYMENT SYSTEMS

Chapter 1—Payment Under Part A

Section 10401. Prospective payment for skilled nursing facility [SNF] services

Current law. Currently Medicare reimburses the great bulk of SNF care on a retrospective cost-based basis. This means that

SNFs are paid after services are delivered for the reasonable costs (as defined by the program) they have incurred for the care they provide. For Medicare reimbursement purposes, the costs SNFs incur for providing services to beneficiaries can be divided into three major categories: (1) routine services costs that include nursing, room and board, administration, and other overhead; (2) ancillary services, such as physical and occupational therapy and speech language pathology, laboratory services, drugs, supplies and other equipment; and (3) capital-related costs.

Routine costs are subject to national average per diem limits. Separate per diem routine cost limits are established for freestanding and hospital-based SNFs by urban or rural area. Freestanding SNF routine limits are set at 112% of the average per diem labor-related and nonlabor-related costs. Hospital-based SNF limits are set at the limit for freestanding SNFs, plus 50% of the difference between the freestanding limits and 112% of the average per diem routine services costs of hospital-based SNFs. Routine cost limits for SNF care are required to be updated every 2 years. In the interim the Secretary applies a SNF market basket developed by The Health Care Financing Administration to reflect changes in the price of goods and services purchased by SNFs. OBRA93 eliminated updates in SNF routine cost limits for cost reporting periods beginning in FY1994 and FY1995.

Ancillary service and capital costs are both paid on the basis of reasonable costs and neither are subject to limits.

Congress on a number of occasions has required the Secretary to develop alternative methods for paying for SNF care on a prospective basis. In response, The Health Care Financing Administration has conducted research to develop a prospective payment system that uses a patient classification system, known as resource utilization groups, that will account for variations in resource use among Medicare SNF patients.

SNFs providing less than 1,500 days of care per year to Medicare patients in the preceding year have the option of being paid a prospective payment rate set at 105 percent of the regional mean for all SNFs in the region. The rate covers routine and capital-related costs (but not ancillary services) and is calculated separately for urban and rural areas, adjusted to reflect differences in wage levels. Prospective rates can not exceed the routine service costs limits that would be applicable to the facility, adjusted to take into account average capital-related costs with respect to the type and location of the facility.

Explanation of provision. The provision would phase in a prospective payment system for SNF care that would pay a Federal per diem rate for covered SNF services. Covered services would include Part A SNF benefits as well as all services for which payment may be made under Part B during the period when the beneficiary is provided covered SNF care (excluding, however, physician services, certain nurse practitioner and physician assistant services, certified nurse-midwife services, qualified psychologist services, services of a certified registered nurse anesthetist, certain dialysis services and drugs and in 1998, the transportation costs of electrocardiogram equipment). The per diem payment would cover

routine service costs, ancillary and capital-related costs, but would not include costs associated with approved educational activities.

During a transition period lasting through the three cost reporting periods beginning on or after July 1, 1998, a portion of the per diem payment to a SNF would be based on a facility-specific rate, and the remaining portion on the Federal rate. For the first cost reporting period, the facility specific percentage would be 75 percent and Federal per diem percentage would be 25. For the second cost reporting period, the facility-specific percentage would be 50 percent and the Federal 50. For the last period, the facility-specific percentage would be 25 percent and the Federal 75.

In determining for a cost reporting period the facility-specific per diem rate for each SNF, the Secretary would calculate, on a per diem basis, the total allowable costs (costs up to the payment limits and exceptions payments) for covered Part A SNF benefits and estimates of amounts that would be payable under Part B for services described above, regardless of whether or not payment had been made for the Part B services to the facility or another entity. The Part A calculations would be done using cost reports for cost reporting periods beginning in fiscal year 1995, with appropriate adjustments made to non-settled fiscal year 1995 cost reports. This total would be updated to the relevant cost reporting period by the SNF historical trend factor. The SNF historical trend factor for a fiscal year or other annual period would be defined as the percentage change, from the midpoint of a prior fiscal year to the midpoint of the year involved, in the SNF routine cost index used for per diem routine cost limits, reduced (on an annualized basis) by 1 percentage point. Beginning with the first cost reporting period of the transition, the facility-specific per diem rate would be updated by the SNF market basket.

For the Federal per diem rate, the Secretary would first estimate, on a per diem basis for each freestanding SNF that received Medicare payments during a cost reporting period beginning in fiscal year 1995 and that was subject to (and not exempted from) routine cost limits of current law, the total allowable costs (costs up to the payment limits and exceptions payments) for covered Part A SNF benefits and an estimate of amounts that would be payable under Part B, regardless of whether or not payment had been made for the Part B services to the facility or another entity. The Part A calculations would be done using cost reports for cost reporting periods beginning in fiscal year 1995, with appropriate adjustments to non-settled fiscal year 1995 cost reports. This total would be updated to the relevant cost reporting period by the SNF historical trend factor (again reflecting a 1 percentage point reduction in the routine cost index). The Secretary would standardize the updated amount for each facility by adjusting for variations among facilities in average wage levels and case mix. The Secretary would then compute a weighted average per diem rate. This would equal the average of the standardized amounts, weighted for each facility by the number of covered days of care provided during the cost reporting period. The Secretary could compute and apply an average separately for facilities located in urban and rural areas.

Beginning with fiscal year 1998, the Secretary would be required to compute for each SNF an unadjusted Federal per diem rate equal to the weighted average per diem rate, updated by the SNF market basket. The actual per diem rate paid to a SNF would include adjustments for case mix based on a resident classification system established by the Secretary to account for relative resource utilization of different patient types. The labor-related portion of the rate would also include budget neutral adjustments to reflect the relative level of wages and wage-related costs for the geographic area in which the facility is located. To deal with case-mix "creep" when changes in the coding or classification of residents result in higher aggregate payments that do not reflect real changes in case mix, the Secretary would be authorized to adjust per diem rates to discount the effect of coding changes.

The Secretary would be required to publish in the Federal Register before July 1 preceding each fiscal year (beginning with fiscal year 1999): (1) the unadjusted Federal per diem rates for covered SNF care during the fiscal year; (2) the case mix classification system to be applied to the rates; and (3) the factors to be applied in making area wage adjustments. SNFs would be required to provide the Secretary resident assessment data necessary to develop and implement per diem rates in the manner and within the timeframes prescribed by the Secretary.

Low volume SNFs and rural hospitals using inpatient beds to provide SNF care (swing-bed hospitals) would be included in the new prospective per diem payment system in a manner and time-frame established by the Secretary (but not earlier than July 1, 1999). If the Secretary includes the low volume providers immediately, she should include their costs in establishing the Federal per diem rates.

For beneficiaries residing in SNFs but no longer eligible for Part A SNF care, payments for Part B covered services would have to be made to the facility without regard as to whether or not the item or service was furnished by the facility, by others under arrangement, or under any other contracting or consulting arrangement. Payments for Part B services would be based on existing or other fee schedules established by the Secretary. Claims for Part B items and services would be required to include a code identifying the items or services delivered.

The Secretary would be required to establish and implement a thorough medical review process to examine the effects of the new prospective payment system on the quality of covered SNF care. In this medical review process, the Secretary would be required to place a particular emphasis on the quality of ancillary services and physician services.

Reason for change. Between 1990 and 1996, there were 5,045 new Medicare-certified skilled nursing facilities. During this same period, Medicare's average payment per day rose from \$100 to \$286. Much of this growth has been fueled by Medicare's cost-based reimbursement system which helps finance start-up costs and encourages providers to deliver more and more services to each beneficiary. The Committee believes that moving from cost-based reimbursement to prospective payment, which rewards efficiency, will make Medicare a more prudent purchaser of these services. The

Committee is also aware that under a prospective payment system that includes all services there may be incentives to decrease the use of ancillary services. To ensure that beneficiaries are receiving the appropriate amount of these services, the Secretary shall require consistent coding of the ancillary services delivered to all SNF patients. This will then allow for an evaluation of the effect of the new system on the provision of such services.

An analysis by the Congressional Budget Office found that Medicare Part B payments to SNFs for rehabilitation services more than tripled between 1990 and 1995. The Committee feels that it is important for the Secretary to monitor these Part B services, especially those delivered to Medicare SNF patients who have exhausted their Part A benefit but remain in a SNF.

Effective date. The provision would be effective for cost-reporting periods beginning on or after July 1, 1998.

Section 10402. Prospective Payment For Inpatient Rehabilitation Hospital Services Based on Discharges Classified By Patient Case Mix Groups

Current law. Under Medicare, five types of specialty hospitals (psychiatric, rehabilitation, long-term care, children's and cancer) and two types of distinct-part units in general hospitals (psychiatric and rehabilitation) are exempt from PPS. They are subject to the payment limitations and incentives established in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). Each provider is paid on the basis of reasonable cost subject to a rate of increase ceiling on inpatient operating costs. The ceiling is based on a target amount per discharge. The target amount for a cost reporting period is equal to the hospital's allowable inpatient operating costs (excluding capital and medical education costs) per discharge in a base year increased by applicable update factors for subsequent years. This amount is then multiplied by Medicare discharges, to yield the ceiling or upper limit on operating costs.

Explanation of provision. The provision would require the Secretary to establish a prospective payment system for inpatient rehabilitation hospital services based on patient case mix groups.

For this system, the Secretary would be required to establish (1) classes of discharges of rehabilitation facilities by patient case mix groups based on impairment, age, related prior hospitalization, comorbidities, and functional capability of the discharged individual and other appropriate factors; and (2) a method of classifying specific discharges from rehabilitation facilities within these groups.

The provision would require the Secretary to assign each case mix group an appropriate weighting which would reflect the relative facility resources used with respect to discharges classified within a group compared to discharges classified within other groups. The Secretary would be required to adjust the classifications and weighting factors to correct for forecast errors and to reflect changes in treatment patterns, technology, case mix, number of discharges paid for under Medicare, and other factors which might affect the relative use of resources. The Secretary would be authorized to require rehabilitation facilities providing inpatient hospital services to submit data on discharges classified according

to case mix group or other rehabilitation impairment groups, measurement of functional disability, and other patient assessment factors as deemed necessary to establish and administer the prospective payment system.

The Secretary would be required to determine a prospective payment rate for each payment unit for which a rehabilitation facility is entitled to be paid under Medicare. The payment rate would be based on the average payment per discharge under Medicare for operating and capital costs of rehabilitation facilities using the latest available data, adjusted by (1) updating such per-unit amounts to the fiscal year involved by the applicable percentage increases provided by the bill for each fiscal year and up to FY2000, and an increase factor specified by the Secretary for subsequent fiscal years; (2) reducing such rates by a factor equal to the proportion of payments by Medicare for outliers; (3) variations among rehabilitation facilities by areas; (4) weighting factors described in the bill; and (5) other factors the Secretary determines are necessary to reflect variations in necessary costs of treatment among rehabilitation facilities.

Prospective payment rates would be phased in between October 1, 2000 and before October 1, 2003, by blending the prospective rate with the TEFRA percentage of the hospital's target amount that would have been paid under Part A if this provision did not apply, and the prospective payment percentage of the per unit payment rate established by the Secretary. For cost reporting periods beginning on or after October 1, 2000 and before October 1, 2001, the TEFRA percentage would be 75% and the prospective payment percentage would be 25%; for cost reporting periods on or after October 1, 2001, and before October 1, 2002, the TEFRA percentage would be 50% and the prospective payment percentage would be 50%; for cost reporting periods on or after October 1, 2002, and before October 1, 2003, the TEFRA percentage would be 25% and the prospective payment percentage would be 75%. Payment rates on or after October 1, 2003, would be equal to the per unit fully prospective payment rate. Payment per unit would mean a discharge, day of inpatient hospital services, or other unit of payment specified by the Secretary.

For fiscal years 2001 through 2004, the Secretary would be required to establish prospective payment amounts that were budget neutral, so that total payments for rehabilitation hospitals would equal 99% of the amount of payments that would have been made if prospective payments had not been made. The Secretary would be required to develop an increase factor which could be based on an appropriate percentage increase in a market basket of goods and services purchased by rehabilitation hospitals. The Secretary would also be required to provide for additional payments for outlier cases that involved unusually long length of stay or were very costly, or other factors. These adjustments would be made in a budget neutral manner. The Secretary would also be required to adjust prospective payments to rehabilitation facilities by a wage index that reflected area differences for wages and wage-related costs. No later than October 1, 2001, the Secretary would be required to update the area wage adjustment factor based on a sur-

vey of wages and wage related costs of providing rehabilitation services.

Reason for change. Between 1990 and 1994, Medicare payments to rehabilitation hospitals and units more than doubled from \$1.9 billion to \$3.9 billion. At the Health Subcommittee hearing on April 10, 1997 on Medicare payments to Rehabilitation facilities, several experts testified regarding problems with the current payment method and the feasibility of implementing a prospective payment system in the near future. The Committee believes that a prospective payment system would increase efficiency and should be implemented as soon as possible.

Effective date. These provisions are effective upon enactment. The prospective payment system will be implemented for cost reporting periods beginning on or after October 1, 2000.

Chapter 2.—Payment Under Part B

SUBCHAPTER A—PAYMENT FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES

Section 10411. Elimination of formula-driven overpayments [FDO] for certain outpatient hospital services.

Current law. Medicare payments for hospital outpatient ambulatory surgery, radiology, and other diagnostic services equals the lesser of: (1) the lower of a hospital's reasonable costs or its customary charges, net of deductible and coinsurance amounts, or (2) a blended amount comprised of a cost portion and a fee schedule portion, net of beneficiary cost-sharing. The cost portion of the blend is based on the lower of the hospital's costs or charges, net of beneficiary cost sharing, and the fee schedule portion is based, in part, on ambulatory surgery center payment rates or the rates for radiology and diagnostic services in other settings, net of beneficiary coinsurance (for those settings). The hospital cost portion and the fee schedule portion for surgical and radiology services are 42% and 58%, respectively. For diagnostic services the hospital cost portion is 50 percent and the fee schedule portion is 50 percent.

A hospital may bill a beneficiary for the coinsurance amount owed for the outpatient service provided. The beneficiary coinsurance is based on 20 percent of the hospital's submitted charges for the outpatient service, whereas Medicare usually pays based on the blend of the hospital's costs and the amount paid in other settings for the same service. This results in an anomaly whereby the amount a beneficiary pays in coinsurance does not equal 20 percent of the program's payment and does not result in a dollar-for-dollar decrease in Medicare program payments.

Explanation of provision. The provision would require that beneficiary coinsurance amounts be deducted later in the reimbursement calculation for hospital outpatient services, so that Medicare payments for covered services would be lower. Medicare's payment for hospital outpatient services would equal the blended amount less any amount the hospital may charge the beneficiary as coinsurance for services furnished during portions of cost reporting periods occurring on or after October 1, 1997.

Reason for change. Because of an anomaly in the formula for determining Medicare payments for services provided in hospital out-

patient departments, the program does not recognize the reduction in payment associated with the actual amount of a beneficiary's coinsurance payment.

Effective date. This provision shall apply to services furnished during portions of cost reporting periods occurring on or after October 1, 1997.

Section 10412. Extension of reductions in payments for costs of hospital outpatient services

Current law

a. Reduction in payments for capital-related costs. Hospitals receive payments for Medicare's share of capital costs associated with outpatient departments. OBRA 93 extended a 10 percent reduction in payments for the capital costs of outpatient departments through FY1998.

b. Reduction in payments for non-capital-related costs. Certain hospital outpatient services are paid on the basis of reasonable costs. OBRA 93 extended a 5.8 percent reduction for those services paid on a cost-related basis through FY1998.

Explanation of provision

a. Reduction in payments for capital-related costs. The provision would extend the 10 percent reduction in payments for outpatient capital through FY1999 and during FY2000 before January 1, 2000.

b. Reduction in payments for non-capital-related costs. The 5.8 percent reduction for outpatient services paid on a cost basis would be extended through FY1999 and during FY2000 before January 1, 2000.

Reason for change. These provisions would otherwise expire.

Effective date. These provisions are effective for cost reporting periods beginning on or after October 1, 1997.

Section 10413. Prospective payment system for hospital outpatient department services

Current law. Medicare payments for hospital outpatient ambulatory surgery, radiology, and other diagnostic services equals the lesser of: (1) the lower of a hospital's reasonable costs or its customary charges, net of deductible and coinsurance amounts, or (2) a blended amount comprised of a cost portion and a fee schedule portion, net of beneficiary cost-sharing. The cost portion of the blend is based on the lower of the hospital's costs or charges, net of beneficiary cost sharing, and the fee schedule portion is based on ambulatory surgery center payment rates or the rates for radiology and diagnostic services in other settings, net of beneficiary coinsurance (for these other settings). For cost reporting periods beginning on or after January 1, 1991, the hospital cost portion and the fee schedule portion for surgical and radiology services are 42 percent and 58 percent, respectively. For diagnostic services the hospital cost portion is 50 percent and the fee schedule portion is 50 percent.

Explanation of provision. The provision would require the Secretary to establish a prospective payment system for covered OPD

services furnished beginning in 1999. The Secretary would be required to develop a classification system for covered OPD services, such that services classified within each group would be comparable clinically and with respect to the use of resources. The Secretary would be required to establish relative payment rates for covered OPD services using 1996 hospital claims and cost report data, and determine projections of the frequency of utilization of each such service or group of services in 1999. The Secretary would be required to determine a wage adjustment factor to adjust the portions of payment attributable to labor-related costs for relative geographic differences in labor and labor-related costs that would be applied in a budget neutral manner. The Secretary would be required to establish other adjustments as necessary, including adjustments to account for variations in coinsurance payments for procedures with similar resource costs, to ensure equitable payments under the system. The Secretary would also be required to develop a method for controlling unnecessary increases in the volume of covered OPD services.

Hospitals OPD coinsurance payments would be limited to 20% of the national median of the charges for the service (or services within the group) furnished in 1996 updated to 1999 using the Secretary's estimate of charge growth during this period. The Secretary would be required to establish rules for the establishment of a coinsurance payment amount for a covered OPD service not furnished during 1996, based on its classification within a group of such services.

For 1999, the Secretary would be required to establish a conversion factor for determining the Medicare OPD fee payment amounts for each covered OPD service (or group of services) furnished in 1999 so that the sum of the products of the Medicare OPD fee payment amounts and the frequencies for each service or group would be required to equal the total amounts estimated by the Secretary that would be paid for OPD services in 1999. In subsequent years, the Secretary would be required to establish a conversion factor for covered OPD services furnished in an amount equal to the conversion factor established for 1999 and applicable to services furnished in the previous year increased by the OPD payment increase factor. The increase factor would be equal to the hospital market basket (MB) percentage increase plus 3.5 percentage points. When the amount of the beneficiary coinsurance for an individual procedure is equal to 20 percent of the total payment, both the coinsurance and the Medicare program payment would be increased by the market basket.

The Secretary would be required to establish a procedure under which a hospital, before the beginning of a year (starting with 1999), could elect to reduce the coinsurance payment for some or all covered OPD services to an amount that is not less than 20% of the total (Medicare program plus beneficiary coinsurance payment) amount for the service involved, adjusted for relative differences in labor costs and other factors. A reduced coinsurance payment could not be further reduced or increased during the year involved, and hospitals could disseminate information on the reduction of coinsurance amounts.

The Secretary would be authorized periodically to review and revise the groups, relative payment weights, and the wage and other adjustments to take into account changes in medical practice, medical technology, the addition of new services new cost data, and other relevant information. Any adjustments made by the Secretary would be made in a budget neutral manner. If the Secretary determined that the volume of services paid for under this subsection increased beyond amounts established through those methodologies, the Secretary would be authorized to adjust the update to the conversion factor otherwise applicable in a subsequent year.

The provision would provide that the coinsurance payment for covered OPD services would be determined by the provisions of this bill instead of the standard 20% coinsurance for other Part B services. The provision would also provide for conforming amendments regarding approved ambulatory surgical center procedures performed in hospital OPDs, for radiology and other diagnostic procedures, and for other hospital outpatient services.

Reason for change. Medicare reimburses hospitals for outpatient department services under a variety of complex methods that are based on cost, charges, or blended payments. The Committee believes that a prospective payment system will be simple to administer and will offer incentives to providers to operate more efficiently.

The Committee has given the Secretary discretion in determining the adjustment factors that will be applied to the OPD prospective rates. In examining the necessary adjustment factors, the Committee would like the Secretary to examine whether an adjustment is warranted for those Eye and Ear specialty hospitals that received payments under a different blend formula for cost reporting periods beginning on or after October 1, 1988 and before January 1, 1995.

The Committee is also concerned about the level of beneficiary coinsurance payments for hospital outpatient department services. Since Medicare beneficiaries pay 20 percent of charges for services received in a hospital outpatient department, their coinsurance payments are often much higher than those in other settings. A ProPAC analysis found that the median coinsurance for many hospital outpatient department services in 1995 was two to three times higher than the rates in other ambulatory settings. By freezing coinsurance payments at the 1999 level, while Medicare payments increase over time, beneficiary liability will decline relative to Medicare payments over time. Further, the provision enables hospitals to further reduce beneficiary liability by allowing hospitals the flexibility to charge lower coinsurance payments.

Effective date. The provision is effective for services delivered on or after January 1, 1999.

SUBCHAPTER B—REHABILITATION SERVICES

Section 10421. Rehabilitation agencies and services

Current law. Medicare provides for special payment rules for certain types of providers of services covered under Part B and paid out of the SMI Trust Fund.

Explanation of provision. For outpatient physical therapy and occupational therapy services, Medicare program payments for serv-

ices provided in 1998 would be, the least of the actual charges for the services or the adjusted reasonable costs for the services minus beneficiary coinsurance payments. Adjusted reasonable costs are defined as operating costs reduced by 5.8% and capital costs reduced by 10%. After 1998, payment for these services would be 80% of the lesser of the actual charge for the services, or 80% of the applicable physician fee schedule amount. The provision would also exclude from Medicare coverage outpatient occupational therapy and physical therapy services furnished as an incident to a physician's professional services that did not meet the standards provided for outpatient physical therapy services furnished by a provider in a clinic, rehabilitation agency, public health agency, or by others under an arrangement with and under the supervision of such providers.

The provision would also apply the per beneficiary cap of \$900 per year for outpatient therapy services beginning in 1999. The cap would be increased each year by the estimated increase in gross domestic product (GDP).

Reason for change. Between 1990 and 1995, Medicare payments to rehabilitation agencies increased more than threefold. During this same period, Part B therapy services delivered by skilled nursing facilities grew from \$151 million to \$827 million. These services are paid based on "allowable costs" and are not subjected to the \$900 cap that is applied to independent therapists who deliver similar services. The Committee believes that a prospective payment system based on an existing fee schedule with a similar cap would be easy to administer, would reward efficient providers, and would apply consistent limits to providers delivering similar services.

Effective date. These provisions are effective for services on or after January 1, 1998.

Section 10422. Comprehensive outpatient rehabilitation facilities [CORFs]

Current law. Medicare provides for special payment rules for certain types of providers of services covered under Part B and paid out of the SMI Trust Fund.

Explanation of provision. CORF payments for services provided in 1998 would be, the least of the actual charges for the services or the adjusted reasonable costs for the services minus beneficiary coinsurance payments. Adjusted reasonable costs are defined as operating costs reduced by 5.8% and capital costs reduced by 10%. After 1998, payment for these services would be 80% of the lesser of the actual charge for the services, or 80% of the applicable physician fee schedule amount. The provision would also exclude from Medicare coverage outpatient occupational therapy and physical therapy services furnished as an incident to a physician's professional services that did not meet the standards provided for outpatient physical therapy services furnished by a provider in a clinic, rehabilitation agency, public health agency, or by others under an arrangement with and under the supervision of such providers.

The provision would also apply the per beneficiary cap of \$900 per year for outpatient therapy services beginning in 1999. The cap

would be increased each year by the estimated increase in gross domestic product (GDP).

Reason for change. Medicare CORF payments increased at an average annual rate of 32 percent between 1990 and 1995. These services are paid on a cost basis and are not subject to a \$900 cap that is applied in other settings. The Committee believes that a prospective payment system will provide proper incentives for cost-effective delivery of services.

Effective date. This provision is effective for services delivered on or after January 1, 1998.

SUBCHAPTER C—AMBULANCE SERVICES

Section 10431. Payments for ambulance services

Current law. Payment for ambulance services provided by freestanding suppliers is based on reasonable charge screens developed by individual carriers based on local billings. Hospital or other provider-based ambulance services are paid on a reasonable cost basis; payment cannot exceed what would be paid to freestanding suppliers.

Explanation of provision. The provision would specify payment rules for ambulance services for fiscal year 1998 through fiscal year 2002. For ambulance services paid on a reasonable cost basis, the annual increase in the costs recognized as reasonable would be limited to the percentage increase in the consumer price index, reduced for fiscal years 1998 and 1999 by 1 percent. Similarly, for ambulance services furnished on a reasonable charge basis, the annual increase in the charges recognized as reasonable would be limited to the percentage increase in the consumer price index, reduced for fiscal years 1998 and 1999 by 1 percent.

The provision would require the Secretary to establish a fee schedule for ambulance services through a negotiated rule-making process. In establishing the fee schedule, the Secretary would be required to: (1) establish mechanisms to control Medicare expenditure increases; (2) establish definitions for services; (3) consider appropriate regional and operational differences; (4) consider adjustments to payment rates to account for inflation and other relevant factors; and (5) phase-in the application of the payment rates in an efficient and fair manner. The Secretary would be required to assure that payments in fiscal year 2000 under the fee schedule did not exceed the aggregate amount of payments which would have been made in the absence of the fee schedule. The annual increase in the payment amounts in each subsequent year would be limited to the increase in the consumer price index. Medicare payments would equal 80% of the lesser of the fee schedule amount or the actual charge.

In addition, the provision would authorize payment for advanced life support (ALS) services provided by paramedic intercept service providers in rural areas. The ALS services would be provided in conjunction with one or more volunteer ambulance services. The volunteer ambulance service involved must be certified as qualified to provide the service, have a contractual agreement with the ALS intercept service, provide only basic life support services at the time of the intercept, and be prohibited by state law from billing

for services. The ALS service provider must be certified to provide the services and bill all recipients (not just Medicare beneficiaries) for ALS intercept services.

Reason for change. Implementation of an ambulance fee schedule will provide greater ease of administration, predictable rate increases, and opportunities for efficient providers. In addition, the provision provides the Health Care Financing Administration with the authority necessary to reimburse non-transporting ALS services that are critical to providing emergency care in rural areas.

Effective date. The provision is effective upon enactment.

Section 10432. Demonstration of coverage of ambulance services under Medicare through contracts with units of local government

Current law. No provision.

Explanation of provision. The provision would require the Secretary to establish up to 3 demonstration projects under which, at the request of a county or parish, the Secretary enters into agreement with such entity to furnish or arrange for the furnishing of ambulance services. The county or parish could not enter into a contract unless the contract covered at least 80% of the residents enrolled in Part B. Individuals or entities furnishing services would have to meet the requirements otherwise applicable. The Secretary would make monthly per capita payments to the county or parish. In the first year, the capitated payment would equal 95% of the average annual per capita payment made in the most recent 3 years for which data is available. In subsequent years, it would equal 95% of the amount established for the preceding year increased by the CPI.

The contract could provide for the inclusion of persons residing in additional counties or parishes, permit transportation to non-hospital providers, and implement other innovations proposed by the county or parish.

The Secretary would be required to evaluate the demonstration projects and report by January 1, 2000, on the study including recommendations regarding modifications to the payment methodology and whether to extend or expand such projects.

Reason for Change. This demonstration authorized by this provision will help provide important data as to whether permitting transportation to non-hospital providers will yield innovations and cost-efficiencies for the Medicare program.

Effective Date. The provision is effective upon enactment.

Chapter 3—Payment Under Parts A and B

Section 10441. Prospective payment for home health services

Current law. Medicare reimburses home health agencies on a retrospective cost-based basis. This means that agencies are paid after services are delivered for the reasonable costs (as defined by the program) they have incurred for the care they provide to program beneficiaries, up to certain limits. In provisions contained in the Orphan Drug Act of 1983, OBRA 87 and OBRA 90, Congress required the Secretary to develop alternative methods for paying for home health care on a prospective basis. In 1994, the Office of Re-

search and Demonstration in the Health Care Financing Administration completed a demonstration project that tested prospective payment on a per visit basis. Preliminary analysis indicates that the per visit prospective payment methodology had no effect on cost per visit or volume of visits. The Health Care Financing Administration has begun a second project, referred to as Phase II, to test prospective payment on a per episode basis, and has also undertaken research to develop a home health case-mix adjustor that would translate patients' varying service needs into specific reimbursement rates.

Explanation of provision. The provision would require the Secretary to establish a prospective payment system for home health and implement the system beginning October 1, 1999. All services covered and paid on a reasonable cost basis at the time of enactment of this section, including medical supplies, would be required to be paid on a prospective basis. In implementing the system, the Secretary could provide for a transition of not longer than 4 years during which a portion of the payment would be based on agency-specific costs, but only if aggregate payments were not greater than they would have been if a transition had not occurred.

In establishing the prospective system, the Secretary would be authorized to consider an appropriate unit of service and the number of visits provided within that unit, potential changes in the mix of services provided within that unit and their cost, and a general system design that provides for continued access to quality services.

Under the new system, the Secretary would compute a standard prospective payment amount (or amounts) that would initially be based on the most current audited cost report data available to the Secretary. For fiscal year 2000, payment amounts under the prospective system would be computed in such a way that total payments would equal amounts that would have been paid had the system not been in effect, but would also reflect a 15% reduction in cost limits and per beneficiary limits in effect September 30, 1999. Payment amounts would be standardized in a manner that eliminates the effect of variations in relative case mix and wage levels among different home health agencies in a budget neutral manner. The Secretary could recognize regional differences or differences based on whether or not services are provided in an urbanized area. Beginning with fiscal year 2001, standard prospective payment amounts would be adjusted by the home health market basket.

The payment amount for a unit of home health service would be adjusted by a case mix adjustor factor established by the Secretary to explain a significant amount of the variation in the cost of different units of service. The labor-related portion of the payment amount would be adjusted by an area wage adjustment factor that would reflect the relative level of wages and wage-related costs in a particular geographic area as compared to the national average. The Secretary could provide for additions or adjustments to payment amounts for outliers because of unusual variations in the type or amount of medically necessary care. The total amount of outlier payments could not exceed 5 percent of total payments projected or estimated to be made in a year. The Secretary would be

required to reduce the standard prospective payments by amounts that in the aggregate would equal outlier adjustments. If a beneficiary were to transfer to or receive services from another home health agency within the period covered by a prospective payment amount, then the payment would be prorated between the agencies involved.

Claims for home health services furnished on or after October 1, 1998, would be required to contain an appropriate identifier for the physician prescribing home health services or certifying the need for care. Claims would also be required to include information (coded in an appropriate manner) on the length of time of a service, as measured in 15 minute increments. The categories of services for which time information would have to be included on a claim would be skilled nursing care; therapies—physical and occupational therapy and speech language pathology; medical social services; and home health aide services.

Periodic interim payments for home health services would be eliminated. All home health care agencies would be paid according to the prospective payment system.

In order for home health services to be considered covered care, home health care agencies would be required to submit claims for all services, and all payments would be made to a home health agency without regard to whether or not the item or service was furnished by the agency, by others under arrangement, or under any other contacting or consulting arrangement.

Reason for change. Medicare's payments for home health care services are one of the fastest growing components of the Medicare program. In 1988, Part A home health care spending represented 3.6 percent of total Part A spending. By 1994, the share of Part A spending attributable to home health care services climbed to 11.7 percent. Much of this growth was fueled by relatively generous payments, coverage policies, and little agency oversight.

At a March 4, 1997 Health Subcommittee hearing on Medicare home health care services, experts testified that the current definition of a visit left much room for too much discretion and variation among agencies. The Committee believes that it is important to require consistent coding in timed increments in order to evaluate the types of services delivered to Medicare beneficiaries.

Since the mid-1980s, Congress has required the Secretary to develop an appropriate case-mix adjuster. This proposal would require the Secretary to not only develop but also implement a case-mix adjusted prospective payment system within two years.

Effective date. The proposal would be effective October 1, 1999.

SUBTITLE F—PROVISIONS RELATING TO PART A

Chapter 1.—Payment of PPS Hospitals

Section 10501. PPS hospital payment update

Current law. Hospitals are paid on the basis of a prospectively fixed payment rate for costs associated with each discharge. Each hospital's basic payment rate is based on a national standardized payment amount, which is higher for hospitals in large urban areas than for other hospitals. Each standardized payment amount is ad-

justed by a wage index. Payment also depends on the relative costliness of the case, based on the diagnosis related group (DRG) to which the discharge is assigned. Additional payments are made for the following: extraordinary costly cases (outliers); indirect costs of medical education; and for hospitals serving a disproportionate share of low-income patients. Other exceptions and adjustments are made.

PPS payment rates are annually updated using an “update factor.” The annual update factor applied to increase the Federal base payment amounts is determined, in part, by the projected increase in the hospital market basket index (MBI), which measures the costs of goods and services purchased by hospitals. Under the Omnibus Budget Reconciliation Act of 1993 (OBRA 93), the PPS update factor in FY 1998 for all PPS hospitals is equal to the percentage increase in the market basket.

Explanation of provision. The proposal sets the update factor for FY 1998 at 0% for all hospitals in all areas; for FY 1999–2002, at MBI minus 1.0 percentage points for all hospitals in all areas, and for FY2003 and each subsequent fiscal year equal to the MBI for all hospitals in all areas.

Reason for change. In 1994, PPS hospitals’ Medicare inpatient operating costs per discharge decreased for the first time. While hospital case-mix (patient acuity) has increased over the past several years, reductions in both hospital cost growth—reflecting changes in the amount and timing of services furnished during inpatient stays—and in the average length of stay have contributed significantly to lower hospital costs. In addition, as hospitals are able to increase their productivity by improving management techniques and taking advantage of technologies that reduce costs, the Committee believes that the Medicare program should share in these savings. Finally, ProPAC estimates the PPS margin (which compares Medicare operating and capital payments to costs) is 14.2 percent in FY 1997 and will be more than 16 percent in FY 1998 under current law.

The proposal to freeze the hospital PPS update is not a freeze on hospital payments. Medicare’s payments to hospitals are still expected to increase by at least 1.9 percent because of case-mix increases.

Historically, the Health Care Financing Administration (HCFA) has analyzed only Medicare Provider Analysis and Review (MedPAR) data in its annual recalibration of diagnosis related group (DRG) relative weights and when considering whether to reclassify certain procedures within the DRG system. Because the *International Classification of Disease 9th Revision Clinical Modification* (ICD–9–CM) system used in conjunction with MedPAR may not be fully updated, tracking the administration of inpatient drug therapies; however, certain drug therapies essentially are eliminated from HCFAs recalibration and reclassification process. Thus, in order to insure that Medicare beneficiaries have access to innovative, new drug therapies, HCFA should consider reliable, validated data other than MedPAR data in annually recalibrating and reclassifying the DRGs. Furthermore, any new procedure coding system adopted under S. 262 of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), P.L. 104–91,

should include a means of tracking the administration of drug therapies such that future MedPAR data shall contain information regarding the utilization of specific drugs.

Effective date. The provision would be effective upon enactment.

Section 10502. Capital payments for PPS hospitals

Current law. In FY1992, Medicare began phasing in prospectively-determined per case rates for capital-related costs. During the 10-year transition to a single capital rate, payments will reflect both hospital-specific costs and a single Federal capital payment rate. During the transition, hospitals are paid according to either a fully prospective method or a "hold harmless" method of payment.

Capital payment rates are updated annually. For the first 5 years of the transition to prospectively determined per-case rates, historical cost increases were used to increase the Federal and hospital-specific rates. Under a budget neutrality requirement, per case capital rates were adjusted in the first 5 years of the transition so that total payments equaled 90 percent of estimated Medicare-allowed capital costs. In FY 1996, the budget neutrality requirement was lifted. In addition, the cost-based updates are replaced by an "update framework" (developed by HCFA and proposed in the June 2, 1995 *Federal Register*), which determines payment rate growth. This analytical framework is to take into account changes in the price of capital and appropriate changes in capital requirements resulting from development of new technologies and other factors. With the expiration of the budget neutrality language in 1996, the federal capital rate jumped 22.6 percent.

Explanation of provision. The provision would require the Secretary to rebase the capital payment rates for FY 1998 using the actual rates in effect in FY 1995, by applying the budget neutrality adjustment factor used to determine the federal capital payment rate on September 30, 1995 to the unadjusted standard federal capital payment rate in effect on September 30, 1997, and to the unadjusted hospital-specific rate in effect on September 30, 1997.

The provision would also revise the exceptions process for certain capital projects provided under PPS.

Reason for change. Most areas of the United States continue to have more hospital beds than necessary. Payments for capital costs have been found to be overestimated by as much as 17 percent. These payment rates reflect two errors: a 7.4 percent overstatement of the FY 1992 base payments rates, and the application of updates for FYs 1993 through 1995 that were based on historical trends, instead of an update framework which reflects anticipated hospital costs.

Effective date. The provision would be effective upon enactment.

Section 10503. Freeze in disproportionate share

Current law. Under PPS, an adjustment is made to the payment to hospitals that serve a disproportionate share of low-income patients. The disproportionate share hospital (DSH) adjustment is intended to compensate hospitals that treat large proportions of low-income patients. The factors considered in determining whether a

hospital qualifies for a DSH payment adjustment include the number of beds, the hospital's location, and the disproportionate patient percentage. A hospital's disproportionate patient percentage is the sum of (1) the total number of inpatient days attributable to Federal SSI beneficiaries divided by the total number of Medicare patient days, and (2) the number of Medicaid patient days divided by total patient days, expressed as a percentage. A hospital is classified as a DSH under any of the following circumstances:

- (1) If its disproportionate patient percentage equals or exceeds:
 - (a) 15 percent for an urban hospital with 100 or more beds, or a rural hospital with 500 or more beds (the latter is set by regulation);
 - (b) 30 percent for a rural hospital with more than 100 beds and fewer than 500 beds or is classified as a sole community hospital (SCH);
 - (c) 40 percent for an urban hospital with fewer than 100 beds; or
 - (d) 45 percent for a rural hospital with 100 or fewer beds, or
- (2) if it is located in an urban area, has 100 or more beds, and can demonstrate that, during its cost reporting period, more than 30 percent of its net inpatient care revenues are derived from State and local government payments for care furnished to indigent payments. (This provision is intended to help hospitals in States that fund care for low-income patients through direct grants rather than expanded Medicaid programs.)

For a hospital qualifying on the basis of (1)(a) above, if its disproportionate patient percentage is greater than 20.2 percent, the applicable PPS payment adjustment factor is 5.88 percent plus 82.5 percent of the difference between 20.2 percent and the hospital's disproportionate patient percentage. If the hospital's disproportionate patient percentage is less than 20.2 percent, the applicable payment adjustment factor is equal to: 2.5 percent plus 65 percent of the difference between 15 percent and the hospital's disproportionate patient percentage. If the hospital qualifies as a DSH on the basis of (1)(b), the payment adjustment factor is determined as follows:

- (a) if the hospital is classified as a rural referral center, the payment adjustment factor is 4 percent plus 60 percent of the difference between the hospital's disproportionate patient percentage and 30 percent;
- (b) if the hospital is a SCH, the adjustment factor is 10 percent;
- (c) if the hospital is classified as both a rural referral center and a SCH, the adjustment factor is the greater of 10 percent or 4 percent plus 60 percent of the difference between the hospital's disproportionate patient percentage and 30 percent; and
- (d) if the hospital is not classified as either a SCH or a rural referral center, the payment adjustment factor is 4 percent.

If the hospital qualifies on the basis of (1)(c), the adjustment factor is equal to 5 percent. If the hospital qualifies on the basis of (1)(d), the adjustment factor is 4 percent. If the hospital qualifies on the basis of (2) above, the payment adjustment factor is 35 percent.

Explanation of provision. The provision would freeze DSH payments for discharges for FY 1998 and FY 1999. The Secretary would be required to develop a proposal to modify the current definitions for DSH payments and transmit the proposal developed to the Committees on Ways and Means of the House and Finance of the Senate by April 1, 1999.

Reason for change. DSH payments have increased from \$1.1 billion in 1989 to \$4.3 billion in 1996, in large part because of legislative changes made in 1989 and 1990. The proposal would limit the increase in payments for FYs 1998 and 1999. Further, growth in this area is not necessarily justified and requires further evaluation. To address the deterioration in the current payment methodology due to changes in both welfare and Medicaid, the Secretary would develop a proposal to more accurately distribute Medicare payments to hospitals that serve a disproportionate number of low-income patients.

Effective date. The provision would be effective upon enactment.

Section 10504. Medicare capital asset sales price equal to book value

Current law. Medicare provides for establishing an appropriate allowance for depreciation and for interest on capital indebtedness and a return on equity capital when a hospital has undergone a change of ownership. The valuation of the asset is the lesser of the allowable acquisition costs of the asset to the owner of record, or the acquisition cost of such asset to the new owner.

Explanation of provision. The provision would eliminate the allowance for return on equity capital, and would provide for a depreciation adjustment of the historical cost of the asset recognized by Medicare, less depreciation allowed, to the owner of record as of the date of enactment of this bill, or to the first owner of record of the asset in the case of an asset not in existence as of the date of enactment. The provision would apply to changes of ownership that occur three months after the date of enactment.

Reason for change. The Committee is concerned with providers which may be gaming the system by creating specious "losses" in order to be eligible for additional Medicare payments. According to the Department of Health and Human Services Office of the Inspector General, Medicare lost \$233 million and stands to lose \$289 million in depreciation adjustments for hospitals sold between 1990 and 1996. Moreover, new losses reported to Medicare have more than quadrupled between 1990 and 1996.

Effective date. The provision would be effective upon enactment.

Section 10505. Elimination of indirect medical education [IME] adjustment and DSH payments attributable to outlier payments

Current law. Medicare provides outlier payments to hospitals that are intended to protect them from the risk of large financial losses associated with cases having exceptionally high costs or unusually long hospital stays. Beginning in FY 1998, the length of

stay outlier policy will terminate, and hospitals will receive outlier payments only for very high cost cases. For each DRG, a specific dollar loss threshold is set, and outlier payments are calculated based on the amount by which a hospital's costs exceed this loss threshold. For teaching and disproportionate share hospitals, however, their estimated cost for each case is reduced by the amount of the hospital's IME and DSH payment adjustments. The amount by which the estimated cost exceeds the outlier threshold thus is less for a case treated at a teaching or disproportionate share hospital, resulting in lower outlier payments. The lower outlier payment amount is then increased by the hospital's IME and DSH adjustments, but this generally is not enough to offset the loss in outlier payments resulting from the reduced cost estimate for the case.

Explanation of provision. The provision would result in teaching and disproportionate share hospitals being treated like all other hospitals in the calculation of outlier payment amounts. Their estimated costs per case would not be reduced by their IME and DSH payments, and an additional IME or DSH adjustment would not be added to these payments. The provision would apply to discharges occurring after September 30, 1997.

Reason for change. All hospitals should be treated equally regarding outlier payments. When calculating outlier payments, teaching hospitals and hospitals which treat a disproportionate share of low-income patients should not be penalized. Outlier payments should be based on the loss incurred on the case excluding the hospital's teaching or disproportionate adjustments.

Effective date. The provision would be effective upon enactment.

Section 10506. Reduction in adjustment for indirect medical education

Current law. Medicare recognizes the costs of graduate medical education in teaching hospitals and the higher costs of providing services in those institutions. Medicare recognizes the costs of graduate medical education under two mechanisms: direct graduate medical education (GME) payments and an indirect medical education (IME) adjustment. The IME is designed to compensate hospitals for indirect costs attributable to the involvement of residents in patient care and the severity of illness of patients requiring specialized services available only in teaching hospitals. The additional payment to a hospital is based on a formula that provides an increase of approximately 7.7 percent in the DRG payment, for each 10 percent increase in the hospital teaching intensity (based on its intern and resident-to-bed).

Explanation of provision. The IME adjustment would be reduced from the aggregate 7.7% to 6.6% in FY 1998, and to 5.5% during and after FY 1999. For discharges occurring on or after October 1, 1997, the total number of residents and interns in either a hospital or non-hospital setting could not exceed the number of interns and residents reported on the hospital's cost report for the period ending December 31, 1996. For hospital's first cost reporting period beginning on or after October 1, 1997, the total number of FTE residents and interns for payment purposes would equal the average of the actual FTE resident and intern count for the cost reporting

period and the preceding year's cost reporting period. For the cost reporting period beginning October 1, 1998, and each subsequent cost reporting period, subject to certain limits, the total number of FTE residents and interns for payment purposes would equal the average of the actual FTE resident count for the cost reporting period and the preceding two year's cost reporting periods. The Secretary would have discretion to establish rules for new residency programs.

Reason for change. In its March 1, 1997 report, ProPAC recommended reducing the IME adjustment finding that the current level of the teaching adjustment continues to be higher than appropriate.

Effective date. The effective date for these provisions, unless otherwise specified would apply to hospital discharges as of October 1, 1997.

Section 10507. Treatment of transfer cases

Current law. No provision. PPS hospitals that move patients to PPS-exempt hospitals and distinct-part hospital units, or skilled nursing facilities are currently considered to have "discharged" the patient and receive a full DRG payment.

Explanation of provision. The provision would define a "transfer case" to include an individual discharged from a PPS hospital who is: (1) admitted as an inpatient to a hospital or distinct-part hospital unit that is not a PPS hospital for further inpatient hospital services; (2) is admitted to a skilled nursing facility or other extended care facility for extended care services; or (3) receives home health services from a home health agency if such services directly relate to the condition or diagnosis for which the individual received inpatient hospital services, and if such services were provided within an appropriate period, as determined by the Secretary in regulations promulgated no later than September 1, 1998. Under the provision, a PPS hospital that "transferred" a patient would be paid on a per diem basis up to the full DRG payment.

The provision, with respect to transfers from PPS-exempt hospitals and SNFs, would apply to discharges occurring on or after October 1, 1997. For home health care, the provision would apply to discharges occurring on or after September 1, 1998.

Reason for change. Over the past decade, hospital length of stays have fallen by more than 25 percent. As patients are discharged from the hospital to post acute care services earlier (resulting from the increases in service efficiencies), the Committee believes that Medicare should capture some of the savings and not pay twice for these services provided in different settings.

Effective date. The provision affecting transfers relating to PPS-exempt hospitals and SNFs would be effective upon enactment. Transfer policies related to home health care would be effective for discharges occurring on or after September 1, 1998.

Section 10508. Increase base payment rate to Puerto Rico hospitals

Current law. Medicare's hospital PPS includes a special provision for determining payment to hospitals in Puerto Rico. These hospitals are paid a blended rate based on a standardized payment amount for large urban or other areas specific to Puerto Rico and

the national standardized payment amount for all areas combined. The two rates have weights of 75 percent and 25 percent, respectively.

Explanation of provision. The provision would adjust the base payment rate to Puerto Rico hospitals to 50 percent local and 50 percent national.

Reason for change. While the PPS margin for urban hospitals in Puerto Rico was substantially higher than in the United States through 1992, it was almost 15 percentage points below the national figure by 1995. This difference corresponds to a 13 percentage point cumulative difference between the cost increases in Puerto Rico and the United States.

Effective date. The provision would be effective October 1, 1997.

Chapter 2—Payment of PPS Exempt Hospitals

Section 10511. Payment update

Current law. Under Medicare, five types of specialty hospitals (psychiatric, rehabilitation, long-term care, children's and cancer) and two types of distinct-part units in general hospitals (psychiatric and rehabilitation) are exempt from PPS. They are subject to the payment limitations and incentives established in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). Each provider is paid on the basis of reasonable cost subject to a rate of increase ceiling on inpatient operating costs. The ceiling is based on a target amount per discharge. The target amount for a cost reporting period is equal to the hospital's allowable inpatient operating costs (excluding capital and medical education costs) per discharge in a base year increased by applicable update factors for subsequent years. This amount is then multiplied by Medicare discharges, to yield the ceiling or upper limit on operating costs.

Updates to the target amounts for fiscal years 1994 through 1997 range from the PPS-excluded market basket index (MBI) to the MBI minus 1.0 percentage point, depending on how a hospital's costs compare to its target amount. For fiscal years 1998 and beyond, the updates are the market basket percentage increase.

Explanation of provision. The provision would set the FY1998 update to 0%, and for FY1999 through FY2002, the update factor would be based on the hospital's target amount. If a hospital's allowable operating costs of inpatient hospital services recognized under Medicare for the most recent cost reporting period (1) is equal to, or exceeds, 110% of the hospital's target amount, the applicable update factor specified under this clause is the market basket percentage; (2) exceeds 100%, but is less than 110% of the hospital target amount, the applicable update factor is the market basket percentage minus 0.25 percentage points for each percentage point by which the allowable operating costs (expressed as a percentage of the target amount) is less than 110% of such target amount; (3) is equal to, or less than 100% of the hospital target amount, but exceeds 2/3 of the target amount for the hospital, the update factor would be the market basket percentage minus 2.5 percentage points; or (4) does not exceed 2/3 of the hospital's target amount, the update factor would be 0%.

Reason for change. Payments to PPS-exempt hospitals represent some of the fastest growing expenditures to Medicare. Between 1990 and 1994, rehabilitation facility payments increased at an average annual rate of 19.7 percent. During this same period, long-term care hospital payments increased at an average annual growth rate of 41.4 percent. The Committee believes that the update factor should reflect each hospital's financial performance, relative to its TEFRA limit.

Effective date. This provision would be effective for cost reporting periods beginning on or after October 1, 1997.

Section 10512. Reductions to capital payments for certain PPS-exempt hospitals and units

Current law. Medicare pays for capital costs for PPS exempt hospitals on a reasonable cost basis.

Explanation of provision. The provision would require the Secretary to reduce capital payment amounts for PPS-exempt hospitals and distinct part units by 10% for fiscal years 1998 through 2002.

Reason for change. This provision would contribute toward slowing the rate of growth in the Part A program.

Effective date. This provision would be effective for cost reporting periods beginning on or after October 1, 1997.

Section 10513. Cap on TEFRA limits

Current law. Medicare places limits, referred to as "TEFRA limits," on the annual increases allowed for the operating costs of certain categories of hospitals.

Explanation of provision. The provision would set the target amounts for PPS-exempt hospitals or units for cost reporting periods beginning on or after October 1, 1997 and before October 1, 2002. The target amounts could not be greater than the 90th percentile of the target amounts for cost reporting periods beginning during that fiscal year. The cap on the target amounts would apply to psychiatric, rehabilitation, and long-term care hospitals and distinct-part units of such hospitals.

Reasons for change. At a hearing on April 10, 1997 on PPS-exempt hospital payment policies, the Health Subcommittee heard testimony regarding the calculation of TEFRA limits and the costs that are included in those limits. An examination of TEFRA limits across providers revealed significant variation. The Committee believes that for each provider group, TEFRA limits should be capped at the 90th percentile.

Effective date. This provision would be effective for cost reporting periods beginning on or after October 1, 1997.

Section 10514. Change in bonus payments

Current law. Medicare provides for bonus payments for hospitals whose operating costs are less than or equal to the target amount, as well as making relief payments to hospitals whose costs exceed their target amount. If the hospital's costs are less than or equal to the target amount for that period, the hospital receives a bonus payment equal to 50% of the amount by which the target amount exceeds the amount of the operating costs, or 5% of the target

amount, whichever is less. If a hospital's operating costs are greater than the target amount, the amount of the payment is equal to (1) the target amount, plus (2) an additional amount equal to 50% of the amount by which the operating costs exceed the target amount, but not more than 10% of the target amount.

Explanation of Provision. The provision would allow bonuses of (1) 10% of the amount by which the target amount exceeds the amount of operating costs, or (2) 1% of operating costs, whichever is less. The provision would change the relief payments to provide that costs would be required to exceed 110% in order to receive relief payments and that the relief payment could not be more than 20% of the target amount.

Reason for change. Bonus payments for PPS-exempt providers were established to reward providers who were able to keep their costs below their TEFRA limit. In recent years, there has been significant growth in the number of new PPS-exempt providers. Many of these providers have higher costs during their first few years of operation than established providers, resulting in higher TEFRA limits. While originally intended to reward providers and reduce Medicare spending, these bonus payments, have actually increased Medicare spending. The Committee believes that this is an appropriate area to reduce to contribute savings toward slowing the rate of growth in Part A spending.

Effective date. This provision would be effective for cost reporting periods beginning on or after October 1, 1997.

Section 10515. Change in payment and target amount for new providers

Current law. No provision.

Explanation of provision. The provision would establish different payment and target amount rules for hospitals or distinct-part units within hospitals that first receive Medicare payments on or after October 1, 1997. The provision would apply to psychiatric, rehabilitation, and long-term care hospitals and distinct-part units of hospitals. For the first two full or partial cost reporting periods, the amount of payment for operating costs under Part A on a per discharge or per admission basis would be equal to the lesser of the amount of operating costs for the respective period, or 150% of the national median operating costs for hospitals in the same class of hospital for cost reporting periods beginning during the same fiscal year, adjusted for labor-related costs. This same limited target amount would then be updated in subsequent years using the update factor described above.

For determining national median operating costs for hospitals in the same class, the Secretary would be required to provide for an appropriate adjustment to the labor-related portion of the amount determined to take into account differences between average wage-related costs in the area the hospital is located in and the national average of such costs within the same class of hospital. The Secretary would also be required to create subclasses of long-term care hospitals based on differences in the case mix and patient acuity in calculating and applying the 150% of the national median cost limits.

Reason for change. The Committee has examined data on the growth in the number of PPS-exempt providers and believes that the current system has fueled an excessive increase in new providers. The increase results partly from the fact that Medicare covers all allowable costs, without limits. Between 1990 and 1996, the number of rehabilitation facilities increased 29 percent and the number of long-term care hospitals doubled. In its March Report to Congress, ProPAC recommended eliminating the initial exemption period for new providers and recommended basing initial payments on the average for facilities serving similar patients.

In establishing the 150 percent of the national median limit for long-term care hospitals, the Committee believes that it was important for the Secretary to recognize differences in the acuity of patients across hospitals. The Committee expects that the Secretary will use existing data or will collect any additional data that is necessary to separate this group into well-defined subgroups when implementing this provision.

Effective date. This provision is effective for cost reporting periods beginning on or after October 1, 1997.

Section 10516. Rebasing

Current law. No provision.

Explanation of provision. The provision would give psychiatric, rehabilitation, and long-term care hospitals and psychiatric and rehabilitation distinct units of hospitals that received Medicare payments for services furnished during cost reporting periods ending before October 1, 1990, the option of electing that the hospital's target amount for the 12-month cost reporting period beginning during FY1998 would be rebased. The rebased target amount would be equal to an average determined by the Secretary as follows: (1) the Secretary would be required to determine the allowable operating cost for inpatient hospital services for the hospital or hospital unit for each of the 5 cost reporting periods for which the Secretary had settled cost reports as of the date of enactment; (2) the Secretary would be required to increase the amount determined for the 5 cost reporting periods by the applicable percentage increase used to update costs for each of the cost reporting periods; (3) the Secretary would be required to identify among the 5 cost reporting periods the periods for which the updated cost amount was the highest and the lowest; (4) the Secretary would be required to compute the average cost per discharge of the updated cost report amounts for the 3 cost reporting periods that were not the highest or the lowest amounts.

The provision would also allow certain qualified long-term care hospitals that elect to do so, to apply for rebasing of their target amount beginning during FY1998. The target amount for the hospital's 12-month cost reporting period would be equal to the allowable operating costs of inpatient hospital services recognized by Medicare for the 12-month cost reporting periods beginning during FY1996, increased by the applicable percentage increase for the cost reporting period beginning during FY1997. The provision defines a qualified long-term care hospital as a PPS-exempt hospital that received Medicare payments during each of the 2 cost reporting periods for which the Secretary has the most recent settled cost

reports as of the date of enactment. In addition, for each of the 2 cost reports the hospital's allowable operating costs of inpatient hospital services under Medicare exceeded 115% of the hospital's target amount, and the hospital had a disproportionate patient percentage of at least 70%.

Reason for change. TEFRA payment limits are based on historical data. For some of the providers, their TEFRA limits are based on data that are more than a decade old and do not reflect current costs or treatment patterns. ProPAC analysis found that providers that have been operating under the TEFRA system for several years generally do not perform as well financially as newer providers. The Committee believes that using more recent data and recalculating the TEFRA limits for the providers that were in operation before 1990 is warranted.

Effective date. This provision is effective for cost reporting periods beginning on or after October 1, 1997.

Section 10517. Treatment of certain long-term care hospitals

Current law. No provision.

Explanation of provision. The provision would extend the status of a hospital that was classified by the Secretary on or before September 30, 1995, as a long-term care hospital, notwithstanding that it was located in the same building as, or on the same campus as, another hospital. The provision would apply to discharges occurring on or after October 1, 1995.

Reason for change. Certain hospitals that have provided quality care to Medicare beneficiaries are in jeopardy because of new HCFA regulations which would make them no longer eligible to qualify as long-term care hospitals. This provision would ensure that they would continue to qualify as long as they maintained an average length of stay of 25 days and other Medicare certification requirements.

Effective date. This provision applies to discharges on or after October 1, 1995.

Section 10518. Elimination of exemptions; report on exceptions and adjustments

Current law. The Secretary is required to provide an exemption from various provisions of the law regarding Medicare payments to PPS-excluded hospitals.

Explanation of provision. The provision would amend the law, replacing the term "exemption from, or an exception and adjustment to," with "an exception and adjustment to" each place it appears, eliminating exemption from the target amounts. The provision would apply to hospitals that qualify as PPS-excluded facilities on or after October 1, 1997.

The provision would also require the Secretary to publish annually in the Federal Register a report describing the total amount of payments made to PPS-excluded hospitals and units for cost reporting periods ending during the previous fiscal year.

Reason for change. The Committee is concerned that under the current system, a significant portion of providers receive exceptions payments which are not regularly tallied by HCFA. The Committee believes that it is important for the Secretary to monitor these pay-

ments and to keep an accurate account of their impact on Part A expenditures.

Effective date. This provision is effective for cost reporting periods ending on or after October 1, 1997.

Chapter 3—Provisions Related to Hospice Services

Section 10521. Payments for hospice services

Current law. Medicare covers hospice care, in lieu of most other Medicare benefits, for terminally ill beneficiaries. Payment for hospice care is based on one of four prospectively determined rates, which correspond to four different levels of care, each day a beneficiary is under the care of the hospice. The four rate categories are routine home care, continuous home care, inpatient respite care, and general inpatient care. The prospective payment rates are updated annually by the hospital market basket (MB).

Explanation of provision. For each of the fiscal years 1998 through 2002, the hospice prospective payment rates would be updated by the market basket minus 1.0 percentage point. The Secretary would be required to collect data from participating hospices on the costs of care they provide for each fiscal year beginning with FY 1999.

Reason for change. Hospice services are among the fastest growing in all of Medicare. Total Medicare hospice payments have grown from \$533 million in 1991 to \$1.9 billion in 1995. Reimbursement per patient has increased from \$4,365 in 1991 to \$6,056 in 1995. Because the Committee is concerned that data is not being collected on margins of these services, the proposal would require the Secretary to begin collecting data on costs relating to such hospice services.

Effective date. The provision relating to payments would be effective upon enactment. The Secretary would begin collecting data for each fiscal year beginning FY 1999.

Section 10522. Payment for home hospice care based on location where care is furnished

Current law. Hospices generally bill Medicare on the basis of the location of the home office, rather than where service is actually delivered.

Explanation of provision. Effective for cost reporting periods beginning on or after October 1, 1997, hospices would be required to submit claims on the basis of the location where a service is actually furnished.

Reason for change. HCFA has found that some hospice agencies have located in urban areas despite providing services in rural areas. Many agencies do this because current law allows for higher reimbursement in urban areas. The Committee believes that payment should reflect the location of the service provided by an entity, not where its headquarters are located.

Effective date. The provision would be effective October 1, 1997.

Section 10523. Hospice care benefits periods

Current law. Persons electing Medicare's hospice benefit are covered for four benefit periods: two 90-day periods, a subsequent 30-day period, and a final period of unlimited duration.

Explanation of provisions. Hospice benefit periods would be restructured to include two 90-day periods, followed by an unlimited number of 60-day periods. The medical director or physician member of the hospice interdisciplinary team would have to re-certify at the beginning of the 60-day periods that the beneficiary is terminally ill.

Reason for change. The current hospice benefit provides for unlimited periods of time in the final benefit period. The Office of Inspector General has found that in many cases, patients are not terminally ill and should not qualify for the hospice benefit.

Effective date. The provision would be effective upon enactment.

Section 10524. Other items and services included in hospice care

Current law. Hospice services are defined in Medicare statute to include nursing care; physical and occupational therapy and speech language pathology services; medical social services; home health aide services; homemaker services; medical supplies (including drugs and biologicals) and medical appliances; physician services; short-term inpatient care (including both respite care and procedures necessary for pain control and acute and chronic symptom management); and counseling. Beneficiaries electing hospice waive coverage to most Medicare services when the services they need are related to the terminal illness.

Explanation of provisions. The definition for hospice care would be amended to include the above-enumerated services as well as any other item or service which is specified in a patient's plan of care and which Medicare may pay for.

Reason for change. The existing statute is ambiguous on the definition of hospice care regarding certain services. On the one hand, the beneficiary when qualifying for hospice must waive coverage under Part B for most services when they are related to the terminal illness. On the other hand, some items and services are not clearly listed under the hospice benefit because they are considered to be medical—not palliative—treatment. For example, certain treatments may be necessary (e.g., such as radiation) for both medical reasons and for pain relief.

Effective date. The provision would be effective upon enactment.

Section 10525. Contracting with independent physicians or physician groups for hospice care services permitted

Current law. Medicare law requires that hospices routinely provide directly substantially all of certain specified services, often referred to as core services. Physician services are among these core services. HCFA has defined "directly" to require that services be provided by hospice employees.

Explanation of provisions. The provision would delete physician services from a hospice's core services and allow hospices to employ or contract with physicians for their services.

Reasons for change. HCFA has interpreted the existing statute as requiring an employer/employee relationship between the hospice

agency and its Medical Director and other staff physicians. Because of the increasing difficulty hospices experience in recruiting part-time physician employees, the Committee believes that hospices should be able to contract for physician services, independent contractor physicians or physician groups.

Effective date. The provision would be effective upon enactment.

Section 10526. Waiver of certain staffing requirements for hospice care programs in non-urbanized areas

Current law. Hospices must provide certain services in order to participate in Medicare.

Explanation of provisions. The provision would allow the Secretary to waive requirements with regard to hospices having to provide certain services so long as they are not located in urbanized areas and can demonstrate to the satisfaction of the Secretary that they have been unable, despite diligent efforts, to recruit appropriate personnel. For these hospices, the Secretary could waive specifically the provision of physical or occupational therapy or speech-language pathology services and dietary counseling.

Reason for change. Certain hospices in rural areas have difficulty becoming Medicare certified because of shortages of certain health professionals. The Committee believes if a hospice can show that, despite diligent efforts, it was unable to recruit certain personnel, waivers to these staffing requirements should be granted by the Secretary.

Effective date. The provision would be effective upon enactment.

Section 10527. Limitation on liability of beneficiaries and providers for certain hospice coverage denials

Current law. Medicare law provides financial relief to beneficiaries and providers for certain services for which Medicare payment would otherwise be denied. Medicare payment under this "limitation of liability" provision is dependent on a finding that the beneficiary or provider did not know and could not reasonably have been expected to know that services would not be covered on one of several bases.

Explanation of provision. The provision would extend limitation of liability protection to determinations that an individual is not terminally ill.

Reason for change. While waiver of liability for "reasonable and necessary" is still available on a case-by-case basis, the statute does not refer to denials of hospice claims on the basis that the beneficiary allegedly did not meet the terminal illness eligibility requirement. HCFA has instructed its fiscal intermediaries to begin focused medical review of these waiver determinations. Waiver of liability protection of beneficiaries is needed and appropriate where denials are based on six-month prognosis issues.

Effective date. The provision would be effective upon enactment.

Section 10528. Extending the period for physician certification of an individual's terminal illness

Current law. At the beginning of the first 90-day period when a Medicare beneficiary elects hospice, both the individual's attending physician and the hospice physician must certify in writing that

the beneficiary is terminally ill not later than 2 days after hospice is initiated (or, verbally not later than 2 days after care is initiated and in writing not later than 8 days after care has begun).

Explanation of provision. The provision would eliminate the specific time frame specified in statute for completion of physicians' certifications for admission to hospice to require only that physicians certify that a beneficiary is terminally ill at the beginning of the initial 90-day period.

Reason for change. Existing statutory requirements for timeliness in documenting physician certifications of terminal illness are very specific in the hospice benefit, creating the potential for technical denials where, for example, the paperwork is completed more than eight days after the patient is admitted. The provision would eliminate the specific time frame specified in statute for completion of physicians' certifications for admission to hospice, to require only that certifications be made at the beginning of each benefit period. The Committee expects that this will allow the Secretary the flexibility to require that written certifications must be obtained before the hospice may submit a bill for services rendered to the patient after the beginning of each period.

Effective date. The provision would be effective upon enactment.

Section 10539. Effective date

Current law. No provision.

Explanation of provision. The provision would specify that except as otherwise indicated, the hospice reforms would apply on or after the date of the enactment of the bill.

Effective date. The provision is generally effective upon enactment.

Section 10531. Modification of Part A home health benefit for individuals enrolled under Part B

Current law. Both Parts A and B of Medicare cover home health. Neither part of the program applies deductibles or coinsurance to covered visits, and beneficiaries are entitled to an unlimited number of visits as long as they meet eligibility criteria. Section 1833(d) of Medicare law prohibits payments to be made under part B for covered services to the extent that individuals are also covered under Part A for the same services. As a result, the comparatively few persons who have no Part A coverage are the only beneficiaries for whom payments are made under Part B.

Explanation of provision. The provision would gradually transfer from Part A to Part B home health visits that are not part of the first 100 visits following a beneficiary's stay in a hospital or skilled nursing facility and during a home health spell of illness. The transfer would be phased in between 1998 and 2002. In order to determine what portion of visits to transfer in a given year, the Secretary would first estimate the amount of payments that would have been made if (1) Part A home health services had the definition they did before enactment of this section and (2) Part A home health services were limited to the 100 visits following an institutional stay. The Secretary would next determine the difference between the two amounts for each year 1998 through 2002 and then multiply that amount by a proportion specified for the given year.

For 1998, the proportion is 1/6; for 1999, 2/6; for 2000, 3/6; for 2001, 4/6; and for 2002, 5/6. The Secretary would be required to specify a visit limit or a post-institutional limitation that would result in a reduction in the amount of Part A home health payments equal to the transfer amount specified above. On or after January 1, 2003, Part A would cover only post-institutional home health services for up to 100 visits during a home health spell of illness, except for those persons with Part A coverage only who would be covered for services without regard to the post-institutional limitation.

Post-institutional home health services would be defined as services furnished to a Medicare beneficiary: (1) after an inpatient hospital or rural primary care hospital stay of at least 3 days, initiated within 14 days after discharge; or (2) after a stay in a skilled nursing facility, initiated within 14 days after discharge. Home health spell of illness would be defined as the period beginning when a patient first receives post-institutional home health services and ending when the beneficiary has not received inpatient hospital, skilled nursing facility, or home health services for 60 days.

Reason for change. The Committee believes that the transfer of Part A home health care services to Part B should be done in a manner that would have the least impact on general fund contributions to the Supplemental Medical Insurance Trust Fund.

Effective date. This provision applies to services delivered on or after January 1, 1998.

Chapter 4.—Other Payment Provisions

Section 10541. Reductions in payments for enrollee's bad debt

Current Law. Certain hospital and other provider bad debts are reimbursed by Medicare on an allowable cost basis. To be qualified for reimbursement, the debt must be related to covered services and derived from deductible and coinsurance amounts left unpaid by Medicare beneficiaries. The provider must be able to establish that reasonable collection efforts were made and that sound business judgement established that there was no likelihood of recovery at any time in the future.

Explanation of Provision. The provision would reduce the allowable costs of bad debt payments to providers to 75% for cost reporting periods beginning during FY1998; 60% for cost reporting periods beginning during FY1999; and 50% for cost reporting periods beginning during FY2000 and each subsequent fiscal year.

Reason for Change. Providers require greater incentives to aggressively pursue bad debt related to Medicare coinsurance and deductibles. Current policy provides little incentive to do so because Medicare reimburses certain hospitals and other providers for its bad debt related to Medicare on an allowable cost basis.

Effective date. The effective date for these provisions, unless otherwise specified, would apply to hospital cost reports beginning after October 1, 1997.

Section 10542. Permanent extension of hemophilia pass-through

Current Law. Medicare makes additional payments for the costs of administering blood clotting factor to Medicare beneficiaries with

hemophilia admitted for hospital stays where the clotting factor was furnished between June 19, 1990 and September 30, 1994.

Explanation of Provision. The provision would make the payment permanent.

Reason for Change. Due to increases in the cost of clotting factor resulting from the increase in AIDS in 1989, the Congress changed the way Medicare paid for inpatient costs of clotting factor by providing an add-on to the PPS payment rates. This change was initially limited to 18 months and then subsequently extended through fiscal year 1994. Information collected throughout this period justifies the separate payment for the clotting factor.

Effective Date. The provision would be effective upon enactment.

Section 10543. Reduction in Part A Medicare premium for certain public retirees

Current Law. Almost all persons age 65 or over are automatically entitled to Part A. These individuals (or their spouses) established entitlement during their working careers by paying the hospital insurance (HI) payroll tax on earnings covered by either the social security or railroad retirement systems.

Persons not automatically entitled to Part A include some state and local government employees. State and local governments can choose whether or not to participate in Medicare for employees hired before April 1, 1986. They are required to participate (and pay the employer share of the payroll taxes) for all employees hired after that date.

Persons not automatically entitled to Part A may obtain coverage by paying the Part A premium. The 1997 premium is \$311. Beginning in 1994, certain persons are entitled to a reduction in the voluntary premium amount. Persons entitled to a reduction are those who (1) had at least 30 quarters of coverage under social security; (2) had been married for at least the previous year to a worker who had at least 30 quarters of coverage; (3) had been married for at least one year to a worker who had at least 30 quarters of coverage before the worker died; or (4) are divorced from (after at least 10 years of marriage to) a worker with at least 30 quarters of coverage. The otherwise applicable premium amount was reduced 25% in 1994, 30% in 1995, 35% in 1996, 40% in 1997, and 45% in 1998 and subsequent years.

Explanation of Provision. The provision would set the Part A premium at zero for certain retirees from public sector employment. For an individual to be covered under this provision, he or she must have been receiving cash benefits under a qualified State or local government retirement system on the basis of the individual's employment over at least 40 calendar quarters (or on the basis of some combination of such covered employment and quarters of coverage under social security totaling at least 40 quarters). Also included would be an individual: (1) married for at least a year to an individual who had at least 40 quarters of such coverage; (2) had been married for at least a year to a worker who had at least 40 quarters of coverage before the worker died; or (3) are divorced from (after at least 10 years of marriage to) a worker with at least 40 quarters of coverage. Individuals covered under this provision are those whose premium will not be paid in whole or part by a

state (including under its Medicaid program), a political subdivision of a state, or agency or instrumentality of one or more states or political subdivisions. Further, for each of the preceding 60 months, the individual's premium was not paid in whole or in part by such governmental entity.

The provision would specify that a qualified state or local government retirement system is one which: (1) is established or maintained by a state or political subdivision, or an agency or instrumentality of one or more states or political subdivisions thereof; (2) covers positions of some or all employees of such entity; and (3) does not adjust cash retirement benefits based on eligibility for a premium reduction.

The provision would be effective January 1, 1998, except that months before that date could be counted in determining whether an individual met the 60 month requirement specified above.

Reason for Change. Today, there are many retired public employees whose governmental unit did not participate in Medicare. For many of these individuals, their original health insurance plans have become very expensive, basically compelling them to purchase Medicare Part A coverage. As a result, monthly premiums for those who buy in themselves can be between \$250 a month or \$3,000 a year.

Effective date. The provision shall apply to premiums for months beginning with January 1998, and months before may be taken into account in the determination of the 60 month requirement.

SUBTITLE G—PROVISIONS RELATING TO PART B ONLY

Chapter 1.—Physicians' Services

Section 10601. Establishment of single conversion factor for 1998

Current Law. Medicare pays for physicians services on the basis of a fee schedule. The fee schedule assigns relative values to services. Relative values reflect three factors: physician work (time, skill, and intensity involved in the service), practice expenses, and malpractice costs. These relative values are adjusted for geographic variations in the costs of practicing medicine. Geographically-adjusted relative values are converted into a dollar payment amount by a dollar figure known as the conversion factor. There are three conversion factors—one for surgical services, one for primary care services, and one for other services. (There is also a separate conversion factor for anesthesia services because payment for these services are based on base units, which reflect complexity, and time units.) The conversion factors in 1997 are \$40.96 for surgical services, \$35.77 for primary care services, and \$33.85 for other services.

Explanation of Provision. The provision would set a single conversion factor for 1998, based on the 1997 primary care conversion factor, updated to 1998 by the Secretary's estimate of the weighted average of the three separate updates that would occur in the absence of the legislation.

Reason for change. The Health Subcommittee received testimony at its March 13, 1997 hearing on Physician Policies from the Physician Payment Review Commission (PPRC) and several physician groups supporting physician payment reform and a move to a sin-

gle conversion factor. This will eliminate the distortions that exist in the current system and will place a greater emphasis on the use of primary care services.

Effective date. This provision is effective for services delivered on or after January 1, 1998.

Section 10602. Establishing update to conversion factor to match spending under sustainable growth rate

Current Law. The conversion factors are updated each year by a formula specified in the law. The update equals inflation plus or minus actual rate of spending growth in a prior period compared to a target known as the Medicare volume performance standard (MVPS). (For example, fiscal year 1995 data were used in calculating the calendar 1997 update.) However, regardless of actual performance during a base period, there is a 5 percentage point limit on the amount of the reduction. There is no limit on the amount of the increase.

Explanation of Provision. The provision would specify the update to the conversion factor that would apply beginning in 1999 (unless otherwise provided for by law). The provision would specify that the update to the single conversion factor for a year would equal the change in the Medicare Economic Index (MEI) subject to an adjustment to match spending under a sustainable growth rate. Specifically, the update for a year would be calculated by multiplying: (1) 1 plus the percentage change in the MEI, times (2) 1 plus the update adjustment factor (expressed as a percentage) for the year. The result would be reduced by 1 and multiplied by 100.

The provision would specify that the update adjustment factor for a year would equal the difference between (1) the cumulative sum of allowed expenditures from July 1, 1997 through June 30 of the year involved and (2) the cumulative sum of actual expenditures from July 1, 1997 through June 30 of the previous year, divided by (3) the actual expenditures for the 12-month period (ending June 30) involved increased by the sustainable growth rate for the year involved (see description of the sustainable growth rate below). For the 12-month period ending June 30, 1997, allowed expenditures would be defined as actual expenditures for the period, as estimated by the Secretary. For a subsequent 12-month period, allowed expenditures would be defined as allowed expenditures established for the previous period, increased by the sustainable growth rate established for the fiscal year which begins during that 12-month period.

The provision would establish limits on the maximum and minimum update each year. The update could not be more than three percentage points above or seven percentage points below the MEI.

Reason for change. The PPRC has strongly recommended moving to a single performance standard and update. Currently, separate updates and performance standards are determined for each of the separate categories of physician services: primary care, surgical, and other nonsurgical services. Because different updates are determined for each of the separate categories, relative value units in different categories are not paid the same amount. As a result, relative value units have become seriously distorted. This distortion violates the basic principle underlying the resource-based relative

value scale (RBRVS), namely that each services should be paid the same amount regardless of the patient or service to which it is attached.

Effective date. This provision would apply to services delivered on or after January 1, 1998.

Section 10603. Replacement of volume performance standard with sustainable growth rate

Current Law. The Medicare Volume Performance Standard (MVPS), used to calculate the update in the conversion factor, is a goal for the rate of expenditure growth from one fiscal year to the next. The MVPS for a year is based on estimates of several factors (changes in fees, enrollment, volume and intensity, and laws and regulations). The calculation is subject to a reduction known as the performance standard factor.

Explanation of Provision. The provision would replace the MVPS with the sustainable growth rate. The rate for FY 1998 and subsequent years would be equal to the product of: (1) 1 plus the weighted average percentage change in fees for all physicians services in the fiscal year; (2) 1 plus the percentage change in the average number of individuals enrolled under Part B (other than private plan enrollees) from the previous fiscal year; (3) 1 plus the Secretary's estimate of the percentage growth in real gross domestic product per capita from the previous fiscal year; and (4) 1 plus the Secretary's estimate of the percentage change in expenditures for all physicians services in the fiscal year which will result from changes in law (excluding changes in volume and intensity resulting from changes in the conversion factor update). The result would be reduced by one and multiplied by 100. The term "physicians services" would exclude services furnished to a MedicarePlus plan enrollee.

Reason for change. The PPRC has recommended that a performance standard formula be linked to projected growth in real gross domestic product per capita instead of a five-year historical trend less an arbitrary deduction. This recommendation provides a more realistic and affordable goal that links the budget targets to the economy as a whole.

Section 10604. Payment rules for anesthesia services

Current Law. Anesthesia services are paid under a separate fee schedule (based on base and time units) with a separate conversion factor. The 1997 conversion factor is \$16.68.

Explanation of Provision. The provision would specify that the conversion factor would equal 46% of the conversion factor established for other services for the year, except as adjusted for changes in work, practice expense, or malpractice relative value units.

Reason for change. PPRC's analysis of the conversion factor for anesthesia services found that after the five-year review process, the conversion factor for anesthesia services represented 46 percent of the conversion factor for all other services. The Committee believes that this is an appropriate level for future conversion factors. The Committee recognizes, however, that the appropriate level may be higher or lower in future years, depending on changes in tech-

nology and other factors and therefore, this percentage may need to be adjusted in future years to reflect changes in work, practice expense, or malpractice relative value units.

Effective date. This provision is effective upon enactment.

Section 10605. Implementation of resource-based physician practice expense

Current Law. P.L. 103–432 required that the Secretary develop and provide for the implementation, beginning in 1998, of a resource-based methodology for payment of practice expenses under the physician fee schedule. Such expenses are currently paid on the basis of historical charges.

Explanation of Provision. The provision would delay implementation of the practice expense methodology for one year until 1999. It would provide for a phase-in of the new methodology. In 1999, 25 percent of the practice payment would be based on the new methodology. This percentage would increase to 50 percent in 2000 and 75 percent in 2001. Beginning in 2002, the payment would be based solely on the new methodology.

Reason for change. The Committee is very concerned by the Secretary's plan to move to a system of resource-based practice expense relative value units that is based on limited data and results in significant changes in payment across specialties. Preliminary data released by HCFA in January 1997 shows that some specialties will see payment reductions of more than 40 percent while others would see significant increases. The Committee believes that it is important for the Secretary to delay the implementation for one year in order to gather additional data regarding both direct and indirect practice costs and to work with the specialty societies to refine the system.

The Committee is concerned that the new system may have a significant impact on hospital-based physicians. The Committee would like the Secretary to submit a report to Congress on the anticipated impact of the resource-based practice expense relative value units on hospital-based physicians by November 1, 1998.

Given the magnitude of the expected changes, the Committee believes that the resource-based practice expense relative value units should be phased in over several years. This will allow for a smoother transition for physicians facing significant decreases and allow the Secretary several opportunities to refine the calculations.

Effective date. These provisions are effective upon enactment.

Section 10606. Dissemination of hospital-specific per admission relative value

Current Law. In general, the law does not include a specific limit on the number or mix of physicians services provided in connection with an inpatient hospital stay. (However, the law does require that certain services provided in connection with a surgery be included in a global surgical package and not billed for separately.)

Explanation of Provision. During 1999 and 2001, the Secretary would determine for each hospital, using already existing hospital and physician claims data, the estimated hospital-specific per discharge relative value for the following year and whether this amount is projected to be excessive (based on the 1998 national me-

dian of such values). The Secretary would be required to notify the medical executive committee of each hospital which was identified as having an excessive hospital-specific relative value.

The hospital-specific relative value projected for a non-teaching hospital would be adjusted for variations in case mix and disproportionate share status. For teaching hospitals, the projected hospital-specific relative value would be: (1) the average per admission relative value for inpatient physicians services furnished by the medical staff; plus (2) the equivalent per admission relative value for physicians services furnished by interns and, adjusted for case-mix, disproportionate share status, and teaching status among hospitals. The Secretary would be required to determine the equivalent relative value unit per intern and resident based on the best available data and could make such adjustment in the aggregate. The Secretary would be required to adjust the allowable per admission relative value otherwise determined to take into account the needs of teaching hospitals and hospitals receiving additional payments under PPS as disproportionate share hospitals or on the basis of their classification as medicare-dependent small rural hospitals. The adjustment for teaching or disproportionate share status could not be less than zero.

Reason for change. Private managed care plans have learned to effectively control costs by providing information to their providers regarding their use patterns. The Committee believes that disseminating information regarding the variation in services delivered by physicians in the inpatient setting maybe an important tool for monitoring Medicare cost growth and informing physicians regarding their spending patterns.

Effective date. This provision is effective upon enactment.

Section 10607. No x-ray required for chiropractic services

Current Law. Medicare covers chiropractic services involving manual manipulation of the spine to correct a subluxation demonstrated to exist by X-ray. Medicare regulations prohibit payment for the X-ray either if performed by a chiropractor or ordered by a chiropractor.

Explanation of Provision. The provision would eliminate the X-ray requirement effective January 1, 1998.

Reason for Change. Current law places limitations on chiropractors' ability to treat patients.

Section 10608. Temporary coverage restoration for portable electrocardiogram transportation

Current Law. The Secretary recently suspended separate payments for transportation of electrocardiogram equipment to beneficiaries in their home or in skilled nursing facilities.

Explanation of Provision. The provision would reinstate separate payments under Part B during calendar year 1998 for the transportation of electrocardiogram equipment to beneficiaries in their home or in skilled nursing facilities based on the status code and relative value units established for such service as of December 31, 1996. The Secretary is required to make a determination by no later than July 1, 1998 regarding whether the coverage of portable

electrocardiogram equipment required by this provision should be continued after 1998.

Reason for Change. The General Accounting Office (GAO) currently is conducting a study regarding the impact on beneficiaries of the discontinuance of separate payment for transportation of electrocardiogram equipment. The Committee believes that these payments should be continued to protect beneficiaries pending the publication of the GAO report and a determination by the Secretary, taking into consideration the findings of GAO and other relevant information, as to whether or not separate payment for such transportation should be continued.

Effective Date. The provision is effective January 1, 1998.

Chapter 2—Other Payment Provisions

Section 10611. Payments for durable medical equipment

Current law

(a) *Freeze in Durable Medical Equipment (DME) Updates.* DME is reimbursed on the basis of a fee schedule. Items are classified into five groups for purposes of determining the fee schedules and making payments: (1) inexpensive or other routinely purchased equipment (defined as items costing less than \$150 or which are purchased at least 75 percent of the time); (2) items requiring frequent and substantial servicing; (3) customized items; (4) oxygen and oxygen equipment; and (5) other items referred to as capped rental items. In general, the fee schedules establish national payment limits for DME. The limits have floors and ceilings. The floor is equal to 85 percent of the weighted median of local payment amounts and the ceiling is equal to 100 percent of the weighted median of local payment amounts. Fee schedule amounts are updated annually by the consumer price index for all urban consumers, CPI-U.

(b) *Update for Orthotics and Prosthetics.* Prosthetics and orthotics are paid according to a fee schedule with principles similar to the DME fee schedule. The fee schedule establishes regional payment limits for covered items. The payment limits have floors and ceilings. The floor is equal to 90 percent of the weighted average of regional payment amounts and the ceiling is 120 percent. Fee schedule amounts are updated annually by CPI-U.

(c) *Payment Freeze for Parenteral and Enteral Nutrients, Supplies, and Equipment.* Parenteral and enteral nutrients, supplies, and equipment are paid on the basis of the lowest reasonable charge levels at which items are widely and consistently available in the community.

Explanation of provision

(a) *Freeze in Durable Medical Equipment (DME) Updates.* The provision would eliminate updates to the DME fee schedules for the period 1998 through 2002.

(b) *Update for Orthotics and Prosthetics.* The update for the prosthetics and orthotics fee schedule would be limited to 1 percent for each of the years 1998 through 2002.

(c) *Payment Freeze for Parenteral and Enteral Nutrients, Supplies, and Equipment.* Payments for PEN would be frozen at 1995 levels for the period 1998 through 2002.

Reason for Change. The provisions on parenteral and enteral payments would otherwise expire, and experience in recent years justifies these payment policies.

Effective Date. The provisions are effective upon enactment.

Section 10612. Oxygen and oxygen equipment

Current Law. Under Medicare oxygen and oxygen equipment are considered durable medical equipment and are paid according to a DME fee schedule. The fee schedule establishes a national payment limit for oxygen and oxygen equipment.

Explanation of Provision. The provision would reduce the national payment limit for oxygen and oxygen equipment by 20 percent in 1998 through 2002.

Reason for Change. In 1996, nearly 480,000 beneficiaries received home oxygen at a cost of \$1.7 billion. Experience in recent years and newly available data from the GAO comparing rates paid for oxygen and oxygen equipment in the Medicare and Veterans' programs justifies this payment policy. The GAO report found that Medicare's fee schedule allowances for home oxygen are significantly higher than the rates paid for oxygen by the Department of Veterans Affairs (VA), which uses competitive contracting arrangements. During the period examined by GAO, Medicare paid more than twice as much as the VA for oxygen. Even after adding a 30 percent "adjustment" to account for additional administrative burdens associated with filing Medicare claims and other differences between the two programs, the GAO concluded that monthly Medicare payments for oxygen are still \$120 more per patient than the rates paid by the VA.

Effective Date. The provisions are effective upon enactment.

Section 10613. Reduction in updates to payment amounts for clinical diagnostic laboratory tests

Current Law. Clinical diagnostic laboratory tests are paid on the basis of areawide fee schedules. The law sets a cap on payment amounts equal to 76% of the median of all fee schedules for the test. The fee schedule amounts are updated by the percentage change in the CPI. Variations exist among carriers in rules governing requirements labs must meet in filing claims for payments.

Explanation of Provision. The provision would freeze fee schedule payments for the 1998–2002 period. It would also lower the cap from 76% of the median to 72% of the median beginning in 1998.

Reason for Change. Experience in recent years, coupled with the administrative efficiencies that can be expected from implementation of the provisions in section 10614 regarding administrative simplification of laboratory claims, justifies this payment policy.

Effective Date. The provision is effective upon enactment.

Section 10614. Simplification in administration of laboratory services benefit

Current Law. Significant variations exist among carriers in rules governing requirements labs must meet in filing claims for payments.

Explanation of Provision. The provision would require the Secretary to divide the country into no more than 5 regions and designate a single carrier for each region to process laboratory claims no later than January 1, 1999. One of the carriers would be selected as a central statistical resource. The assignment of claims to a particular carrier would be based on whether the carrier serves the geographic area where the specimen was collected or an other method selected by the Secretary.

The provision would require the Secretary, by July 1, 1998, to adopt uniform coverage, administration, and payment policies for lab tests using a negotiated rule-making process. The policies would be designed to promote uniformity and program integrity and reduce administrative burdens with respect to clinical diagnostic laboratory tests in connection with beneficiary information submitted with a claim, physicians' obligations for documentation and recordkeeping, claims filing procedures, documentation, and frequency limitations.

The provision would provide that during the period prior to the implementation of uniform policies, carriers could implement new requirements under certain circumstances.

The provision would permit the use of interim regional policies where a uniform national policy had not been established. The Secretary would establish a process under which designated carriers could collectively develop and implement interim national standards for up to 2 years.

The Secretary would be required to conduct a review, at least every 2 years, of uniform national standards. The review would consider whether to incorporate or supercede interim regional or national policies.

With regard to the implementation of new requirements in the period prior to the adoption of uniform policies, and the development of interim regional and interim national standards, carriers must provide advance notice to interested parties and allow a 45 day period for parties to submit comments on proposed modifications.

The provision would require the inclusion of a laboratory representative on carrier advisory committees. The representative would be selected by the committee from nominations submitted by national and local organizations representing independent clinical labs.

Reason for Change. Significant concerns have been raised regarding the widely varying payment policies and concomitant documentation requirements of Medicare carriers regarding claims for clinical laboratory tests. This situation is compounded because many laboratories send claims to multiple carriers. For example, for a simple cholesterol test, the carrier for one part of New York State accepts 735 different diagnosis codes, while another carrier in another part of New York accepts only 341 codes. And, in Michigan and Illinois, the carrier accepts only 9 codes for this test. The

provision is intended to promote efficiency, increase uniformity, and reduce administrative burdens in claims administration and billing procedures.

Effective Date. The provision is effective upon enactment.

Section 10615. Updates for ambulatory surgical services

Current Law. Medicare pays for ambulatory surgical center (ASC) services on the basis of prospectively determined rates. These rates are updated annually by the CPI-U. OBRA 93 eliminated updates for ASCs for FY1994 and FY1995.

Explanation of Provision. The provision would set the updates for FY 1998 through FY2002 at the increase in the CPI-U minus 2.0 percentage points.

Reason for change. This provision would contribute to slowing unsustainable growth in Part B expenditures.

Effective date. This provision is effective for services delivered on or after October 1, 1997.

Section 10616. Reimbursement for drugs and biologicals

Current Law. Payment for drugs is based on the lower of the estimated acquisition cost or the national average wholesale price. Payment may also be made as part of a reasonable cost or prospective payment.

Explanation of Provision. The provision would specify that in any case where payment is not made on a cost or prospective payment basis, the payment shall be equal to 95 percent of the average wholesale price for the drug or biological involved.

Reason for Change. The Inspector General for the Department of Health and Human Services has found evidence that over the past several years Medicare has paid significantly more for drugs and biologicals than physicians and pharmacists pay to acquire such pharmaceuticals. For example, the Office of Inspector General reports that Medicare reimbursement for the top 10 oncology drugs ranges from 20 percent to nearly 1000 percent per dosage more than acquisition costs. The Committee intends that the Secretary, in determining the average wholesale price, should take into consideration commercially available information including such information as may be published or reported in various commercial reporting services. The Committee will monitor AWP's to ensure that this provision does not simply result in a 5% increase in AWP's.

Effective Date. The provision is effective January 1, 1998.

Section 10617. Coverage of oral anti-nausea drugs under chemotherapeutic regimen

Current Law. Medicare provides coverage for certain oral cancer drugs. The Administration has specified that Medicare will pay for anti-emetic drugs when they are needed for the administration and absorption of primary Medicare covered oral anticancer chemotherapeutic agents when a high likelihood of vomiting exists.

Explanation of Provision. The provision would provide coverage, under specified conditions, for a self-administered oral drug used as an acute anti-emetic used as part of an anticancer chemotherapeutic regimen. It would have to be administered by or under the supervision of a physician for use immediately before,

during or after the administration of the chemotherapeutic agent and used as a full replacement for the anti-emetic therapy which would otherwise be administered intravenously.

The provision would establish a per dose payment limit equal to 90 percent of the average per dose payment basis for the equivalent intravenous anti-emetics administered during the year, as computed based on the payment basis applied in 1996. The Secretary would be required to make adjustments in the coverage of or payment for the anti-nausea drugs so that an increase in aggregate payments per capita does not result.

Reason for Change. In certain cases, HCFA does not provide coverage for pharmaceuticals approved for coverage by the Food and Drug Administration, even when such pharmaceuticals meet criteria necessary for coverage under current law.

Effective Date. The provision is effective January 1, 1998.

Section 10618. Rural health clinics (RHCs)

Current Law. Medicare establishes payment limits for RHC services provided by independent (RHCs). RHCs, among other requirements, must have appropriate procedures for utilization review of clinic services. The Secretary is required to waive the RHC requirement for certain staffing of health professionals if the clinic has been unable to hire a physician assistant, nurse practitioner, or certified nurse-midwife in the previous nine years. The Secretary is prohibited from granting a waiver to a facility if the request for the waiver is made less than 6 months after the date of the expiration of previous waiver of the facility. RHCs are required to be located in a health professional shortage area. For RHCs that are in operation and subsequently fail to meet the requirement of being located in a health professional shortage area, the Secretary would be required to continue to consider the facility to meet the health professions shortage area requirement.

Explanation of Provision. The provision would apply per-visit payment limits to all RHCs, other than such clinics in rural hospitals with less than 50 beds. The provision would require that RHCs have a quality assessment and performance improvement program, in addition to appropriate procedures for utilization review. The provision would amend the waiver on the staffing requirement, to provide a waiver if the facility can not meet the requirement of having a nurse practitioner, physician assistant, or a certified nurse-midwife available 50% of the time the clinic operates; such a waiver is only available to clinics once they have been certified. The provision would require that shortage designations for RHCs be reviewed every three years. The provision would further amend the shortage area requirement by adding that RHCs must be located in areas in which there are insufficient numbers of needed health care practitioners as determined by the Secretary. The provision would require that operating RHCs that subsequently fail to meet the requirement of being located in a health professional shortage area, continue to be considered to meet the health professional shortage requirement, but only when, under criteria established by the Secretary in regulations, the RHCs are determined to be essential to the delivery of primary care services that would otherwise be unavailable in the geographic area served

by the clinic. The Secretary would be required to issue final regulations implementing the grandfathered clinics that would take effect no later than January 1 of the third calendar year beginning at least one month after enactment. The provision would take effect on the effective date of the regulations.

Reason for Change. The number of RHCs has grown by more than 30 percent a year since 1989. Unlike independent RHCs, provider-based RHCs are not subject to a per visit payment cap and as a result, costs for provider-based RHCs are increasing more rapidly. The Committee believes that there should be recertification requirements for RHCs.

Effective Date. The provision would be effective January 1 of the second calendar year following enactment of the bill.

Section 10619. Increased Medicare reimbursement for nurse practitioners and clinical nurse specialists

Current Law. Separate payments are made for nurse practitioner (NP) services provided in collaboration with a physician, which are furnished in a nursing facility. Recognized payments equal 85% of the physician fee schedule amount. Nurse practitioners and clinical nurse specialists (CNSs) are paid directly for services provided in collaboration with a physician in a rural area. Payment equals 75% of the physician fee schedule amount for services furnished in a hospital and 85% of the fee schedule amount for other services.

Explanation of Provision. The provision would remove the restriction on settings. It would also provide that payment for NP and CNS services could only be made if no facility or other provider charges are paid in connection with the service. Payment would equal 80% of the lesser of either the actual charge or 85% of the fee schedule amount for the same service if provided by a physician. For assistant-at-surgery services, payment would equal 80% of the lesser of either the actual charge or 85% of the amount that would be recognized for a physician serving as an assistant at surgery. The provision would authorize direct payment for NP and CNS services.

The provision would clarify that a clinical nurse specialist is a registered nurse licensed to practice in the state and who holds a master's degree in a defined clinical area of nursing from an accredited educational institution.

Reason for change. Medicare does not provide direct reimbursement for services provided by NPs and CNSs in certain settings.

Effective date. The provision applies to services furnished or supplies provided on or after January 1, 1998.

Section 10620. Increased Medicare reimbursement for physician assistants

Current Law. Separate payments are made for physician assistant (PA) services when provided under the supervision of a physician: (1) in a hospital, skilled nursing or nursing facility, (2) as an assistant at surgery, or (3) in a rural area designated as a health professional shortage area.

Explanation of Provision. The provision would remove the restriction on settings. It would also provide that payment for PA services could only be made if no facility or other provider charges are paid

in connection with the service. Payment would equal 80% of the lesser of either the actual charge or 85% of the fee schedule amount for the same service if provided by a physician. For assistant-at-surgery services, payment would equal 80% of the lesser of either the actual charge or 85% of the amount that would be recognized for a physician serving as an assistant at surgery. The provision would further provide that the PA could be in an independent contractor relationship with the physician. Employer status would be determined in accordance with state law.

Reason for change. Medicare does not provide direct reimbursement for services provided by PAs in certain facilities.

Effective Date. The provision applies to services furnished or supplies provided on or after January 1, 1998.

Section 10621. Renal dialysis-related services

Current law. Medicare covers persons who suffer from end-stage renal disease. Facilities providing dialysis services must meet certain requirements.

Explanation of provision. The provision would require the Secretary to audit a sample of cost reports of renal dialysis providers for 1995 and for each third year thereafter. The Secretary would also be required to develop and implement by January 1, 1999, a method to measure and report on the quality of renal dialysis services provided under Medicare in order to reduce payments for inappropriate or low quality care.

Reason for change. In its March Report to Congress, ProPAC recommended that HCFA regularly audit a sample of cost reports for dialysis facilities in order to validate the accuracy of the data and to assess the adequacy of Medicare's payment rates. The establishment of quality standards is more important than ever as more ESRD patients participate in managed care plans.

Effective date. This provision is effective upon enactment.

Chapter 3—Part B Premium

Section 10631. Part B premium

Current Law. When Medicare was established in 1965, the Part B monthly premium was intended to equal 50% of program costs. The remainder was to be financed by federal general revenues, i.e., tax dollars. Legislation enacted in 1972 limited the annual percentage increase in the premium to the same percentage by which social security benefits were adjusted for cost-of-living increases (i.e., cost-of-living or COLA adjustments). As a result, revenues dropped to below 25% of program costs in the early 1980s. Since the early 1980s, Congress has regularly voted to set the premium equal to 25% of costs. Under current law, the 25% provision is extended through 1998; the COLA limitation would again apply in 1999.

Explanation of Provision. In conjunction with the transfer of a portion of home health care spending from Part A to Part B, this provision would transition to the calculation of a Part B premium equal to 25% of program costs.

Reason for Change. The Committee is committed to moving to a premium that reflects 25 percent of Part B spending as soon as possible.

Effective date. This provision is effective on January 1, 1998.

SUBTITLE H—PROVISIONS RELATING TO PARTS A & B

Chapter 1—Provisions Relating to Medicare Secondary Payer

Section 10701. Permanent extension of certain secondary payer provisions

Current Law. Generally, Medicare is the primary payer, that is, it pays health claims first, with an individual's private or other public plan filling in some or all of the coverage gaps. In certain cases, the individual's other coverage pays first, while Medicare is the secondary payer. This is known as the Medicare secondary payer (MSP) program. The MSP provisions apply to group health plans for the working aged, large group health plans for the disabled, and employer health plans (regardless of size) for the end-stage renal disease (ESRD) population for 18 months. The MSP provisions for the disabled expire October 1, 1998. The MSP provisions for the ESRD population apply for 12 months, except the period is extended to 18 months for the February 1, 1991—October 1, 1998 period.

The law authorizes a data match program which is intended to identify potential secondary payer situations. Medicare beneficiaries are matched against data contained in the Social Security Administration and Internal Revenue Service files to identify cases where a working beneficiary (or working spouse) may have employer-based health insurance coverage.

Explanation of Provision. The provision would make permanent the provisions relating to the disabled and the data match program.

The provision would extend application of the MSP provisions for the ESRD population for 30-months.

Reason for Change. The provision would otherwise expire.

Effective Date. The provision would apply to items and services furnished on or after enactment with respect to periods beginning on or after the date that is 18 months prior to enactment.

Section 10702. Clarification of time and filing limitations

Current Law. In many cases where MSP recoveries are sought, claims have never been filed with the primary payer. Identification of potential recoveries under the data match process typically takes several years—considerably in excess of the period many health plans allow for claims filing. A 1994 appeals court decision held that HCFA could not recover overpayments without regard to an insurance plan's filing requirements.

Explanation of Provision. The provision would specify that the United States government could seek to recover payments if the request for payments was submitted to the entity required or responsible to pay within three years from the date the item or service was furnished. This provision would apply notwithstanding any other claims filing time limits that may apply under an employer group health plan. The provision should not be construed as permitting any waiver of the 3-year requirement in the case of items and services furnished more than 3 years before enactment.

Reason for Change. Recent court decisions have reduced the effectiveness of MSP recovery efforts.

Effective Date. The provision would apply to items and services furnished after 1990.

Section 10703. Clarification of liability of third party administrators

Current Law. A 1994 appeals court decision held that HCFA could not recover from third party administrators of self-insured plans.

Explanation of Provision. The provision would permit recovery from third party administrators of primary plans. However, recovery would not be permitted where the third-party administrator would not be able to recover the amount at issue from the employer or group health plan for whom it provides administrative services due to the insolvency or bankruptcy of the employer or plan.

The provision would clarify that the beneficiary is not liable in MSP recovery cases unless the benefits were paid directly to the beneficiary.

Reason for Change. Recent court decisions have reduced the effectiveness of MSP recovery efforts. In addition, the provision is necessary to protect beneficiaries from liability in certain cases.

Effective Date. The provision would apply to services furnished on or after enactment.

Chapter 2—Home Health Services

Section 10711. Recapturing savings resulting from temporary freeze on payment increases from home health services

Current Law. Home health care agencies are currently reimbursed on the basis of reasonable costs, up to specified limits. Cost limits are determined separately for each type of covered home health service (skilled nursing care, physical therapy, speech pathology, occupational therapy, medical social services, and home health aide), and according to whether an agency is located in an urban or rural area. Cost limits, however, are applied to aggregate agency expenditures; that is, an aggregate cost limit is set for each agency that equals the limit for each type of service multiplied by the number of visits of each type provided by the agency. Limits for the individual services are set at 112 percent of the mean labor-related and nonlabor per visit costs for freestanding agencies. Cost limits are updated annually by applying a market basket index to base year data derived from home health agency cost reports. The labor-related portion of a service limit is adjusted by the current hospital wage index.

The Omnibus Budget Reconciliation Act of 1993 (OBRA 93) required that there be no changes in home health cost limits (including no adjustments for changes in the wage index or other updates of data) for cost reporting periods beginning on or after July 1, 1994, and before July 1, 1996. The Secretary was also required, when granting or extending exceptions to cost limits, to limit any exception to the amount that would have been granted if there were no restriction on changes in the cost limits. OBRA 93 also repealed the requirement that additional payments be made to hos-

pital-based home health agencies for costs attributable to excess overhead allocations, effective for cost reporting periods beginning on or after October 1, 1993.

Explanation of Provision. In establishing home health limits for cost reporting periods beginning after September 30, 1997, the Secretary would be required to capture the savings stream resulting from the OBRA 93 freeze of home health limits by not allowing for the market basket updates to the limits that occurred during the cost reporting periods July 1, 1994 through June 30, 1996. In granting exemptions or exceptions to the cost limits, the Secretary would not consider the preceding provision for recapturing savings from the OBRA 93 freeze.

Reason for Change. The two-year freeze established in OBRA 1993 expired in 1996. Since that time, spending has reverted to over-inflated levels. The provision would permanently capture the savings and not allow for these inflated levels that occurred during the freeze.

Effective Date. The provision would be effective upon enactment.

Section 10712. Interim payments for home health services

Current Law. Limits for individual home health services are set at 112 percent of the mean labor-related and nonlabor per visit costs for freestanding agencies (i.e., agencies not affiliated with hospitals). The limits are effective for cost reporting periods beginning on or after July 1 of a given year and ending June 30 of the following year.

Explanation of Provision. The provision would reduce per visit cost limits to 105 percent of the national median of labor-related and nonlabor costs for freestanding home health agencies, effective for cost-reporting periods beginning October 1, 1997 (in effect, delaying the cycle for updating the limits).

For cost reporting periods beginning on or after October 1, 1997, home health agencies would be paid the lesser of: (1) their actual costs (i.e., allowable reasonable costs); (2) the per visit limits, reduced to 105% of the national median; or (3) a new blended agency-specific per beneficiary annual limit. The blended per beneficiary limit would be based 75 percent on an agency's own costs per beneficiary and 25 percent on the average cost per beneficiary for agencies in the same census region (adjusted for differences in labor costs). These costs would be calculated using cost reports for cost reporting periods ending in 1994, updated by the home health market basket and would include the costs associated with non-routine medical supplies. For new providers and those providers without a 12-month cost reporting period ending in calendar year 1994, the per beneficiary limit would be equal to the median of these limits (or the Secretary's best estimates) applied to home health agencies. Home health agencies that have altered their corporate structure or name would not be considered new providers for these purposes. For beneficiaries using more than one home health agency, the per beneficiary limitation would be prorated among the agencies.

The Secretary would be required to expand research on a prospective payment system for home health that ties prospective payments to a unit of service, including an intensive effort to develop a reliable case mix adjuster that explains a significant amount of

variance in cost. The Secretary would be authorized to require all home health agencies to submit additional information that is necessary for the development of a reliable case-mix system, effective for cost reporting periods beginning on or after October 1, 1997.

Reason for Change. The Committee supports breaking the link with cost-based reimbursement for home health care services as soon as possible and moving towards the establishment of a case-mix adjusted prospective payment system. However, the Committee is seriously concerned with proposals to establish a per visit payment system because of the strong incentives for home health agencies to shorten the duration and intensity of all visits, regardless of the needs and characteristics of the patient. In addition, because Medicare does not provide for a definition of a visit, the Medicare program would have great difficulty providing oversight of the quality of care being furnished to its beneficiaries. Finally, the Committee is concerned that more data collection was needed to ensure that the Secretary would move towards implementation of a prospective payment system by October 1, 1999. As a result, the provision would revise the current cost limits to limit over-utilization and curb excessive home health care spending.

Effective Date. The provision would be effective upon enactment.

Section 10713. Clarification of part-time or intermittent nursing care

Current Law. Both Parts A and B of Medicare cover home health visits for persons who need skilled nursing care on an intermittent basis or physical therapy or speech therapy. Once beneficiaries qualify for the benefit, the program covers part-time or intermittent nursing care provided by or under the supervision of a registered nurse and part-time or intermittent home health aide services, among other services. Coverage guidelines issued by HCFA have defined part-time and intermittent.

Explanation of Provision. Effective for services furnished on or after October 1, 1997, the provision would include in Medicare statute definitions for part-time and intermittent skilled nursing and home health aide services. For purposes of receiving skilled nursing and home health aide services, "part-time or intermittent" would mean skilled nursing and home health aide services furnished any number of days per week as long as they are furnished (combined) less than 8 hours each day and 28 or fewer hours each week (or, subject to review on a case-by-case basis as to the need for care, less than 8 hours each day and 35 or fewer hours per week). For purposes of qualifying for Medicare's home health benefit because of a need for intermittent skilled nursing care, "intermittent" would mean skilled nursing care that is either provided or needed on fewer than 7 days each week, or less than 8 hours of each day for periods of 21 days or less (with extensions in exceptional circumstances when the need for additional care is finite and predictable).

Reason for Change. The number of home health visits provided to beneficiaries receiving home health care has nearly tripled in recent years from an average of 26 visits per year in 1989 to an average of 76 visits per year in 1996. The skyrocketing growth in home

health care reflects in part weak criteria and definitions of the current home health care benefit.

Effective Date. The provision would be effective upon enactment.

Section 10714. Study on definition of homebound

Current Law. In order to be eligible for home health care, a Medicare beneficiary must be confined to his or her home. The law specifies that this “homebound” requirement is met when the beneficiary has a condition that restricts the ability of the individual to leave home, except with the assistance of another individual or with the aid of a supportive device (such as crutches, a cane, a wheelchair, or a walker), or if the individual has a condition such that leaving his or her home is medically contraindicated. The law further specifies that while an individual does not have to be bedridden to be considered confined to home, the condition of the individual should be such that there exists a normal inability to leave home, that leaving home requires a considerable and taxing effort by the individual, and that absences from home are infrequent or of relatively short duration, or are attributable to the need to receive medical treatment.

Explanation of Provision. The provision would require the Secretary of Health and Human Services to conduct a study on the criteria that should be applied with regards to the determination of whether an individual is considered homebound for purposes of receiving the home health benefit. The Secretary would be required to report no later than October 1, 1998 to Congress and make specific recommendations on such criteria.

Reasons for change. The current definition of homebound is vague and overly broad, allowing for considerable discretion in interpretation and opens opportunities for fraud and abuse. Review of HCFA home health data shows that Medicare routinely reimburses care to beneficiaries who are not truly homebound. As a result, Medicare is currently reimbursing for items and services related to home health care which were never intended to be covered. The Committee is concerned with the current vagueness of the definition and its impact on enforcement. The Committee believes that the current definition should be strengthened and that the definition of homebound not be expanded beyond Medicare’s current covered benefits.

Effective Date. The provision would be effective upon enactment.

Section 10715. Payment based on location where home health service is furnished

Current Law. Some home health agencies are established with the home office in an urban area and branch offices in rural areas. Payment is based on where the service is billed, in this case the urban area with its higher wage rate, even if the service had been delivered in a rural area.

Explanation of Provision. Effective for cost reporting periods beginning on or after October 1, 1997, home health agencies would be required to submit claims on the basis of the location where a service is actually furnished.

Reason for Change. Currently, an increasing number of home health agencies are locating in urban areas in order to receive

higher Medicare reimbursement rates. The recommendations would require home health agencies to submit claims for home health care services in the location of where the service was provided.

Effective Date. The proposal would be effective upon enactment.

Section 10716. Normative standards for home health claims denials

Current Law. As long as they remain eligible, home health users are entitled to unlimited number of visits.

Explanation of Provision. The provision would authorize the Secretary to establish normative guidelines for the frequency and duration of home health services. Payments would be denied for visits that exceed the normative standards. The provision would also authorize the Secretary to establish a process for notifying a physician in which the number of home health visits furnished according to a prescription or certification of the physician significantly exceeds the threshold normative number of visits that would be covered for specific conditions or situations.

Reason for Change. Under current law, when Medicare denies payment for a home health visit, the agency must prove that a specific visit was not medically necessary, thereby creating difficulties in enforcement. Allowing the Secretary to establish more objective criteria will help Medicare gain more control over excessive home health care utilization.

Effective Date. The proposal would be effective upon enactment.

Section 10717. No home health benefits based solely on drawing blood

Current Law. In order to qualify for Medicare's home health benefit, a person must be homebound and be in need of intermittent skilled nursing care or physical or speech therapy.

Explanation of Provision. The provision would clarify that a person could not qualify for Medicare's home health benefit on the basis of needing skilled nursing care for venipuncture for the purpose of obtaining a blood sample.

Reason for Change. Eliminating venipuncture as a qualified skilled service for Medicare home health eligibility would limit payments for other home health services for beneficiaries who would otherwise be ineligible for services under the home health benefit. This proposal would close a loophole and continue to allow beneficiaries to receive blood monitoring services under Part B.

Effective Date. The proposal would be effective upon enactment.

Chapter 3—Baby Boom Generation Medicare Commission

Section 10721. Bipartisan commission on the effect of the baby boom generation on the medicare program

Current Law. No provision.

Explanation of Provision. The provision would establish a commission to be known as the Bipartisan Commission on the Effect of the Baby Boom Generation on the Medicare Program, hereafter referred to as "the Commission." It would be required to: (1) examine the financial impact on the Medicare program of the significant increase in the number of Medicare eligible individuals which will occur approximately during 2010 and lasting for approximately 25

years; (2) make specific recommendations to Congress with respect to a comprehensive approach to preserve the Medicare program for the period during which such individuals are eligible for Medicare; and (3) study the feasibility and desirability of establishing an independent Commission to make annual recommendations to Congress for consideration under an expedited process. In making its recommendations, the Commission would be required to consider: (1) the amount and sources of Federal funds to finance Medicare, including innovative financing methods; (2) methods used by other nations to respond to comparable demographics; (3) modifying age-based eligibility to correspond to that under the OASDI program; and (4) trends in employment-related health care for retirees, including the use of medical savings accounts and similar financing devices.

The Commission would be composed of 15 voting members, 6 appointed by the Majority Leader of the Senate in consultation with the Minority Leader, of whom no more than 4 are of the same party; 6 by the Speaker of the House, after consultation with the Minority Leader, of whom no more than 4 are in the same party; and 3 ex officio members of the Board of Trustees of the Federal Hospital Insurance Trust Fund and of the Federal Supplementary Medical Insurance Trust Fund who are Cabinet level officials. The provision spells out the appointment of a chair and vice chair, appointment of staff and consultants, compensation, the procedure for filling vacancies, and requirements relating to meetings and quorums. The Chairman, in consultation with the vice chairman, could appoint an advisory panel. Upon request of the Commission, the Comptroller General would be required to conduct such studies or investigations as the Commission determined were needed to carry out its duties. The Director of CBO would be required to provide the commission with cost estimates, for which CBO would be compensated. The Commission would be authorized to detail it to employees of Federal agencies, and to obtain technical assistance and information from Federal agencies.

The Commission would be required to submit to Congress a report, no later than May 1, 1999, 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 a period of projected solvency of the Federal Old-Age and Survivors Insurance Trust Fund). The report would be required to include detailed recommendations for appropriate legislative initiatives respecting how to accomplish this objective. The Commission would terminate 30 days after the date of submission of the mandated report. An amount of \$1.5 million would be authorized to be appropriated; 60% would be payable from the Federal Hospital Insurance Trust Fund and 40% from the Federal Supplementary Medical Insurance Trust Fund. In addition, within 12 months of enactment, the Commission could report to Congress on specific recommendations regarding changes in the law to implement its recommendations.

Reason for Change. While the Act brings Medicare into fiscal balance until 2007 and provides additional choices for Medicare beneficiaries through MedicarePlus reforms, the significant demographic shift occurring with the retirement of the so-called baby

boom generation will require further Congressional action to preserve the Medicare program for the long-term.

Effective Date. The provision would be effective upon enactment.

Chapter 4—Provisions Relating to Direct Graduate Medical Education

Section 10731. Limitation on payment based on number of residents and implementation of rolling average FTE count

Current Law. The direct costs of approved graduate medical education (GME) programs (such as the salaries of residents and faculty, and other costs related to medical education programs) are excluded from PPS and are paid on the basis of a formula that reflects Medicare's share of each hospital's per resident costs. Medicare's payment to each hospital equals the hospital's costs per full-time-equivalent (FTE) resident, times the weighted average number of FTE residents, times the percentage of inpatient days attributable to Medicare Part A beneficiaries. Each hospital's cost per resident amount is calculated using data from the hospital's cost reporting period that began in FY1984, increased by 1 percent for hospital cost reporting periods beginning July 1, 1985, and updated in subsequent cost reporting periods by the change in the CPI. OBRA 93 provided that the per resident amount would not be updated by the CPI for costs reporting periods during FY1994 and FY1995, except for primary care residents in obstetrics and gynecology. The number of FTE residents is weighted at 100 percent for residents in their initial residency period (i.e., the number of years of formal training necessary to satisfy specialty requirements for board eligibility). Residents in preventive care or geriatrics are allowed a period of up to 2 additional years in the initial residency training period. For residents not in their initial residency period, the weighting factor is 50 percent. On or after July 1, 1986, residents who are foreign medical graduates can only be counted as FTE residents if they have passed designated examinations.

Explanation of Provision. For cost reporting periods beginning on or after October 1, 1997, the provision would limit the total number of full-time equivalent (FTE) residents for which Medicare would make payments to the number of FTE residents in training during the hospital's cost reporting period ending December 31, 1996. For the cost reporting period beginning on or after October 1, 1997, the total number of FTE equivalent residents counted for determining the hospital's direct GME payment would equal the average FTE counts for the cost reporting period and the preceding cost reporting period. For each subsequent cost reporting period, the total number of FTEs residents counted for determining the hospital's direct GME payment, would be equal to the average of the actual FTE counts for the cost reporting period and preceding two cost reporting periods. The provision would allow that, if a hospital's cost reporting period beginning on or after October 1, 1997, was not equal to 12 months, the Secretary would make appropriate modifications to ensure that the average FTE resident counts are based on the equivalent of full 12-month cost reporting periods. The provision would require the Secretary to establish rules for new residency medical training programs.

Reason for Change. Hospitals have little incentive to reduce the size of their residency programs because they receive large Medicare payments for each resident. Since residents primarily provide patient care, the subsidy creates an incentive for teaching hospitals to substitute them in lieu of other types of caregivers (physician assistants and nurse practitioners).

Because of the Committee's concern with the impact of the provision on new residency programs, the Secretary is asked to develop rules for new programs. The Committee believes that this can be done in such a way so that an aggregate cap could be applied to residency training programs that are under the auspices of the same school of graduate medical education, but use multiple sites for training. The Committee is concerned that absent such an aggregate cap, there may be room for gaming through trading or even possible sales of residency positions to other sites.

Effective Date. The provision would be effective upon enactment.

Section 10732. Phased-in limitation on hospital overhead and supervisory physician component of direct medical education costs

Current Law. Medicare's direct medical education costs for a cost reporting period includes an aggregate amount that is the product of the hospital's approved FTE resident amount and the weighted average number of FTE residents in the hospital's approved medical residency training programs in that period.

Explanation of Provision. The provision would phase-in over five years a limitation on hospital overhead and supervisory physician costs. For hospitals with overhead GME amounts that exceed the 75th percentile of the overhead GME for all hospitals, the GME amount made for periods beginning on or after October 1, 1997, would be reduced by the lesser of: (1) 20% of the amount by which the overhead GME amount exceeds the 75th percentile amount, or (2) 15% of the hospital's overhead GME amount otherwise determined without regard to this provision.

The overhead GME amount for a period would be the product of the percentage of the hospital's per resident payment amount for the base period that was not attributable to salaries and fringe benefits, and the hospital specific per resident payment amount for the period involved. The base period would be defined as the cost reporting period beginning in FY1984 or the period used to establish the hospital's per resident payment amount for hospitals that did not have approved residency training programs in FY1984.

Reason for Change. There is considerable variation in hospital-specific per resident payment amounts. Per resident payment amounts range from less than \$20,000 to well over \$100,000. Furthermore, twenty-five percent of residents are in hospitals with a per resident payment amount of less than \$48,000, while another twenty-five percent are in hospitals with per resident payment amounts over \$77,000. The Committee is concerned that this variation is generally inequitable and unjustified, and that differences in the cost of doing business from one area to another do not explain the vast difference in cost.

Section 10733. Permitting payment to non-hospital providers

Current Law. No provision.

Explanation of Provision. The provision would require the Secretary to submit to Congress, no later than 18 months after enactment, a proposal for payment to qualified non-hospital providers for their direct costs of medical education, if those costs are incurred in the operation of a Medicare approved medical residency training program. The proposal would be required to specify the amounts, form, and manner in which such payments would be made, and the portion of the payments that would be made from each of the Medicare trust funds. The Secretary would be authorized to implement the proposal for residency years beginning no earlier than 6 months after the date the report is submitted. Qualified non-hospital providers would include federally qualified health centers, rural health clinics, MedicarePlus organizations, and other providers the Secretary determines to be appropriate.

The provision would also require the Secretary to reduce the hospital's approved amount to the extent payment would be made to non-hospital providers for residents included in the hospital's count of FTE residents. In the case of residents not included in the FTE count, the Secretary would be required to provide for such a reduction in aggregate approved amounts under this subsection to assure that the application of non-hospital providers does not result in any increase in expenditures than would have occurred if payments were not made to non-hospital providers.

Reason for Change. Medicare's current system restricts GME payments to hospitals and discourages the development of training in alternative sites such as federally qualified health centers, rural health clinics and health maintenance organizations. Although residents spend time in ambulatory settings, that time is only recognized for Medicare's direct GME payment if the hospital incurs all or substantially all of the costs of training. Medicare's policy does not reflect the changes that have occurred in resident training since Medicare was enacted. Today, training is not limited exclusively to teaching hospitals.

Effective Date. The provision would be effective upon enactment.

Section 10734. Incentive payments under plans for voluntary reduction in number of residents

Current Law. No provision.

Explanation of Provision. The provision would establish a program to provide incentive payments to hospitals that developed plans for the voluntary reduction in the number of residents in a training program. For voluntary residency reduction plans for which an application was approved, the qualifying entity submitting the plan would be required to be paid an applicable percentage (defined below) equal to the sum of the following: (1) the amount of payment which would have been made under this subsection if there had been a 5% reduction in the number of FTE residents in the approved medical education training programs as of June 30, 1997, exceeded the amount of the payment which would be made taking into account the reduction in the number of effected FTEs under the plan; and, (2) the amount of the reduction in payment under Medicare's indirect medical education adjustment that was attributable to the reduction in the number of residents effected under the plan.

The base number of residents would be defined as the number of FTE residents in residency training program of the entity as of June 30, 1997. The "applicable hold harmless percentage" for entities electing a 5-year reduction plan would be 100% for the first and second residency training years in the reduction plan; 75% in the third year; 50% in the fourth year; and 25% in the fifth year. The "applicable hold harmless percentage" for entities electing a 6-year reduction plan would be 100% in the first residency training year of the plan; 95% in the second year of the plan; 85% in the third year; 70% in the fourth year; 50% in the fifth year; 25% in the sixth year. In addition, if payments were made under this program to an entity that increased the number of FTE residents above the number provided in the plan, the entity would then be liable for repayment to the Secretary of the total amount paid under the plan. The Secretary would also be required to establish rules regarding the counting of residents who are assigned to institutions that do not have medical residency training programs participating in a residency reduction plan.

The provision specifies that qualifying entities would include individual hospitals operating one or more approved medical residency training programs; two or more hospitals operating residency programs that apply as a single qualifying entity; or a qualifying consortium. In the case of an application by a qualifying entity consisting of two hospitals, the Secretary would be prohibited from approving the application unless the application represented that the qualifying entity either would not: (1) reduce the number of FTE residents in primary care during the period of the plan, or (2) reduce the proportion of its residents in primary care (to the total number of residents) below such proportion as in effect during the period the residency reduction plan was in effect. In the case of an application from a consortia, the Secretary would be prohibited from approving the application unless the application represented that the qualifying entity would not reduce the proportion of residents in primary care (to total residents) below such proportion in effect during the period the residency reduction plan was in effect.

For individual hospital applicants, the number of FTE residents in all the approved medical residency training programs operated by or through the facility would be required to be reduced as follows: (1) if the base number of residents exceeded 750 residents, by a number equal to at least 20% of the base number; (2) if the base number of residents exceeded 500, but was less than 750 residents, by 150 residents; (3) if the base number of residents did not exceed 500 residents, by a number equal to at least 25% of the base number; (4) in the case of a qualifying entity that was a consortia, by a number equal to at least 20% of the base number. The reductions in the number of FTE residents in the approved medical residency programs operated through or by an entity would be below the base number of residents for the entity and would be fully effective no later than the 5th residency training year for entities electing a 5-year plan, or the 6th residency training year for entities making the election of a 6-year reduction plan.

The provision would require that entities provide assurance that in reducing the number of residents, entities maintained their primary care residents. Entities would be required to provide assur-

ance that they would maintain the number of primary care residents if: (1) the base number of residents is less than 750; (2) the number of FTE residents in primary care included in the base year was at least 10% of the total number of residents; and (3) the entity represented in its application that there would be no reduction under the plan in the number of FTE residents in primary care. If the entity failed to comply with the requirement that the number of FTE residents in primary care were maintained, the entity would be subject to repayment of all amounts received under this program.

The requirements of the residency reduction plan would not apply to any residency training demonstration project approved by HCFA as of May 27, 1997. The Secretary would be required to take necessary action to assure that in no case the amount of payments under the plan would exceed 95% of what payments would have been prior to the plan for direct GME payments under Medicare. As of May 27, 1997, the Secretary would be prohibited from approving any demonstration project that would provide for additional Medicare payments in connection with reductions in the number of residents in a training program for any residency training year beginning before July 1, 2006. The Secretary would be authorized to promulgate regulations, that take effect on an interim basis, after notice and pending opportunity for public comment, by no later than 6 months after the date of enactment.

Reason for Change. Teaching hospitals have few incentives to reduce residency slots because Medicare's indirect and direct GME payment is based on the teaching hospital's total number of residents. The February 1997 HCFA GME demonstration in New York encourages teaching hospitals to reduce their number of residents by providing GME payments provided that hospitals agree to meet the terms and conditions of the demonstration, which require a 20 to 25 percent reduction in the number of residents over a five or six year period.

Several issues, however, have been raised about the demonstration. First, the New York demonstration provided for incentive payments for all residency reductions, including the initial five percent reduction. Concerns have been expressed that while other teaching hospitals around the country were responding to market pressures and beginning to reduce their number of residents, participating New York hospitals would be receiving incentive payments that were not available to other teaching hospitals which had already (or were in the process) of reducing residency positions. Second, other states were not able to participate in the demonstration thereby creating an unlevel playing field.

Effective Date. The provision would be effective on an interim basis through regulations six months after enactment.

Section 10735. Demonstration project on use of consortia

Current Law. No provision.

Explanation of Provision. The provision would require the Secretary to establish a demonstration project under which, instead of making direct GME payments to teaching hospitals, the Secretary would make payments to each consortium that met the requirements of the demonstration project. A qualifying consortia would be

required to be in compliance with the following: (1) the consortium would consist of an approved medical residency training program in a teaching hospital and one or more of the following entities: a school of allopathic or osteopathic medicine, another teaching hospital, including a children's hospital, another approved medical residency training program, a federally qualified health center, a medical group practice, a managed care entity, an entity providing outpatient services, or an entity determined to be appropriate by the Secretary; (2) the members of the consortium would have agreed to participate in the programs of graduate medical education that are operated by entities in the consortium; (3) with respect to receipt by the consortium of direct GME payments, the members of the consortium would agree on a method for allocating the payments among the members; and (4) the consortium would meet additional requirements established by the Secretary. The total payments to a qualifying consortium for a fiscal year would not be permitted to exceed the amount that would have been paid under the direct GME payment to teaching hospitals in the consortium. The payments would be required to be made in such proportion from each of the Medicare trust funds as the Secretary specifies.

Reason for Change. Consortia are thought of as a way to reduce the degree of centralized decision making involved in distributing graduate medical education funds. Funding consortia, instead of individual teaching hospitals, could help to lessen the inconsistencies between current payment policies and resident supply and specialty distribution decisions driven by other recent changes in health care delivery and financing.

When determining qualifying consortia, consideration should be given to locations where approved medical residency training programs for geriatric medicine are conducted. These locations include skilled nursing facilities, adult day treatment programs, hospice programs and rehabilitation facilities.

Effective Date. The provision would be effective upon enactment.

Section 10736. Recommendations on long-term payment policies regarding financing teaching hospitals and graduate medical education

Current Law. No provision.

Explanation of Provision. The provision would require the Medicare Payment Advisory Commission (established by the bill) to examine and develop recommendations on whether and to what extent Medicare payment policies and other federal policies regarding teaching hospitals and graduate medical education should be reformed. The Commission's recommendations would be required to include each of the following: (1) the financing of graduate medical education, including consideration of alternative broad-based sources of funding for such education and models for the distribution of payments under any all-payer financing mechanism; (2) the financing of teaching hospitals, including consideration of the difficulties encountered by such hospitals as competition among health care entities increases, including consideration of the effects on teaching hospitals of the method of financing used for the MedicarePlus program under part C of Medicare; (3) possible meth-

odologies for making payments for graduated medical education and the selection of entities to receive such payments, including consideration of matters as (A) issues regarding children's hospitals and approved medical residency training programs in pediatrics, and (B) whether and to what extent payments were being made (or should be made) for training in the various nonphysician health professions; (4) federal policies regarding international graduates; (5) the dependence of schools of medicine on service-generated income; (6) whether and to what extent the needs of the U.S. regarding the supply of physicians, in the aggregate and in different specialties, would change during the 10-year period beginning on October 1, 1997, and whether and to what extent any such changes would have significant financial effects of teaching hospitals; and, (7) methods for promoting an appropriate number, mix, and geographical distribution of health professionals.

The Commission would be required to consult with the Council on Graduate Medical Education and individuals with expertise in the area of graduate medical education, including (1) deans from allopathic and osteopathic schools of medicine; (2) chief executive officers (or their equivalent) from academic health centers, integrated health care systems, approved medical residency training programs, and teaching hospitals that sponsor approved medical residency training programs; (3) chairs of departments or divisions from allopathic and osteopathic schools of medicine, schools of dentistry, and approved medical residency training programs in oral surgery; (4) individuals with leadership experience from allopathic and osteopathic schools of dentistry and approved medical residency training programs in oral surgery; (5) individuals with experience from representative fields of non-physician health professionals; (6) individuals with experience in the study of issues regarding the composition of the U.S. health care workforce; and, (7) individuals with expertise on the financing of health care.

The Commission would be required to submit a report to the Congress no later than 2 years after enactment providing its recommendations under this section and the reasons and justifications for such recommendations.

Reasons for Change. The Committee recognizes that the measures undertaken to reform the methods used to reimburse teaching hospitals and graduate medical education are only initial steps. The Committee agrees that much more needs to be done in this area.

Today, Medicare is the nation's primary funding source for the costs of graduate medical education. These expenditures have ensured the U.S. position as the world leader in medical education and allow us to provide the highest quality health care to our citizens.

Because the private health care market is changing so dramatically, the Committee strongly believes that a stable, adequate funding source for teaching hospitals and graduate medical education is needed. However, at this time, there is no agreement about the exact structure of that funding source. The Committee is assigning the Medicare Payment Advisory Commission to review issues relating to graduate medical education and teaching hospital payment to indicate its strong commitment to finding a solution for the fu-

ture of teaching hospitals and graduate medical education funding in the United States.

Effective Date. The provision would be effective upon enactment.

Section 10737. Medicare special reimbursement rule for certain combined residency programs.

Current Law. Combined programs run concurrently for a period of time that is longer than the required time for certification in either program, but shorter than would be required if the programs were taken sequentially. Medicare makes direct GME payments for residents in their initial residency period. The initial residency period is defined as the number of years of formal training necessary to satisfy specialty requirements for board eligibility, but not more than 5 years, with an exception for residents in preventive care or geriatrics who are allowed a period of up to 2 additional years in the initial residency training period. Residents in their initial residency period are counted as 1.0 FTE during their initial residency period and as 0.5 FTE for subsequent years. For combined residency training programs there is no special provision in current law, so that regardless of the number of additional years the second program requires for certification, during the initial residency period residents are counted as a full (1.0) FTE and subsequent years are paid at half (0.5) the FTE.

Explanation of Provision. The provision would provide a new rule for those residents enrolled in dual primary care residency training programs. Specifically, the period of board eligibility shall be the minimum number of years of formal training required to satisfy the requirements for initial board eligibility in the longest of the individual programs plus one additional year.

Reason for Change. Certain rural and underserved urban areas have a shortage of primary care physicians. This provision would help increase the number of physicians who practice primary care medicine by supporting training to the full extent required for board certification in more than one area of primary care medicine. The Committee is supportive of efforts to ensure that a sufficient number of primary care physicians receive training.

Effective Date. The provision is effective for residency years beginning on or after July 1, 1997.

Section 10741. Centers of excellence

Current Law. No provision.

Explanation of Provision. The provision would create a new program, the Centers of Excellence, under which the Secretary would be required to use a competitive process to contract with specific hospitals or other entities for furnishing services related to surgical procedures, and for furnishing services (unrelated to surgical procedures) to hospital inpatients that the Secretary determines to be appropriate. The services could include any services covered by Medicare that the Secretary determined were appropriate, including post-hospital services. The Secretary would be required to contract with entities that meet quality standards established by the Secretary, and contracting entities would be required to implement a quality improvement plan approved by the Secretary.

Payment for services provided under the program would be made on the basis of a negotiated all-inclusive rate. The amount of payment made for services covered under a contract would be required to be less than the aggregate amount of payments that would have been made otherwise for these same services. The contract period would be required to be 3 years, and could be renewed as long as the entity continued to meet quality and other contractual standards. Entities under these contracts would be permitted to furnish additional services (at no cost to a Medicare beneficiary) or waive cost-sharing, subject to approval by the Secretary. The Secretary would be required to limit the number of centers in a geographic area to the number needed to meet project demand for contracted services.

Reason for change. Private managed care plans have been able to reduce expenditures by bundling together groups of services for payment purposes and giving providers of those services incentives to economize. The Committee believes that the Centers of Excellence program would provide an opportunity for the Secretary to use private sector tools and Medicare purchasing power to reduce aggregate expenditures.

The Committee is aware, however, that some well respected centers have been reluctant to participate in the current Centers of Excellence demonstration projects. Reasons cited for not participating include: an emphasis on discounting over quality, lack of sufficient severity adjusters for within DRG variation; waivers of coinsurance that benefit primarily medigap insurers; and requirements to provide extra amenities to certain Medicare patients that are not provided to all patients. The Committee believes that the discounted payment rates should reflect such factors as quality results, long term cost savings resulting from better outcomes, and severity adjustments.

Effective date. This provision is effective upon enactment.

Section 10742. Medicare part B special enrollment period and waiver of part B late enrollment penalty and medigap special open enrollment period for certain military retirees and dependents

Current Law. Persons generally enroll in Part B when they turn 65. Persons who delay enrollment in the program after their initial enrollment period are subject to a premium penalty. This penalty is a surcharge equal to 10% of the premium amount for each 12 months of delayed enrollment. There is no upper limit on the amount of penalty that may apply. Further, the penalty continues to apply for the entire time the individual is enrolled in Part B.

Some persons declined Part B coverage because they thought they would be able to get health care coverage at a nearby military base; many of these bases subsequently closed.

Explanation of Provision. The provision would waive the delayed enrollment penalty for certain persons who enroll during a special six month enrollment period which begins with the first month that begins at least 45 days after enactment. An individual covered under this provision is one: (1) who, on the date of enactment is at least 65 and eligible to enroll in Part B; (2) who, at the time the individual first met the enrollment requirements was a "covered beneficiary" under the military medical and dental care program.

Covered beneficiary as defined in section 1072(5) of title 10 of the U.S. Code excludes an active duty beneficiary. Part B coverage would begin the month after enrollment.

The provision would also guarantee issuance of a Medigap type "A", "B", "C", or "F" policy to an individual who enrolls with a Medigap plan during the same 6-month enrollment period.

Reason for Change. The provision allows a safe-harbor period for military retirees and dependents who may otherwise face reductions in health care services due to military base closings and realignments in military health care services so that they may enroll in Medicare Part B and certain Medigap plans.

Effective Date. The provision would be effective upon enactment.

Section 10743. Protections under the medicare program for disabled workers who lose benefits under a group health plan

Current Law. Persons generally enroll in Part B when they turn 65. Persons who delay enrollment in the program after their initial enrollment period are subject to a premium penalty. This penalty is a surcharge equal to 10% of the premium amount for each 12 months of delayed enrollment. There is no upper limit on the amount of penalty that may apply. Further, the penalty continues to apply for the entire time the individual is enrolled in Part B.

Some persons declined Part B coverage because they thought they would be able to continue to get health care coverage from their employer-sponsored health plan.

Explanation of Provision. The provision would waive the Part B enrollment penalty for certain disabled retired workers who were continuously enrolled in a group health plan and whose coverage was involuntarily terminated. To qualify, individuals must be disabled and continuously enrolled under a group health plan at the time they first become eligible to enroll in Medicare Part B. Individuals meeting these requirements may enroll in Medicare Part B without penalty within the 6-month enrollment period beginning on the date their employer-provided coverage is terminated at a time when enrollment under the plan is not by reason of the individual's, or the individual's spouse's, current employment.

Reason for Change. The provision is designed to make full Medicare participation more accessible for certain disabled individuals who have lost coverage through no fault of their own and may otherwise find Medicare Part B enrollment penalties a significant barrier to obtaining coverage for physician services and other Part B services.

Effective Date. The provision is effective upon enactment.

Section 10744. Placement of advance directive in medical record

Current Law. The Patient Self-Determination Act of 1990 requires that hospitals, skilled nursing facilities, home health agencies, hospice programs and health maintenance organizations which participate in Medicare guarantee that every adult receiving medical care be given written information concerning patient involvement in treatment decisions. Providers must document in the medical record whether the patient has an advance directive or not.

Explanation of Provision. The provision would require that the individual's medical record be placed in a prominent part of the individual's current medical record.

Reason for Change. While significant progress has been made regarding the use of advanced directives and durable powers of attorney, issues remain regarding the accessibility of forms related to the patient's advanced directive or durable power of attorney. Requiring that such information be placed in a prominent part of the patient's chart would assist health care providers in accessing such information in a more timely fashion.

SUBTITLE I—MEDICAL LIABILITY REFORM

Chapter 1.—General Provisions

Section 10801. Federal reform of health care liability actions

Current Law. There are no uniform Federal standards governing health care liability actions.

Explanation of Provision. The provision would provide for Federal reform of health care liability actions. It would apply to any health care liability action brought in any State or Federal court. The provisions would not apply to any action for damages arising from a vaccine-related injury or death or to the extent that the provisions of the National Vaccine Injury Compensation Program apply. The provisions would also not apply to actions under the Employment Retirement Income Security Act. The provisions would preempt State law to the extent State law provisions were inconsistent with the new requirements. However, it would not preempt State law to the extent State law provisions were more stringent. The provision would not affect or waive the defense of sovereign immunity asserted by any State or the U.S., affect the applicability of the Foreign Sovereign Immunities Act of 1976, preempt State choice-of-law rules with respect to claims brought by a foreign nation or citizen, or affect the right of any court to transfer venue.

Reason for Change. The provision is necessary to reduce health care costs and promote efficiencies in health care delivery. There is now considerable evidence, based on actual State experience, that these reforms will reduce costs associated with the practice of defensive medicine. The American Academy of Actuaries recently completed a study in which they found that comprehensive State malpractice reforms, including reforms limiting non-economic damages and instituting joint-and-several liability resulted in lower malpractice costs and insurance premiums.

Professor Mark McClellan of Stanford University found even more dramatic results directly applicable to the Medicare program. Professor McClellan found that State malpractice reforms resulted in lower average spending on heart attack patients and patients with ischemic heart disease, with little or no effect on readmission or mortality rates. In other words, effective health care was not sacrificed by providing *lower-cost* health care to patients. In addition, McClellan concluded that the Medicare program could save up to \$600 million dollars a year on heart disease alone if the type of

malpractice reforms contained in this Subtitle of the Act were enacted.

While medical liability reform has largely been undertaken at the State level, federal reforms are necessary because of State constitutional impediments to reform. For example: (1) statutes of limitation have been held to violate State constitutions in Arizona and New Hampshire; (2) limits on punitive damages have been held unconstitutional in Alabama; and (3) periodic payment schedules have been held to violate State constitutions in Arizona, New Hampshire, and Ohio. Moreover, because federal government contributions constitute a considerable proportion of total health care spending in the United States, there is a significant federal interest in medical liability reform.

Effective Date. The provision is generally effective upon enactment, except that health care liability claims or actions arising prior to the date of enactment are governed by the applicable statute of limitations in effect at the time the injury occurred.

Section 10802. Definitions

Current Law. No provision.

Explanation of Provision. The provision would define the following terms for purposes of the Federal reforms: actual damages; alternative dispute resolution system; claimant; clear and convincing evidence; collateral source payments; drug; economic loss; harm; health benefit plan; health care liability action; health care liability claim; health care provider; health care service; medical device; noneconomic damages; person; product seller; punitive damages; and State.

Effective Date. The provision is generally effective upon enactment, except that health care liability claims or actions arising prior to the date of enactment are governed by the applicable statute of limitations in effect at the time the injury occurred.

Section 10803. Effective date

Current Law. No provision.

Explanation of Provision. The provision would specify that Federal reforms apply to any health care liability action brought in any State or Federal court that is initiated on or after the date of enactment. The provision would also apply to any health care liability claim subject to an alternative dispute resolution system. Any health care liability claim or action arising from an injury occurring prior to enactment would be governed by the statute of limitations in effect at the time the injury occurred.

Effective Date. The provision is generally effective upon enactment, except that health care liability claims or actions arising prior to the date of enactment are governed by the applicable statute of limitations in effect at the time the injury occurred.

Chapter 2—Uniform Standards for Health Care Liability Actions

Section 10811. Statute of limitations

Current Law. To date, reforms of the malpractice system have occurred primarily at the State level and have generally involved

changes in the rules governing tort cases. (A tort case is a civil action to recover damages, other than for a breach of contract.)

Explanation of Provision. The provision would establish uniform standards for health care liability claims. It would establish a uniform statute of limitations. Actions could not be brought more than two years after the injury was discovered or reasonably should have been discovered. In no event could the action be brought more than five years after the date of the alleged injury.

Reason for Change. This provision is necessary to prevent frivolous and unnecessary litigation and to provide a reasonable period of repose to providers.

Effective Date. The provision is generally effective upon enactment, except that health care liability claims or actions arising prior to the date of enactment are governed by the applicable statute of limitations in effect at the time the injury occurred.

Section 10812. Calculation and payment of damages

Current Law. No provision.

Explanation of Provision. The provision would limit noneconomic damages to \$250,000 in a particular case. The limit would apply regardless of the number of persons against whom the action was brought or the number of actions brought.

The provision would specify that a defendant would only be liable for the amount of noneconomic damages attributable to that defendant's proportionate share of the fault or responsibility for that claimant's injury.

The provision would permit the award of punitive damages (to the extent allowed under State law) only if the claimant established by clear and convincing evidence either that the harm was the result of conduct that specifically intended to cause harm or the conduct manifested a conscious flagrant indifference to the rights or safety of others. The amount of punitive damages awarded could not exceed \$250,000 or three times the amount of economic damages, whichever was greater. The determination of punitive damages would be determined by the court and not be disclosed to the jury. The provision would not create a cause of action for punitive damages. Further, it would not preempt or supersede any State or Federal law to the extent that such law would further limit punitive damage awards.

The provision would permit either party to request a separate proceeding (bifurcation) on the issue of whether punitive damages should be awarded and in what amount. If a separate proceeding was requested, evidence related only to the claim of punitive damages would be inadmissible in any proceeding to determine whether actual damages should be awarded.

The provision would prohibit the award of punitive damages against a manufacturer or product seller in a case where a drug or medical device was subject to premarket approval by the Food and Drug Administration (or generally recognized as safe according to conditions established by the FDA), unless there was misrepresentation or fraud. A manufacturer or product seller would not be held liable for punitive damages related to adequacy of required tamper resistant packaging unless the packaging or labeling was

found by clear and convincing evidence to be substantially out of compliance with the regulations.

The provision would permit the periodic (rather than lump sum) payment of future losses in excess of \$50,000. The judgment of a court awarding periodic payments could not, in the absence of fraud, be reopened at any time to contest, amend, or modify the schedule or amount of payments. The provision would not preclude a lump sum settlement.

The provision would permit a defendant to introduce evidence of collateral source payments. Such payments are those which are any amounts paid or reasonably likely to be paid by health or accident insurance, disability coverage, workers compensation, or other third party sources. If such evidence was introduced, the claimant could introduce evidence of any amount paid or reasonably likely to be paid to secure the right to such collateral source payments. No provider of collateral source payments would be permitted to recover any amount against the claimant or against the claimant's recovery.

Reason for Change. The provision is necessary to reduce the burden of paying large health care claims, and because similar reforms enacted at the State level have lowered health care costs.

Section 10813. Alternative dispute resolution

Current Law. No Provision.

Explanation of Provision. The provision would require that any alternative dispute resolution system used to resolve health care liability actions or claims must include provisions identical to those specified in the bill relating to statute of limitations, non-economic damages, joint and several liability, punitive damages, collateral source rule, and periodic payments.

Reason for Change. The provision is necessary to encourage early settlements of liability actions and to promote the resolution of such claims in a more convenient, timely, and affordable manner.

III. VOTES OF THE COMMITTEE

In compliance with clause 2(1)(2)(B) of rule XI of the Rules of the House of Representatives, the following statements are made concerning the votes of the Committee on Ways and Means in its consideration of the budget reconciliation health recommendations:

Motion to report budget reconciliation health recommendations

The Committee on Ways and Means ordered favorably reported to the Committee on the Budget its budget reconciliation health recommendations by a roll call vote of 36 yeas to 3 nays (with a quorum being present). The vote was as follows:

Representatives	Yea	Nay	Present	Representatives	Yea	Nay	Present
Mr. Archer	X	.....	.....	Mr. Rangel	X	.....	.....
Mr. Crane	X	.....	.....	Mr. Stark	X	.....	.....
Mr. Thomas	X	.....	.....	Mr. Matsui	X	.....	.....
Mr. Shaw	X	.....	.....	Mrs. Kennelly	X	.....	.....
Mrs. Johnson	X	.....	.....	Mr. Coyne	X	.....	.....
Mr. Bunning	X	.....	.....	Mr. Levin	X	.....	.....
Mr. Houghton	X	.....	.....	Mr. Cardin	X	.....	.....
Mr. Herger	X	.....	.....	Mr. McDermott .....	.....	X	.....

Representatives	Yea	Nay	Present	Representatives	Yea	Nay	Present
Mr. McCrery	X	.....	.....	Mr. Kleczka	X	.....	.....
Mr. Camp	X	.....	.....	Mr. Lewis	X	.....	.....
Mr. Ramstad	X	.....	.....	Mr. Neal	X	.....	.....
Mr. Nussle	X	.....	.....	Mr. McNulty .....	.....	X	.....
Mr. Johnson	X	.....	.....	Mr. Jefferson .....	.....	X	.....
Ms. Dunn	X	.....	.....	Mr. Tanner	X	.....	.....
Mr. Collins	X	.....	.....	Mr. Becerra	X	.....	.....
Mr. Portman	X	.....	.....	Mrs. Thurman	X	.....	.....
Mr. English	X	.....	.....		
Mr. Ensign	X	.....	.....		
Mr. Christensen	X	.....	.....		
Mr. Watkins	X	.....	.....		
Mr. Hayworth	X	.....	.....		
Mr. Weller	X	.....	.....		
Mr. Hulshof	X	.....	.....		

Votes on amendments

Roll call votes were conducted on the following amendments to the Chairman's amendment in the nature of a substitute:

An amendment by Mr. Becerra to Subtitle A to eliminate Part B premiums for beneficiaries above 120 percent and below 150 percent of poverty and reduce MSA demonstration was defeated by a roll call vote of 15 yeas to 22 nays. The vote was as follows:

Representatives	Yea	Nay	Present	Representatives	Yea	Nay	Present
Mr. Archer	X	.....	Mr. Rangel	X	.....	.....
Mr. Crane	X	.....	Mr. Stark	X	.....	.....
Mr. Thomas	X	.....	Mr. Matsui	X	.....	.....
Mr. Shaw	X	.....	Mrs. Kennelly	X	.....	.....
Mrs. Johnson	X	.....	Mr. Coyne	X	.....	.....
Mr. Bunning	Mr. Levin	X	.....	.....
Mr. Houghton	X	.....	Mr. Cardin .....	.....	.....	.....
Mr. Herger	X	.....	Mr. McDermott	X	.....	.....
Mr. McCrery	X	.....	Mr. Kleczka	X	.....	.....
Mr. Camp	X	.....	Mr. Lewis	X	.....	.....
Mr. Ramstad	X	.....	Mr. Neal	X	.....	.....
Mr. Nussle	X	.....	Mr. McNulty	X	.....	.....
Mr. Johnson	X	.....	Mr. Jefferson	X	.....	.....
Ms. Dunn	X	.....	Mr. Tanner	X	.....	.....
Mr. Collins	X	.....	Mr. Becerra	X	.....	.....
Mr. Portman	X	.....	Mrs. Thurman	X	.....	.....
Mr. English	X	.....			
Mr. Ensign	X	.....			
Mr. Christensen	X	.....			
Mr. Watkins	X	.....			
Mr. Hayworth	X	.....			
Mr. Weller	X	.....			
Mr. Hulsoff	X	.....			

An amendment by Mr. Tanner to Subtitle A to provide a Department of Defense Subvention program demonstration and reduce MSA demonstration to 300,000 was defeated by a roll call vote of 18 yeas to 19 nays. The vote was as follows:

Representatives	Yea	Nay	Present	Representatives	Yea	Nay	Present
Mr. Archer	X	.....	Mr. Rangel	X	.....	.....
Mr. Crane	X	.....	Mr. Stark	X	.....	.....
Mr. Thomas	X	.....	Mr. Matsui	X	.....	.....
Mr. Shaw	X	.....	Mrs. Kennelly	X	.....	.....
Mrs. Johnson	X	.....	Mr. Coyne	X	.....	.....
Mr. Bunning	Mr. Levin	X	.....	.....

Representatives	Yea	Nay	Present	Representatives	Yea	Nay	Present
Mr. Houghton		X		Mr. Cardin			
Mr. Herger		X		Mr. McDermott	X		
Mr. McCreery		X		Mr. Kleczka	X		
Mr. Camp		X		Mr. Lewis	X		
Mr. Ramstad		X		Mr. Neal	X		
Mr. Nussle		X		Mr. McNulty	X		
Mr. Johnson		X		Mr. Jefferson	X		
Ms. Dunn		X		Mr. Tanner	X		
Mr. Collins	X			Mr. Becerra	X		
Mr. Portman		X		Mrs. Thurman	X		
Mr. English		X					
Mr. Ensign	X						
Mr. Christensen		X					
Mr. Watkins	X						
Mr. Hayworth		X					
Mr. Weller		X					
Mr. Hulshof		X					

An amendment by Mr. McDermott to Subtitle A to create a Children's Hospital Graduate Medical Education Trust Fund was defeated by roll call vote of 14 yeas to 22 nays. The vote was as follows:

Representatives	Yea	Nay	Present	Representatives	Yea	Nay	Present
Mr. Archer		X		Mr. Rangel			
Mr. Crane		X		Mr. Stark	X		
Mr. Thomas		X		Mr. Matsui	X		
Mr. Shaw		X		Mrs. Kennelly	X		
Mrs. Johnson		X		Mr. Coyne	X		
Mr. Bunning		X		Mr. Levin	X		
Mr. Houghton		X		Mr. Cardin			
Mr. Herger		X		Mr. McDermott	X		
Mr. McCreery		X		Mr. Kleczka	X		
Mr. Camp		X		Mr. Lewis	X		
Mr. Ramstad		X		Mr. Neal	X		
Mr. Nussle		X		Mr. McNulty	X		
Mr. Johnson		X		Mr. Jefferson	X		
Ms. Dunn		X		Mr. Tanner	X		
Mr. Collins		X		Mr. Becerra	X		
Mr. Portman		X		Mrs. Thurman	X		
Mr. English		X					
Mr. Ensign		X					
Mr. Christensen		X					
Mr. Watkins		X					
Mr. Hayworth		X					
Mr. Weller		X					
Mr. Hulshof		X					

An amendment by Mrs. Thurman to Subtitle D to repeal three HIPAA provisions regarding research advisory opinions, and limitations on managed care programs, and modifications of standard of proof in certain cases, and additional minor provisions was defeated by roll call vote of 16 yeas and 21 nays. The vote was as follows:

Representatives	Yea	Nay	Present	Representatives	Yea	Nay	Present
Mr. Archer		X		Mr. Rangel	X		
Mr. Crane		X		Mr. Stark	X		
Mr. Thomas		X		Mr. Matsui	X		
Mr. Shaw		X		Mrs. Kennelly	X		
Mrs. Johnson		X		Mr. Coyne	X		
Mr. Bunning		X		Mr. Levin	X		
Mr. Houghton		X		Mr. Cardin	X		

Representatives	Yea	Nay	Present	Representatives	Yea	Nay	Present
Mr. Herger		X	.....	Mr. McDermott	X	.....	.....
Mr. McCrery		X	.....	Mr. Kleczka	X	.....	.....
Mr. Camp		X	.....	Mr. Lewis	X	.....	.....
Mr. Ramstad		X	.....	Mr. Neal	X	.....	.....
Mr. Nussle	Mr. McNulty	X	.....	.....
Mr. Johnson		X	.....	Mr. Jefferson	X	.....	.....
Ms. Dunn		X	.....	Mr. Tanner	X	.....	.....
Mr. Collins	Mr. Becerra	X	.....	.....
Mr. Portman		X	.....	Mrs. Thurman	X	.....	.....
Mr. English		X	.....			
Mr. Ensign		X	.....			
Mr. Christensen		X	.....			
Mr. Watkins		X	.....			
Mr. Hayworth		X	.....			
Mr. Weller		X	.....			
Mr. Hulshof		X	.....			

An amendment by Mr. Lewis to Subtitle F to strike provisions that would provide cost reimbursement for hospital capital expenditures related to property taxes and payments in lieu of taxes was agreed to by a roll call vote of 20 yeas to 19 nays. The vote was as follows:

Representatives	Yea	Nay	Present	Representatives	Yea	Nay	Present
Mr. Archer	X	.....	.....	Mr. Rangel	X	.....	.....
Mr. Crane		X	.....	Mr. Stark	X	.....	.....
Mr. Thomas		X	.....	Mr. Matsui	X	.....	.....
Mr. Shaw		X	.....	Mrs. Kennelly	X	.....	.....
Mrs. Johnson	X	.....	.....	Mr. Coyne	X	.....	.....
Mr. Bunning		X	.....	Mr. Levin	X	.....	.....
Mr. Houghton		X	.....	Mr. Cardin	X	.....	.....
Mr. Herger		X	.....	Mr. McDermott	X	.....	.....
Mr. McCrery		X	.....	Mr. Kleczka	X	.....	.....
Mr. Camp	X	.....	.....	Mr. Lewis	X	.....	.....
Mr. Ramstad		X	.....	Mr. Neal	X	.....	.....
Mr. Nussle		X	.....	Mr. McNulty	X	.....	.....
Mr. Johnson		X	.....	Mr. Jefferson	X	.....	.....
Ms. Dunn	X	.....	.....	Mr. Tanner	X	.....	.....
Mr. Collins		X	.....	Mr. Becerra	X	.....	.....
Mr. Portman		X	.....	Mrs. Thurman	X	.....	.....
Mr. English		X	.....			
Mr. Ensign		X	.....			
Mr. Christensen		X	.....			
Mr. Watkins		X	.....			
Mr. Hayworth		X	.....			
Mr. Weller		X	.....			
Mr. Hulshof		X	.....			

An amendment by Mr. Kleczka to strike Subtitle I on malpractice was defeated by a roll call vote of 15 yeas to 24 nays. The vote was as follows:

Representatives	Yea	Nay	Present	Representatives	Yea	Nay	Present
Mr. Archer		X	.....	Mr. Rangel	X	.....	.....
Mr. Crane		X	.....	Mr. Stark	X	.....	.....
Mr. Thomas		X	.....	Mr. Matsui	X	.....	.....
Mr. Shaw		X	.....	Mrs. Kennelly	X	.....	.....
Mrs. Johnson		X	.....	Mr. Coyne	X	.....	.....
Mr. Bunning		X	.....	Mr. Levin	X	.....	.....
Mr. Houghton		X	.....	Mr. Cardin	X	.....	.....
Mr. Herger		X	.....	Mr. McDermott	X	.....	.....
Mr. McCrery		X	.....	Mr. Kleczka	X	.....	.....

Representatives	Yea	Nay	Present	Representatives	Yea	Nay	Present
Mr. Camp		X	.....	Mr. Lewis	X	.....	.....
Mr. Ramstad		X	.....	Mr. Neal	X	.....	.....
Mr. Nussle		X	.....	Mr. McNulty		X	.....
Mr. Johnson		X	.....	Mr. Jefferson	X	.....	.....
Ms. Dunn		X	.....	Mr. Tanner		X	.....
Mr. Collins		X	.....	Mr. Becerra	X	.....	.....
Mr. Portman		X	.....	Mrs. Thurman	X	.....	.....
Mr. English	X	.....	.....	.....	.....	.....	.....
Mr. Ensign		X	.....	.....	.....	.....	.....
Mr. Christensen		X	.....	.....	.....	.....	.....
Mr. Watkins		X	.....	.....	.....	.....	.....
Mr. Hayworth		X	.....	.....	.....	.....	.....
Mr. Weller		X	.....	.....	.....	.....	.....
Mr. Hulshof		X	.....	.....	.....	.....	.....

IV. BUDGET EFFECTS OF THE BILL

A. COMMITTEE ESTIMATE OF BUDGETARY EFFECTS

In compliance with clause 7(a) of rule XIII of the Rules of the House of Representatives, the following statement is made concerning the effects on budget of this bill, the Budget Reconciliation Health Recommendation, as reported: The Committee agrees with the estimate prepared by the Congressional Budget Office (CBO) which is included below.

B. STATEMENT REGARDING NEW BUDGET AUTHORITY AND TAX EXPENDITURES

In compliance with clause 2(1)(3)(B) of rule XI of the Rules of the House of Representatives, the Committee states the legislation would result in net decreased budget authority for direct spending programs relative to current law, and new tax expenditures.

C. COST ESTIMATE PREPARED BY THE CONGRESSIONAL BUDGET OFFICE

In compliance with clause 2(1)(3)(C) of rule XI of the Rules of the House of Representatives requiring a cost estimate prepared by the Congressional Budget Office, the following report prepared by CBO is provided.

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, June 16, 1997.

Hon. BILL ARCHER,
*Chairman, Committee on Ways and Means,
House of Representatives, Washington, DC*

DEAR MR. CHAIRMAN. The Congressional Budget Office has prepared the enclosed federal cost estimate, intergovernmental mandate statement, and private-sector mandate statement for the Medicare reconciliation recommendations approved by the House Committee on Ways and Means on June 9, 1997.

The federal cost estimate shows the budgetary effects of the committee's proposals over the 1998–2007 period. CBO understands that the Committee on the Budget will be responsible for interpreting how these proposals compare with the reconciliation instruc-

tions in the budget resolution. The estimate assumes the reconciliation bill will be enacted by August 15, 1997, with timely implementation of policies that would take effect at the beginning of fiscal year 1998. The estimate could change if the bill is enacted later.

If you wish further details on these estimates, we will be pleased to provide them.

Sincerely,

JUNE E. O'NEILL, *Director*.

Enclosures.

Medicare Reconciliation Recommendations of the House Committee on Ways and Means (Title X)

Summary.—The bill would provide for the establishment of MedicarePlus plans, expand preventive benefits, reduce payment rates to certain health care providers, increase premiums required of beneficiaries, and make other changes to reduce the growth of Medicare spending and extend the solvency of the Hospital Insurance trust fund.

CBO projects that under current law spending for Medicare benefits would grow at an annual rate of 8.5 percent from 1997 to 2002. The bill would slow the rate of growth to 5.9 percent a year on average. Compared with spending under current law, the bill would reduce Medicare outlays by \$115.0 billion over the 1998–2002 period. The bill would postpone the projected depletion of the Hospital Insurance trust fund from 2002 to 2007.

The bill would give Medicare beneficiaries the option to remain in the existing fee-for-service Medicare program or to enroll in MedicarePlus plans, which would replace Medicare's current risk plans. MedicarePlus plans would include health maintenance organizations (HMOs), point-of-service (POS) plans, preferred provider organizations (PPOs), provider-sponsored organizations (PSOs), as well insurance plans operated in conjunction with a medical savings account (MSA). New or expanded benefits would be added for mammography, pap smears and pelvic exams, screening for prostate and colorectal cancer, diabetes self-management and supplies, and the diagnosis of osteoporosis.

Payments to hospitals, home health agencies, skilled nursing facilities, and other providers of health care services would be scaled back from the levels anticipated under current law. The proposal would reduce projected payment rates for physicians' services, inpatient and outpatient hospital services, hospitals' cost of capital, disproportionate share hospitals, clinical laboratory services, and durable medical equipment. The proposal would also establish new payment methods for nursing facilities, outpatient hospital services, home health services, and rehabilitation hospitals.

To delay the depletion of the trust fund for Hospital Insurance (HI, or Part A), the bill would transfer payment of certain home health services from Part A to Part B of Medicare (also known as Supplementary Medical Insurance, or SMI). After a phase-in period of 6 years, only the first 100 home health visits following a hospitalization would be payable under part A. The impact of this transfer on the Part B premium would be phased in over 7 years, however. Otherwise, the premium for Part B would be set to cover 25 percent of program costs in future years, as it is now, instead

being allowed to decline as a share of spending, as would be the case under current law.

Estimated cost to the Federal Government.—Compared with spending projected under current law, the bill would reduce Medicare outlays by \$6.8 billion in fiscal year 1998, \$41.2 billion in 2002, and \$115.0 billion over the 1998–2002 period. Major elements of the savings are:

\$18.1 billion from provisions related to the MedicarePlus program, including reductions in the rate of growth in payments to HMOs (subtitle A).

\$23.1 billion associated with the formation of prospective payment systems for skilled nursing facilities, rehabilitation hospitals, outpatient hospital services, outpatient therapy providers, and home health services (subtitle E).

\$37.1 billion from slower growth of payments to hospitals and other changes (subtitle F).

\$22.9 billion from reducing payments for physician services, laboratory services, durable medical equipment and maintaining the Part B premium at 25 percent of program costs (subtitle G).

\$19.8 billion from reductions in home health payments, extension of Medicare's secondary-payer status for enrollees with employment-based coverage, and other miscellaneous changes (subtitle H).

\$0.2 billion from medical liability reforms (subtitle I).

These savings would be partially offset by the following items of cost:

\$4.6 billion for prevention initiatives (subtitle B).

\$0.4 billion for rural health care (subtitle C).

\$1.1 billion from reductions in premiums for people purchasing Part A.

The bill would also increase federal spending for Medicaid by \$1.0 billion over the 1998–2002 periods.

Table 1 summarizes the effects of the bill on Medicare. Table 2 (attached) shows the budgetary effects of each subtitle and major provisions for 1998 through 2007.

TABLE 1. BUDGETARY IMPACT OF THE MEDICARE RECONCILIATION PROPOSALS OF THE HOUSE COMMITTEE ON WAYS AND MEANS

	By fiscal years, in billions of dollars					
	1997	1998	1999	2000	2001	2002
PROJECTED SPENDING UNDER CURRENT LAW						
Benefit payments ¹	208.8	227.0	248.2	273.0	285.6	313.7
Premiums	-20.2	-21.4	-22.4	-23.4	-24.5	-25.6
Total, Medicare	188.6	205.5	225.7	249.5	261.1	288.1
PROPOSED CHANGES						
Benefit payments ¹	0	-72	-16.3	-23.2	-21.4	-35.2
Premiums	0	0.5	-0.4	-1.9	-3.7	-6.1
Total, Medicare	0	-6.8	-16.8	-25.1	-25.1	-41.2
PROJECTED SPENDING UNDER PROPOSAL						
Benefit payments ¹	208.8	219.7	231.8	249.8	264.2	278.5

TABLE 1. BUDGETARY IMPACT OF THE MEDICARE RECONCILIATION PROPOSALS OF THE HOUSE COMMITTEE ON WAYS AND MEANS—Continued

	By fiscal years, in billions of dollars					
	1997	1998	1999	2000	2001	2002
Premiums	-20.2	-21.0	-22.9	-25.4	-28.2	-31.6
Total, Medicare	188.6	198.8	208.9	224.4	236.0	246.9

¹ Includes mandatory administrative costs.

Note: Totals may not add because of rounding.

Basis of estimate.—Many provisions of the bill would reduce reimbursements to fee-for-service providers by reducing the price paid for a unit of service. To estimate the savings from these provisions, CBO compared the rate of increase in payments under the bill with the rate of increase projected under current law. For example, under the bill, hospital payments per admission would increase approximately 3 percentage points less in 1998 than under current law and 1 percentage point less each year thereafter. The estimated savings from this provision equals the change in the payment per admission times the projected number of admissions, assuming no change in the number of fee-for-service beneficiaries and adjusting for the effects of behavioral responses by providers.

Reducing payments to fee-for-service providers would also reduce payments to risk-based plans, because Medicare currently pays these plans 95 percent of the estimated average cost of comparable beneficiaries in the fee-for-service sector. These savings are included in the part of the estimate relating to MedicarePlus plans (subtitle A). The bill would further reduce payments to risk plans by lowering the payment rate to 92.5 percent of fee-for-service costs over 5 years. The MedicarePlus estimate also includes the incremental costs associated with additional enrollment in Medicare's capitated sector.

CBO's estimate of the effects of the bill uses the economic and technical assumptions underlying the baseline used for the 1998 budget resolution. The following paragraphs provide further details on the estimating process and the most important assumptions.

Subtitle A, MedicarePlus program

Subtitle A would reduce Medicare outlays by an estimated \$18.1 billion over the 1998–2002 period. Reductions in payments to capitated, risk-based plans would save \$18.6 billion. Those savings would be partially offset by \$0.2 billion in new spending for changes to the portability and issuance rules for Medigap plans and \$0.3 billion for specialized capitated programs and other items.

Payments to risk-based plans

Over the 1998–2002 period, estimated savings in payments to risk-based plans would total \$18.6 billion. The components of this change are shown in Table 3 (attached). About \$23.7 billion in savings would result from slower growth in capitation payments for MedicarePlus plans, and Medicare outlays would increase by \$5.0 billion for people choosing PSOs and high-deductible/MSA plans. The proposal would also accelerate MedicarePlus payments that otherwise would have been payable on October 1, 2001, to the last

business day of September 2001. That provision would shift approximately \$4.8 billion in spending from fiscal year 2002 to fiscal year 2001 but would have no impact on total Medicare spending over the five-year period.

Slower Growth in Capitation Payments. The bill would retain a link between fee-for-service spending and capitation payments but would reduce the growth of capitation payments by 0.5 percentage points a year for 5 years. As under current law, variation in fee-for-service costs among different enrollee groups (defined by age, sex, reason for entitlement, and other factors) would be used to adjust capitation payments to reflect the demographic mix of each plan's enrollees. Of the \$23.7 billion in five-year savings from slower growth in capitation rates, \$20.5 billion stems from reductions in the growth of fee-for-service spending, and \$3.2 billion is the result of the 0.5 percentage-point reduction in the update.

Enrollment in Capitated Plans. CBO projects that the share of Medicare beneficiaries in risk-based capitated plans will grow from 12 percent in 1997 to 23 percent in 2002 under current law. This growth is expected for two main reasons. First, each year a larger share of newly eligible beneficiaries will have had experience with managed care plans during their working years. Second, the cost of Medigap policies is likely to continue to rise.

The bill would later alter Medicare in ways intended to encourage more plans and more enrollment in its capitated sector, called MedicarePlus. Options in the MedicarePlus sector would be expanded to include the whole range of plans now available to privately insured people—including both closed-and open-panel HMOs, preferred provider organizations, fee-for-service indemnity plans, provider-sponsored organizations, and MSA plans. The Secretary of Health and Human Services (HHS) would establish an annual open enrollment period for MedicarePlus plans and would provide enrollees with comparative information about the options available to them. Enrollees in MSA plans would be required to maintain a medical savings account into which Medicare's contributions in excess of the premium would be deposited. (The bill would limit enrollment in MSA plans to 500,000.) Outside of the MedicarePlus program, the bill would allow for increased portability of Medigap insurance under certain conditions.

A number of elements in the bill would tend to accelerate enrollment in capitated plans. More risk-based plans would be willing to participate, because additional sponsors and organizational forms would be permitted. For the first time all beneficiaries would have uniform, comprehensive, and timely comparative information about the Medicare options available to them. Finally, the availability of PSOs and MSAs and the reduction of geographic differences in payment rates would expand Medicare's capitated sector to rural areas.

Other factors would tend to reduce enrollment in capitated plans. Capitation rates would grow slightly more slowly than costs in the fee-for-service sector, potentially eroding the additional benefits that many risk-based plans now provide. Provisions requiring some plans to increase coverage of emergency services and modify certain incentives for providers could also limit the ability of those plans to offer additional benefits. Finally, expanded coverage of

preventive and other benefits in Medicare's fee-for-service program might encourage some beneficiaries to remain in the fee-for-service system.

CBO's estimate assumes that the bill would increase enrollment in Medicare's capitated sector to 27 percent of the total by 2002. All of the net additional enrollment is assumed to flow to PSO's and MSA plans. Enrollment in PSO's would grow from zero to a 3 percent share, and enrollment in high-deductible, MSA plans would reach the 500,000 cap in 2000. CBO assumes that the share of Medicare enrollment in traditional risk plans would be 23 percent in 2002, the same as in CBO's baseline.

Floor on Payment Rates. Because average fee-for-service spending in rural areas tends to be low, Medicare's capitation payments in rural counties tend to be low as well. Risk plans have therefore tended to avoid low-payment counties or to charge additional premiums for beneficiaries residing in those areas.

The Ways and Means bill would set a floor of \$350 a month per person, on average, for capitation payments. The bill would further reduce geographic differences in payments by paying risk plans a blend of national and local rates. In 1998, plans would receive a payment based 10 percent on national rates and 90 percent on local rates; in 2002 and thereafter, payments would be based on a 50-50 blend.

Enrollment in capitated plans, especially PSO's and MSA plans, would increase in rural areas because of the new incentives. As a result of the increases in rural payment rates, Medicare's costs would rise because payment rates to capitated plans would exceed the payments that would have been made had enrollees remained in fee-for-service. CBO estimates that the impact of the rural payment changes would increase Medicare spending by \$1.6 billion between 1998 and 2002. Most of the additional costs would probably be associated with PSO's offering MedicarePlus plans in areas that otherwise would have had limited access to risk plans.

Costs from Enrollment in MSA Plans. The bill would introduce on a demonstration basis an option in MedicarePlus for an MSA plan. Up to 500,000 beneficiaries would be allowed to enroll in the option through January 2003. By March 2002, the Secretary of HHS would recommend changes in the enrollment limit based on evaluations of the option up to that time.

Beneficiaries choosing the option would be required to select a MedicarePlus plan that met certain requirements on its deductible and reimbursements. The MedicarePlus plan would have to provide coverage of at least the items and services covered by Parts A and B of the fee-for-service sector, but only after a deductible was met. The deductible could not exceed \$6,000. For expenses above the deductible, the plan would have to reimburse at least 100 percent of the amounts that would have been paid under parts A and B. Thus enrollees could incur out-of-pocket costs after meeting their deductible because Medicare does not provide catastrophic coverage.

Medicare would deposit in the enrollee's MSA any excess of the capitation amount over the cost of the enrollee's medical insurance plan. Enrollees could withdraw funds from their MSA to pay for qualifying medical expenses or other purposes. Withdrawals for other purposes, however, would be subject to a 50 percent penalty

tax to the extent they reduced the account balance in the current year below 60 percent of the deductible of their insurance plan. As long as withdrawals for non-medical purposes did not deplete the balance in the MSA below this threshold, they would be free from tax or penalty. In addition, interest earned on MSA balances would be excluded from income taxation. Medigap insurers would not be allowed to sell Medigap policies to MSA enrollees to cover expenses under the deductible.

The bill would not require those who switched to an alternative MedicarePlus option or to the traditional Medicare fee-for-service sector to repay remaining balances in their MSA or amounts spent in earlier years on nonqualified purposes. Beneficiaries who were also enrolled in the Federal Employee Health Benefits Plan (FEHBP) would be ineligible for the MSA plan, until such time as coordination policies had been adopted to ensure that such enrollment would not increase federal expenditures for FEHBP.

MSA plans with a high deductible would tend to experience more favorable risk selection than would other MedicarePlus plans or the fee-for-service sector. Beneficiaries could take financial advantage of the system by choosing a high-deductible plan when they were healthy and moving to another MedicarePlus plan or the fee-for-service sector if they developed medical problems or wanted to schedule expensive non-emergency procedure, such as a hip replacement. However the bill would limit the impact of favorable selection by allowing only 500,000 beneficiaries to enroll, requiring enrollments to be for a full year, and by limiting enrollment beyond January 2003.

The CBO estimate assumes that Medicare's risk adjusters would not fully compensate for favorable selection into MSA plans. CBO also assumes that the number of people selecting the MSA option would grow to the limit of 500,000 by 2000. With this level of participation, Medicare's costs would increase by \$2.0 billion over five years.

Costs from Enrollment in Provider-Sponsored Organizations. Although the bill would generally require MedicarePlus plans to be licensed by the states, PSOs could obtain a waiver from state requirements in certain circumstances. In particular, unlicensed PSOs could become certified Medicare PSOs if the states imposed more rigorous solvency standards on PSOs than the federal government required. The bill directs the Secretary of HHS to establish solvency standards for PSOs that take into account the delivery system assets of the organization, the ability of the organization to provide services directly to enrollees, and a variety of alternative means of protecting against insolvency. Those provisions could result in solvency standards for PSOs being less rigorous than those for other, state-licensed MedicarePlus plans. In addition, PSOs would face considerably lower minimum enrollment requirements than other plans.

Looser standards would encourage the development of PSOs, especially when taken in conjunction with the \$350 minimum payment for MedicarePlus plans. Rural beneficiaries, in particular, might have more health plan choices as a result. PSOs might also have a competitive advantage compared to other MedicarePlus plans, which would be subject to state licensing requirements.

Greater availability of PSOs could exacerbate risk selection problems in Medicare because doctors in many provider-sponsored networks would be able to steer healthy patients to the network and advise sick patients to remain in Medicare's fee-for-service program. Assuming that the number of people selecting a PSO would grow gradually to 3 percent by 2002, the PSO option would increase total program costs by an estimated \$1.4 billion over 5 years.

Medigap portability

CBO estimates that guaranteeing issue of Medigap coverage to certain elderly beneficiaries would raise Medicare spending by \$0.2 billion over the 1998–2002 period. CBO assumes that approximately 25,000 people would newly purchase Medigap coverage each year and that about 20,000 people would drop coverage. CBO assumes that those gaining coverage would generally be less healthy than people who dropped coverage as a result of price increases. Because gap coverage would increase beneficiaries' use of Medicare services, each new Medigap enrollee would cost Medicare about \$2,200 a year. CBO assumes that half of those beneficiaries dropping coverage would join a capitated plan. Therefore, CBO estimates that the savings to Medicare from those dropping coverage would be quite low—only about \$700 a year for each beneficiary.

Other provisions

Other provisions in Subtitle A, including funding for specialized capitation programs, would add about \$0.3 billion in Medicare spending.

Subtitle B, Prevention initiatives

CBO estimates that the expansion of clinical preventive services under this bill would increase Medicare spending by \$4.6 billion over the 1998–2002 period. The proposal would provide for both new and expanded coverage of screening tests for breast, cervical, prostate, and colorectal cancer. It would waive the Part B deductible for some screening tests and provide new and expanded Medicare coverage of services and supplies for the management of diabetes. It would also provide a uniform coverage policy for bone mass measurements, which would include screening for women at risk for osteoporosis. In general, the estimated net cost of each proposal equals spending on newly-covered services and supplies, plus spending on follow-up diagnostic tests and treatment, less expected savings in treatment costs from the early detection of disease and the improvement of medical management.

Subtitle C, Rural initiatives

The bill would spend an additional \$0.4 billion over five years to assist rural hospitals and would authorize a \$30 million demonstration project for telemedicine. It would consolidate and make permanent several existing limited service hospital demonstrations. Eligible hospitals must be located at least 30 minutes away from another hospital, have no more than 15 acute-care beds, and discharge or transfer patients within 96 hours of admission. These hospitals would be paid on the basis of costs in the first two years

of limited service operation and on the basis of updated base-period costs thereafter. This provision would increase Medicare spending by \$0.2 billion through 2002. A second provision would pay a blend of prospective-payment and cost-based amounts to small rural hospitals that depend on Medicare for at least 60 percent of inpatient cases. This provision would increase Medicare spending by an additional \$0.2 billion.

The proposal would direct the Secretary of HHS to establish a telemedicine demonstration project to improve primary care for diabetics living in medically underserved areas. To participate in the project, a telemedicine network would have to be located in an area with one of the highest concentrations of medical schools and tertiary care facilities in the United States.

Subtitle D, Fraud and abuse

The bill would tighten some anti-fraud measures and loosen others, with no net savings or costs. To help Medicare track excluded and fraudulent providers, Medicare providers other than individual practitioners and groups of practitioners would be required to submit their Social Security and employer identification numbers. In addition, the bill would require durable medical equipment suppliers to provide Medicare with a surety bond of not less than \$50,000. Other providers would be required to provide bonds as determined by the Secretary of HHS. By deterring and eliminating some fraudulent providers of these services, CBO estimates this provision would reduce the growth in the number of providers and services paid by Medicare, saving \$0.2 billion over the 1998–2002 period.

Another provision would require the Secretary to issue written advisory opinions on whether a referral for medical services was prohibited under the physician self-referral provisions of the Social Security Act. Because these advisory opinions could hinder the HHS Inspector General's ability to prosecute fraud and abuse cases successfully, CBO estimates that this provisions would cost \$0.2 billion over five years.

Subtitle E, Prospective payment systems

The proposal would require the Secretary to implement prospective payment systems or fee schedules for skilled nursing facilities, rehabilitation hospitals, outpatient hospital services, outpatient therapy providers, and home health services. CBO estimates that these provisions would save \$23.1 billion over five years. For some of these items, CBO estimates that the savings would stem from the new payment regime; in other cases, the savings stem from traditional savings mechanisms, such as reducing cost limits.

Skilled nursing facilities

Under current law, skilled nursing facilities (SNFs) are reimbursed for routine services (nursing, room and board, administrative costs, and other overhead) on the basis of reasonable costs, subject to per diem limits. Nonroutine, or ancillary, services and capital payments are also paid on a reasonable cost basis, but these payments are not subject to limits. SNF expenditures have been increasing rapidly in recent years and are expected to grow at an av-

erage annual rate of about 8 percent between now and 2002. The primary sources of growth have been growth in nonroutine services, especially therapy services, and growth in the number of beneficiaries using SNF services.

The bill would establish a prospective payment system for skilled nursing services. Payments would be based on a per-diem rate covering all three types of nursing facility costs (routine, ancillary, and capital). During a transition period, the rate would be a blend of facility-specific and national costs, updated by the SNF market basket index minus one percentage point up to the year preceding implementation and by the full index amount thereafter. The facility-specific rate would be based on allowable costs, and the national rate would be based on costs for all freestanding facilities, excluding exemption payments for new facilities. SNFs would be required to bill Medicare for almost all services their residents receive, and other entities would be prohibited from billing for beneficiaries receiving Medicare-covered services while in SNFs.

The proposal would save an estimated \$9.8 billion over five years. Under current law, nursing facilities can and have increased daily reimbursement by providing more and more ancillary services to residents. Under the proposed change, facilities that receive a fixed daily payment rate would no longer have an incentive to provide more ancillary services to their patients.

Rehabilitation hospitals

Rehabilitation hospitals and distinct rehabilitation units of hospitals are currently excluded from the prospective payment system (PPS). Payments to these hospitals are determined based on a comparison of actual costs and updated historical costs. The bill would require the Secretary to establish a system for classifying patients and to implement a prospective payment system for discharges in fiscal year 2001 and thereafter. The PPS would be phased in over four years, with hospitals paid a blend of prospective and cost-based amounts for 2001 through 2003. (The proposals in Subtitle F affecting non-PPS hospitals would affect discharges starting in 1998).

The proposal specifies that payment rates should be established such that aggregate payments to rehabilitation hospitals and units in the first year (2001) equal what spending would have been had the prospective payment system not been established. The Secretary would be directed to adjust payment rates for case-mix "creep" (changes in case mix that do not reflect changes in the resource requirements of patients treated in rehabilitation hospitals and units) and errors in forecasting real case-mix change.

CBO estimates that this provision would increase Medicare spending in the short term and lower spending in the long run. Spending would rise by \$0.3 billion over the 1998–2002 period but would fall by \$0.8 billion over the 10-year period through 2007. This pattern stems from two components of the transition to a prospective payment system. First, although the PPS is intended to budget-neutral with respect to payments to rehabilitation hospitals and units, concurrent changes in payments to other hospitals, skilled nursing facilities, and home health agencies would likely result in a shift of patients into rehabilitation hospitals. That shift

would not be fully accounted for in implementing the budget neutrality provision. Second, CBO assumes that the Secretary would underadjust for case-mix creep in the early years of the prospective payment system. Experience shows that coding practices change when patient classification systems used for payment are revised. Because the classification system for rehabilitation patients would be based on data that have not been used for payment purposes, there would be extraordinary case-mix creep until coding practices stabilized. It would take several years for this stabilization to occur and for Medicare to adjust payment rates to compensate for case-mix creep.

Hospital outpatient services

Under current law, beneficiaries pay 20 percent of charges for hospital outpatient services. After adjusting for coinsurance, Medicare pays the lesser of the hospital's cost, charge, or a blend of cost and the respective fee from the physician fee schedule. Because charges have grown faster than costs and the fee schedule, beneficiaries currently pay 47 percent of the total amount reimbursed to hospitals. Nonetheless, Medicare's spending for outpatient services has risen rapidly. The bill contains provisions designed to deal with both of these issues. On balance, they would reduce Medicare's spending by \$7.2 billion over the 1998–2002 period.

Three provisions are aimed at reducing the rate of growth of Medicare spending for outpatient services. First, the bill would revise Medicare's payment formula to account fully for the beneficiary's coinsurance. Second, it would extend the reductions in payments for capital and other costs made by the Omnibus Budget Reconciliation Act of 1993. Third, it would establish a fee schedule for outpatient services. The fee schedule would be implemented in January 1999 without changing projected Medicare or beneficiary spending in that year. If the amounts in the fee schedule were updated by the rate of increase in the hospital market basket, these three provisions would save a total of \$9.5 billion over five years.

To effect a gradual reduction in coinsurance rates, beneficiaries' total payments would be frozen at the 1999 amount. Medicare's fee schedule amounts would be increased by an additional 3.5 percentage points a year above the market basket to soften the effect of the freeze on hospitals. This provision would cost \$2.2 billion over 5 years.

Outpatient therapy providers

Under current law, Medicare reimbursement and beneficiaries' copayment for services provided by independent physical therapists and independent occupational therapists are based on the physician fee schedule. A beneficiary is covered for up to \$900 worth of services for each type of provider per year.

Therapy services provided in any other outpatient therapy setting—hospital outpatient department, SNF, comprehensive outpatient facility (CORF), or rehabilitation agency—are reimbursed by Medicare based on cost and beneficiaries pay 20 percent of charges. Therapy services provided by a physician are reimbursed on the physician fee schedule. Medicare does not limit the amount of services the beneficiary may use per year for these providers.

This bill would apply the reimbursement method currently used for independent therapists to all outpatient therapy providers except hospital outpatient departments. SNFs, CORFs, and rehabilitation agencies would be reimbursed according to the physician fee schedule, and beneficiaries would be covered for up to \$900 worth of services by each type of provider per year. Beginning in January 2000, the limit on each type of provider would be updated annually. Total spending on therapy services would not be capped. The provision would reduce spending by \$2.1 billion through over the 1998–2002 period.

Home health services

Under current law, home health agencies (HHAs) are reimbursed on a retrospective cost basis up to an agency-specific aggregate limit. This limit is the product of per-visit cost limits (by type of home health service) and the number of visits an agency provides. The current system provides no incentive for agencies below their limits to control costs. Agencies near or above their limits have an incentive to decrease the average cost per visit but do not face any meaningful constraint on total reimbursement. Home health expenditures, visits, and users have all been increasing rapidly in recent years, and expenditures are expected to grow at an average annual rate of 9 percent through 2002.

Both Subtitle E and Subtitle H would revise payments for home health benefits. Subtitle H would reduce agency-specific cost limits and establish an interim payment system under which home health agencies would be paid the lesser of actual costs, the per-visit limit, or a new agency-specific annual limit on spending. That limit would be based on the product of per-beneficiary spending limits and the number of beneficiaries served by an agency. Per beneficiary spending limits would reflect reasonable costs in 1994, updated by a home health market basket index. The proposal would also require that payments be based on the location where home health services were provided not where the services were billed. Subtitle E would require that the Secretary, beginning in fiscal year 2000, provide for payments for home health services under a prospective payment system. Prospective payment rates would be based on cost limits and per-beneficiary limits decreased by 15 percent. These rates would be updated by the home health market basket in future years. Periodic interim payments would be eliminated for home health agencies.

The proposal would save an estimated \$15.6 billion over five years—\$11.3 billion from the reduced cost limits and interim payment system in Subtitle H and \$4.4 billion from the 15 percent rate cut in Subtitle E. Although the proposal would limit the growth of spending per home health user, CBO assumes that some savings would be offset by efforts of home health agencies to increase the number of users. Without additional detail regarding how a prospective payment system would work, CBO cannot estimate any additional impact from its implementation.

Subtitle F, Provisions relating to part A only

The largest amount of Medicare savings in the package—\$37.1 billion between 1998 and 2002—results from policies in Subtitle F

concerning spending for hospital services. Subtitle F also includes a provision that would allow certain state and local government retirees to purchase Medicare at reduced rates. Subtitle F and Subtitle H both contain provisions affecting Medicare payments for medical education.

Update for PPS hospitals

Under current law, the basic operating payment for inpatient cases treated in hospitals paid under the prospective payment system is increased each year by the rate of growth in the hospital market basket—a measure of changes in hospital input prices. The market basket is projected to increase by 3.0 percent in fiscal year 1998 and by about 3.5 percent in each subsequent year. The bill would freeze the basic payment in fiscal 1998 and reduce the updates by 1 percentage point in fiscal years 1999 through 2002. This provision would save \$14.0 billion through 2002.

PPS hospital capital

The bill would reduce reimbursements to hospitals paid under the prospective payment system for their inpatient capital-related costs and would change the distribution of capital payments.

During the transition to a fully prospective payment system for capital spending, payments are determined by a complicated method based on a number of factors, including federal and hospital-specific payment rates. These rates are increased annually. Recent data suggest that the initial federal and hospital-specific rates have been overestimated. The Omnibus Budget Reconciliation Act of 1990 directed the Secretary to set rates during fiscal years 1992 through 1995 that resulted in a 10 percent reduction in the amounts that would have been paid under the old reasonable cost system. The bill would reinstate the 15.7 percent reduction factor that was used to adjust the federal and hospital-specific capital rates under the transitional rate-setting mechanism in fiscal year 1995. This provision would save \$4.7 billion over five years.

The special exceptions payments for hospitals that have begun and will complete large capital projects during the transition to fully-prospective capital payments would be modified in a budget-neutral manner. The proposed change would increase the number of hospitals that qualify for special exceptions payments, and would increase the amount of the payment to each qualifying hospital. The federal capital rate would be reduced to offset the increase in special exceptions payments. The number of hospitals that would qualify for these payments and the amount that would be redistributed are unknown.

Hospital depreciation

When a hospital is sold, Medicare pays a share of the amount by which the depreciated value of capital assets exceeds book value. This proposal would set depreciated value equal to book value at the time of a sale, producing \$0.3 billion in savings through 2002.

Outlier payments

Medicare provides outlier payments to hospitals for patients whose cost of care is well above average. The proposal would mod-

ify the formula used to calculate outlier costs and payments, resulting in \$2.2 billion in savings through 2002.

Graduate medical education

Medicare currently has two mechanisms to pay for costs incurred by hospitals that train physicians. Medicare's indirect medical education (IME) payments are an add-on to the payments Medicare makes to PPS hospitals to reflect the higher patient care costs incurred by teaching hospitals. Medicare also uses the graduate medical education (GME) pass-through payment to cover its share of the cost of operating a teaching program (including residents' salaries and benefits, physician supervisory costs, and overhead) on a per-resident basis.

The proposal would reduce both IME and GME spending by reducing the number of residents counted for the purposes of these payments, and by modifying the payment formulas. Under the current IME adjustment, a hospital receives 7.7 percent more in payments for each 0.1 increase in the resident-to-bed ratio. The proposal would reduce this factor to 5.5 percent for each 0.1 increase in the resident-to-bed ratio by 1999. These changes to IME would save \$6.7 billion through 2002.

GME spending would be reduced through a phased reduction of the overhead and physician supervisory component of the per-resident amounts in hospitals where those amounts exceed the 75th percentile. The proposal would also permit the Secretary to provide incentive payments to hospitals that commit to substantial reductions in the number of residents trained. Medicare and the participating hospitals would share in the resulting reduction in GME (and IME) spending for five or six years, after which all savings would accrue to Medicare. The proposal would also permit Medicare to make GME payments to non-hospital providers and consortia of hospitals and medical schools. These changes in GME policies (included in Subtitle H) would reduce GME spending by \$1.2 billion in the 1998–2002 period.

Treatment of transfer cases

Medicare currently pays PPS hospitals for cases that are transferred to another PPS hospital on a per diem basis, up to the full prospective payment amount. The PPS hospital that ultimately discharges the patient is paid the full prospective amount. Payment rates are recalibrated each year in an attempt to ensure that changes in transferring patterns do not increase aggregate Medicare spending. The proposal would extend the transfer payment and recalibration mechanisms to include cases that are transferred from a PPS hospital to a non-PPS hospital, a skilled nursing facility, or a home health agency. This proposal would save \$3.7 billion through 2002.

PPS-exempt hospitals

Payments to hospitals excluded from PPS are based on a comparison of actual costs and updated historical costs. Hospitals in which actual costs are less than updated historical costs (the target amount) are paid actual costs plus incentive payments. The incentive payments are half of the difference between actual costs and

the target amount, up to a maximum of 10 percent of the target amount. Hospitals in which actual costs exceed the target amount are paid the target amount plus penalty payments of half of the difference, up to a maximum of 10 percent of the target amount.

The proposal would limit the target amounts and reduce incentive and penalty payments. The target amounts for existing providers would be capped at the 90th percentile of target amounts, with separate caps established for rehabilitation hospitals and units, psychiatric hospitals and units, and long-term hospitals. (Children's hospitals and cancer hospitals would not be subject to these caps.) The target amount for new providers would be capped at 150 percent of the median in each category. Incentive payments would be limited to 10 percent of the difference between actual costs and the new target amounts, with a maximum of 1 percent of operating costs. There would be no penalty payments for the first 10 percentage points by which costs exceed the target amount, and penalty payments would be limited to 10 percent of the target amount. Hospitals in which costs exceeded the target amount would receive annual updates equal to the increase in the hospital market basket. This update would be reduced in stages to 2.5 percentage points less than the market basket increase for hospitals in which costs were at least 10 percent below the target amount. Hospitals in which costs were less than two-thirds of the target amount would not get an update. Capital payments to hospitals excluded from PPS would be reduced by 10 percent. These provisions would reduce spending by \$5.2 billion through 2002. The annual savings would total \$1.5 billion in 2002 but would decline in subsequent years, because the changes in the incentive payment formula would likely contribute to faster growth in both hospitals' costs and cost-based payments.

Reduction for enrollee bad debt

Medicare beneficiaries are required to pay a deductible for a spell of illness that results in admission to a hospital and coinsurance for inpatient days in excess of 60 days. Medicare pays hospitals for the amount of these deductibles and coinsurance that hospitals do not collect. The proposal would phase-in a reduction in these bad debt payments to half of the amount that hospitals did not collect from beneficiaries, resulting in \$0.6 billion in savings through 2002.

State and local buy-in

Employees of certain state or local government agencies hired before 1986 were not required to pay Hospital Insurance payroll taxes. Those who have reached age 65 but have not earned entitlement to Part A coverage through other employment (or through the employment of a spouse) are permitted to enroll in Part A by paying a monthly premium. In most of these cases the Part A premium is paid by the state or local government employer on behalf of the individual. However, about 30,000 individuals pay their own premiums; most are former teachers in the California school systems. The bill would permit such individuals who Part A premiums are not paid by a former employer to enroll in Part A for free after they have paid the Part A premium for five years. Premiums paid

prior to enactment would be counted toward the five-year requirement. CBO estimates that this provision would reduce Part A premium receipts from individuals who would be paying their own premiums by \$0.7 billion through 2002. Others, who would have chosen not to pay the Part A premium would be induced to enroll by the prospect for free Part A coverage after five years. Likewise, some who have chosen not to enroll in Part B would also be induced to enroll. Payments for benefits on behalf of costs for these new enrollees are estimated to exceed the additional premium receipts by \$0.1 billion through 2002.

Subtitle G, Provisions relating to part B only

Major items in subtitle G include a revised system for paying physicians; additional spending for chiropractic services; reduced payment rates for laboratory services, durable medical equipment, and oxygen; changes in payments for drugs and biologicals; changes in standards for rural health clinics; direct payment of non-physician providers; and increases in Part B premiums. These provisions would save a total of \$22.9 billion over the 1998–2002 period.

Physicians' services

The fees that Medicare pays for physician services are determined by a complicated set of formulas based on trends in practice costs, utilization, and other factors. The formulas generally attempt to reward physicians as a group for low growth of physician spending by raising fees in subsequent years and to penalize them for rapid growth of spending by cutting future fees.

This bill would simplify the setting of physician fees. In general, fees would be set so that overall physician spending would increase at the rate of growth in gross domestic product. By comparing actual spending with a cumulative target, and by increasing the range over which the Secretary could adjust fees to meet that target, the new formulas would better ensure that spending remains on track. Because the new spending targets would be lower than CBO's projections of physician spending under current law, this provision would save \$5.3 billion in the 1998–2002 period.

Medicare's payments to physicians are based on a conversion factor, which averages \$35.95 in 1997. Under current law, the conversion factor is projected to decline to about \$35.66 in 2002. Under the bill, it would decline somewhat more rapidly, to about \$32.63 in 2002.

Eliminate X-ray requirement for chiropractors

Under current law, Medicare payment to chiropractors is permitted only for treatment of a subluxation of the spine. Chiropractors must document the subluxation and the need for treatment with an X-ray of the patient. The proposal would eliminate the requirement for an X-ray. CBO assumes waiving the requirement for a diagnostic X-ray would add to the demand for chiropractic services. Over 5 years, CBO estimates that the additional costs would total \$0.6 billion.

Durable medical equipment, orthotics and prosthetics, and parenteral and enteral nutrition

Payment rates for durable medical equipment, and orthotics and prosthetics would be frozen at 1997 levels through 2002. Starting in 2003, payments would be updated by the CPI-U. Updated for parenteral and enteral nutrition (PEN) would be reduced to their 1995 level for fiscal years 1998–2002. These provisions would save \$0.8 billion over the 1998–2002 period.

Oxygen and oxygen equipment

Payments for oxygen and oxygen equipment would be cut by 20 percent in 1998 and frozen through 2002. This provision would result in \$1.6 billion in savings between 1998 and 2002.

Laboratory updates

Under the proposal, the payment update for laboratory services would be frozen through 2002. This provision would also reduce the laboratory payment limit from 76 percent of the median fee schedule amount to 72 percent of this amount. These changes would save medicare \$2.5 billion cumulatively through 2002.

Laboratory administrative simplification

The proposal would standardize the claims processing system for most laboratory services covered under Part B. The Secretary would select five regional carriers to process claims for all laboratory services, except those furnished in an independent physician's office. Claims would be processed by the regional carrier covering the area where the lab specimen was collected.

The Secretary would also be required to use a negotiated rule-making process to adopt uniform coverage, payment and administration policies for laboratory tests. The proposal would allow regional carriers to implement interim coverage policies in situations where no uniform national policy existed and carriers would be required to respond to excessive or fraudulent spending. The Secretary would review these interim policies every two years and decide whether to incorporate them into national policy. She would also periodically review proposals to change the uniform national policies.

Because there are no data indicating whether employing regional carriers and instituting uniform national policies would result in program costs or savings, CBO estimates that this provision would have no net budgetary effect.

Pharmaceutical payments

This provision would change the payment basis for drugs and biologicals covered under Part B. Currently, Medicare pays the average wholesale price (AWP) for drugs, which is a price reported by the manufacturer. Under the proposal, Medicare would pay 95 percent of the AWP for all drugs and biologicals covered under Part B, except those paid on a cost or prospective basis. Because the provision has no mechanism for controlling inflation in drug prices, CBO assumes that manufacturers would raise the AWP for their products to compensate for the payment cuts. Nevertheless, the provision would save \$0.4 billion over five years.

Coverage of oral anti-emetics

The bill would allow Part B payment for oral anti-nausea drugs used as part of a chemotherapeutic regimen, but only if they were administered by a physician as a full replacement for intravenous (IV) antiemetic therapy. Reimbursement for oral antiemetics would be limited to 90 percent of the average payment amount for the equivalent IV antiemetic. CBO estimates that this provision would be budget neutral because payment for the oral drug would be indexed to the 1996 payment amount for the equivalent IV drug. The pharmaceutical reimbursement proposal described above would also help control the costs of covering oral antiemetics.

Rural health clinic services

To expand health care services in areas with few providers, Medicare certifies providers serving shortage areas as rural health clinics and reimburses them based on their costs. This amount is higher than that received by comparable providers serving non-shortage areas. Once providers are classified as rural health clinics, the shortage-area requirement is no longer reviewed. This bill would require verification of the status of these clinics every three years and would use the physician fee schedule to pay providers no longer serving a shortage. In addition, the bill would apply the per-visit cap currently applied to independent rural health clinics to provider-based clinics. CBO estimates these provisions would save \$0.2 billion over the 1998–2002 period.

Payments to nurse practitioners, physician assistants, and clinical nurse specialists

The proposal would allow Medicare to reimburse nurse practitioners, physician assistants, and clinical nurse specialists directly at 85 percent of the physician fee schedule rates under certain circumstances in all areas of the country. Direct payments would be allowed in outpatient, home, and inpatient settings. Medicare would also relax its physician supervision requirements to some extent. In some cases, direct payments at 85 percent would substitute for payments made under current law at 100 percent of the fee schedule amounts. Nonetheless, CBO estimates that additional demand for services would more than offset any savings achieved for lowering rates. CBO estimates that this provision would add approximately \$0.5 billion to Medicare outlays over five years.

Part B premiums

Part B premiums currently cover 25 percent of program costs. After 1998, however, the premium is to increase by the rate of the cost-of-living adjustment for Social Security and will fall as a share of costs. The proposal would set the premium to cover 25 percent of program costs after 1998. In addition, home health spending transferred to Part B would affect the premiums as if the transfer was phased-in evenly over 7 years. CBO estimates the savings from this proposal, net of interactions with other provisions, would total \$12.9 billion between 1998 and 2002. Approximately \$9.3 billion of that savings would result from the home health transfer.

The following table shows monthly premiums under current law and the proposal and the incremental effect of the home health transfer on the premium amount (by calendar year, in dollars):

Calendar year	Current law	Proposal	Effect of the home health transfer
1998	45.80	44.80	1.30
1999	47.10	49.30	2.70
2000	48.50	54.20	4.20
2001	50.00	59.80	6.00
2002	51.50	66.60	8.20
2003	53.00	74.40	10.50
2004	54.60	83.10	12.90

Subtitle H, provisions relating to parts A and B

Of the \$19.3 billion in savings attributed to policies under subtitle H, \$11.3 billion result from changes in payments for home health care, which have been discussed above under subtitle E. Extensions and expansions of Medicare rules that make employment-based health plans primary payers for certain beneficiaries account for an additional \$7.9 billion in savings. About \$1.2 billion in savings results from changes in Medicare payments for direct graduate medical education and \$0.3 billion from a policy to designate certain centers of excellence for specialized care. CBO estimates that a proposal to allow reduced premiums for certain military retirees and disabled workers would add about \$1.0 billion in new spending to the Medicare program.

Medicare as secondary payer

This bill contains several proposals to expand and improve accounting of claims where Medicare is secondary payer. It would permanently extend Medicare as secondary payer for the working disabled and permanently authorize the data match requirement for employers. It would expand from 12 or 18 months to 30 months the period before Medicare becomes the primary insurer for working beneficiaries with end-stage renal disease. CBO estimates that these provisions would save \$7.5 billion between 1998 and 2002.

The proposal would also improve accounting for secondary payer situations by permitting Medicare to notify primary insurers of erroneous payments for up to three years after a claim is filed. In addition, the bill would enable Medicare to require reimbursement from third-party administrators of health insurance plans in cases where Medicare erroneously made the primary payment. CBO estimates that this provision would save \$0.4 billion over five years.

Reduced premiums for certain military retirees and disabled workers

CBO estimates that a provision to waive Part B late enrollment penalties for certain military retirees and disabled workers will add \$1.3 billion to Medicare's costs, partially offset by additional premium collections of \$0.3 billion. For military retirees, the premium penalty for late enrollment would be waived for a limited period of time. For disabled workers losing employment-based retiree health insurance, the premium penalty would be waived with no time limit. CBO assumes that, as a result, 100,000 additional military

retirees and 10,000 additional disabled workers would enroll in Part B by 2002.

Subtitle I, medical liability reform

This subtitle would revise medical liability law and preempt less restrictive state laws. It would cap noneconomic damages at \$250,000 and limit punitive damages to the greater of \$250,000 or three times the amount of economic damages. Punitive damages would be awarded only if the claimant could establish intentional harm or conscious and flagrant indifference on the part of the defendant. The proposal would establish a two-year statute of limitations for medical liability cases, starting on the date the alleged injury was, or should reasonably have been, discovered. In any event, no legal action could be taken more than five years after the date the alleged injury occurred. Defendants in liability cases would be allowed to introduce evidence of collateral source payments. Finally, the proposal would require that these reforms apply to any alternative dispute resolution system used to resolve medical liability claims. These reforms would apply to all medical liability actions in state or federal court that are initiated after the enactment of the subtitle. Liability suits concerning injuries that occurred before enactment of this subtitle would be governed by the statute of limitations in effect at the time that the injury occurred.

If these provisions were enacted, carriers of medical malpractice insurance would likely lower their premiums slightly. This reduction would in turn lower Medicare physician payments, which are partly based on the cost of malpractice insurance. CBO estimates that the resulting savings to Medicare would be \$0.2 billion over five years.

Estimate prepared by: Tom Bradley, Cyndi Dudzinski, Anne Hunt, Jennifer Jenson, Jeff Lemieux, Murray Ross, and Robin Rudowitz.

Estimate approved by: Paul N. Van de Water, Assistant Director for Budget Analysis.

TABLE 2. MEDICARE PROVISIONS AS APPROVED BY THE COMMITTEE ON WAYS AND MEANS

(By fiscal year, in billions of dollars)

	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	'98-02	'98-07
CHANGE IN DIRECT SPENDING													
Subtitle A Medicare Plus Program:													
Payments to risk-based plans ¹	0.0	-0.9	-2.2	-4.2	0.1	-11.5	-7.7	-9.1	-11.9	-13.3	-14.5	-18.6	-75.2
Medicare plus funding of peer review	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	-0.4
Coverage of PACE under Medicare	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1
PACE as State Medicaid option and demos	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Social health maintenance organizations (SHMOs)	0.0	0.0	0.1	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2	0.2
Municipal health services plans	0.0	0.0	0.0	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2	0.2
Community nursing demo extension	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1
Medigap changes	0.0	0.0	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.6
Competitive pricing demos	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total, Subtitle A	0.0	-0.7	-2.0	-4.1	0.2	-11.5	-7.7	-9.0	-11.9	-13.3	-14.4	-18.1	-74.5
Subtitle B Prevention Initiatives:													
Screening mammography	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2	0.4
Screening pap smears and pelvic exams	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.3
Prostate screening	0.0	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	1.0	2.0
Colorectal screening Part A	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.0
Colorectal screening Part B	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.5	0.9
Diabetes self management Part A	0.0	-0.0	-0.0	-0.0	-0.0	-0.0	-0.0	-0.0	-0.0	-0.0	-0.0	-0.1	-0.1
Diabetes self management Part B	0.0	0.4	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	2.5	5.2
Bone mass measurement	0.0	0.0	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.3	0.6
Total, Subtitle B	0.0	0.7	1.0	1.0	1.0	0.9	0.9	0.9	0.9	0.9	0.9	4.6	9.2
Subtitle C Rural Initiatives:													
Rural primary care hospitals	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2	0.3
Reclassification of rural referral center(s)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1
Geographic reclassification for DSH	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Medicare dependent hospitals	0.0	0.0	0.1	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2	0.2
Floor on area wage index	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Telemedicine, education, medical informatics	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total, Subtitle C	0.0	0.1	0.1	0.1	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.4	0.7
Subtitle D Fraud and Abuse:													
Advisory opinions regarding self-referral	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2	0.2
Fraud and abuse provisions	0.0	-0.0	-0.0	-0.0	-0.0	-0.0	-0.0	-0.0	-0.0	-0.1	-0.1	-0.2	-0.4

TABLE 2. MEDICARE PROVISIONS AS APPROVED BY THE COMMITTEE ON WAYS AND MEANS—Continued
 (By fiscal year, in billions of dollars)

	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	'98-02	'98-07
Physician profiling for high-cost staff	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Eliminate X-ray requirement for chiropractors	0.0	0.0	0.1	0.1	0.2	0.2	0.3	0.3	0.4	0.5	0.5	0.6	2.6
Reestablish payment for transport of portable EKG ³	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Durable medical equipment, P+O and PEN	0.0	0.0	-0.1	-0.2	-0.2	-0.3	-0.4	-0.4	-0.5	-0.5	-0.5	-0.8	-3.1
Oxygen	0.0	-0.2	-0.3	-0.3	-0.4	-0.4	-0.5	-0.6	-0.6	-0.7	-0.7	-1.6	-4.7
Lab updates	0.0	-0.2	-0.4	-0.5	-0.6	-0.8	-0.9	-0.9	-1.0	-1.1	-1.1	-2.5	-7.5
Lab administrative simplification	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Ambulatory surgical centres	0.0	-0.0	-0.0	-0.1	-0.1	-0.1	-0.2	-0.2	-0.2	-0.2	-0.2	-0.4	-1.3
Pharmaceutical payments ⁴	0.0	-0.1	-0.1	-0.1	-0.0	-0.0	-0.0	-0.0	-0.0	-0.0	-0.1	-0.4	-0.6
Coverage of oral anti-emetics	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Rural health clinic services	0.0	-0.0	-0.0	-0.0	-0.0	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.2	-0.6
NPs, PAs, and CNSs	0.0	0.0	0.1	0.1	0.1	0.2	0.2	0.3	0.3	0.3	0.3	0.5	1.9
Dialysis audits and quality standards	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Part B premium	0.0	0.3	-0.6	-2.2	-4.0	-6.4	-9.3	-12.7	-16.2	-19.7	-23.3	-12.9	-94.0
Total, Subtitle G	0.0	-0.2	-2.2	-4.5	-6.8	-9.3	-11.9	-15.0	-18.8	-23.1	-27.3	-22.9	-119.0
Subtitle H:													
MSP extension, 30 month ESRD	0.0	-0.1	-1.7	-1.8	-1.9	-2.0	-2.1	-2.2	-2.3	-2.5	-2.6	-7.5	-19.2
Clarification of time and filing limitations, recovery against TPAs	0.0	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.4	-0.9
Home health policies	0.0	-1.0	-1.9	-2.3	-2.8	-3.2	-3.7	-4.2	-4.8	-5.3	-6.0	-11.3	-35.3
Direct GME: Resident counts and non-hospital providers	0.0	-0.1	-0.1	-0.1	-0.2	-0.2	-0.3	-0.3	-0.4	-0.5	-0.5	-0.7	-2.7
Direct GME: Cap on overhead	0.0	-0.0	-0.0	-0.1	-0.1	-0.1	-0.2	-0.2	-0.2	-0.2	-0.2	-0.3	-1.1
Direct GME: Incentive payments	0.0	-0.0	-0.0	-0.0	-0.1	-0.1	-0.1	-0.1	-0.2	-0.2	-0.2	-0.2	-1.1
Direct GME: Consortia	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Centers of excellence	0.0	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.3	-0.8
Part B premium penalty and gap for military retirees—benefits	0.0	0.1	0.2	0.3	0.3	0.3	0.3	0.4	0.4	0.4	0.4	1.2	3.1
Part B premium penalty and gap for military retirees—premiums	0.0	-0.0	-0.0	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.3	-0.8
Part B premium penalty for disabled workers—benefits	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.1	0.3
Part B premium penalty for disabled workers—premiums	0.0	-0.0	-0.0	-0.0	-0.0	-0.0	-0.0	-0.0	-0.0	-0.0	-0.0	-0.0	-0.1
Total, Subtitle H	0.0	-1.3	-3.8	-4.3	-4.9	-5.5	-6.2	-7.0	-7.7	-8.5	-9.3	-19.8	-58.4
Subtitle I Medical Liability Reform	0.0	-0.0	-0.0	-0.0	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.2	-0.6
Part A Premium Interaction	0.0	0.1	0.1	0.2	0.3	0.4	0.5	0.5	0.6	0.7	0.8	1.1	4.1

Total, Medicare net outlays 0.0 -6.8 -16.8 -25.1 -41.2 -41.2 -46.7 -54.6 -61.2 -67.5 -115.0 -386.3

Notes—Assumes enactment on August 15, 1997 with no delay in implementation of FY98 policies. Later enactment would reduce savings.

¹October 1, 2001 Medicare Plus payments accelerated to September 2001.

²Assumes limits on adjustments to MEI are +3% and -7%.

³Assumes payments would be limited to services provided in calendar year 1998.

⁴Payments for prescription drugs would equal AWP-5%, effective January 1, 1998.

TABLE 2. MEDICARE PROVISIONS AS APPROVED BY THE COMMITTEE ON WAYS AND MEANS

(By fiscal year, in billions of dollars)

	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	'98-02	'98-07
MEMORANDUM													
Monthly Part B Premium (By calendar year)													
Estimated Premium under proposal	\$42.50	\$43.80	\$44.80	\$49.30	\$54.20	\$59.80	\$66.60	\$74.40	\$83.10	\$91.50	\$108.20		
Estimated Premium under current law	\$42.50	\$43.80	\$45.80	\$47.10	\$48.50	\$50.00	\$51.50	\$53.00	\$54.60	\$56.20	\$59.70		
Home Health Transfer													
Amount of HH Transfer, in billions of dollars			1.2	3.9	6.3	9.3	12.8	16.6	18.6	19.9	21.2	22.7	33.6
HMO Interaction: Spending Transferred to Part B			0.2	0.6	1.3	1.8	2.9	4.2	5.9	8.0	9.0	9.8	6.8
Impact on Medicaid Spending (In billions of dollars)													
Federal Spending for Premiums			-0.0	0.1	0.2	0.4	0.6	0.8	1.1	1.5	1.8	2.1	1.1
State and Local Spending for Premiums			-0.0	0.0	0.1	0.3	0.4	0.6	0.9	1.1	1.3	1.6	0.9
Total Federal and State and Local from Premiums			-0.0	0.1	0.3	0.6	1.0	1.5	2.0	2.6	3.1	3.7	2.0
Rural Health Clinic Services—Federal Share			-0.0	-0.0	-0.0	-0.0	-0.0	-0.0	-0.0	-0.0	-0.0	-0.1	-0.1
Rural Health Clinic Services—State and Local Share			-0.0	-0.0	-0.0	-0.0	-0.0	-0.0	-0.0	-0.0	-0.0	-0.0	-0.1
Total Federal and State and Local from Rural Clinics			-0.0	-0.0	-0.0	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.2
Total, Federal			-0.1	0.0	0.2	0.3	0.5	0.8	1.1	1.4	1.7	2.0	1.0
Total, State and Local			-0.0	0.0	0.1	0.2	0.4	0.6	0.8	1.1	1.3	1.5	0.7
Total, Federal and State and Local			-0.1	0.0	0.3	0.6	0.9	1.4	1.9	2.5	3.0	3.6	1.7
Status of Hospital Insurance Trust Fund (In billions of dollars)													
Income	127.7	131.0	136.5	142.2	147.7	154.0	160.3	166.6	173.4	180.3	187.1		
Outlays	137.4	142.5	146.5	152.7	154.1	162.5	169.7	179.4	195.4	204.6	212.7		
Surplus	-9.7	-11.5	-10.0	-10.5	-6.3	-8.5	-9.4	-12.8	-22.0	-24.3	-25.6		

TABLE 2. MEDICARE PROVISIONS AS APPROVED BY THE COMMITTEE ON WAYS AND MEANS—Continued

[By fiscal year, in billions of dollars]

	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	'98-02	98-07
Balance at End of Year	115.6	104.1	94.1	83.6	77.2	68.8	59.4	46.6	24.6	0.3	-25.3	.....	.....

Notes.—Assumes enactment on August 15, 1997 with no delay in implementation of FY98 policies. Later enactment would reduce savings.

TABLE 3. COMPONENTS OF THE CHANGE IN PAYMENT TO RISK-BASED PLANS

[By fiscal year, in billions of dollars]

	1998	1999	2000	2001	2002	1998–2002
Slower growth in fee-for-service spending	–0.9	–2.6	–4.7	–5.3	–7.0	–20.5
Reducing update by 0.5 percentage points a year	–0.1	–0.3	–0.6	–0.8	–1.3	–3.2
Accelerating October 2001 payment	0	0	0	4.8	–4.8	0
Subtotal	–1.0	–3.0	–5.4	–1.3	–13.1	–23.7
Floor on payment rates	0	0.2	0.3	0.5	0.6	1.6
Risk selection in provider-sponsored organizations	0	0.2	0.3	0.4	0.5	1.4
Risk selection in high-deductible/MSA plans	0	0.4	0.5	0.5	0.6	2.0
Subtotal	0.1	0.8	1.1	1.4	1.6	5.0
Total	–0.9	–2.2	–4.2	–0.1	–11.5	–18.6
Memoranda:						
Enrollment in counties initially subject to floor on payments (millions)	0.1	0.4	0.6	0.8	1.0	
Incremental Cost Per Enrollee (dollar)	500	550	550	550	600	
Enrollment in provider-sponsored organizations (millions)	0.1	0.4	0.6	0.8	1.0	
Incremental cost per enrollee (dollars)	500	500	500	500	500	
Enrollment in high-deductible/MSA plans (millions)	0	0.4	0.5	0.5	0.5	
Incremental cost per enrollee (dollars)	0	1,000	1,000	1,050	1,150	

Source: Congressional Budget Office.

CONGRESSIONAL BUDGET OFFICE INTERGOVERNMENTAL MANDATE
STATEMENT

*Medicare Reconciliation Recommendations of the House Committee
on Ways and Means (Title X)*

Summary.—Title X would make numerous changes to the Medicare program in order to achieve federal budgetary savings. Some of these changes would impose intergovernmental mandates and affect the budgets of state, local, and tribal governments.

Intergovernmental mandates contained in bill.—The title would impose several intergovernmental mandates as defined in the Unfunded Mandates Reform Act (UMRA). Specifically, the title would:

Prohibit states from imposing premium taxes on MedicarePlus plans;

extend and expand the existing mandate that health plans sponsored by state and local governments for their employees be the primary payer for the working disabled and for individuals with end-stage renal disease (ESRD);

preempt states from prohibiting certain provider sponsored organizations (PSOs) from operating as Medicare Plus organizations in their state;

preempt state laws that are inconsistent with the standards for MedicarePlus plans and organizations developed by the Secretary of Health and Human Services;

impose a notification requirement on health plans that are sponsored by state and local governments and supplement Medicare;

preempt certain state laws affecting medical liability; and
require separate court proceedings for punitive damages in medical liability cases if either party requests it.

Estimated direct costs of mandates to State, local, and tribal governments.—Is the Statutory Threshold Exceeded?

CBO is uncertain whether the threshold for intergovernmental mandates (\$50 million in 1996, adjusted annually for inflation) would be exceeded in any of the next five years, because UMRA is unclear about including the costs of extending an existing mandate. If the costs of extending the primary payer requirement are included, then the total costs of the intergovernmental mandates in this title would be at or near the threshold in 1999. If such costs are not included, then the threshold would not be exceeded in any year.

Total direct costs of mandates.—The costs of complying with the intergovernmental mandates contained in this bill are summarized in the following table.

DIRECT COSTS OF INTERGOVERNMENTAL MANDATES

[By federal fiscal year, in millions of dollars]

	1997	1998	1999	2000	2001	2002
Premium tax preemption	0	20	25	33	33	42
Expand primary payer requirement	0	6	2	0	0	0
Medical liability (requirement and preemption)	0	(¹)	(^{1})	(^{1})	(^{1})	(^{1})
Other mandates	0	(¹)	(^{1})	(^{1})	(^{1})	(^{1})
Total, without extension	0	26	27	33	33	42
Extend primary payer requirement	0	0	24	0	0	0
Total, with extension	0	26	51	33	33	42

¹ Less than \$500,000.

Basis of estimate.—Preemption of Premium taxes collected by States

A handful of states currently collect premium taxes from Medicare managed care plans that would be excluded from state premium tax collections by this title. Based on the tax rates, average payment per enrollee, and managed care enrollment in these states, CBO estimates that states will collect about \$15 million in premium taxes from these managed care plans in 1997 under current law. Assuming such tax collections increase by an average of 25 percent over the next five years (largely as a result of enrollment growth in these plans), CBO estimates that this preemption would result in a loss of state tax collections totaling about \$20 million to \$40 million annually over the 1998–2002 period.

Medicare as Secondary Payer.—Under current law, employment based health plans (including state and local government plans) are mandated to be the primary payer (with Medicare being the secondary payer) for individuals with ESRD for the first 18 months of Medicare eligibility and for the working disabled without time limitations. These requirements will expire on October 1, 1998, when these employment based plans will become the primary payer for individuals with ESRD for only the first 12 months and the secondary payer for the working disabled. This title would extend these requirements and expand them by making employment based health plans the primary payer for individuals with ESRD for the first 30 months.

Expanding the Requirement.—By itself, expanding the ESRD requirement to 30 months would shift spending of between \$20 million and \$25 million annually from Medicare to health plans sponsored by state and local governments. (Based on data from the Current Population Survey, CBO estimates that health plans sponsored by state and local governments account for about 15 percent of the shift from Medicare to employment-based health plans.) As a result of higher health care costs, state and local governments would reduce other elements of their employees' compensation packages by a corresponding amount. Some governmental entities, however, would be unable to immediately adjust the compensation package of all their employees. About 40 percent of state and local employees are members of unions and are covered by collectively bargaining agreements that fix compensation packages for, on average, about two years. During this transitional period, state and local governments would face additional costs totaling \$8 million. In the long run, the total amount of compensation paid by state and local governments would not change.

Extending the requirement.—Extending the primary payer requirement beyond 1998 would shift an additional \$240 million to \$280 million in spending annually from Medicare to the state and local plans. State and local governments would face additional direct costs of \$24 million in 1999 until they shift these costs to their employees.

Medical liability.—The preemption of state laws affecting medical liability that are less stringent than provided for in this title would decrease the incentive for people to bring malpractice suits. This decrease would likely reduce state judicial costs. However, the requirement that state courts provide separate proceedings for punitive damages if requested by either party would increase judicial costs. Based on data from the National Center for State Courts and an analysis of medical liability laws in each state from the Association of Trial Lawyers of America, CBO estimates that these two effects would largely offset each other and the net change in costs would not be significant.

Other mandates.—CBO estimates that the other mandates discussed above would impose no significant costs on state, local, or tribal governments.

Appropriation or other federal financial assistance provided in bill to cover mandate costs.—None.

Other significant impacts on State, local, and tribal governments.—Public Hospitals and clinics.—The proposed reductions in Medicare spending would reduce the revenues of public hospitals and clinics. According to the Prospective Payment Assessment Commission, hospitals owned by urban and rural governments (which do not include those owned by states, special taxing districts, and public universities) account for about 15 percent of the payments under Medicare's prospective payment system. In addition, according to the National Association of Public Hospitals and Health Systems (which represents 100 large safety net hospitals that are in urban areas), Medicare accounts for about 20 percent of its members' net revenue and inpatient days.

Medicaid and Part B premium.—The title would make the Part B monthly premium collected from enrollees increase faster than it

would under current law. Because states are required under the Medicaid program to pay for about 43 percent of Part B premiums for low-income Medicare beneficiaries, state spending for these individuals would increase by \$900 million between 1998 and 2002. This requirement would not constitute a mandate under UMRA, however, because new requirements for large entitlement programs are not mandates if the states have the flexibility to offset costs by reducing their own financial or programmatic responsibilities in the program. Under Medicaid, states have the ability to reduce their coverage of optional services or benefits to offset these additional costs.

Medicaid and rural health clinics.—The title would drop the requirement that Medicaid reimburse certain rural health clinics on a cost basis. The states' share of these savings would total about \$100 million over five years.

Estimate prepared by: John Patterson.

Estimate approved by: Paul N. Van de Water, Assistant Director for Budget Analysis.

CONGRESSIONAL BUDGET OFFICE PRIVATE-SECTOR MANDATE
STATEMENT

*Medicare Reconciliation Recommendations of the House Committee
on Ways and Means (Title X)*

Summary.—Title X would make numerous changes to the Medicare program in order to achieve federal budget savings. Some of these changes would impose private-sector mandates affecting private insurers.

Private-sector mandates contained in bill.—Title X contains several private-sector mandates as defined in the Unfunded Mandates Reform Act of 1995. These mandates would affect employment-based health insurance plans and medigap plans.

Mandates on employment-based health insurance plans

Section 10701 of the bill would make permanent an existing mandate on health insurance providers that requires them to treat Medicare as second payer (MSP) for disabled enrollees who have employment-based insurance through current employment, either their own or that of their spouse. It would also make permanent a current provision that makes Medicare the second payer for Medicare enrollees with end-stage renal disease (ESRD) who have employment-based insurance. Under current law, both of these private-sector mandates expire at the end of fiscal year 1998. In addition, the bill would increase the length of time for which an employment-based plan would be primary payer for ESRD enrollees from 18 months to 30 months.

Mandates on employment-based and medigap plans

Section 10031 of the bill would impose a mandate on private insurers who provide supplemental insurance to Medicare enrollees. In particular, if those insurers terminated their policies, they would have to notify enrollees of the legal obligations of issuers of Medicare supplemental policies and of enrollees' rights in the purchase of replacement policies. The bill would impose a similar re-

quirement on HMOs and other plans in the Medicare Plus sector, but for these plans the requirement would be a condition for participating in the Medicare program and, as such, would not be a mandate under UMRA.

Mandates on medigap plans

Section 10031 of the bill would impose two additional mandates on medigap plans. First, it would prohibit coverage exclusions for preexisting conditions for aged Medicare enrollees who purchased a medigap plan within 6 months of their enrollment in Part B, so long as they had insurance coverage for at least six months prior to medigap enrollment. Second, the bill would require medigap plans, under specified conditions, to issue policies (limited to standardized plans A, B, C, or F) to Medicare enrollees who wished to change their coverage from another medigap plan, an HMO, or employment-based insurance as long as any lapse in coverage was no more than 63 days. Medigap plans would also be prohibited from having coverage exclusions for preexisting conditions in this circumstance. Under current law, medigap plans may exclude coverage for up to six months for preexisting conditions that the patient was treated for during the six months prior to medigap enrollment.

Section 10742 would impose an additional mandate on medigap plans. It would require that medigap insurers hold a one-time special open enrollment period of six months for certain military retirees and their dependents. It would not prohibit medigap plans from imposing a six-month coverage exclusion for preexisting conditions in this case. Those people affected would have to be 65 or older and eligible to enroll under Part B of Medicare at the time of enactment. Further, when they first became eligible for Part B, they must have been eligible for health benefits from the Department of Defense and they must have elected not to enroll in part B.

Estimated direct cost to the private sector.—CBO estimates that the direct costs of the private-sector mandates in title X would total \$120 million in fiscal year 1998. In 1999–2002, the costs could be considerably higher, depending on how the Unfunded Mandates Reform Act is interpreted regarding the extension of a mandate that is scheduled to expire under current law (see below). Under one interpretation, the mandate costs of this title would be about \$150 million in 1999; under another interpretation, the mandate costs in 1999 would be \$1.4 billion. The estimates for each of the specific mandates in title X are shown in the following table.

DIRECT COSTS OF PRIVATE-SECTOR MANDATES

[Fiscal year dollars in millions]

Provision	1998	1999	2000	2001	2002
MSP Extension					
Cost compared to no MSP mandate	110	1,370	1,440	1,520	1,600
Cost compared to current MSP mandate	110	120	120	130	140
Notification	0	0	0	0	0
Medigap Requirements at Initial Enrollment	0	0	0	0	0
Medigap Requirements when Changing Plans	10	30	30	30	30
Medigap Open Enrollment for Certain Military Retirees and Dependents	0	0	0	0	0

DIRECT COSTS OF PRIVATE-SECTOR MANDATES—Continued

[Fiscal year dollars in millions]

Provision	1998	1999	2000	2001	2002
Total Cost					
Compared to no MSP mandate	120	1,400	1,470	1,550	1,630
Compared to current MSP mandate	120	150	150	160	170

The remainder of this analysis discusses the basis for CBO's estimate of the direct costs of these private-sector mandates.

Direct cost of mandates on employment-based insurance plans

The MSP provisions in the bill would transfer the primary liability for most Medicare-covered services from Medicare to the employment-based plans that enroll disabled Medicare beneficiaries who have a current employment link. Thus, the total cost of these provisions would equal the savings to the Medicare program, which are described in CBO's federal cost estimate for this title. To calculate the share of these costs attributable to private-sector plans, CBO used information from the March 1996 Current Population Survey. According to that source, about 80 percent of the approximately 500,000 disabled Medicare enrollees who would be affected by these provisions have insurance from private-sector employers. (About 15 percent of the affected disabled enrollees have insurance from state or local government employers, and the remaining 5 percent have insurance through the federal government as an employer.) The total cost to private-sector plans of extending of MSP mandate beyond 1998 would be \$1,250 million in 1999, rising to \$1,460 in 2002. The cost of increasing from 18 months to 30 months the ESRD provision would be \$110 million in 1998, rising to \$140 million in 2002.

It is unclear to CBO how to treat the cost of extending an expiring mandate in terms of its direct private-sector impact. The Unfunded Mandates Reform Act could be interpreted as requiring the estimate of the direct cost of mandate extension to be based on a comparison with costs under the existing mandate. In that case, the direct cost of extending the mandate would be zero, and the only cost of the MSP provisions would be the cost of increasing from 18 months to 30 months the ESRD provision. An alternative interpretation is that the estimate of direct cost should assume the mandate expires at the end of fiscal year 1998, as under current law. The direct cost of the mandate under that approach would be the cost of extending the expiration date of the MSP provisions, plus the cost of the additional ESRD provision. The private-sector mandate cost under each of these interpretations is displayed in the table.

Direct cost of mandate on employment-based and medigap plans

The direct cost of the proposed notification mandate would be negligible. Plans terminating coverage would have to notify policyholders even without this mandate, and the incremental costs of including a sheet notifying those people of their legal rights concerning replacement coverage would be minimal.

Direct cost of mandates on medigap plans

There would be negligible costs from the mandate to prohibit medigap plans from excluding coverage for preexisting conditions for Medicare enrollees who purchased a medigap plan within six months of becoming eligible for and enrolling in Medicare Part B, and who had health insurance coverage prior to Medicare enrollment. At most, this provision would increase the average annual medigap premium of approximately \$1,300 by about \$6—under the extreme assumption that virtually all services used by the affected enrollees during the first six months of medigap coverage would otherwise be excluded from coverage. However, according to the American Academy of Actuaries few medigap plans enforce exclusion provisions for those enrolling at age 65. Hence, CBO estimates no costs for this mandate.

Regarding the mandate on medigap plans that would require them to guarantee issue and prohibit coverage exclusions for continuously covered Medicare enrollees switching plans, only movement by HMO enrollees into medigap plans would impose new costs on the plans. This provision is already law for people who switch from one medigap plan to another, and people moving from employment-based plans to medigap plans would be unlikely to be more costly than the average medigap enrollee. However, analysis by the Physician Payment Review Commission indicates that HMO enrollees who return to the fee-for-service sector are about 60 percent more costly than average.

Because the American Association of Retired Persons (AARP) sponsors guaranteed-issue community-rated medigap plans at all states, the guaranteed-issue provision should, by itself, have no effect on HMO disenrollment rates or average premium costs for current medigap enrollees—although it might lower AARP premiums (and premiums for those Blue Cross plans that have community rating) while increasing the premiums of other plans. But the prohibition of coverage exclusions for continuously covered enrollees might increase the number of HMO enrollees who returned to the fee-for-service sector, and it would increase covered benefit costs for the medigap plans chosen by HMO disenrollees.

However, the bill would prohibit coverage exclusions by medigap plans only in a limited set of cases—for those who were involuntarily disenrolled from an HMO because they relocated or the HMO no longer served their area, and a one-time prohibition for those who left an HMO within the first six months of enrolling. About 0.5 percent of HMO enrollees return to the fee-for-service sector for involuntary reasons (Physician Payment Review Commission, Annual Report, 1997). About 10 percent of first-time HMO enrollees return to the fee-for-service sector within six months. (Prospective Payment Assessment Commission, Report to the Congress, June 1996). Given current HMO enrollment and projected growth rates, this implies that about 3 percent of HMO enrollees (or about 170,000 people) in 1998 would return to the fee-for-service sector and be affected by this mandate. As a result, average annual premiums for medigap enrollees might increase by about \$3 when fully effective. The costs of this mandate on medigap plans would be about \$10 million in fiscal year 1998 and about \$30 million in 2002.

The cost of the mandate requiring a one-time open enrollment period for certain military retirees and their dependents would be negligible. It would have no appreciable effect on average premium costs for current medigap enrollees because medigap coverage is already offered in every state by AARP with continuous open enrollment, and because this mandate would prohibit plans from imposing a 6-month coverage exclusion for preexisting conditions.

Appropriation or other Federal financial assistance provided in bill to cover mandate costs.—None

Estimate prepared by.—Sandra Christensen.

Estimate approved by.—Joseph Antos, Assistant Director for Health and Human Resources.

V. OTHER MATTERS TO BE DISCUSSED UNDER THE RULES OF THE HOUSE

A. COMMITTEE OVERSIGHT FINDINGS AND RECOMMENDATIONS

With respect to subdivision (A) of clause 2(l)(3) of rule XI of the Rules of the House of Representatives (relating to oversight findings), the Committee advises that it was as a result of the Committee's oversight activities concerning the financial problems facing both the Hospital Insurance and Supplementary Medical Insurance Trust Funds that the Committee concluded that is appropriate to enact the provisions contained in the bill.

B. SUMMARY OF FINDINGS AND RECOMMENDATIONS OF THE COMMITTEE GOVERNMENT REFORM AND OVERSIGHT

With respect to subdivision (D) of clause 2(l)(3) of rule XI of the Rules of the House of Representatives (relating to oversight findings), the Committee advises that no oversight findings or recommendations have been submitted to this Committee by the Committee on Government Reform and Oversight with respect to the provisions contained in this bill.

C. CONSTITUTIONAL AUTHORITY STATEMENT

With respect to clause 2(l)(4) of rule XI of the Rules of the House of Representatives, relating to Constitutional Authority, the Committee states that the Committee's action in reporting the bill is derived from Article I of the Constitution, Section 8 ("The Congress shall have power to lay and collect taxes, duties, imposts and excises, to pay the debts and to provide for * * * the general Welfare of the United States * * *").

VI. APPLICABILITY OF HOUSE RULE XXI 5(C)

Clause 5(c) of rule XXI of the Rules of the House of Representatives provides that "No bill or joint resolution, amendment, or conference report carrying a Federal income tax rate increase shall be considered as passed or agreed to unless so determined by a vote of not less than three-fifths of the Members voting." The Committee has carefully reviewed the provisions of the Budget Reconciliation Health Recommendations approved by the Committee to determine whether any of these provisions constitute a Federal income tax rate increase within the meaning of the House Rules. It

is the opinion of the Committee that there is no provision of the Budget Reconciliation Health Recommendations that constitutes a Federal income tax rate increase within the meaning of House Rule XX1 5(c) or (d).

VII. APPLICABILITY OF FEDERAL ADVISORY COMMITTEE ACT

Pursuant to the Federal Advisory Committee Act (5 U.S.C., App., section 5(b)), the Committee states that any advisory bodies created by the bill, such as the Medicare Payment Advisory Commission and the Bi-Partisan Commission on the Effect of the Baby Boom Generation on the Medicare Program in section 10721, are consciously created, and are deemed appropriate and necessary to carry out the purposes of the bill. It is the view of the Committee that the functions of any such advisory bodies are not being and could not be performed by one or more agencies or by an advisory committee already in existence, or by enlarging the mandate of an existing advisory committee.

VIII. CHANGES IN EXISTING LAW MADE BY THE RECOMMENDATIONS AS REPORTED

In compliance with clause 3 of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

SOCIAL SECURITY ACT

* * * * *

TITLE XI—GENERAL PROVISIONS, PEER REVIEW, AND ADMINISTRATIVE SIMPLIFICATION

* * * * *

PART A—GENERAL PROVISIONS

* * * * *

DISCLOSURE OF OWNERSHIP AND RELATED INFORMATION

SEC. 1124. (a)(1) The Secretary shall by regulation or by contract provision provide that each disclosing entity (as defined in paragraph (2)) shall—

- (A) as a condition of the disclosing entity's participation in, or certification or recertification under, any of the programs established by titles V, XVIII, and XIX, or
 - (B) as a condition for the approval or renewal of a contract or agreement between the disclosing entity and the Secretary or the appropriate State agency under any of the programs established under titles V, XVIII, and XIX,
- supply the Secretary or the appropriate State agency with full and complete information as to the identity of each person with an ownership or control interest (as defined in paragraph (3)) in the entity

or in any subcontractor (as defined by the Secretary in regulations) in which the entity directly or indirectly has a 5 per centum or more ownership interest *and supply the Secretary with the both the employer identification number (assigned pursuant to section 6109 of the Internal Revenue Code of 1986) and social security account number (assigned under section 205(c)(2)(B)) of the disclosing entity, each person with an ownership or control interest (as defined in subsection (a)(3)), and any subcontractor in which the entity directly or indirectly has a 5 percent or more ownership interest.*

* * * * *

DISCLOSURE REQUIREMENTS FOR OTHER PROVIDERS UNDER PART B OF
MEDICARE

SEC. 1124A. (a) DISCLOSURE REQUIRED TO RECEIVE PAYMENT.—
No payment may be made under part B of title XVIII for items or services furnished by any disclosing part B provider unless such provider has provided the Secretary with full and complete information—

(1) on the identity of each person with an ownership or control interest in the provider or in any subcontractor (as defined by the Secretary in regulations) in which the provider directly or indirectly has a 5 percent or more ownership interest; **and**

(2) with respect to any person identified under paragraph (1) or any managing employee of the provider—

(A) on the identity of any other entities providing items or services for which payment may be made under title XVIII with respect to which such person or managing employee is a person with an ownership or control interest at the time such information is supplied or at any time during the 3-year period ending on the date such information is supplied, and

(B) as to whether any penalties, assessments, or exclusions have been assessed against such person or managing employee under section 1128, 1128A, or 1128B~~[,]~~; *and*

(3) *including the employer identification number (assigned pursuant to section 6109 of the Internal Revenue Code of 1986) and social security account number (assigned under section 205(c)(2)(B)) of the disclosing part B provider and any person, managing employee, or other entity identified or described under paragraph (1) or (2).*

* * * * *

(c) VERIFICATION.—

(1) TRANSMITTAL BY HHS.—*The Secretary shall transmit—*

(A) *to the Commissioner of Social Security information concerning each social security account number (assigned under section 205(c)(2)(B)), and*

(B) *to the Secretary of the Treasury information concerning each employer identification number (assigned pursuant to section 6109 of the Internal Revenue Code of 1986), supplied to the Secretary pursuant to subsection (a)(3) or section 1124(c) to the extent necessary for verification of such information in accordance with paragraph (2).*

(2) VERIFICATION.—The Commissioner of Social Security and the Secretary of the Treasury shall verify the accuracy of, or correct, the information supplied by the Secretary to such official pursuant to paragraph (1), and shall report such verifications or corrections to the Secretary.

(3) FEES FOR VERIFICATION.—The Secretary shall reimburse the Commissioner and Secretary of the Treasury, at a rate negotiated between the Secretary and such official, for the costs incurred by such official in performing the verification and correction services described in this subsection.

[(c)] (d) DEFINITIONS.—For purposes of this section—

(1) the term “disclosing part B provider” means any entity receiving payment on an assignment-related basis (or, for purposes of subsection (a)(3), any entity receiving payment) for furnishing items or services for which payment may be made under part B of title XVIII, except that such term does not include an entity described in section 1124(a)(2);

* * * * *

EXCLUSION OF CERTAIN INDIVIDUALS AND ENTITIES FROM PARTICIPATION IN MEDICARE AND STATE HEALTH CARE PROGRAMS

SEC. 1128. (a) MANDATORY EXCLUSION.—The Secretary shall exclude the following individuals and entities from participation in [any program under title XVIII and shall direct that the following individuals and entities be excluded from participation in any State health care program (as defined in subsection (h))] any Federal health care program (as defined in section 1128B(f)):

(1) * * *

* * * * *

(b) PERMISSIVE EXCLUSION.—The Secretary may exclude the following individuals and entities from participation in [any program under title XVIII and may direct that the following individuals and entities be excluded from participation in any State health care program] any Federal health care program (as defined in section 1128B(f)):

(1) * * *

* * * * *

(8) ENTITIES CONTROLLED BY A SANCTIONED INDIVIDUAL.—Any entity with respect to which the Secretary determines that a person—

(A)(i) who has a direct or indirect ownership or control interest of 5 percent or more in the entity or with an ownership or control interest (as defined in section 1124(a)(3)) in that entity, [or]

(ii) who is an officer, director, agent, or managing employee (as defined in section 1126(b)) of that entity[—]; or

(iii) who was described in clause (i) but is no longer so described because of a transfer of ownership or control interest, in anticipation of (or following) a conviction, assessment, or exclusion described in subparagraph (B) against the person, to an immediate family member (as defined in subsection (j)(1)) or a member of the household of the per-

son (as defined in subsection (j)(2)) who continues to maintain an interest described in such clause—
 is a person—

* * * * *
 (c) NOTICE, EFFECTIVE DATE, AND PERIOD OF EXCLUSION.—
 (1) * * *

* * * * *
 (3)(A) The Secretary shall specify, in the notice of exclusion under paragraph (1) and the written notice under section 1128A, the minimum period (or, in the case of an exclusion of an individual under subsection (b)(12) or in the case described in subparagraph (G), the period) of the exclusion.

(B) [In the case] *Subject to subparagraph (G), in the case of an exclusion under subsection (a), the minimum period of exclusion shall be not less than five years, except that, upon the request of a State, the Secretary may waive the exclusion under subsection (a)(1) in the case of an individual or entity that is the sole community physician or sole source of essential specialized services in a community. The Secretary’s decision whether to waive the exclusion shall not be reviewable.*

* * * * *
 (D) [In the case] *Subject to subparagraph (G), in the case of an exclusion of an individual or entity under paragraph (1), (2), or (3) of subsection (b), the period of the exclusion shall be 3 years, unless the Secretary determines in accordance with published regulations that a shorter period is appropriate because of mitigating circumstances or that a longer period is appropriate because of aggravating circumstances.*

* * * * *
 (G) *In the case of an exclusion of an individual under subsection (a) based on a conviction occurring on or after the date of the enactment of this subparagraph, if the individual has (before, on, or after such date and before the date of the conviction for which the exclusion is imposed) been convicted—*

- (i) on one previous occasion of one or more offenses for which an exclusion may be effected under such subsection, the period of the exclusion shall be not less than 10 years, or*
- (ii) on 2 or more previous occasions of one or more offenses for which an exclusion may be effected under such subsection, the period of the exclusion shall be permanent.*

* * * * *
 (j) DEFINITION OF IMMEDIATE FAMILY MEMBER AND MEMBER OF HOUSEHOLD.—*For purposes of subsection (b)(8)(A)(iii):*

- (1) The term “immediate family member” means, with respect to a person—*
 - (A) the husband or wife of the person;*
 - (B) the natural or adoptive parent, child, or sibling of the person;*
 - (C) the stepparent, stepchild, stepbrother, or stepsister of the person;*

(D) the father-, mother-, daughter-, son-, brother-, or sister-in-law of the person;

(E) the grandparent or grandchild of the person; and

(F) the spouse of a grandparent or grandchild of the person.

(2) The term "member of the household" means, with respect to any person, any individual sharing a common abode as part of a single family unit with the person, including domestic employees and others who live together as a family unit, but not including a roomer or boarder.

CIVIL MONETARY PENALTIES

SEC. 1128A. (a) Any person (including an organization, agency, or other entity, but excluding a beneficiary, as defined in subsection (i)(5)) that—

(1) knowingly presents or causes to be presented to an officer, employee, or agent of the United States, or of any department or agency thereof, or of any State agency (as defined in subsection (i)(1)), a claim (as defined in subsection (i)(2)) that the Secretary determines—

(A) * * *

* * * * *

(D) is for a medical or other item or service furnished, ordered, or prescribed by such person during a period in which the person was excluded (pursuant to this title or title XVIII) from the program under which the claim was made [pursuant to a determination by the Secretary under this section or under section 1128, 1156, 1160(b) (as in effect on September 2, 1982), 1862(d) (as in effect on the date of the enactment of the Medicare and Medicaid Patient and Program Protection Act of 1987), or 1866(b) or as a result of the application of the provisions of section 1842(j)(2), or],

(E) is for a medical or other item or service ordered or prescribed by a person excluded (pursuant to this title or title XVIII) from the program under which the claim was made, and the person furnishing such item or service knows or should know of such exclusion, or

[(E)] (F) is for a pattern of medical or other items or services that a person knows or should know are not medically necessary;

* * * * *

(4) in the case of a person who is not an organization, agency, or other entity, is excluded from participating in a program under title XVIII or a State health care program in accordance with this subsection or under section 1128 and who, at the time of a violation of this subsection—

(A) retains a direct or indirect ownership or control interest in an entity that is participating in a program under title XVIII or a State health care program, and who knows or should know of the action constituting the basis for the exclusion; or

(B) is an officer or managing employee (as defined in section 1126(b)) of such an entity; **[or]**

(5) offers to or transfers remuneration to any individual eligible for benefits under title XVIII of this Act, or under a State health care program (as defined in section 1128(h)) that such person knows or should know is likely to influence such individual to order or receive from a particular provider, practitioner, or supplier any item or service for which payment may be made, in whole or in part, under title XVIII, or a State health care program (as so defined); *or*

(6) *arranges or contracts (by employment or otherwise) with an individual or entity that the person knows or should know is excluded from participation in a Federal health care program (as defined in section 1128B(f)), for the provision of items or services for which payment may be made under such a program;*

shall be subject, in addition to any other penalties that may be prescribed by law, to a civil money penalty of not more than \$10,000 for each item or service (or, in cases under paragraph (3), \$15,000 for each individual with respect to whom false or misleading information was given; in cases under paragraph (4), \$10,000 for each day the prohibited relationship occurs). In addition, such a person shall be subject to an assessment of not more than 3 times the amount claimed for each such item or service in lieu of damages sustained by the United States or a State agency because of such claim. In addition the Secretary may make a determination in the same proceeding to exclude the person from participation in the Federal health care programs (as defined in section 1128B(f)(1)) and to direct the appropriate State agency to exclude the person from participation in any State health care program.

* * * * *

(i) For the purposes of this section:

(1) * * *

* * * * *

(6) The term “remuneration” includes the waiver of coinsurance and deductible amounts (or any part thereof), and transfers of items or services for free or for other than fair market value. The term “remuneration” does not include—

(A) * * *

(B) differentials in coinsurance and deductible amounts as part of a benefit plan design as long as the differentials have been disclosed in writing to all beneficiaries, third party payers, and providers, to whom claims are presented and as long as the differentials meet the standards as defined in regulations promulgated by the Secretary not later than 180 days after the date of the enactment of the Health Insurance Portability and Accountability Act of 1996; **[or]**

(C) incentives given to individuals to promote the delivery of preventive care as determined by the Secretary in regulations so promulgated**[.]**; *or*

(D) a reduction in the copayment amount for covered OPD services under section 1833(t)(5)(B).

* * * * *

GUIDANCE REGARDING APPLICATION OF HEALTH CARE FRAUD AND ABUSE SANCTIONS

SEC. 1128D. (a) * * *

(b) ADVISORY OPINIONS.—

(1) ISSUANCE OF ADVISORY OPINIONS.—The Secretary, in consultation with the Attorney General, shall issue written advisory opinions as provided in this subsection.

(2) MATTERS SUBJECT TO ADVISORY OPINIONS.—The Secretary shall issue advisory opinions as to the following matters:

(A) * * *

* * * * *

(D) What constitutes an inducement to reduce or limit services to individuals entitled to benefits under title XVIII or title XIX within the meaning of section [1128B(b)] 1128A(b).

* * * * *

HEALTH CARE FRAUD AND ABUSE DATA COLLECTION PROGRAM

SEC. 1128E. (a) * * *

(b) REPORTING OF INFORMATION.—

(1) * * *

* * * * *

(6) SANCTIONS FOR FAILURE TO REPORT.—

(A) HEALTH PLANS.—Any health plan that fails to report information on an adverse action required to be reported under this subsection shall be subject to a civil money penalty of not more than \$25,000 for each such adverse action not reported. Such penalty shall be imposed and collected in the same manner as civil money penalties under subsection (a) of section 1128A are imposed and collected under that section.

(B) GOVERNMENTAL AGENCIES.—The Secretary shall provide for a publication of a public report that identifies those Government agencies that have failed to report information on adverse actions as required to be reported under this subsection.

* * * * *

(g) DEFINITIONS AND SPECIAL RULES.—For purposes of this section:

(1) * * *

* * * * *

(3) GOVERNMENT AGENCY.—The term “Government agency” shall include:

(A) The Department of Justice.

(B) The Department of Health and Human Services.

(C) Any other Federal agency that either administers or provides payment for the delivery of health care services, including, but not limited to the Department of Defense and the [Veterans' Administration] *Department of Veterans Affairs*.

* * * * *

(5) DETERMINATION OF CONVICTION.—For purposes of paragraph (1), the existence of a conviction shall be determined under [paragraph (4)] *paragraphs (1) through (4)* of section 1128(i).

* * * * *

TITLE XVIII—HEALTH INSURANCE FOR THE AGED AND DISABLED

* * * * *

MEDICARE PAYMENT ADVISORY COMMISSION

SEC. 1805. (a) ESTABLISHMENT.—There is hereby established the Medicare Payment Advisory Commission (in this section referred to as the "Commission").

(b) DUTIES.—

(1) REVIEW OF PAYMENT POLICIES AND ANNUAL REPORTS.—The Commission shall—

(A) review payment policies under this title, including the topics described in paragraph (2);

(B) make recommendations to Congress concerning such payment policies;

(C) by not later than March 1 of each year (beginning with 1998), submit a report to Congress containing the results of such reviews and its recommendations concerning such policies and an examination of issues affecting the Medicare program; and

(D) by not later than June 1 of each year (beginning with 1998), submit a report to Congress containing an examination of issues affecting the Medicare program, including the implications of changes in health care delivery in the United States and in the market for health care services on the Medicare program.

(2) SPECIFIC TOPICS TO BE REVIEWED.—

(A) MEDICAREPLUS PROGRAM.—Specifically, the Commission shall review, with respect to the MedicarePlus program under part C, the following:

(i) The methodology for making payment to plans under such program, including the making of differential payments and the distribution of differential updates among different payment areas.

(ii) The mechanisms used to adjust payments for risk and the need to adjust such mechanisms to take into account health status of beneficiaries.

(iii) The implications of risk selection both among MedicarePlus organizations and between the

MedicarePlus option and the medicare fee-for-service option.

(iv) The development and implementation of mechanisms to assure the quality of care for those enrolled with MedicarePlus organizations.

(v) The impact of the MedicarePlus program on access to care for medicare beneficiaries.

(vi) Other major issues in implementation and further development of the MedicarePlus program.

(B) FEE-FOR-SERVICE SYSTEM.—Specifically, the Commission shall review payment policies under parts A and B, including—

(i) the factors affecting expenditures for services in different sectors, including the process for updating hospital, skilled nursing facility, physician, and other fees,

(ii) payment methodologies, and

(iii) their relationship to access and quality of care for medicare beneficiaries.

(C) INTERACTION OF MEDICARE PAYMENT POLICIES WITH HEALTH CARE DELIVERY GENERALLY.—Specifically, the Commission shall review the effect of payment policies under this title on the delivery of health care services other than under this title and assess the implications of changes in health care delivery in the United States and in the general market for health care services on the medicare program.

(3) COMMENTS ON CERTAIN SECRETARIAL REPORTS.—If the Secretary submits to Congress (or a committee of Congress) a report that is required by law and that relates to payment policies under this title, the Secretary shall transmit a copy of the report to the Commission. The Commission shall review the report and, not later than 6 months after the date of submittal of the Secretary's report to Congress, shall submit to the appropriate committees of Congress written comments on such report. Such comments may include such recommendations as the Commission deems appropriate.

(4) AGENDA AND ADDITIONAL REVIEWS.—The Commission shall consult periodically with the chairmen and ranking minority members of the appropriate committees of Congress regarding the Commission's agenda and progress towards achieving the agenda. The Commission may conduct additional reviews, and submit additional reports to the appropriate committees of Congress, from time to time on such topics relating to the program under this title as may be requested by such chairmen and members and as the Commission deems appropriate.

(5) AVAILABILITY OF REPORTS.—The Commission shall transmit to the Secretary a copy of each report submitted under this subsection and shall make such reports available to the public.

(6) APPROPRIATE COMMITTEES.—For purposes of this section, the term "appropriate committees of Congress" means the Committees on Ways and Means and Commerce of the House of Representatives and the Committee on Finance of the Senate.

(c) MEMBERSHIP.—

(1) *NUMBER AND APPOINTMENT.*—The Commission shall be composed of 19 members appointed by the Comptroller General.

(2) *QUALIFICATIONS.*—

(A) *IN GENERAL.*—The membership of the Commission shall include individuals with national recognition for their expertise in health finance and economics, actuarial science, health facility management, health plans and integrated delivery systems, reimbursement of health facilities, allopathic and osteopathic physicians, and other providers of health services, and other related fields, who provide a mix of different professionals, broad geographic representation, and a balance between urban and rural representatives.

(B) *INCLUSION.*—The membership of the Commission shall include (but not be limited to) physicians and other health professionals, employers, third party payers, 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.

(C) *MAJORITY NONPROVIDERS.*—Individuals who are directly involved in the provision, or management of the delivery, of items and services covered under this title shall not constitute a majority of the membership of the Commission.

(D) *ETHICAL DISCLOSURE.*—The Comptroller General shall establish a system for public disclosure by members of the Commission of financial and other potential conflicts of interest relating to such members.

(3) *TERMS.*—

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

(4) *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.

(5) 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.

(6) 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—

(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 Commissions use in making reports and recommendations.

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

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

(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 appropriated 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.

PART A—HOSPITAL INSURANCE BENEFITS FOR THE AGED AND DISABLED

* * * * *

SCOPE OF BENEFITS

SEC. 1812. (a) The benefits provided to an individual by the insurance program under this part shall consist of entitlement to have payment made on his behalf or, in the case of payments referred to in section 1814(d)(2) to him (subject to the provisions of this part) for—

(1) * * *

* * * * *

(3) [home health services] for individuals not enrolled in part B, home health services, and for individuals so enrolled, part A home health services (as defined in subsection (g)); and

(4) in lieu of certain other benefits, hospice care with respect to the individual during up to two periods of 90 days each[, a subsequent period of 30 days, and a subsequent extension period] and an unlimited number of subsequent periods of 60 days each with respect to which the individual makes an election under subsection (d)(1).

* * * * *

(d)(1) Payment under this part may be made for hospice care provided with respect to an individual only during two periods of 90 days each[, a subsequent period of 30 days, and a subsequent extension period] and an unlimited number of subsequent periods of 60 days each during the individuals lifetime and only, with respect to each such period, if the individual makes an election under this paragraph to receive hospice care under this part provided by, or

under arrangements made by, a particular hospice program instead of certain other benefits under this title.

(2)(A) * * *

(B) After an individual makes such an election with respect to a **[90- or 30-day period or a subsequent extension period]** *90-day period or a subsequent 60-day period*, the individual may revoke the election during the period, in which case—

(i) * * *

* * * * *

(g)(1) *For purposes of this section, the term “part A home health services” means—*

(A) *for services furnished during each year beginning with 1998 and ending with 2002, home health services subject to the transition reduction applied under paragraph (2)(C) for services furnished during the year, and*

(B) *for services furnished on or after January 1, 2003, post-institutional home health services for up to 100 visits during a home health spell of illness.*

(2) *For purposes of paragraph (1)(B), the Secretary shall specify, before the beginning of each year beginning with 1998 and ending with 2002, a transition reduction in the home health services benefit under this part as follows:*

(A) *The Secretary first shall estimate the amount of payments that would have been made under this part for home health services furnished during the year if—*

(i) *part A home health services were all home health services, and*

(ii) *part A home health services were limited to services described in paragraph (1)(B).*

(B)(i) *The Secretary next shall compute a transfer reduction amount equal to the appropriate proportion (specified under clause (ii)) of the amount by which the amount estimated under subparagraph (A)(i) for the year exceeds the amount estimated under subparagraph (A)(ii) for the year.*

(ii) *For purposes of clause (i), the “appropriate proportion is equal to—*

(I) $\frac{1}{6}$ *for 1998,*

(II) $\frac{2}{6}$ *for 1999,*

(III) $\frac{3}{6}$ *for 2000,*

(IV) $\frac{4}{6}$ *for 2001, and*

(V) $\frac{5}{6}$ *for 2002.*

(C) *The Secretary shall establish a transition reduction by specifying such a visit limit (during a home health spell of illness) or such a post-institutional limitation on home health services furnished under this part during the year as the Secretary estimates will result in a reduction in the amount of payments that would otherwise be made under this part for home health services furnished during the year equal to the transfer amount computed under subparagraph (B)(i) for the year.*

(3) *Payment under this part for home health services furnished an individual enrolled under part B—*

(A) *during a year beginning with 1998 and ending with 2003, may not be made for services that are not within the visit limit or other limitation specified by the Secretary*

under the transition reduction under paragraph (3)(C) for services furnished during the year; or

(B) on or after January 1, 2004, may not be made for home health services that are not post-institutional home health services or for post-institutional furnished to the individual after such services have been furnished to the individual for a total of 100 visits during a home health spell of illness.

(4) With respect to computing the monthly actuarial rate for enrollees age 65 and over for purposes of applying section 1839, such rate shall be computed as though any reference in a previous provision of this subsection to 2002 or 2003 is a reference to the succeeding year and as through the appropriate proportion described in paragraph (3)(B)(ii) were equal to—

- (A) 1/7 for 1998,*
- (B) 2/7 for 1999,*
- (C) 3/7 for 2000,*
- (D) 4/7 for 2001,*
- (E) 5/7 for 2002, and*
- (F) 6/7 for 2003.*

[(g)] *(h) For definition of “spell of illness, and for definitions of other terms used in this part, see section 1861.*

* * * * *

CONDITIONS OF AND LIMITATIONS ON PAYMENT FOR SERVICES

Requirement of Requests and Certifications

SEC. 1814. (a) Except as provided in subsections (d) and (g) and in section 1876, payment for services furnished an individual may be made only to providers of services which are eligible therefor under section 1866 and only if—

(1) * * *

(2) a physician, or, in the case of services described in subparagraph (B), a physician, or a nurse practitioner or clinical nurse specialist who does not have a direct or indirect employment relationship with the facility but is working in collaboration with a physician, certifies (and recertifies, where such services are furnished over a period of time, in such cases, with such frequency, and accompanied by such supporting material, appropriate to the case involved, as may be provided by regulations, except that the first of such recertifications shall be required in each case of inpatient hospital services not later than the 20th day of such period) that—

(A) * * *

* * * * *

(C) in the case of home health services, such services are or were required because the individual is or was confined to his home (except when receiving items and services referred to in section 1861(m)(7)) and needs or needed skilled nursing care (*other than solely venipuncture for the purpose of obtaining a blood sample*) on an intermittent basis or physical or speech therapy or, in the case of an individual who has been furnished home health services based on

such a need and who no longer has such a need for such care or therapy, continues or continued to need occupational therapy; a plan for furnishing such services to such individual has been established and is periodically reviewed by a physician; and such services are or were furnished while the individual was under the care of a physician; or

- * * * * *
- (7) in the case of hospice care provided an individual—
- (A)(i) in the first 90-day period—
- (I) the individuals attending physician (as defined in section 1861(dd)(3)(B)), and
- (II) the medical director (or physician member of the interdisciplinary group described in section 1861(dd)(2)(B)) of the hospice program providing (or arranging for) the care,
- each certify in writing~~],~~ not later than 2 days after hospice care is initiated (or, if each certify verbally not later than 2 days after hospice care is initiated, not later than 8 days after such care is initiated)~~]~~ *at the beginning of the period*, that the individual is terminally ill (as defined in section 1861(dd)(3)(A)), *and*
- (ii) in a subsequent 90- or ~~30-day~~ *60-day* period, the medical director or physician described in clause (i)(II) recertifies at the beginning of the period that the individual is terminally ill~~], and~~.
- ~~[(iii) in a subsequent extension period, the medical director or physician described in clause (i)(II) recertifies at the beginning of the period that the individual is terminally ill;]~~

- * * * * *
- (8) in the case of inpatient rural primary care hospital services, a physician certifies that the individual may reasonably be expected to be discharged or transferred to a hospital within ~~72~~ 96 hours after admission to the rural primary care hospital.

To the extent provided by regulations, the certification and recertification requirements of paragraph (2) shall be deemed satisfied where, at a later date, a physician, nurse practitioner, or clinical nurse specialist (as the case may be) makes certification of the kind provided in subparagraph (A), (B), (C), or (D) of paragraph (2) (whichever would have applied), but only where such certification is accompanied by such medical and other evidence as may be required by such regulations. With respect to the physician certification required by paragraph (2) for home health services furnished to any individual by a home health agency (other than an agency which is a governmental entity) and with respect to the establishment and review of a plan for such services, the Secretary shall prescribe regulations which shall become effective no later than July 1, 1981, and which prohibit a physician who has a significant ownership interest in, or a significant financial or contractual relationship with, such home health agency from performing such certification and from establishing or reviewing such plan, except that

such prohibition shall not apply with respect to a home health agency which is a sole community home health agency (as determined by the Secretary). For purposes of the preceding sentence, service by a physician as an uncompensated officer or director of a home health agency shall not constitute having a significant ownership interest in, or a significant financial or contractual relationship with, such agency. For purposes of paragraph (2)(C), an individual shall be considered to be “confined to his home if the individual has a condition, due to an illness or injury, that restricts the ability of the individual to leave his or her home except with the assistance of another individual or the aid of a supportive device (such as crutches, a cane, a wheelchair, or a walker), or if the individual has a condition such that leaving his or her home is medically contraindicated. While an individual does not have to be bedridden to be considered “confined to his home, the condition of the individual should be such that there exists a normal inability to leave home, that leaving home requires a considerable and taxing effort by the individual, and that absences of the individual from home are infrequent or of relatively short duration, or are attributable to the need to receive medical treatment. *With respect to the previous two sentences, the individual must have a condition due to an illness or injury that restricts the individual's ability to leave the home for more than an average of 16 hours per calendar month for purposes other than to receive medical treatment that cannot be provided in the home; infrequent means an average of 5 or fewer absences per calendar month, excluding absences to receive medical treatment that cannot be furnished in the home; short duration means an absence from the home of 3 or fewer hours, on average per absence, within a calendar month excluding absences to receive medical treatment that cannot be furnished in the home; and medical treatment means any services that are furnished by the physician or furnished based on and in conformance with the physician's order, by or under the supervision of a licensed health professional, and for the purpose of diagnosis or treatment of an illness or injury.*

Amount Paid to Providers

(b) The amount paid to any provider of services (other than a hospice program providing hospice care, other than a rural primary care hospital providing inpatient rural primary care hospital services, and other than a home health agency with respect to durable medical equipment) with respect to services for which payment may be made under this part shall, subject to the provisions of sections 1813 [and 1886] 1886, and 1895, be—

(1) * * *

* * * * *

Payment for Hospice Care

(i)(1)(A) * * *

* * * * *

(C)(i) * * *

(ii) With respect to routine home care and other services included in hospice care furnished during a subsequent fiscal year, the pay-

ment rates for such care and services shall be the payment rates in effect under this subparagraph during the previous fiscal year increased by—

(I) * * *

* * * * *

(V) for fiscal year 1997, the market basket percentage increase for the fiscal year minus 0.5 percentage point; **and**

(VI) for each of fiscal years 1998 through 2002, the market basket percentage increase for the fiscal year involved minus 1.0 percentage points; and

[(VI)] (VII) for a subsequent fiscal year, the market basket percentage increase for the fiscal year.

(2)(A) * * *

* * * * *

(D) A hospice program shall submit claims for payment for hospice care furnished in an individuals home under this title only on the basis of the geographic location at which the service is furnished, as determined by the Secretary.

(3) The Secretary shall provide for the collection of data, from hospice programs providing hospice care for which payment is made under this subsection, with respect to the costs for providing such care for each fiscal year beginning with fiscal year 1999.

Payment for Inpatient Rural Primary Care Hospital Services

[(1)(1)] The amount of payment under this part for inpatient rural primary care hospital services—

[(A)] in the case of the first 12-month cost reporting period for which the facility operates as such a hospital, is the reasonable costs of the facility in providing inpatient rural primary care hospital services during such period, as such costs are determined on a per diem basis, and

[(B)] in the case of a later reporting period, is the per diem payment amount established under this paragraph for the preceding 12-month cost reporting period, increased by the applicable percentage increase under section 1886(b)(3)(B)(i) for that particular cost reporting period applicable to hospitals located in a rural area.

The payment amounts otherwise determined under this paragraph shall be reduced, to the extent necessary, to avoid duplication of any payment made under section 1820(a)(2) (or under section 4005(e) of the Omnibus Budget Reconciliation Act of 1987) to cover the provision of inpatient rural primary care hospital services.

[(2)] The Secretary shall develop a prospective payment system for determining payment amounts for inpatient rural primary care hospital services under this part furnished on or after January 1, 1996.

(1) PAYMENT FOR INPATIENT RURAL PRIMARY CARE HOSPITAL SERVICES.—The amount of payment under this part for inpatient rural primary care hospital services is the reasonable costs of the rural primary care hospital in providing such services.

PAYMENT TO PROVIDERS OF SERVICES

SEC. 1815. (a) * * *

* * * * *

(e)(1) * * *

(2) The Secretary shall provide (or continue to provide) for payment on a periodic interim payment basis (under the standards established under section 405.454(j) of title 42, Code of Federal Regulations, as in effect on October 1, 1986) with respect to—

(A) * * *

* * * * *

(C) extended care services; and

[(D) home health services; and

[(E)] (D) hospice care;

if the provider of such services elects to receive, and qualifies for, such payments.

* * * * *

USE OF PUBLIC AGENCIES OR PRIVATE ORGANIZATIONS TO FACILITATE
PAYMENT TO PROVIDERS OF SERVICES

SEC. 1816. (a) * * *

* * * * *

(i)(1) * * *

* * * * *

(4) *Nothing in this subsection shall be construed to prohibit reimbursement by an agency or organization under subsection (m).*

* * * * *

(m) An agreement with an agency or organization under this section shall require that such agency or organization reimburse the Secretary for any amounts paid by the agency or organization for a service under this title which is furnished, directed, or prescribed by an individual or entity during any period for which the individual or entity is excluded pursuant to section 1128, 1128A, or 1156, from participation in the program under this title, if the amounts are paid after the Secretary notifies the agency or organization of the exclusion.

HOSPITAL INSURANCE BENEFITS FOR UNINSURED ELDERLY
INDIVIDUALS NOT OTHERWISE ELIGIBLE

SEC. 1818. (a) * * *

* * * * *

(d)(1) * * *

(2) The Secretary shall, during September of each year determine and promulgate the dollar amount which shall be applicable for premiums for months occurring in the following year. Subject to [paragraph (4)] paragraphs (4) and (5), the amount of an individual's monthly premium under this section shall be equal to the monthly actuarial rate determined under paragraph (1) for that following year. Any amount determined under the preceding sentence which is not a multiple of \$1 shall be rounded to the nearest mul-

multiple of \$1 (or, if it is a multiple of 50 cents but not a multiple of \$1, to the next higher multiple of \$1).

* * * * *

(5)(A) *The amount of the monthly premium shall be zero in the case of an individual who is a person described in subparagraph (B) for a month, if—*

(i) *the individual's premium under this section for the month is not (and will not be) paid for, in whole or in part, by a State (under title XIX or otherwise), a political subdivision of a State, or an agency or instrumentality of one or more States or political subdivisions thereof; and*

(ii) *in each of 60 months before such month, the individual was enrolled in this part under this section and the payment of the individual's premium under this section for the month was not paid for, in whole or in part, by a State (under title XIX or otherwise), a political subdivision of a State, or an agency or instrumentality of one or more States or political subdivisions thereof.*

(B) *A person described in this subparagraph for an month is a person who establishes to the satisfaction of the Secretary that, as of the last day of the previous month—*

(i)(I) *the person was receiving cash benefits under a qualified State or local government retirement system (as defined in subparagraph (C)) on the basis of the person's employment in one or more positions covered under any such system, and (II) the person would have at least 40 quarters of coverage under title II if remuneration for medicare qualified government employment (as defined in paragraph (1) of section 210(p), but determined without regard to paragraph (3) of such section) paid to such person were treated as wages paid to such person and credited for purposes of determining quarters of coverage under section 213;*

(ii)(I) *the person was married (and had been married for the previous 1-year period) to an individual who is described in clause (i), or (II) the person met the requirement of clause (i)(II) and was married (and had been married for the previous 1-year period) to an individual described in clause (i)(I);*

(iii) *the person had been married to an individual for a period of at least 1 year (at the time of such individual's death) if (I) the individual was described in clause (i) at the time of the individual's death, or (II) the person met the requirement of clause (i)(II) and the individual was described in clause (i)(I) at the time of the individual's death; or*

(iv) *the person is divorced from an individual and had been married to the individual for a period of at least 10 years (at the time of the divorce) if (I) the individual was described in clause (i) at the time of the divorce, or (II) the person met the requirement of clause (i)(II) and the individual was described in clause (i)(I) at the time of the divorce.*

(C) *For purposes of subparagraph (B)(i)(I), the term "qualified State or local government retirement system means a retirement system that—*

- (i) is established or maintained by a State or political subdivision thereof, or an agency or instrumentality of one or more States or political subdivisions thereof;
- (ii) covers positions of some or all employees of such a State, subdivision, agency, or instrumentality; and
- (iii) does not adjust cash retirement benefits based on eligibility for a reduction in premium under this paragraph.

* * * * *

REQUIREMENTS FOR, AND ASSURING QUALITY OF CARE IN, SKILLED NURSING FACILITIES

SEC. 1819. (a) * * *

(b) REQUIREMENTS RELATING TO PROVISION OF SERVICES.—

(1)

(3) RESIDENTS' ASSESSMENT.—

(A) * * *

* * * * *

(C) FREQUENCY.—

(i) IN GENERAL.—**[Such]** *Subject to the timeframes prescribed by the Secretary under section 1888(t)(6), such an assessment must be conducted—*

(I) promptly upon (but no later than 14 days after the date of) admission for each individual admitted on or after October 1, 1990, and by not later than January 1, 1991, for each resident of the facility on that date;

(II) promptly after a significant change in the resident's physical or mental condition; and

(III) in no case less often than once every 12 months.

* * * * *

[ESSENTIAL ACCESS COMMUNITY HOSPITAL PROGRAM

[SEC. 1820. (a) IN GENERAL.—There is hereby established a program under which the Secretary—

[(1) shall make grants to not more than 7 States to carry out the activities described in subsection (d)(1);

[(2) shall make grants to eligible hospitals and facilities (or consortia of hospitals and facilities) to carry out the activities described in subsection (d)(2); and

[(3) shall designate (under subsection (i)) hospitals and facilities located in States receiving grants under paragraph (1) as essential access community hospitals or rural primary care hospitals.

[(b) ELIGIBILITY OF STATES FOR GRANTS.—A State is eligible to receive a grant under subsection (a)(1) only if the State submits to the Secretary, at such time and in such form as the Secretary may require, an application containing—

[(1) assurances that the State—

[(A) has developed, or is in the process of developing, a State rural health care plan that—

[(i) provides for the creation of one or more rural health networks (as defined in subsection (g)) in the State,

[(ii) promotes regionalization of rural health services in the State,

[(iii) improves access to hospital and other health services for rural residents of the State, and

[(iv) enhances the provision of emergency and other transportation services related to health care;

[(B) has developed the rural health care plan described in subparagraph (A) in consultation with the hospital association of the State and rural hospitals located in the State (or, in the case of a State in the process of developing such plan, that assures the Secretary that it will consult with its State hospital association and rural hospitals located in the State in developing such plan); and

[(C) has designated, or is in the process of designating, rural non-profit or public hospitals or facilities located in the State as essential access community hospitals or rural primary care hospitals within such networks; and

[(2) such other information and assurances as the Secretary may require.

[(c) ELIGIBILITY OF HOSPITALS AND CONSORTIA FOR GRANTS.—

[(1) IN GENERAL.—Except as provided in paragraph (3) or subsection (k), a hospital or facility is eligible to receive a grant under subsection (a)(2) only if the hospital or facility—

[(A) is located in a State receiving a grant under subsection (a)(1);

[(B) is designated as an essential access community hospital or a rural primary care hospital by the State in which it is located or is a member of a rural health network (as defined in subsection (g));

[(C) submits to the State in which it is located and to the Secretary, at such time and in such form as the Secretary may require, an application containing such information and assurances as the Secretary may require; and

[(D) the State in which the hospital or facility is located certifies to the Secretary that—

[(i) the receiving of such a grant by the hospital or facility is consistent with the State's rural health care plan (described in subsection (b)(1)(A)), and

[(ii) the State has approved the application submitted under subparagraph (C).

[(2) TREATMENT OF CONSORTIA.—A consortium of hospitals or facilities each of which is part of the same rural health network is eligible to receive a grant under subsection (a)(2) if each of its members would individually be eligible to receive such a grant.

[(3) ELIGIBILITY OF RPC HOSPITALS NOT LOCATED IN A STATE RECEIVING GRANT.—A facility designated as a rural primary care hospital by the Secretary under subsection (i)(2)(C) shall be eligible to receive a grant under subsection (a)(2).

[(d) ACTIVITIES FOR WHICH GRANTS MAY BE USED.—

【(1) GRANTS TO STATES.—A State shall use a grant received under subsection (a)(1) to carry out the program established under this section in the State. Such grant may be used for engaging in activities relating to planning and implementing a rural health care plan and rural health networks, designating hospitals or facilities in the State as essential access community hospitals or rural primary care hospitals, and developing and supporting communication and emergency transportation systems.

【(2) GRANTS TO HOSPITALS, FACILITIES, AND CONSORTIA.—A hospital or facility shall use a grant received under subsection (a)(2) to finance the costs it incurs in converting itself to a rural primary care hospital or an essential access community hospital or in becoming part of a rural health network in the State in which it is located, including capital costs, costs incurred in the development of necessary communications systems, and costs incurred in the development of an emergency transportation system. A consortium shall use a grant received under subsection (a)(2) to finance the costs it incurs in converting hospitals or facilities that are part of the consortium into rural primary care hospitals or in developing and implementing a rural health network consisting of its members in the State in which it is located, including capital costs, costs incurred in the development of necessary communications systems, and costs incurred in the development of an emergency transportation system.

【(e) DESIGNATION BY STATE OF ESSENTIAL ACCESS COMMUNITY HOSPITALS.—A State may designate a hospital as an essential access community hospital only if the hospital—

【(1)(A) except in the case of a hospital located in an urban area, is located more than 35 miles from any hospital that either (i) has been designated as an essential access community hospital or (ii) is classified by the Secretary as a rural referral center under section 1886(d)(5)(C), or (B) meets such other criteria relating to geographic location as the State may impose with the approval of the Secretary;

【(2) has at least 75 inpatient beds or is located more than 35 miles from any other hospital;

【(3) has in effect an agreement to provide emergency and medical backup services to rural primary care hospitals participating in the rural health network of which it is a member and throughout its service area;

【(4) has in effect an agreement, with each rural primary care hospital participating in the rural health network of which it is a member, to accept patients transferred from such primary care hospital, to receive data from and transmit data to such primary care hospital, and to provide staff privileges to physicians providing care at such primary care hospital; and

【(5) meets any other requirements imposed by the State with the approval of the Secretary.

【(f) DESIGNATION BY STATE OF RURAL PRIMARY CARE HOSPITALS.—

【(1) CRITERIA FOR DESIGNATION.—A State may designate a facility as a rural primary care hospital only if the facility—

[(A) is located in a rural area (as defined in section 1866(d)(2)(D)), or is located in a county whose geographic area is substantially larger than the average geographic area for urban counties in the United States and whose hospital service area is characteristic of service areas of hospitals located in rural areas;

[(B) at the time such facility applies to the State for designation as a rural primary care hospital, is a hospital (or, in the case of a facility that closed during the 12-month period that ends on the date the facility applies for such designation, at the time the facility closed), with a participation agreement in effect under section 1866(a) and had not been found, on the basis of a survey under section 1864, to be in violation of any requirement to participate as a hospital under this title;

[(C) has ceased, or agrees (upon the approval of such application) to cease, providing inpatient care (except as required under subparagraph (F));

[(D) in the case of a facility that is a member of a rural health network, has in effect an agreement to participate with other hospitals and facilities in the communications system of such network, including the network's system for the electronic sharing of patient data, including telemetry and medical records, if the network has in operation such a system;

[(E) makes available 24-hour emergency care;

[(F) subject to paragraph (4), provides not more than 6 inpatient beds (meeting such conditions as the Secretary may establish) for providing inpatient care to patients requiring stabilization before discharge or transfer to a hospital, except that the facility may not provide any inpatient hospital services—

[(i) to any patient whose attending physician does not certify that the patient may reasonably be expected to be discharged or transferred to a hospital within 72 hours of admission to the facility; or

[(ii) consisting of surgery or any other service requiring the use of general anesthesia (other than surgical procedures specified by the Secretary under section 1833(i)(1)(A)), unless the attending physician certifies that the risk associated with transferring the patient to a hospital for such services outweighs the benefits of transferring the patient to a hospital for such services.

[(G) 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 subparagraph (E),

[(ii) the facility may provide any services otherwise required to be provided by a full-time, on-site dieti-

cian, pharmacist, laboratory technician, medical technologist, and radiological technologist on a part-time, off-site basis, and

[(iii) the inpatient care described in subparagraph (F) may be provided by a physician's assistant or nurse practitioner, subject to the oversight of a physician; and

[(H) meets the requirements of subparagraphs (C) through (J) of paragraph (2) of section 1861(aa) and of clauses (ii) and (iv) of the second sentence of that paragraph, 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) PREFERENCE GIVEN TO HOSPITALS OR FACILITIES PARTICIPATING IN RURAL HEALTH NETWORK.—In designating facilities as rural primary care hospitals under paragraph (1), the State shall give preference to hospitals or facilities participating in a rural health network.

[(3) PERMITTING RURAL PRIMARY CARE HOSPITALS TO MAINTAIN SWING BEDS.—Nothing in this subsection shall be construed to prohibit a State from designating a facility as a rural primary care hospital solely because, at the time the facility applies to the State for designation as a rural primary care hospital, there is in effect an agreement between the facility and the Secretary under section 1883 under which the facility's inpatient hospital facilities are used for the furnishing of extended care services, except that the number of beds used for the furnishing of such services may not exceed the total number of licensed inpatient beds at the time the facility applies to the State for such designation (minus the number of inpatient beds used for providing inpatient care pursuant to paragraph (1)(F)). For purposes of the previous sentence, the number of beds of the facility used for the furnishing of extended care services shall not include any beds of a unit of the facility that is licensed as a distinct-part skilled nursing facility at the time the facility applies to the State for designation as a rural primary care hospital.

[(4) LIMITATION ON AVERAGE LENGTH OF INPATIENT STAYS.—The Secretary may terminate a designation of a rural primary care hospital under paragraph (1) if the Secretary finds that the average length of stay for inpatients at the facility during the previous year in which the designation was in effect exceeded 72 hours. In determining the compliance of a facility with the requirement of the previous sentence, there shall not be taken into account periods of stay of inpatients in excess of 72 hours to the extent such periods exceed 72 hours because transfer to a hospital is precluded because of inclement weather or other emergency conditions.

[(g) RURAL HEALTH NETWORK DEFINED.—For purposes of this section, the term "rural health network" means, with respect to a State, an organization—

[(1) consisting of—

[(A) at least 1 hospital that—

[(i) the State has designated or plans to designate as an essential access community hospital under subsection (b)(1)(C),

[(ii) is classified by the Secretary as a regional referral center under section 1886(d)(5)(C), or

[(iii) is located in an urban area and meets the criteria for classification as a regional referral center under such section, and

[(B) at least 1 facility that the State has designated or plans to designate as a rural primary care hospital, and

[(2) the members of which have entered into agreements regarding—

[(A) patient referral and transfer,

[(B) the development and use of communications systems, including (where feasible) telemetry systems and systems for electronic sharing of patient data, and

[(C) the provision of emergency and non-emergency transportation among the members.

[(h) LIMIT ON AMOUNT OF GRANT TO HOSPITAL OR FACILITY.—A grant made to a hospital or facility under subsection (a)(2) may not exceed \$200,000.

[(i) ELIGIBILITY OF HOSPITALS OR FACILITIES FOR DESIGNATION BY SECRETARY.—

[(1) ESSENTIAL ACCESS COMMUNITY HOSPITAL.—(A) The Secretary shall designate a hospital as an essential access community hospital if the hospital—

[(i) is located in a State receiving a grant under subsection (a)(1) (except as provided in subsection (k));

[(ii) is designated as an essential access community hospital by the State in which it is located (except as provided in subparagraph (B) or subsection (k)); and

[(iii) meets such other criteria as the Secretary may require.

[(B) In the case of a hospital that is not eligible for designation as an essential access community hospital under this paragraph solely because it is not designated as an essential access community hospital by the State in which it is located, the Secretary may designate such hospital as an essential access community hospital under this paragraph if the hospital is not so designated by the State in which it is located solely because of its failure to meet the criteria described in paragraph (2) of subsection (e).

[(2) RURAL PRIMARY CARE HOSPITAL.—(A) The Secretary shall designate a facility as a rural primary care hospital if the facility—

[(i) is located in a State receiving a grant under subsection (a)(1) (except as provided in subsection (k));

[(ii) is designated as a rural primary care hospital by the State in which it is located (except as provided in subparagraph (B) or subsection (k)); and

[(iii) meets such other criteria as the Secretary may require.

[(B) In the case of a facility that is not eligible for designation as a rural primary care hospital under this paragraph solely because it is not designated as a rural primary care hospital by the State in which it is located, the Secretary may designate such facility as a rural primary care hospital under this paragraph if the facility is not so designated by the State in which it is located solely because of its failure to meet the criteria described in subparagraphs (C), (F), or (G) of subsection (f)(1).

[(C) The Secretary may designate not more than 15 facilities as rural primary care hospitals under this paragraph that do not meet the requirements of clauses (i) and (ii) of subparagraph (A) if such a facility meets the criteria described in subparagraphs (A), (B), and (E) of subsection (f)(1), except that nothing in this subparagraph shall be construed to prohibit the Secretary from designating a facility as a rural primary care hospital solely because the facility has entered into an agreement with the Secretary under section 1883 under which the facility's inpatient hospital facilities may be used for the furnishing of extended care services. In designating facilities as rural primary care hospitals under this subparagraph, the Secretary shall give preference to facilities not meeting the requirements of clause (i) of subparagraph (A) that have entered into an agreement described in subsection (g)(2) with a rural health network located in a State receiving a grant under subsection (a)(1).

[(j) WAIVER OF CONFLICTING PART A PROVISIONS.—The Secretary is authorized to waive such provisions of this part and part C as are necessary to conduct the program established under this section.

[(k) ELIGIBILITY OF HOSPITALS NOT LOCATED IN PARTICIPATING STATES.—Notwithstanding any other provision of this section—

[(1) for purposes of including a hospital or facility as a member institution of a rural health network, a State may designate a hospital or facility that is not located in the State as an essential access community hospital or a rural primary care hospital if the hospital or facility is located in an adjoining State and is otherwise eligible for designation as such a hospital;

[(2) the Secretary may designate a hospital or facility that is not located in a State receiving a grant under subsection (a)(1) as an essential access community hospital or a rural primary care hospital if the hospital or facility is a member institution of a rural health network of a State receiving a grant under such subsection; and

[(3) a hospital or facility designated pursuant to this subsection shall be eligible to receive a grant under subsection (a)(2).

[(l) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated from the Federal Hospital Insurance Trust Fund for each of the fiscal years 1990 through 1997—

[(1) \$10,000,000 for grants to States under subsection (a)(1); and

【(2) \$15,000,000 for grants to hospitals, facilities, and consortia under subsection (a)(2).】

MEDICARE RURAL PRIMARY CARE HOSPITAL PROGRAM

SEC. 1820. (a) STATE DESIGNATION OF FACILITIES.—

(1) IN GENERAL.—A State may designate one or more facilities as a rural primary care hospital in accordance with paragraph (2).

(2) CRITERIA FOR DESIGNATION AS RURAL PRIMARY CARE HOSPITAL.—A State may designate a facility as a rural primary care hospital if the facility—

(A) is a nonprofit or public hospital, and is located in a county (or equivalent unit of local government) in a rural area (as defined in section 1886(d)(2)(D)) that—

(i) is located a distance that corresponds to a travel time of greater than 30 minutes (using the guidelines specified under part IB1(b) of Appendix A to part 5 of title 42, Code of Federal Regulations, as in effect on October 1, 1996), from a hospital, or another facility described in this subsection, or

(ii) is certified by the State as being a necessary provider of health care services to residents in the area because of local geography or service patterns; “

(B) makes available 24-hour emergency care services;

(C) provides at any time not more than 15 acute care inpatient beds (meeting such standards as the Secretary may establish) for providing inpatient care for a period not to exceed 96 hours (unless a longer period is required because transfer to a hospital is precluded because of inclement weather or other emergency conditions), except that a peer review organization or equivalent entity may, on request, waive the 96-hour restriction on a case-by-case basis;

(D) 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 and fully staffed, except insofar as the facility is required to make available emergency care services as determined under subparagraph (B) and must have nursing services available on a 24-hour basis, but need not otherwise staff the facility except when an inpatient is present,

(ii) the facility may provide any services otherwise required to be provided by a full-time, on-site dietitian, pharmacist, laboratory technician, medical technologist, and radiological technologist on a part-time, off-site basis under arrangements as defined in section 1861(w)(1), and

(iii) the inpatient care described in subparagraph (C) may be provided by a physicians assistant, nurse practitioner, or clinical nurse specialist subject to the over-

sight of a physician who need not be present in the facility;

(E) meets the requirements of subparagraph (I) of paragraph (2) of section 1861(aa); and

(F) has executed and in effect an agreement described in subsection (b)(1).

(b) AGREEMENTS.—

(1) IN GENERAL.—Each rural primary care hospital shall have an agreement with respect to each item described in paragraph (2) with at least 1 hospital (as defined in section 1861(e)).

(2) ITEMS DESCRIBED.—The items described in this paragraph are the following:

(A) Patient referral and transfer.

(B) The development and use of communications systems including (where feasible)—

(i) telemetry systems, and

(ii) systems for electronic sharing of patient data.

(C) The provision of emergency and non-emergency transportation among the facility and the hospital.

(3) CREDENTIALING AND QUALITY ASSURANCE.—Each rural primary care hospital shall have an agreement with respect to credentialing and quality assurance with at least 1—

(A) hospital,

(B) peer review organization or equivalent entity, or

(C) other appropriate and qualified entity identified by the State.

(c) CERTIFICATION BY THE SECRETARY.—The Secretary shall certify a facility as a rural primary care hospital if the facility—

(1) is designated as a rural primary care hospital by the State in which it is located; and

(2) meets such other criteria as the Secretary may require.

(d) PERMITTING MAINTENANCE OF SWING BEDS.—Nothing in this section shall be construed to prohibit a State from designating or the Secretary from certifying a facility as a rural primary care hospital solely because, at the time the facility applies to the State for designation as a rural primary care hospital, there is in effect an agreement between the facility and the Secretary under section 1883 under which the facility's inpatient hospital facilities are used for the provision of extended care services, so long as the total number of beds that may be used at any time for the furnishing of either such services or acute care inpatient services does not exceed 25 beds and the number of beds used at any time for acute care inpatient services does not exceed 15 beds. For purposes of the previous sentence, any bed of a unit of the facility that is licensed as a distinct-part skilled nursing facility at the time the facility applies to the State for designation as a rural primary care hospital shall not be counted.

(e) WAIVER OF CONFLICTING PART A PROVISIONS.—The Secretary is authorized to waive such provisions of this part and part C as are necessary to conduct the program established under this section.

PART B—SUPPLEMENTARY MEDICAL INSURANCE BENEFITS FOR THE
AGED AND DISABLED

SCOPE OF BENEFITS “

* * * * *

SEC. 1832. (a) The benefits provided to an individual by the insurance program established by this part shall consist of—

(1) entitlement to have payment made to him or on his behalf (subject to the provisions of this part) for medical and other health services, except those described in subparagraphs (B) and (D) of paragraph **[(2);]** (2), *section 1842(b)(6)(E)*, and *section 1842(b)(6)(F)*; and

(2) entitlement to have payment made on his behalf (subject to the provisions of this part) for—

(A) home health services (other than items described in subparagraph (G) or subparagraph (I));

(B) medical and other health services (other than items described in subparagraph (G) or subparagraph (I)) furnished by a provider of services or by others under arrangement with them made by a provider of services, excluding—

(i) * * *

* * * * *

(iv) services of a nurse practitioner or clinical nurse specialist **[(provided in a rural area (as defined in section 1886(d)(2)(D))]** *but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services*; and

* * * * *

PAYMENT OF BENEFITS

SEC. 1833. (a) Except as provided in section 1876, and subject to the succeeding provisions of this section, there shall be paid from the Federal Supplementary Medical Insurance Trust Fund, in the case of each individual who is covered under the insurance program established by this part and incurs expenses for services with respect to which benefits are payable under this part, amounts equal to—

(1) in the case of services described in section 1832(a)(1)—80 percent of the reasonable charges for the services; except that (A) an organization which provides medical and other health services (or arranges for their availability) on a prepayment basis may elect to be paid 80 percent of the reasonable cost of services for which payment may be made under this part on behalf of individuals enrolled in such organization in lieu of 80 percent of the reasonable charges for such services if the organization undertakes to charge such individuals no more than 20 percent of such reasonable cost plus any amounts payable by them as a result of subsection (b), (B) with respect to items and services described in section 1861(s)(10)(A), the amounts paid shall be 100 percent of the reasonable charges for such items and services, (C) with respect to expenses incurred for those physicians' services for which payment may be made

under this part that are described in section 1862(a)(4), the amounts paid shall be subject to such limitations as may be prescribed by regulations, (D) with respect to clinical diagnostic laboratory tests for which payment is made under this part (i) on the basis of a fee schedule under subsection (h)(1) or section 1834(d)(1), the amount paid shall be equal to 80 percent (or 100 percent, in the case of such tests for which payment is made on an assignment-related basis) of the lesser of the amount determined under such fee schedule, the limitation amount for that test determined under subsection (h)(4)(B), or the amount of the charges billed for the tests, or (ii) on the basis of a negotiated rate established under subsection (h)(6), the amount paid shall be equal to 100 percent of such negotiated rate, (E) with respect to services furnished to individuals who have been determined to have end stage renal disease, the amounts paid shall be determined subject to the provisions of section 1881, (F) with respect to clinical social worker services under section 1861(s)(2)(N), the amounts paid shall be 80 percent of the lesser of (i) the actual charge for the services or (ii) 75 percent of the amount determined for payment of a psychologist under clause (L), (H) with respect to services of a certified registered nurse anesthetist under section 1861(s)(11), the amounts paid shall be 80 percent of the least of the actual charge, the prevailing charge that would be recognized (or, for services furnished on or after January 1, 1992, the fee schedule amount provided under section 1848) if the services had been performed by an anesthesiologist, or the fee schedule for such services established by the Secretary in accordance with subsection (I), (I) with respect to covered items (described in section 1834(a)(13)), the amounts paid shall be the amounts described in section 1834(a)(1), and (J) with respect to expenses incurred for radiologist services (as defined in section 1834(b)(6)), subject to section 1848, the amounts paid shall be 80 percent of the lesser of the actual charge for the services or the amount provided under the fee schedule established under section 1834(b), (K) with respect to certified nurse-midwife services under section 1861(s)(2)(L), the amounts paid shall be 80 percent of the lesser of the actual charge for the services or the amount determined by a fee schedule established by the Secretary for the purposes of this subparagraph (but in no event shall such fee schedule exceed 65 percent of the prevailing charge that would be allowed for the same service performed by a physician, or, for services furnished on or after January 1, 1992, 65 percent of the fee schedule amount provided under section 1848 for the same service performed by a physician), (L) with respect to qualified psychologist services under section 1861(s)(2)(M), the amounts paid shall be 80 percent of the lesser of the actual charge for the services or the amount determined by a fee schedule established by the Secretary for the purposes of this subparagraph, (M) with respect to prosthetic devices and orthotics and prosthetics (as defined in section 1834(h)(4)), the amounts paid shall be the amounts described in section 1834(h)(1), (N) with respect to expenses incurred for physicians' services (as defined in section 1848(j)(3)),

the amounts paid shall be 80 percent of the payment basis determined under section 1848(a)(1), **[(O)** with respect to services described in section 1861(s)(2)(K)(iii) (relating to nurse practitioner or clinical nurse specialist services provided in a rural area), the amounts paid shall be 80 percent of the lesser of the actual charge or the prevailing charge that would be recognized (or, for services furnished on or after January 1, 1992, the fee schedule amount provided under section 1848) if the services had been performed by a physician (subject to the limitation described in subsection (r)(2)), and **]** *(O) with respect to services described in section 1861(s)(2)(K)(ii) (relating to nurse practitioner or clinical nurse specialist services), the amounts paid shall be equal to 80 percent of (i) the lesser of the actual charge or 85 percent of the fee schedule amount provided under section 1848 or (ii) in the case of services as an assistant at surgery, the lesser of the actual charge or 85 percent of the amount that would otherwise be recognized if performed by a physician who is serving as an assistant at surgery;* **(P)** with respect to surgical dressings, the amounts paid shall be the amounts determined under section 1834(i)**;** **]** and *(Q) with respect to ambulance service, the amounts paid shall be 80 percent of the lesser of the actual charge for the services or the amount determined by a fee schedule established by the Secretary under section 1834(l);*

(2) in the case of services described in section 1832(a)(2) (except those services described in subparagraphs (C), (D), (E), (F), (G), (H), and (I) of such section and unless otherwise specified in section 1881)—

[(A) with respect to home health services (other than a covered osteoporosis drug (as defined in section 1861(kk))), and to items and services described in section 1861(s)(10)(A), the lesser of—

[(i) the reasonable cost of such services, as determined under section 1861(v), or

[(ii) the customary charges with respect to such services,

or, if such services are furnished by a public provider of services, or by another provider which demonstrates to the satisfaction of the Secretary that a significant portion of its patients are low-income (and requests that payment be made under this provision), free of charge or at nominal charges to the public, the amount determined in accordance with section 1814(b)(2);**]**

(A) with respect to home health services (other than a covered osteoporosis drug (as defined in section 1861(kk))), the amount determined under the prospective payment system under section 1895;

(B) with respect to other items and services (except those described in subparagraph (C), (D), or (E) of this paragraph and except as may be provided in section 1886 or section 1888(e)(9)—

(i) furnished before January 1, 1999, the lesser of—

(I) the reasonable cost of such services, as determined under section 1861(v), or

(II) the customary charges with respect to such services,—less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A), but in no case may the payment for such other services exceed 80 percent of such reasonable cost, or

(ii) if such services are furnished *before January 1, 1999*, by a public provider of services, or by another provider which demonstrates to the satisfaction of the Secretary that a significant portion of its patients are low-income (and requests that payment be made under this clause), free of charge or at nominal charges to the public, 80 percent of the amount determined in accordance with section 1814(b)(2), or

(iii) *if such services are furnished on or after January 1, 1999, the amount determined under subsection (t), or*

[(iii)] (iv) if (and for so long as) the conditions described in section 1814(b)(3) are met, the amounts determined under the reimbursement system described in such section;

(C) with respect to services described in the second sentence of section 1861(p), 80 percent of the reasonable charges for such services;

(D) with respect to clinical diagnostic laboratory tests for which payment is made under this part (i) on the basis of a fee schedule determined under subsection (h)(1) *or section 1834(d)(1)*, the amount paid shall be equal to 80 percent (or 100 percent, in the case of such tests for which payment is made on an assignment-related basis or to a provider having an agreement under section 1866) of the lesser of the amount determined under such fee schedule, the limitation amount for that test determined under subsection (h)(4)(B), or the amount of the charges billed for the tests, or (ii) on the basis of a negotiated rate established under subsection (h)(6), the amount paid shall be equal to 100 percent of such negotiated rate for such tests;

(E) with respect to—

(i) outpatient hospital radiology services (including diagnostic and therapeutic radiology, nuclear medicine and CAT scan procedures, magnetic resonance imaging, and ultrasound and other imaging services, but excluding screening mammography), and

(ii) effective for procedures performed on or after October 1, 1989, diagnostic procedures (as defined by the Secretary) described in section 1861(s)(3) (other than diagnostic x-ray tests and diagnostic laboratory tests), the amount determined under subsection (n) *or, for services or procedures performed on or after January 1, 1999, (t); [and]*

(F) with respect to a covered osteoporosis drug (as defined in section 1861(kk)) furnished by a home health agency, 80 percent of the reasonable cost of such service, as determined under section 1861(v); *and*

(G) with respect to items and services described in section 1861(s)(10)(A), the lesser of—

(i) the reasonable cost of such services, as determined under section 1861(v), or

(ii) the customary charges with respect to such services,

or, if such services are furnished by a public provider of services, or by another provider which demonstrates to the satisfaction of the Secretary that a significant portion of its patients are low-income (and requests that payment be made under this provision), free of charge or at nominal charges to the public, the amount determined in accordance with section 1814(b)(2);

(3) in the case of services described in [subparagraphs (D) and (E) of section 1832(a)(2)] *section 1832(a)(2)(E)*, the costs which are reasonable and related to the cost of furnishing such services or which are based on such other tests of reasonableness as the Secretary may prescribe in regulations, including those authorized under section 1861(v)(1)(A), less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A), but in no case may the payment for such services (other than for items and services described in section 1861(s)(10)(A)) exceed 80 percent of such costs;

(4) in the case of facility services described in section 1832(a)(2)(F), and outpatient hospital facility services furnished in connection with surgical procedures specified by the Secretary pursuant to section 1833(i)(1)(A), the applicable amount as determined under paragraph (2) or (3) of subsection (i) or subsection (t);

(5) in the case of covered items (described in section 1834(a)(13)) the amounts described in section 1834(a)(1);

(6) in the case of outpatient rural primary care hospital services, the amounts described in section 1834(g); [and]

(7) in the case of prosthetic devices and orthotics and prosthetics (as described in section 1834(h)(4)), the amounts described in section 1834(h)[.];

(8) in the case of services described in section 1832(a)(2)(C), (that are not described in section 1832(a)(2)(B)), the amounts described in section 1834(k); and

(9) in the case of services described in section 1832(a)(2)(E), the amounts described in section 1834(k).

(b) Before applying subsection (a) with respect to expenses incurred by an individual during any calendar year, the total amount of the expenses incurred by such individual during such year (which would, except for this subsection, constitute incurred expenses from which benefits payable under subsection (a) are determinable) shall be reduced by a deductible of \$75 for calendar years before 1991 and \$100 for 1991 and subsequent years; except that (1) such total amount shall not include expenses incurred for items and services described in section 1861(s)(10)(A), (2) such deductible shall not apply with respect to home health services (other than a covered osteoporosis drug (as defined in section 1861(kk))), (3) such deductible shall not apply with respect to clinical diagnostic laboratory tests for which payment is made under this part (A) under

subsection (a)(1)(D)(i) or (a)(2)(D)(i) on an assignment-related basis, or to a provider having an agreement under section 1866, or (B) on the basis of a negotiated rate determined under subsection (h)(6), **[and]** (4) such deductible shall not apply to Federally qualified health center services, (5) *such deductible shall not apply with respect to screening mammography (as described in section 1861(jj)), and (6) such deductible shall not apply with respect to screening pap smear and screening pelvic exam (as described in section 1861(nn))*. The total amount of the expenses incurred by an individual as determined under the preceding sentence shall, after the reduction specified in such sentence, be further reduced by an amount equal to the expenses incurred for the first three pints of whole blood (or equivalent quantities of packed red blood cells, as defined under regulations) furnished to the individual during the calendar year, except that such deductible for such blood shall in accordance with regulations be appropriately reduced to the extent that there has been a replacement of such blood (or equivalent quantities of packed red blood cells, as so defined); and for such purposes blood (or equivalent quantities of packed red blood cells, as so defined) furnished such individual shall be deemed replaced when the institution or other person furnishing such blood (or such equivalent quantities of packed red blood cells, as so defined) is given one pint of blood for each pint of blood (or equivalent quantities of packed red blood cells, as so defined) furnished such individual with respect to which a deduction is made under this sentence. The deductible under the previous sentence for blood or blood cells furnished an individual in a year shall be reduced to the extent that a deductible has been imposed under section 1813(a)(2) to blood or blood cells furnished the individual in the year.

* * * * *

(f) In establishing limits under subsection (a) on payment for rural health clinic services provided by **[independent rural health clinics]** *rural health clinics (other than such clinics in rural hospitals with less than 50 beds)*, the Secretary shall establish such limit, for services provided—

(1) in 1988, after March 31, at \$46 *per visit*, and

(2) in a subsequent year, at the limit established under this subsection for the previous year increased by the percentage increase in the MEI (as defined in section 1842(i)(3)) applicable to primary care services (as defined in section 1842(i)(4)) furnished as of the first day of that year.

(g)(1) In the case of **[services described in the second sentence of section 1861(p)]** *physical therapy services of the type described in section 1861(p) (regardless of who furnishes the services or whether the services may be covered as physicians' services so long as the services are furnished other than in a hospital setting)*, with respect to expenses incurred in any calendar year, no more than the amount specified in paragraph (2) for the year shall be considered as incurred expenses for purposes of subsections (a) and (b).

(2) *The amount specified in this paragraph—*

(A) *for 1999, and each preceding year, is \$900, and*

(B) *for a subsequent year is the amount specified in this paragraph for the preceding year increased by the Secretary's estimate of the projected percentage growth in real gross domestic*

product per capita from the fiscal year ending in the preceding year to the fiscal year ending in such subsequent year.

(3) In the case of [outpatient occupational therapy services which are described in the second sentence of section 1861(p) through the operation of section 1861(g)] *occupational therapy services (of the type that are described in section 1861(p) through the operation of section 1861(g)), regardless of who furnishes the services or whether the services may be covered as physicians' services so long as the services are furnished other than in a hospital setting, with respect to expenses incurred in any calendar year, no more than the amount specified in paragraph (2) for the year shall be considered as incurred expenses for purposes of subsections (a) and (b).*

(h)(1)(A) [The Secretary] *Subject to paragraphs (1) and (4)(A) of section 1834(d), the Secretary shall establish fee schedules for clinical diagnostic laboratory tests (including prostate cancer screening tests under section 1861(o)) consisting of prostate-specific antigen blood tests) for which payment is made under this part, other than such tests performed by a provider of services for an inpatient of such provider.*

* * * * *

(2)(A)(i) Except as provided in paragraph (4), the Secretary shall set the fee schedules at 60 percent (or, in the case of a test performed by a qualified hospital laboratory (as defined in paragraph (1)(D)) for outpatients of such hospital, 62 percent) of the prevailing charge level determined pursuant to the third and fourth sentences of section 1842(b)(3) for similar clinical diagnostic laboratory tests for the applicable region, State, or area for the 12-month period beginning July 1, 1984, adjusted annually (to become effective on January 1 of each year) by a percentage increase or decrease equal to the percentage increase or decrease in the Consumer Price Index for All Urban Consumers (United States city average), and subject to such other adjustments as the Secretary determines are justified by technological changes.

(ii) Notwithstanding clause (i)—

(I) * * *

* * * * *

(IV) the annual adjustment in the fee schedules determined under clause (i) for each of the years 1994 and 1995 *and 1998 through 2002* shall be 0 percent.

* * * * *

(4)(A) * * *

(B) For purposes of subsections (a)(1)(D)(i) and (a)(2)(D)(i), the limitation amount for a clinical diagnostic laboratory test performed—

(i) * * *

* * * * *

(vi) after December 31, 1994, and before January 1, 1996, is equal to 80 percent of such median, [and]

(vii) after December 31, 1995, *and before January 1, 1998*, is equal to 76 percent of such median[.], and

(viii) *after December 31, 1997, is equal to 72 percent of such median.*

(i)(1) * * *
 (2)(A) * * *

* * * * *

(C) Notwithstanding the second sentence of subparagraph (A) or the second sentence of subparagraph (B), if the Secretary has not updated amounts established under such subparagraphs with respect to facility services furnished during a fiscal year (beginning with fiscal year 1996), such amounts shall be increased [by the percentage increase in the consumer price index for all urban consumers (U.S. city average) as estimated by the Secretary for the 12-month period ending with the midpoint of the year involved.] as follows:

(i) For fiscal years 1996 and 1997, by the percentage increase in the consumer price index for all urban consumers (U.S. city average) as estimated by the Secretary for the 12-month period ending with the midpoint of the year involved.

(ii) For each of fiscal years 1998 through 2002 by such percentage increase minus 2.0 percentage points.

(iii) For each succeeding fiscal year by such percentage increase.

(3)(A) The aggregate amount of the payments to be made under this part for outpatient hospital facility services or rural primary care hospital services furnished before January 1, 1999, in connection with surgical procedures specified under paragraph (1)(A) [in a cost reporting period] shall be equal to the lesser of—

(i) the amount determined with respect to such services under subsection (a)(2)(B); or

(ii) the blend amount (described in subparagraph (B)).

(B)(i) The blend amount for a cost reporting period is the sum of—

(I) the cost proportion (as defined in clause (ii)(I)) of the amount described in subparagraph (A)(i), and

(II) the ASC proportion (as defined in clause (ii)(II)) [of 80 percent] of the standard overhead amount payable with respect to the same surgical procedure as if it were provided in an ambulatory surgical center in the same area, as determined under paragraph (2)(A)[.], less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A).

* * * * *

(n)(1)(A) The aggregate amount of the payments to be made for all or part of a cost reporting period for services described in subsection (a)(2)(E)(i) furnished under this part on or after October 1, 1988, and before January 1, 1999, and for services described in subsection (a)(2)(E)(ii) furnished under this part on or after October 1, 1989, and before January 1, 1999, shall be equal to the lesser of—

(i) the amount determined with respect to such services under subsection (a)(2)(B), or

(ii) the blend amount for radiology services and diagnostic procedures determined in accordance with subparagraph (B).

(B)(i) The blend amount for radiology services and diagnostic procedures for a cost reporting period is the sum of—

(I) the cost proportion (as defined in clause (ii)) of the amount described in subparagraph (A)(i); and

(II) the charge proportion (as defined in clause (ii)(II)) of 62 percent (for services described in subsection (a)(2)(E)(i)), or (for procedures described in subsection (a)(2)(E)(ii)), 42 percent or such other percent established by the Secretary (or carriers acting pursuant to guidelines issued by the Secretary) based on prevailing charges established with actual charge data, [of 80 percent] of the prevailing charge or (for services described in subsection (a)(2)(E)(i) furnished on or after January 1, 1989) the fee schedule amount established for participating physicians for the same services as if they were furnished in a physician's office in the same locality as determined under section 1842(b), *less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A).*

* * * * *

(r)(1) With respect to services described in [section 1861(s)(2)(K)(iii) (relating to nurse practitioner or clinical nurse specialist services provided in a rural area)] *section 1861(s)(2)(K)(ii) (relating to nurse practitioner or clinical nurse specialist services)*, payment may be made on the basis of a claim or request for payment presented by the nurse practitioner or clinical nurse specialist furnishing such services, or by a hospital, rural primary care hospital, skilled nursing facility or nursing facility (as defined in section 1919(a)), physician, group practice, or ambulatory surgical center with which the nurse practitioner or clinical nurse specialist has an employment or contractual relationship that provides for payment to be made under this part for such services to such hospital, physician, group practice, or ambulatory surgical center.

[(2)(A) For purposes of subsection (a)(1)(O), the prevailing charge for services described in section 1861(s)(2)(K)(iii) may not exceed the applicable percentage (as defined in subparagraph (B)) of the prevailing charge (or, for services furnished on or after January 1, 1992, the fee schedule amount provided under section 1848) determined for such services performed by physicians who are not specialists.

[(B) In subparagraph (A), the term "applicable percentage" means—

[(i) 75 percent in the case of services performed in a hospital, and

[(ii) 85 percent in the case of other services.]

[(3)] (2) No hospital or rural primary care hospital that presents a claim or request for payment under this part for services described in [section 1861(s)(2)(K)(iii)] *section 1861(s)(2)(K)(ii)* may treat any uncollected coinsurance amount imposed under this part with respect to such services as a bad debt of such hospital for purposes of this title.

* * * * *

(t) *PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES.*—

(1) *IN GENERAL.*—*With respect to hospital outpatient services designated by the Secretary (in this section referred to as "cov-*

ered OPD services”) and furnished during a year beginning with 1999, the amount of payment under this part shall be determined under a prospective payment system established by the Secretary in accordance with this subsection.

(2) **SYSTEM REQUIREMENTS.**—Under the payment system—

(A) the Secretary shall develop a classification system for covered OPD services;

(B) the Secretary may establish groups of covered OPD services, within the classification system described in subparagraph (A), so that services classified within each group are comparable clinically and with respect to the use of resources;

(C) the Secretary shall, using data on claims from 1996 and using data from the most recent available cost reports, establish relative payment weights for covered OPD services (and any groups of such services described in subparagraph (B)) based on median hospital costs and shall determine projections of the frequency of utilization of each such service (or group of services) in 1999;

(D) the Secretary shall determine a wage adjustment factor to adjust the portion of payment and coinsurance attributable to labor-related costs for relative differences in labor and labor-related costs across geographic regions in a budget neutral manner;

(E) the Secretary shall establish other adjustments, in a budget neutral manner, as determined to be necessary to ensure equitable payments, such as outlier adjustments, adjustments to account for variations of coinsurance payments for procedures with similar resource costs, or adjustments for certain classes of hospitals; and

(F) the Secretary shall develop a method for controlling unnecessary increases in the volume of covered OPD services.

(3) **CALCULATION OF BASE AMOUNTS.**—

(A) **AGGREGATE AMOUNTS THAT WOULD BE PAYABLE IF DEDUCTIBLES WERE DISREGARDED.**—The Secretary shall estimate the total amounts that would be payable from the Trust Fund under this part for covered OPD services in 1999, determined without regard to this subsection, as though the deductible under section 1833(b) did not apply, and as though the coinsurance described in section 1866(a)(2)(A)(ii) (as in effect before the date of the enactment of this subsection) continued to apply.

(B) **UNADJUSTED COPAYMENT AMOUNT.**—

(i) **IN GENERAL.**—For purposes of this subsection, the “unadjusted copayment amount” applicable to a covered OPD service (or group of such services) is 20 percent of national median of the charges for the service (or services within the group) furnished during 1996, updated to 1999 using the Secretary’s estimate of charge growth during the period.

(ii) **ADJUSTED TO BE 20 PERCENT WHEN FULLY PHASED IN.**—If the pre-deductible payment percentage for a covered OPD service (or group of such services)

furnished in a year would be equal to or exceed 80 percent, then the unadjusted copayment amount shall be 25 percent of amount determined under subparagraph (D)(i).

(iii) *RULES FOR NEW SERVICES.*—The Secretary shall establish rules for establishment of an unadjusted copayment amount for a covered OPD service not furnished during 1997, based upon its classification within a group of such services.

(C) *CALCULATION OF CONVERSION FACTORS.*—

(i) *FOR 1999.*—

(I) *IN GENERAL.*—The Secretary shall establish a 1999 conversion factor for determining the medicare pre-deductible OPD fee payment amounts for each covered OPD service (or group of such services) furnished in 1999. Such conversion factor shall be established on the basis of the weights and frequencies described in paragraph (2)(C) and in a manner such that the sum for all services and groups of the products (described in subclause (II) for each such service or group) equals the total projected amount described in subparagraph (A).

(II) *PRODUCT DESCRIBED.*—The product described in this subclause, for a service or group, is the product of the medicare pre-deductible OPD fee payment amounts (taking into account appropriate adjustments described in paragraphs (2)(D) and (2)(E)) and the frequencies, for each service or group.

(ii) *SUBSEQUENT YEARS.*—Subject to paragraph (8)(B), the Secretary shall establish a conversion factor for covered OPD services furnished in subsequent years in an amount equal to the conversion factor established under this subparagraph and applicable to such services furnished in the previous year increased by the OPD payment increase factor specified under clause (iii) for the year involved.

(iii) *OPD PAYMENT INCREASE FACTOR.*—For purposes of this subparagraph, the “OPD payment increase factor” for services furnished in a year is equal to the sum of—

(I) market basket percentage increase (applicable under section 1886(b)(3)(B)(iii) to hospital discharges occurring during the fiscal year ending in such year, and

(II) in the case of a covered OPD service (or group of such services) furnished in a year in which the pre-deductible payment percentage would not exceed 80 percent, 3.5 percentage points, but in no case greater than such number of percentage points as will result in the pre-deductible payment percentage exceeding 80 percent.

In applying the previous sentence for years beginning with 2000, the Secretary may substitute for the market basket percentage increase under subclause (I) an annual percentage increase that is computed and applied with respect

to covered OPD services furnished in a year in the same manner as the market basket percentage increase is determined and applied to inpatient hospital services for discharges occurring in a fiscal year.

(D) *PRE-DEDUCTIBLE PAYMENT PERCENTAGE.*—The pre-deductible payment percentage for a covered OPD service (or group of such services) furnished in a year is equal to the ratio of—

(i) the conversion factor established under subparagraph (C) for the year, multiplied by the weighting factor established under paragraph (2)(C) for the service (or group), to

(ii) the sum of the amount determined under clause (i) and the unadjusted copayment amount determined under subparagraph (B) for such service or group.

(E) *CALCULATION OF MEDICARE OPD FEE SCHEDULE AMOUNTS.*—The Secretary shall compute a medicare OPD fee schedule amount for each covered OPD service (or group of such services) furnished in a year, in an amount equal to the product of—

(i) the conversion factor computed under subparagraph (C) for the year, and

(ii) the relative payment weight (determined under paragraph (2)(C)) for the service or group.

(4) *MEDICARE PAYMENT AMOUNT.*—The amount of payment made from the Trust Fund under this part for a covered OPD service (and such services classified within a group) furnished in a year is determined as follows:

(A) *FEE SCHEDULE AND COPAYMENT AMOUNT.*—Add (i) the medicare OPD fee schedule amount (computed under paragraph (3)(E)) for the service or group and year, and (ii) the unadjusted copayment amount (determined under paragraph (3)(B)) for the service or group.

(B) *SUBTRACT APPLICABLE DEDUCTIBLE.*—Reduce the sum determined under subparagraph (A) by the amount of the deductible under section 1833(b), to the extent applicable.

(C) *APPLY PAYMENT PROPORTION TO REMAINDER.*—Multiply the amount so determined under subparagraph (B) by the pre-deductible payment percentage (as determined under paragraph (3)(D)) for the service or group and year involved.

(D) *LABOR-RELATED ADJUSTMENT.*—The amount of payment is the product determined under subparagraph (C) with the labor-related portion of such product adjusted for relative differences in the cost of labor and other factors determined by the Secretary, as computed under paragraph (2)(D).

(5) *COPAYMENT AMOUNT.*—

(A) *IN GENERAL.*—Except as provided in subparagraph (B), the copayment amount under this subsection is determined as follows:

(i) *UNADJUSTED COPAYMENT.*—Compute the amount by which the amount described in paragraph (4)(B) ex-

ceeds the amount of payment determined under paragraph (4)(C).

(ii) *LABOR ADJUSTMENT.*—The copayment amount is the difference determined under clause (i) with the labor-related portion of such difference adjusted for relative differences in the cost of labor and other factors determined by the Secretary, as computed under paragraphs (2)(D). The adjustment under this clause shall be made in a manner that does not result in any change in the aggregate copayments made in any year if the adjustment had not been made.

(B) *ELECTION TO OFFER REDUCED COPAYMENT AMOUNT.*—The Secretary shall establish a procedure under which a hospital, before the beginning of a year (beginning with 1999), may elect to reduce the copayment amount otherwise established under subparagraph (A) for some or all covered OPD services to an amount that is not less than 25 percent of the medicare OPD fee schedule amount (computed under paragraph (3)(E)) for the service involved, adjusted for relative differences in the cost of labor and other factors determined by the Secretary, as computed under subparagraphs (D) and (E) of paragraph (2). Under such procedures, such reduced copayment amount may not be further reduced or increased during the year involved and the hospital may disseminate information on the reduction of copayment amount effected under this subparagraph.

(C) *NO IMPACT ON DEDUCTIBLES.*—Nothing in this paragraph shall be construed as affecting a hospital's authority to waive the charging of a deductible under section 1833(b).

(6) *PERIODIC REVIEW AND ADJUSTMENTS COMPONENTS OF PROSPECTIVE PAYMENT SYSTEM.*—

(A) *PERIODIC REVIEW.*—The Secretary may periodically review and revise the groups, the relative payment weights, and the wage and other adjustments described in paragraph (2) to take into account changes in medical practice, changes in technology, the addition of new services, new cost data, and other relevant information and factors.

(B) *BUDGET NEUTRALITY ADJUSTMENT.*—If the Secretary makes adjustments under subparagraph (A), then the adjustments for a year may not cause the estimated amount of expenditures under this part for the year to increase or decrease from the estimated amount of expenditures under this part that would have been made if the adjustments had not been made.

(C) *UPDATE FACTOR.*—If the Secretary determines under methodologies described in subparagraph (2)(F) that the volume of services paid for under this subsection increased beyond amounts established through those methodologies, the Secretary may appropriately adjust the update to the conversion factor otherwise applicable in a subsequent year.

(7) *SPECIAL RULE FOR AMBULANCE SERVICES.*—The Secretary shall pay for hospital outpatient services that are ambulance services on the basis described in the matter in subsection (a)(1) preceding subparagraph (A).

(8) *SPECIAL RULES FOR CERTAIN HOSPITALS.—In the case of hospitals described in section 1886(d)(1)(B)(v)—*

(A) the system under this subsection shall not apply to covered OPD services furnished before January 1, 2000; and

(B) the Secretary may establish a separate conversion factor for such services in a manner that specifically takes into account the unique costs incurred by such hospitals by virtue of their patient population and service intensity.

(9) *LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1878 or otherwise of—*

(A) the development of the classification system under paragraph (2), including the establishment of groups and relative payment weights for covered OPD services, of wage adjustment factors, other adjustments, and methods described in paragraph (2)(F);

(B) the calculation of base amounts under paragraph (3);

(C) periodic adjustments made under paragraph (6); and

(D) the establishment of a separate conversion factor under paragraph (8)(B).

SPECIAL PAYMENT RULES FOR PARTICULAR ITEMS AND SERVICES

SEC. 1834. (a) PAYMENT FOR DURABLE MEDICAL EQUIPMENT.—

(1) * * *

(2) PAYMENT FOR INEXPENSIVE AND OTHER ROUTINELY PURCHASED DURABLE MEDICAL EQUIPMENT.—

(A) * * *

(B) PAYMENT AMOUNT.—For purposes of subparagraph (A), the amount specified in this subparagraph, with respect to the purchase or rental of an item furnished in a carrier service area—

(i) * * *

* * * * *

(iv) in 1993 and each subsequent year is the national limited payment amount for the item or device computed under subparagraph (C)(ii) for that year (*reduced by 10 percent, in the case of a blood glucose testing strip furnished after 1997 for an individual with diabetes*).

* * * * *

(9) MONTHLY PAYMENT AMOUNT RECOGNIZED WITH RESPECT TO OXYGEN AND OXYGEN EQUIPMENT.—For purposes of paragraph (5), the amount that is recognized under this paragraph for payment for oxygen and oxygen equipment is the monthly payment amount described in subparagraph (C) of this paragraph. Such amount shall be computed separately (i) for all items of oxygen and oxygen equipment (other than portable oxygen equipment) and (ii) for portable oxygen equipment (each such group referred to in this paragraph as an “item”).

(A) * * *

* * * * *

(C) MONTHLY PAYMENT AMOUNT RECOGNIZED.—For purposes of paragraph (5), the amount that is recognized under this paragraph as the base monthly payment amount for each item furnished—

(i) in 1989 and in 1990, is 100 percent of the local average monthly payment rate computed under subparagraph (A)(ii) for the item;

(ii) in 1991, is the sum of (I) 67 percent of the local average monthly payment rate computed under subparagraph (A)(ii)(II) for the item for 1991, and (II) 33 percent of the national limited monthly payment rate computed under subparagraph (B)(i) for the item for 1991;

(iii) in 1992, is the sum of (I) 33 percent of the local average monthly payment rate computed under subparagraph (A)(ii)(II) for the item for 1992, and (II) 67 percent of the national limited monthly payment rate computed under subparagraph (B)(ii) for the item for 1992; [and]

(iv) in [a subsequent year] 1993, 1994, 1995, 1996, and 1997, is the national limited monthly payment rate computed under subparagraph (B) for the item for that year[.];

(v) in each of the years 1998 through 2002, is 80 percent of the national limited monthly payment rate computed under subparagraph (B) for the item for the year; and

(vi) in a subsequent year, is the national limited monthly payment rate computed under subparagraph (B) for the item for the year.

* * * * *

(14) COVERED ITEM UPDATE.—In this subsection, the term “covered item update” means, with respect to a year—

(A) for 1991 and 1992, the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 12-month period ending with June of the previous year reduced by 1 percentage point; [and]

(B) for [a subsequent year] 1993, 1994, 1995, 1996, and 1997, the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 12-month period ending with June of the previous year[.];

(C) for each of the years 1998 through 2002, 0 percentage points; 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.

* * * * *

(16) CONDITIONS FOR ISSUANCE OF PROVIDER NUMBER.—The Secretary shall not provide for the issuance (or renewal) of a provider number for a supplier of durable medical equipment, for purposes of payment under this part for durable medical

equipment furnished by the supplier, unless the supplier provides the Secretary on a continuing basis with—

(A)(i) full and complete information as to the identity of each person with an ownership or control interest (as defined in section 1124(a)(3)) in the supplier or in any subcontractor (as defined by the Secretary in regulations) in which the supplier directly or indirectly has a 5 percent or more ownership interest, and

(ii) to the extent determined to be feasible under regulations of the Secretary, the name of any disclosing entity (as defined in section 1124(a)(2)) with respect to which a person with such an ownership or control interest in the supplier is a person with such an ownership or control interest in the disclosing entity; and

(B) a surety bond in a form specified by the Secretary and in an amount that is not less than \$50,000.

The Secretary may waive the requirement of a bond under subparagraph (B) in the case of a supplier that provides a comparable surety bond under State law.

* * * * *

(c) PAYMENTS AND STANDARDS FOR SCREENING MAMMOGRAPHY.—

(1) IN GENERAL.—Notwithstanding any other provision of this part, with respect to expenses incurred for screening mammography (as defined in section 1861(jj))—

(A) * * *

* * * * *

(C) the amount of the payment under this part shall **[(** subject to the deductible established under section 1833(b), **)]** be equal to 80 percent of the least of—

- (i) the actual charge for the screening,
- (ii) the fee schedule established under subsection (b) or the fee schedule established under section 1848, whichever is applicable, with respect to both the professional and technical components of the screening mammography, or
- (iii) the limit established under paragraph (3) for the screening mammography.

(2) FREQUENCY COVERED.—

(A) IN GENERAL.—Subject to revision by the Secretary under subparagraph (B)—

(i) No payment may be made under this part for screening mammography performed on a woman under 35 years of age.

(ii) Payment may be made under this part for only 1 screening mammography performed on a woman over 34 years of age, but under 40 years of age.

[((iii) In the case of a woman over 39 years of age, but under 50 years of age, who—

(I) is at a high risk of developing breast cancer (as determined pursuant to factors identified by the Secretary), payment may not be made under this part for a screening mammography performed within the 11 months following the month in

which a previous screening mammography was performed, or

[(II) is not at a high risk of developing breast cancer, payment may not be made under this part for a screening mammography performed within the 23 months following the month in which a previous screening mammography was performed.]

[(iv) In the case of a woman over 49 years of age, but under 65 years of age, payment may not be made under this part for screening mammography performed within 11 months following the month in which a previous screening mammography was performed.]

[(v) In the case of a woman over 64 years of age, payment may not be made for screening mammography performed within 23 months following the month in which a previous screening mammography was performed.]

(iii) In the case of a woman over 39 years of age, payment may not be made under this part for screening mammography performed within 11 months following the month in which a previous screening mammography was performed.

* * * * *

(d) FREQUENCY AND PAYMENT LIMITS FOR COLORECTAL CANCER SCREENING TESTS.—

(1) SCREENING FECAL-OCCULT BLOOD TESTS.—

(A) PAYMENT LIMIT.—In establishing fee schedules under section 1833(h) with respect to colorectal cancer screening tests consisting of screening fecal-occult blood tests, except as provided by the Secretary under paragraph (4)(A), the payment amount established for tests performed—

(i) in 1998 shall not exceed \$5; and

(ii) in a subsequent year, shall not exceed the limit on the payment amount established under this subsection for such tests for the preceding year, adjusted by the applicable adjustment under section 1833(h) for tests performed in such year.

(B) FREQUENCY LIMIT.—Subject to revision by the Secretary under paragraph (4)(B), no payment may be made under this part for colorectal cancer screening test consisting of a screening fecal-occult blood test—

(i) if the individual is under 50 years of age; or

(ii) if the test is performed within the 11 months after a previous screening fecal-occult blood test.

(2) SCREENING FLEXIBLE SIGMOIDOSCOPIES.—

(A) FEE SCHEDULE.—The Secretary shall establish a payment amount under section 1848 with respect to colorectal cancer screening tests consisting of screening flexible sigmoidoscopies 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) *PAYMENT LIMIT.*—*In the case of screening flexible sigmoidoscopy services—*

(i) *the payment amount may not exceed such amount as the Secretary specifies, based upon the rates recognized under this part for diagnostic flexible sigmoidoscopy services; and*

(ii) *that, in accordance with regulations, may be performed in an ambulatory surgical center and for which the Secretary permits ambulatory surgical center payments under this part and that are performed in an ambulatory surgical center or hospital outpatient department, the payment amount under this part may not exceed the lesser of (I) the payment rate that would apply to such services if they were performed in a hospital outpatient department, or (II) the payment rate that would apply to such services if they were performed in an ambulatory surgical center.*

(C) *SPECIAL RULE FOR DETECTED LESIONS.*—*If during the course of such screening flexible sigmoidoscopy, a lesion or growth is detected which results in a biopsy or removal of the lesion or growth, payment under this part shall not be made for the screening flexible sigmoidoscopy but shall be made for the procedure classified as a flexible sigmoidoscopy with such biopsy or removal.*

(D) *FREQUENCY LIMIT.*—*Subject to revision by the Secretary under paragraph (4)(B), no payment may be made under this part for a colorectal cancer screening test consisting of a screening flexible sigmoidoscopy—*

(i) *if the individual is under 50 years of age; or*

(ii) *if the procedure is performed within the 47 months after a previous screening flexible sigmoidoscopy.*

(3) *SCREENING COLONOSCOPY FOR INDIVIDUALS AT HIGH RISK FOR COLORECTAL CANCER.*—

(A) *FEE SCHEDULE.*—*The Secretary shall establish a payment amount under section 1848 with respect to colorectal cancer screening test consisting of a screening colonoscopy for individuals at high risk for colorectal cancer (as defined in section 1861(pp)(2)) 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) *PAYMENT LIMIT.*—*In the case of screening colonoscopy services—*

(i) *the payment amount may not exceed such amount as the Secretary specifies, based upon the rates recognized under this part for diagnostic colonoscopy services; and*

(ii) *that are performed in an ambulatory surgical center or hospital outpatient department, the payment amount under this part may not exceed the lesser of (I) the payment rate that would apply to such services if they were performed in a hospital outpatient department, or (II) the payment rate that would apply to such*

services if they were performed in an ambulatory surgical center.

(C) *SPECIAL RULE FOR DETECTED LESIONS.*—If during the course of such screening colonoscopy, a lesion or growth is detected which results in a biopsy or removal of the lesion or growth, payment under this part shall not be made for the screening colonoscopy but shall be made for the procedure classified as a colonoscopy with such biopsy or removal.

(D) *FREQUENCY LIMIT.*—Subject to revision by the Secretary under paragraph (4)(B), no payment may be made under this part for a colorectal cancer screening test consisting of a screening colonoscopy for individuals at high risk for colorectal cancer if the procedure is performed within the 23 months after a previous screening colonoscopy.

(4) *REDUCTIONS IN PAYMENT LIMIT AND REVISION OF FREQUENCY.*—

(A) *REDUCTIONS IN PAYMENT LIMIT FOR SCREENING FECAL-OCCULT BLOOD TESTS.*—The Secretary shall review from time to time the appropriateness of the amount of the payment limit established for screening fecal-occult blood tests under paragraph (1)(A). The Secretary may, with respect to tests performed in a year after 2000, reduce the amount of such limit as it applies nationally or in any area to the amount that the Secretary estimates is required to assure that such tests of an appropriate quality are readily and conveniently available during the year.

(B) *REVISION OF FREQUENCY.*—

(i) *REVIEW.*—The Secretary shall review periodically the appropriate frequency for performing colorectal cancer screening tests based on age and such other factors as the Secretary believes to be pertinent.

(ii) *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 may be paid for under this subsection, but no such revision shall apply to tests performed before January 1, 2001.

(5) *LIMITING CHARGES OF NONPARTICIPATING PHYSICIANS.*—

(A) *IN GENERAL.*—In the case of a colorectal cancer screening test consisting of a screening flexible sigmoidoscopy or a screening colonoscopy provided to an individual at high risk for colorectal cancer for which payment may be made under this part, if a nonparticipating physician provides the procedure to an individual enrolled under this part, the physician may not charge the individual more than the limiting charge (as defined in section 1848(g)(2)).

(B) *ENFORCEMENT.*—If a physician or supplier knowing and willfully imposes a charge in violation of subparagraph (A), the Secretary may apply sanctions against such physician or supplier in accordance with section 1842(j)(2).

* * * * *

[(g) PAYMENT FOR OUTPATIENT RURAL PRIMARY CARE HOSPITAL SERVICES.—

[(1) IN GENERAL.—The amount of payment for outpatient rural primary care hospital services provided during a year before the prospective payment system described in paragraph (2) is in effect in a rural primary care hospital under this part shall be determined by one of the 2 following methods, as elected by the rural primary care hospital:

[(A) COST-BASED FACILITY FEE PLUS PROFESSIONAL CHARGES.—

[(i) FACILITY FEE.—With respect to facility services, not including any services for which payment may be made under clause (ii), there shall be paid amounts equal to the amounts described in section 1833(a)(2)(B) (describing amounts paid for hospital outpatient services).

[(ii) REASONABLE CHARGES FOR PROFESSIONAL SERVICES.—In electing treatment under this subparagraph, payment for professional medical services otherwise included within outpatient rural primary care hospital services shall be made under such other provisions of this part as would apply to payment for such services if they were not included in outpatient rural primary care hospital services.

[(B) ALL-INCLUSIVE RATE.—With respect to both facility services and professional medical services, there shall be paid amounts equal to the costs which are reasonable and related to the cost of furnishing such services or which are based on such other tests of reasonableness as the Secretary may prescribe in regulations, less than the amount the hospital may charge as described in clause (i) of section 1866(a)(2)(A), but in no case may the payment for such services (other than for items and services described in section 1861(s)(10)(A)) exceed 80 percent of such costs.

The amount of payment shall be determined under either method without regard to the amount of the customary or other charge.

[(2) DEVELOPMENT AND IMPLEMENTATION OF ALL INCLUSIVE PROSPECTIVE PAYMENT SYSTEM.—Not later than January 1, 1996, the Secretary shall develop and implement a prospective payment system for determining payments under this part for outpatient rural primary care hospital services using a methodology that includes all costs in providing all such services (including related professional medical services) and that determines the payment amount for such services on a prospective basis.]

(g) PAYMENT FOR OUTPATIENT RURAL PRIMARY CARE HOSPITAL SERVICES.—The amount of payment under this part for outpatient rural primary care hospital services is the reasonable costs of the rural primary care hospital in providing such services.

(h) PAYMENT FOR PROSTHETIC DEVICES AND ORTHOTICS AND PROSTHETICS.—

(1) * * *

* * * * *

(4) DEFINITIONS.—In this subsection—

(A) the term “applicable percentage increase” means—
 (i) * * *

* * * * *

- (iii) for 1994 and 1995, 0 percent[, and];
- (iv) for [a subsequent year] 1996 and 1997, the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period ending with June of the previous year;
- (v) for each of the years 1998 through 2002, 1 percent, and
- (vi) for a subsequent year, the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period ending with June of the previous year;

* * * * *

(k) PAYMENT FOR OUTPATIENT THERAPY SERVICES AND COMPREHENSIVE OUTPATIENT REHABILITATION FACILITY SERVICES.—

(1) IN GENERAL.—With respect to outpatient physical therapy services (which includes outpatient speech-language pathology services) and outpatient occupational therapy services and with respect to comprehensive outpatient rehabilitation facility services for which payment is determined under this subsection, the payment basis shall be—

- (A) for services furnished during 1998, the amount determined under paragraph (2); or*
- (B) for services furnished during a subsequent year, 80 percent of the lesser of—*
 - (i) the actual charge for the services, or*
 - (ii) the applicable fee schedule amount (as defined in paragraph (3)) for the services.*

(2) PAYMENT IN 1998 BASED UPON ADJUSTED REASONABLE COSTS.—The amount under this paragraph for services is the lesser of—

- (A) the charges imposed for the services, or*
- (B) the adjusted reasonable costs (as defined in paragraph (4)) for the services,*
less 20 percent of the amount of the charges imposed for such services.

(3) APPLICABLE FEE SCHEDULE AMOUNT.—In this paragraph, the term “applicable fee schedule amount” means, with respect to services furnished in a year, the fee schedule amount established under section 1848(b) for such services furnished during the year or, if there is no such fee schedule amount established for such services, for such comparable services as the Secretary specifies.

(4) ADJUSTED REASONABLE COSTS.—In paragraph (2), the term “adjusted reasonable costs” means reasonable costs determined reduced by—

- (A) 5.8 percent of the reasonable costs for operating costs,*
and
- (B) 10 percent of the reasonable costs for capital costs.*

(5) *UNIFORM CODING.*—For claims for services submitted on or after April 1, 1998, for which the amount of payment is determined under this subsection, the claim shall include a code (or codes) under a uniform coding system specified by the Secretary that identifies the services furnished.

(6) *RESTRAINT ON BILLING.*—The provisions of subparagraphs (A) and (B) of section 1842(b)(18) shall apply to therapy services for which payment is made under this subsection in the same manner as they apply to services provided by a practitioner described in section 1842(b)(18)(C).

(l) *ESTABLISHMENT OF FEE SCHEDULE FOR AMBULANCE SERVICES.*—

(1) *IN GENERAL.*—The Secretary shall establish a fee schedule for payment for ambulance services under this part through a negotiated rulemaking process described in title 5, United States Code, and in accordance with the requirements of this subsection.

(2) *CONSIDERATIONS.*—In establishing such fee schedule the Secretary shall—

(A) establish mechanisms to control increases in expenditures for ambulance services under this part;

(B) establish definitions for ambulance services which link payments to the type of services provided;

(C) consider appropriate regional and operational differences;

(D) consider adjustments to payment rates to account for inflation and other relevant factors; and

(E) phase in the application of the payment rates under the fee schedule in an efficient and fair manner.

(3) *SAVINGS.*—In establishing such fee schedule the Secretary shall—

(A) ensure that the aggregate amount of payments made for ambulance services under this part during 2000 does not exceed the aggregate amount of payments which would have been made for such services under this part during such year if the amendments made by section 10431 of the Balanced Budget Act of 1997 had not been made; and

(B) set the payment amounts provided under the fee schedule for services furnished in 2001 and each subsequent year at amounts equal to the payment amounts under the fee schedule for service furnished during the previous year, increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 12-month period ending with June of the previous year.

(4) *CONSULTATION.*—In establishing the fee schedule for ambulance services under this subsection, the Secretary shall consult with various national organizations representing individuals and entities who furnish and regulate ambulance services and share with such organizations relevant data in establishing such schedule.

(5) *LIMITATION ON REVIEW.*—There shall be no administrative or judicial review under section 1869 or otherwise of the amounts established under the fee schedule for ambulance serv-

ices under this subsection, including matters described in paragraph (2).

(6) *RESTRAINT ON BILLING.*—The provisions of subparagraphs (A) and (B) of section 1842(b)(18) shall apply to ambulance services for which payment is made under this subsection in the same manner as they apply to services provided by a practitioner described in section 1842(b)(18)(C).

(m) *SPECIAL RULES FOR PAYMENT FOR ORAL ANTI-NAUSEA DRUGS.*—

(1) *LIMITATION ON PER DOSE PAYMENT BASIS.*—Subject to paragraph (2), the per dose payment basis under this part for oral anti-nausea drugs (as defined in paragraph (3)) administered during a year shall not exceed 90 percent of the average per dose payment basis for the equivalent intravenous antiemetics administered during the year, as computed based on payment basis applied during 1996.

(2) *AGGREGATE LIMIT.*—The Secretary shall make such adjustment in the coverage of, or payment basis for, oral anti-nausea drugs so that coverage of such drugs under this part does not result in any increase in aggregate payments per capita under this part above the levels of such payments per capita that would otherwise have been made if there were no coverage for such drugs under this part.

(3) *ORAL ANTI-NAUSEA DRUGS DEFINED.*—For purposes of this subsection, the term “oral anti-nausea drugs” means drugs for which coverage is provided under this part pursuant to section 1861(s)(2)(P).

PROCEDURE FOR PAYMENT OF CLAIMS OF PROVIDERS OF SERVICES

SEC. 1835. (a) Except as provided in subsections (b), (c), and (e), payment for services described in section 1832(a)(2) furnished an individual may be made only to providers of services which are eligible therefor under section 1866(a), and only if—

(1) written request, signed by such individual, except in cases in which the Secretary finds it impracticable for the individual to do so, is filed for such payment in such form, in such manner and by such person or persons as the Secretary may by regulation prescribe, no later than the close of the period of 3 calendar years following the year in which such services are furnished (deeming any services furnished in the last 3 calendar months of any calendar year to have been furnished in the succeeding calendar year) except that, where the Secretary deems that efficient administration so requires, such period may be reduced to not less than 1 calendar year; and

(2) a physician certifies (and recertifies, where such services are furnished over a period of time, in such cases, with such frequency, and accompanied by such supporting material, appropriate to the case involved, as may be provided by regulations) that—

(A) in the case of home health services (i) such services are or were required because the individual is or was confined to his home (except when receiving items and services referred to in section 1861(m)(7)) and needs or needed skilled nursing care (*other than solely venipuncture for the*

purpose of obtaining a blood sample) on an intermittent basis or physical or speech therapy or, in the case of an individual who has been furnished home health services based on such a need and who no longer has such a need for such care or therapy, continues or continued to need occupational therapy, (ii) a plan for furnishing such services to such individual has been established and is periodically reviewed by a physician, and (iii) such services are or were furnished while the individual is or was under the care of a physician;

* * * * *

ENROLLMENT PERIODS

SEC. 1837. (a) * * *

* * * * *

(i)(1) In the case of an individual who—

(A) * * *

* * * * *

there shall be a special enrollment period described in paragraph (3). In the case of an individual not described in the previous sentence who has not attained the age of 65, at the time the individual first satisfies paragraph (1) of section 1836, is enrolled in a large group health plan (as that term is defined in section ~~1862(b)(1)(B)(iv)~~ 1862(b)(1)(B)(iii)) by reason of the individual's current employment status (or the current employment status of a family member of the individual), and has elected not to enroll (or to be deemed enrolled) under this section during the individual's initial enrollment period, there shall be a special enrollment period described in paragraph (3)(B).

(2) In the case of an individual who—

(A) * * *

* * * * *

there shall be a special enrollment period described in paragraph (3). In the case of an individual not described in the previous sentence who has not attained the age of 65, has enrolled (or has been deemed to have enrolled) in the medical insurance program established under this part during the individual's initial enrollment period, or is an individual described in the second sentence of paragraph (1), has enrolled in such program during any subsequent special enrollment period under this subsection during which the individual was not enrolled in a large group health plan (as that term is defined in section ~~1862(b)(1)(B)(iv)~~ 1862(b)(1)(B)(iii)) by reason of the individual's current employment status (or the current employment status of a family member of the individual), and has not terminated enrollment under this section at any time at which the individual is not enrolled in such a large group health plan by reason of the individual's current employment status (or the current employment status of a family member of the individual), there shall be a special enrollment period described in paragraph (3)(B).

(3)(A) * * *

(B) The special enrollment period referred to in the second sentences of paragraphs (1) and (2) is the period including each month during any part of which the individual is enrolled in a large group health plan (as that term is defined in section **【1862(b)(1)(B)(iv)】** *1862(b)(1)(B)(iii)*) by reason of the individual's current employment status (or the current employment status of a family member of the individual) ending with the last day of the eighth consecutive month in which the individual is at no time so enrolled.

* * * * *

AMOUNTS OF PREMIUMS

SEC. 1839. (a)(1) * * *

(2) The monthly premium of each individual enrolled under this part for each month after December 1983 shall, except as provided in subsections **【(b) and (e)】** *(b), (c), and (f)*, be the amount determined under paragraph (3).

(3) **【**The Secretary shall, during September of 1983 and of each year thereafter, determine and promulgate the monthly premium applicable for individuals enrolled under this part for the succeeding calendar year. The monthly premium shall (except as otherwise provided in subsection (e)) be equal to the smaller of—

【(A) the monthly actuarial rate for enrollees age 65 and over, determined according to paragraph (1) of this subsection, for that calendar year, or

【(B) the monthly premium rate most recently promulgated by the Secretary under this paragraph, increased by a percentage determined as follows: The Secretary shall ascertain the primary insurance amount computed under section 215(a)(1), based upon average indexed monthly earnings of \$900, that applied to individuals who became eligible for and entitled to old-age insurance benefits on November 1 of the year before the year of the promulgation. He shall increase the monthly premium rate by the same percentage by which that primary insurance amount is increased when, by reason of the law in effect at the time the promulgation is made, it is so computed to apply to those individuals for the following November 1.**】**
The Secretary, during September of each year, shall determine and promulgate a monthly premium rate for the succeeding calendar year. That monthly premium rate shall be equal to 50 percent of the monthly actuarial rate for enrollees age 65 and over, determined according to paragraph (1), for that succeeding calendar year.

Whenever the Secretary promulgates the dollar amount which shall be applicable as the monthly premium *rate* for any period, he shall, at the time such promulgation is announced, issue a public statement setting forth the actuarial assumptions and bases employed by him in arriving at the amount of an adequate actuarial rate for enrollees age 65 and older as provided in paragraph (1) **【**and the derivation of the dollar amounts specified in this paragraph**】**.

(b) In the case of an individual whose coverage period began pursuant to an enrollment after his initial enrollment period (determined pursuant to subsection (c) or (d) of section 1837), the month-

ly premium determined under subsection (a) or (e) shall be increased by 10 percent of the monthly premium so determined for each full 12 months (in the same continuous period of eligibility) in which he could have been but was not enrolled. For purposes of the preceding sentence, there shall be taken into account (1) the months which elapsed between the close of his initial enrollment period and the close of the enrollment period in which he enrolled, plus (in the case of an individual who reenrolls) (2) the months which elapsed between the date of termination of a previous coverage period and the close of the enrollment period in which he reenrolled, but there shall not be taken into account months for which the individual can demonstrate that the individual was enrolled in a group health plan described in section 1862(b)(1)(A)(v) by reason of the individual's (or the individual's spouse's) current employment or months during which the individual has not attained the age of 65 and for which the individual can demonstrate that the individual was enrolled in a large group health plan as an active individual (as those terms are defined in section ~~1862(b)(1)(B)(iv)~~ *1862(b)(1)(B)(iii)*). Any increase in an individual's monthly premium under the first sentence of this subsection with respect to a particular continuous period of eligibility shall not be applicable with respect to any other continuous period of eligibility which such individual may have.

* * * * *

[(e)(1)(A) Notwithstanding the provisions of subsection (a), the monthly premium for each individual enrolled under this part for each month after December 1995 and prior to January 1999 shall be an amount equal to 50 percent of the monthly actuarial rate for enrollees age 65 and over, as determined under subsection (a)(1) and applicable to such month.

[(B) Notwithstanding the provisions of subsection (a), the monthly premium for each individual enrolled under this part for each month in—

- [(i) 1991 shall be \$29.90,
- [(ii) 1992 shall be \$31.80,
- [(iii) 1993 shall be \$36.60,
- [(iv) 1994 shall be \$41.10, and
- [(v) 1995 shall be \$46.10.

[(2) Any increases in premium amounts taking effect prior to January 1998 by reason of paragraph (1) shall be taken into account for purposes of determining increases thereafter under subsection (a)(3).]

* * * * *

[(g) (e)(1) Upon the request of a State, the Secretary may enter into an agreement with the State under which the State agrees to pay on a quarterly or other periodic basis to the Secretary (to be deposited in the Treasury to the credit of the Federal Supplementary Medical Insurance Trust Fund) an amount equal to the amount of the part B late enrollment premium increases with respect to the premiums for eligible individuals (as defined in paragraph (3)(A)).

* * * * *

USE OF CARRIERS FOR ADMINISTRATION OF BENEFITS

SEC. 1842. (a) * * *
 (b)(1) * * *
 (2)(A) * * *

* * * * *

(E) With respect to the payment of claims for home health services under this part that, but for the amendments made by section 10531 of the Balanced Budget Act of 1997, would be payable under part A instead of under this part, the Secretary shall continue administration of such claims through fiscal intermediaries under section 1816.

(3) Each such contract shall provide that the carrier—

*(A) * * **

* * * * *

*(I) will submit annual reports to the Secretary describing the steps taken to recover payments made under this part for items or services for which payment has been or could be made under a primary plan (as defined in section 1862(b)(2)(A)); **and***

(J) will reimburse the Secretary for any amounts paid by the carrier for an item or service under this part which is furnished, directed, or prescribed by an individual or entity during any period for which the individual or entity is excluded pursuant to section 1128, 1128A, or 1156, from participation in the program under this title, if the amounts are paid after the Secretary notifies the carrier of the exclusion, and

* * * * *

*(6) No payment under this part for a service provided to any individual shall (except as provided in section 1870) be made to anyone other than such individual or (pursuant to an assignment described in subparagraph (B)(ii) of paragraph (3)) the physician or other person who provided the service, except that (A) payment may be made (i) to the employer of such physician or other person if such physician or other person is required as a condition of his employment to turn over his fee for such service to his employer, or (ii) (where the service was provided in a hospital, rural primary care hospital, clinic, or other facility) to the facility in which the service was provided if there is a contractual arrangement between such physician or other person and such facility under which such facility submits the bill for such service, (B) payment may be made to an entity (i) which provides coverage of the services under a health benefits plan, but only to the extent that payment is not made under this part, (ii) which has paid the person who provided the service an amount (including the amount payable under this part) which that person has accepted as payment in full for the service, and (iii) to which the individual has agreed in writing that payment may be made under this part, (C) in the case of services described in **clauses (i), (ii), or (iv)** clause (i) of section 1861(s)(2)(K) payment shall be made to the employer of the physician assistant **or nurse practitioner** involved, **and** (D) payment may be made to a physician for physicians services (and services furnished incident to such services) furnished by a second physician to patients of the first physician if (i) the first physician is unavailable to provide the services; (ii) the*

services are furnished pursuant to an arrangement between the two physicians that (I) is informal and reciprocal, or (II) involves per diem or other fee-for-time compensation for such services; (iii) the services are not provided by the second physician over a continuous period of more than 60 days; and (iv) the claim form submitted to the carrier for such services includes the second physician's unique identifier (provided under the system established under subsection (r)) and indicates that the claim meets the requirements of this subparagraph for payment to the first physician. No payment which under the preceding sentence may be made directly to the physician or other person providing the service involved (pursuant to an assignment described in subparagraph (B)(ii) of paragraph (3)) shall be made to anyone else under a reassignment or power of attorney (except to an employer or facility as described in clause (A) of such sentence); but nothing in this subsection shall be construed (i) to prevent the making of such a payment in accordance with an assignment from the individual to whom the service was provided or a reassignment from the physician or other person providing such service if such assignment or reassignment is made to a governmental agency or entity or is established by or pursuant to the order of a court of competent jurisdiction, or (ii) to preclude an agent of the physician or other person providing the service from receiving any such payment if (but only if) such agent does so pursuant to an agency agreement under which the compensation to be paid to the agent for his services for or in connection with the billing or collection of payments due such physician or other person under this title is unrelated (directly or indirectly) to the amount of such payments or the billings therefor, and is not dependent upon the actual collection of any such payment. (E) in the case of an item or service (other than services described in section 1888(e)(2)(A)(ii)) furnished to an individual who (at the time the item or service is furnished) is a resident of a skilled nursing facility, payment shall be made to the facility (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), and (F) in the case of home health services furnished to an individual who (at the time the item or service is furnished) is under a plan of care of a home health agency, payment shall be made to the agency (without regard to whether or not the item or service was furnished by the agency, by others under arrangement with them made by the agency, or when any other contracting or consulting arrangement, or otherwise). For purposes of clause (C) of the first sentence of this paragraph, an employment relationship may include any independent contractor arrangement, and employer status shall be determined in accordance with the law of the State in which the services described in such clause are performed.

* * * * *

[(12)(A) With respect to services described in clauses (i), (ii), or (iv) of section 1861(s)(2)(K) (relating to a physician assistants and nurse practitioners)—

[(i) payment under this part may only be made on an assignment-related basis; and

[(ii) the prevailing charges determined under paragraph (3) shall not exceed—

[(I) in the case of services performed as an assistant at surgery, 65 percent of the amount that would otherwise be recognized if performed by a physician who is serving as an assistant at surgery, or

[(II) in other cases, the applicable percentage (as defined in subparagraph (B)) of the prevailing charge rate determined for such services (or, for services furnished on or after January 1, 1992, the fee schedule amount specified in section 1848) performed by physicians who are not specialists.

[(B) In subparagraph (A)(ii)(II), the term “applicable percentage means—

[(i) 75 percent in the case of services performed (other than as an assistant at surgery) in a hospital, and

[(ii) 85 percent in the case of other services.]

(12) *With respect to services described in section 1861(s)(2)(K)(i)—*

(A) payment under this part may only be made on an assignment-related basis; and

(B) the amounts paid under this part shall be equal to 80 percent of (i) the lesser of the actual charge or 85 percent of the fee schedule amount provided under section 1848 for the same service provided by a physician who is not a specialist; or (ii) in the case of services as an assistant at surgery, the lesser of the actual charge or 85 percent of the amount that would otherwise be recognized if performed by a physician who is serving as an assistant at surgery.

* * * * *

(19) *For purposes of section 1833(a)(1), the reasonable charge for ambulance services (as described in section 1861(s)(7)) provided during a fiscal year (beginning with fiscal year 1998 and ending with fiscal year 2002) may not exceed the reasonable charge for such services provided during the previous fiscal year, increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) as estimated by the Secretary for the 12-month period ending with the midpoint of the year involved reduced (in the case of each of fiscal years 1998 and 1999) by 1 percentage point.*

* * * * *

(h)(1) * * *

* * * * *

(7) The Secretary shall provide that each explanation of benefits provided under this part for services furnished in the United States, in conjunction with the payment of claims under section 1833(a)(1) (made other than on an assignment-related basis), shall include—

(A) * * *

* * * * *

(C)(i) an offer of assistance to such an individual in obtaining the names of participating physicians of appropriate specialty

and (ii) an offer to provide a free copy of the appropriate participating physician directory, [and]

(D) in the case of services for which the billed amount exceeds the limiting charge imposed under section 1848(g), information regarding such applicable limiting charge (including information concerning the right to a refund under section 1848(g)(1)(A)(iv)) [.] , and

(E) a toll-free telephone number maintained by the Inspector General in the Department of Health and Human Services for the receipt of complaints and information about waste, fraud, and abuse in the provision or billing of services under this title.

* * * * *

(o) If a physician's, supplier's, or any other person's bill or request for payment for services includes a charge for a drug or biological for which payment may be made under this part and the drug or biological is not paid on a cost or prospective payment basis as otherwise provided in this part, the amount payable for the drug or biological is equal to exceed 95 percent of the average wholesale price.

* * * * *

(s) The Secretary may refuse to enter into an agreement with a physician or supplier under subsection (h) or may terminate or refuse to renew such agreement, in the event that such physician or supplier has been convicted of a felony under Federal or State law for an offense which the Secretary determines is inconsistent with the best interests of program beneficiaries.

* * * * *

APPROPRIATIONS TO COVER GOVERNMENT CONTRIBUTIONS AND CONTINGENCY RESERVE

SEC. 1844. (a) There are authorized to be appropriated from time to time, out of any moneys in the Treasury not otherwise appropriated, to the Federal Supplementary Medical Insurance Trust Fund—

(1)(A) a Government contribution equal to the aggregate premiums payable for a month for enrollees age 65 and over under this part and deposited in the Trust Fund, multiplied by the ratio of—

(i) twice the dollar amount of the actuarially adequate rate per enrollee age 65 and over as determined under section 1839(a)(1) for such month minus the dollar amount of the premium per enrollee for such month, as determined under section 1839(a)(3) [or 1839(e), as the case may be], to

(ii) the dollar amount of the premium per enrollee for such month, plus

(B) a Government contribution equal to the aggregate premiums payable for a month for enrollees under age 65 under this part and deposited in the Trust Fund, multiplied by the ratio of—

(i) twice the dollar amount of the actuarially adequate rate per enrollee under age 65 as determined under section 1839(a)(4) for such month minus the dollar amount of the

premium per enrollee for such month, as determined under section 1839(a)(3) [or 1839(e), as the case may be], to

* * * * *

【PHYSICIAN PAYMENT REVIEW COMMISSION

【SEC. 1845. (a)(1) The Director of the Congressional Office of Technology Assessment (hereinafter in this section referred to as the “Director” and the “Office”, respectively) shall provide for the appointment of a Physician Payment Review Commission (hereinafter in this section referred to as the “Commission”), to be composed of individuals with national recognition for their expertise in health economics, physician reimbursement, medical practice, and other related fields appointed by the Director (without regard to the provisions of title 5, United States Code, governing appointments in the competitive service).

【(2) The Commission shall consist of 13 individuals. Members of the Commission shall first be appointed no later than May 1, 1986, for a term of three years, except that the Director may provide initially for such shorter terms as will insure that (on a continuing basis) the terms of no more than four members expire in any one year.

【(3) The membership of the Commission shall include (but need not be limited to) physicians, other health professionals, individuals skilled in the conduct and interpretation of biomedical, health services, and health economics research, and representatives of consumers and the elderly.

【(b)(1) The Commission shall make recommendations to the Congress, not later than March 31 of each year (beginning with 1987), regarding adjustments to the reasonable charge levels for physicians’ services recognized under section 1842(b) and changes in the methodology for determining the rates of payment, and for making payment, for physicians’ services under this title and other items and services under this part.

【(2) In making its recommendations, the Commission shall—

【(A) assess the likely impact of different adjustments in payment rates, particularly their impact on physician participation in the participation program established under section 1842(h) and on beneficiary access to necessary physicians’ services;

【(B) make recommendations on ways to increase physician participation in that participation program and the acceptance of payment under this part on an assignment-related basis;

【(C) identify those procedures, involving the use of assistants at surgery, for which payment for those assistants should not be made under this title without prior approval;

【(D) identify those procedures for which an opinion of a second physician should be required before payment is made under this title;

【(E) consider policies for moderating the rate of increase in expenditures under this part and the rate of increase in utilization of services under this part;

【(F) make recommendations regarding major issues in the implementation of the resource-based relative value scale established under section 1848(c);

[(G) make recommendations regarding further development of the volume performance standards established under section 1848(f), including the development of State-based programs;

[(H) consider policies to provide payment incentives to increase patient access to primary care and other physician services in large urban and rural areas, including policies regarding payments to physicians pursuant to title XIX;

[(I) review and consider the number and practice specialties of physicians in training and payments under this title for graduate medical education costs;

[(J) make recommendations regarding issues relating to utilization review and quality of care, including the effectiveness of peer review procedures and other quality assurance programs applicable to physicians and providers under this title and physician certification and licensing standards and procedures;

[(K) make recommendations regarding options to help constrain the costs of health insurance to employers, including incentives under this title;

[(L) comment on the recommendations affecting physician payment under the medicare program that are included in the budget submitted by the President pursuant to section 1105 of title 31, United States Code; and

[(M) make recommendations regarding medical malpractice liability reform and physician certification and licensing standards and procedures.

[(c)(1) The following provisions of section 1886(e)(6) shall apply to the Commission in the same manner as they apply to the Prospective Payment Assessment Commission:

[(A) Subparagraph (C) (relating to staffing and administration generally).

[(B) Subparagraph (D) (relating to compensation of members).

[(C) Subparagraph (F) (relating to access to information).

[(D) Subparagraph (G) (relating to use of funds).

[(E) Subparagraph (H) (relating to periodic GAO audits).

[(F) Subparagraph (J) (relating to requests for appropriations).

[(2) In order to carry out its functions, the Commission shall collect and assess information on medical and surgical procedures and services, including information on regional variations of medical practice. In collecting and assessing information, the Commission shall—

[(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 for the development of useful and valid guidelines by the Commission, and

[(C) adopt procedures allowing any interested party to submit information with respect to physicians' services (including new practices, such as the use of new technologies and treat-

ment modalities), which information the Commission shall consider in making reports and recommendations to the Secretary and Congress.

[(d) There are authorized to be appropriated such sums as may be necessary to carry out the provisions of this section. Such sums shall be payable from the Federal Supplementary Medical Insurance Trust Fund.

[(e)(1) Not later than December 31st of each year (beginning with 1988), the Secretary shall transmit to the Physician Payment Review Commission, to the Congressional Budget Office, and to the Congressional Research Service of the Library of Congress national data (known as the Part B Medicare Annual Data System) for the previous year respecting part B of this title.

[(2) The Secretary, in consultation with the Physician Payment Review Commission, the Congressional Budget Office, and the Congressional Research Service of the Library of Congress, shall establish and annually revise standards for the data reporting system described in paragraph (1).

[(3) The Secretary shall also provide to the entities described in paragraph (1) additional data respecting the program under this part as may be reasonably requested by them on an agreed-upon schedule.

[(4) The Secretary shall develop, in consultation with the Physician Payment Review Commission, the Congressional Budget Office, and the Congressional Research Service of the Library of Congress, a system for providing to each of such entities on a quarterly basis summary data on aggregate expenditures under this part by type of service and by type of provider. Such data shall be provided not later than 90 days after the end of each quarter (for quarters beginning with the calendar quarter ending on March 31, 1989).]

* * * * *

PAYMENT FOR PHYSICIANS' SERVICES

SEC. 1848. (a) PAYMENT BASED ON FEE SCHEDULE.—

(1) * * *

(2) TRANSITION TO FULL FEE SCHEDULE.—

(A) LIMITING REDUCTIONS AND INCREASES TO 15 PERCENT IN 1992.—

(i) LIMIT ON INCREASE.—In the case of a service (*other than a colorectal cancer screening test consisting of a screening colonoscopy provided to an individual at high risk for colorectal cancer or a screening flexible sigmoidoscopy*) in a fee schedule area (as defined in subsection (j)(2)) for which the adjusted historical payment basis (as defined in subparagraph (D)) is less than 85 percent of the fee schedule amount for services furnished in 1992, there shall be substituted for the fee schedule amount an amount equal to the adjusted historical payment basis plus 15 percent of the fee schedule amount otherwise established (without regard to this paragraph).

(ii) LIMIT IN REDUCTION.—In the case of a service (*other than a colorectal cancer screening test consisting*

of a screening colonoscopy provided to an individual at high risk for colorectal cancer or a screening flexible sigmoidoscopy) in a fee schedule area for which the adjusted historical payment basis exceeds 115 percent of the fee schedule amount for services furnished in 1992, there shall be substituted for the fee schedule amount an amount equal to the adjusted historical payment basis minus 15 percent of the fee schedule amount otherwise established (without regard to this paragraph).

* * * * *

(c) DETERMINATION OF RELATIVE VALUES FOR PHYSICIANS' SERVICES.—

(1) * * *

(2) DETERMINATION OF RELATIVE VALUES.—

(A) * * *

(B) PERIODIC REVIEW AND ADJUSTMENTS IN RELATIVE VALUES.—

(i) * * *

* * * * *

(iii) CONSULTATION.—The Secretary, in making adjustments under clause (ii), shall consult with the **Physician Payment Review Commission** *Medicare Payment Advisory Commission* and organizations representing physicians.

(C) COMPUTATION OF RELATIVE VALUE UNITS FOR COMPONENTS.—For purposes of this section for each physicians' service—

(i) * * *

(ii) PRACTICE EXPENSE RELATIVE VALUE UNITS.—The Secretary shall determine a number of practice expense relative value units for the service for years before **1998** *1999* equal to the product of—

(I) the base allowed charges (as defined in subparagraph (D)) for the service, and

(II) the practice expense percentage for the service (as determined under paragraph (3)(C)(ii)), and for years beginning with **1998** *1999* based, *to the extent provided under subparagraph (G)*, on the relative practice expense resources involved in furnishing the service.

* * * * *

(G) TRANSITIONAL RULE FOR RESOURCE-BASED PRACTICE EXPENSE UNITS.—In applying subparagraph (C)(ii) for 1999, 2000, 2001, and subsequent year, the number of units under such subparagraph shall be based 75 percent, 50 percent, 25 percent, and 0 percent, respectively, on the practice expense relative value units in effect in 1998 (or the Secretary's imputation of such units for new or revised codes) and the remainder on the relative value expense resources involved in furnishing the service.

(3) COMPONENT PERCENTAGES.—For purposes of paragraph (2), the Secretary shall determine a work percentage, a practice expense percentage, and a malpractice percentage for each physician's service as follows:

(A) * * *

* * * * *

(C) DETERMINATION OF COMPONENT PERCENTAGES.—

(i) * * *

(ii) PRACTICE EXPENSE PERCENTAGE.—For years before [1998] 2002, the practice expense percentage for a service (or class of services) is equal to the sum (for all physician specialties) of—

(I) the average percentage division for the practice expense component for each physician specialty (determined under subparagraph (B)), multiplied by

(II) the proportion (determined under subparagraph (A)) of such service (or services) performed by physicians in that specialty.

* * * * *

(d) CONVERSION FACTORS.—

(1) ESTABLISHMENT.—

(A) IN GENERAL.—The conversion factor [(or factors)] for each year shall be the conversion factor [(or factors)] established under this subsection for the previous year (or, in the case of 1992, specified in subparagraph (B)) adjusted by the update [or updates] (established under paragraph (3)) for the year involved.

* * * * *

(C) SPECIAL RULES FOR 1998.—*Except as provided in subparagraph (D), the single conversion factor for 1998 under this subsection shall be the conversion factor for primary care services for 1997, increased by the Secretary's estimate of the weighted average of the three separate updates that would otherwise occur were it not for the enactment of chapter 1 of subtitle G of title X of the Medicare Amendments Act of 1997.*

(D) SPECIAL RULES FOR ANESTHESIA SERVICES.—*The separate conversion factor for anesthesia services for a year shall be equal to 46 percent of the single conversion factor established for other physicians' services, except as adjusted for changes in work, practice expense, or malpractice relative value units.*

[(C)] (E) PUBLICATION.—The Secretary shall cause to have published in the Federal Register, during the last 15 days of October of—

(i) 1991, the conversion factor which will apply to physicians' services for 1992, and the update (or updates) determined under paragraph (3) for 1992 and

(ii) each succeeding year, the conversion factor [(or factors)] which will apply to physicians services for the following year and the update [(or updates)] determined under paragraph (3) for such year.

[(2) RECOMMENDATION OF UPDATE.—

[(A) IN GENERAL.—Not later than April 15 of each year (beginning with 1991), the Secretary shall transmit to the Congress a report that includes a recommendation on the appropriate update (or updates) in the conversion factor (or factors) for all physicians services (as defined in subsection (f)(5)(A)) in the following year. The Secretary may recommend a uniform update or different updates for different categories or groups of services. In making the recommendation, the Secretary shall consider—

[(i) the percentage change in the medicare economic index (described in the fourth sentence of section 1842(b)(3)) for that year;

[(ii) the percentage by which actual expenditures for all physicians' services and for the services involved under this part for the fiscal year ending in the year preceding the year in which such recommendation is made were greater or less than actual expenditures for such services in the fiscal year ending in the second preceding year;

[(iii) the relationship between the percentage determined under clause (ii) for a fiscal year and the performance standard rate of increase (established under subsection (f)(2)) for that fiscal year;

[(iv) changes in volume or intensity of services;

[(v) access to services; and

[(vi) other factors that may contribute to changes in volume or intensity of services or access to services.

For purposes of making the comparison under clause (iii), the Secretary shall adjust the performance standard rate of increase for a fiscal year to reflect changes in the actual proportion of individuals who are enrolled under this part who are HMO enrollees (as defined in subsection (f)(5)(B)) in that fiscal year compared with such proportion for the previous fiscal year.

[(B) ADDITIONAL CONSIDERATIONS.—In making recommendations under subparagraph (A), the Secretary may also consider—

[(i) unexpected changes by physicians in response to the implementation of the fee schedule;

[(ii) unexpected changes in outlay projections;

[(iii) changes in the quality or appropriateness of care; and

[(v) any other relevant factors not measured in the resource-based payment methodology.

[(C) SPECIAL RULE FOR 1992 UPDATE.—In considering the update for 1992, the Secretary shall make a separate determination of the percentage and relationship described in clauses (ii) and (iii) of subparagraph (A) with respect to the category of surgical services (as defined by the Secretary pursuant to subsection (j)(1)).

[(D) EXPLANATION OF UPDATE.—The Secretary shall include in each report under subparagraph (A)—

[(i) the update recommended for each category of physicians' services (established by the Secretary under subsection (j)(1)) and for each of the following groups of physicians' services: nonsurgical services, visits, consultations, and emergency room services;

[(ii) the rationale for the recommended update (or updates) for each category and group of services described in clause (i); and

[(iii) the data and analyses underlying the update (or updates) recommended.

[(E) COMPUTATION OF BUDGET-NEUTRAL ADJUSTMENT.—

[(i) IN GENERAL.—The Secretary shall include in the report made under subparagraph (A) in a year a statement of the percentage by which (I) the actual expenditures for physicians' services under this part (during the fiscal year ending in the preceding year, as set forth in the most recent annual report made pursuant to section 1841(b)(2)), exceeded, or was less than (II) the expenditures projected for the fiscal year under clause (ii).

[(ii) PROJECTED EXPENDITURES.—For purposes of clause (i), the expenditures projected under this clause for a fiscal year is the actual expenditures for physicians services made under this part in the second preceding fiscal year—

[(I) increased by the weighted average percentage increase permitted under this part for payments for physicians services in the preceding fiscal year;

[(II) adjusted to reflect the percentage change in the average number of individuals enrolled under this part (who are not enrolled with a risk-sharing contract under section 1876) for the preceding fiscal year compared with the second preceding fiscal year;

[(III) adjusted to reflect the average annual percentage growth in the volume and intensity of physicians services under this part for the five-fiscal-year period ending with the second preceding fiscal year; and

[(IV) adjusted to reflect the percentage change in expenditures for physicians' services under this part in the preceding fiscal year (compared with the second preceding fiscal year) which result from changes in law or regulations.

[(F) COMMISSION REVIEW.—The Physician Payment Review Commission shall review the report submitted under subparagraph (A) in a year and shall submit to the Congress, by not later than May 15 of the year, a report including its recommendations respecting the update (or updates) in the conversion factor (or factors) for the following year.

[(3) UPDATE.—

[(A) BASED ON INDEX.—

[(i) IN GENERAL.—Unless Congress otherwise provides, subject to subparagraph (B), except as provided in clauses (iii) through (v), for purposes of this section the update for a year is equal to the Secretary's estimate of the percentage increase in the appropriate update index (as defined in clause (ii)) for the year.

[(ii) APPROPRIATE UPDATE INDEX DEFINED.—In clause (i), the term “appropriate update index” means—

[(I) for services for which prevailing charges in 1989 were subject to a limit under the fourth sentence of section 1842(b)(3), the medicare economic index (referred to in that sentence), and

[(II) for other services, such index (such as the consumer price index) that was applicable under this part in 1989 to increases in the payment amounts recognized under this part with respect to such services.

[(iii) ADJUSTMENT IN PERCENTAGE INCREASE.—In applying clause (i) for services furnished in 1992 for which the appropriate update index is the index described in clause (ii)(I), the percentage increase in the appropriate update index shall be reduced by 0.4 percentage points.

[(iv) ADJUSTMENT IN PERCENTAGE INCREASE FOR 1994.—In applying clause (i) for services furnished in 1994, the percentage increase in the appropriate update index shall be reduced by—

[(I) 3.6 percentage points for services included in the category of surgical services (as defined for purposes of subsection (j)(1)), and

[(II) 2.6 percentage points for other services.

[(v) ADJUSTMENT IN PERCENTAGE INCREASE FOR 1995.—In applying clause (i) for services furnished in 1995, the percentage increase in the appropriate update index shall be reduced by 2.7 percentage points.

[(vi) EXCEPTION FOR CATEGORY OF PRIMARY CARE SERVICES.—Clauses (iv) and (v) shall not apply to services included in the category of primary care services (as defined for purposes of subsection (j)(1)).

[(B) ADJUSTMENT IN UPDATE.—

[(i) IN GENERAL.— The update for a category of physicians services for a year provided under subparagraph (A) shall, subject to clause (ii), be increased or decreased by the same percentage by which (I) the percentage increase in the actual expenditures for services in such category in the second previous fiscal year over the third previous fiscal year, was less or greater, respectively, than (II) the performance standard rate of increase (established under subsection (f)) for such category of services for the second previous fiscal year.

[(ii) RESTRICTIONS ON ADJUSTMENT.—The adjustment made under clause (i) for a year may not result in a decrease of more than—

[(I) 2 percentage points for the update for 1992 or 1993,

[(II) 2½ percentage points for the update for 1994, and

[(III) 5 percentage points for the update for any succeeding year.]

(3) UPDATE.—

(A) *IN GENERAL.*—Unless otherwise provided by law, subject to subparagraph (D) and the budget-neutrality factor determined by the Secretary under subsection (c)(2)(B)(ii), the update to the single conversion factor established in paragraph (1)(C) for a year beginning with 1999 is equal to the product of—

(i) 1 plus the Secretary's estimate of the percentage increase in the MEI (as defined in section 1842(i)(3)) for the year (divided by 100), and

(ii) 1 plus the Secretary's estimate of the update adjustment factor for the year (divided by 100), minus 1 and multiplied by 100.

(B) *UPDATE ADJUSTMENT FACTOR.*—For purposes of subparagraph (A)(ii), the “update adjustment factor” for a year is equal to the quotient (as estimated by the Secretary) of—

(i) the difference between (I) the sum of the allowed expenditures for physicians' services (as determined under subparagraph (C)) during the period beginning July 1, 1997, and ending on June 30 of the year involved, and (II) the sum of the amount of actual expenditures for physicians' services furnished during the period beginning July 1, 1997, and ending on June 30 of the preceding year; divided by

(ii) the actual expenditures for physicians' services for the 12-month period ending on June 30 of the preceding year, increased by the sustainable growth rate under subsection (f) for the fiscal year which begins during such 12-month period.

(C) *DETERMINATION OF ALLOWED EXPENDITURES.*—For purposes of this paragraph, the allowed expenditures for physicians' services for the 12-month period ending with June 30 of—

(i) 1997 is equal to the actual expenditures for physicians' services furnished during such 12-month period, as estimated by the Secretary; or

(ii) a subsequent year is equal to the allowed expenditures for physicians' services for the previous year, increased by the sustainable growth rate under subsection (f) for the fiscal year which begins during such 12-month period.

(D) *RESTRICTION ON VARIATION FROM MEDICARE ECONOMIC INDEX.*—Notwithstanding the amount of the update adjustment factor determined under subparagraph (B) for

a year, the update in the conversion factor under this paragraph for the year may not be—

(i) greater than 100 times the following amount:
 $(1.03 + (MEI \text{ percentage}/100)) - 1$; or

(ii) less than 100 times the following amount: $(0.93 + (MEI \text{ percentage}/100)) - 1$,

where “MEI percentage means the Secretary’s estimate of the percentage increase in the MEI (as defined in section 1842(i)(3)) for the year involved.

* * * * *

(f) MEDICARE [VOLUME PERFORMANCE STANDARD RATES OF INCREASE] SUSTAINABLE GROWTH RATE.—

(1) PROCESS FOR ESTABLISHING MEDICARE [VOLUME PERFORMANCE STANDARD RATES OF INCREASE] SUSTAINABLE GROWTH RATE.—

[(A) SECRETARY’S RECOMMENDATION.—By not later than April 15 of each year (beginning with 1990), the Secretary shall transmit to the Congress a recommendation on performance standard rates of increase for all physicians’ services and for each category of such services for the fiscal year beginning in such year. In making the recommendation, the Secretary shall confer with organizations representing physicians and shall consider—

[(i) inflation,

[(ii) changes in numbers of enrollees (other than HMO enrollees) under this part,

[(iii) changes in the age composition of enrollees (other than HMO enrollees) under this part,

[(iv) changes in technology,

[(v) evidence of inappropriate utilization of services,

[(vi) evidence of lack of access to necessary physicians’ services, and

[(vii) such other factors as the Secretary considers appropriate.

[(B) COMMISSION REVIEW.—The Physician Payment Review Commission shall review the recommendation transmitted during a year under subparagraph (A) and shall make its recommendation to Congress, by not later than May 15 of the year, respecting the performance standard rates of increase for the fiscal year beginning in that year.]

(C) PUBLICATION OF [PERFORMANCE STANDARD RATES OF INCREASE] SUSTAINABLE GROWTH RATE.—The Secretary shall cause to have published in the Federal Register, in the last 15 days of October of each year (beginning [with 1991], the performance standard rates of increase for all physicians’ services and for each category of physicians’ services for the fiscal year beginning in that year.] *with 1999*, the sustainable growth rate for the fiscal year beginning in that year. The Secretary shall cause to have published in the Federal Register, by not later than [January 1, 1990, the performance standard rate of increase under

subparagraph (D) for fiscal year 1990] *January 1, 1999, the sustainable growth rate for fiscal year 1999.*

* * * * *

[(2) SPECIFICATION OF PERFORMANCE STANDARD RATES OF INCREASE FOR SUBSEQUENT FISCAL YEARS.—

[(A) IN GENERAL.—Unless Congress otherwise provides, subject to paragraph (4), the performance standard rate of increase, for all physicians' services and for each category of physicians' services, for a fiscal year (beginning with fiscal year 1991) shall be equal to 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 or for the category of physicians' services, respectively), 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 or of the category of physicians' services, respectively, under this part for the 5-fiscal-year period ending with the preceding fiscal year (based upon information contained in the most recent annual report made pursuant to section 1841(b)(2)), and

[(iv) 1 plus the Secretary's estimate of the percentage increase or decrease (divided by 100) in expenditures for all physicians' services or of the category of physicians' services, respectively, in the fiscal year (compared with the preceding fiscal year) which will result from changes in law or regulations including changes in law and regulations affecting the percentage increase described in clause (i) and which 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 (B)). In clause (i), the term "fees" means, with respect to 1991, reasonable charges and, with respect to any succeeding year, fee schedule amounts.

[(B) PERFORMANCE STANDARD FACTOR.—For purposes of subparagraph (A), the performance standard factor—

[(i) for 1991 is 1 percentage point,

[(ii) for 1992 is 1½ percentage points,

[(iii) for 1993 is 2 percentage points,

[(iv) for 1994 is 3½ percentage points, and

[(v) for each succeeding year is 4 percentage points.

[(C) PERFORMANCE STANDARD RATES OF INCREASE FOR FISCAL YEAR 1991.—Notwithstanding subparagraph (A), the performance standard rate of increase for a category of

physicians' services for fiscal year 1991 shall be the sum of—

[(i) the Secretary's estimate of the percentage by which actual expenditures for the category of physicians' services under this part for fiscal year 1991 exceed actual expenditures for such category of services in fiscal year 1990 (determined without regard to the amendments made by the Omnibus Budget Reconciliation Act of 1990), and

[(ii) the Secretary's estimate of the percentage increase or decrease in expenditures for the category of services in fiscal year 1991 (compared with fiscal year 1990) that will result from changes in law and regulations (including the Omnibus Budget Reconciliation Act of 1990), reduced by 2 percentage points.

[(3) QUARTERLY REPORTING.—The Secretary shall establish procedures for providing, on a quarterly basis to the Physician Payment Review Commission, the Congressional Budget Office, the Congressional Research Service, the Committees on Ways and Means and Energy and Commerce of the House of Representatives, and the Committee on Finance of the Senate, information on compliance with performance standard rates of increase established under this subsection.

[(4) SEPARATE GROUP-SPECIFIC PERFORMANCE STANDARD RATES OF INCREASE.—

[(A) IMPLEMENTATION OF PLAN.—Subject to subparagraph (B), the Secretary shall, after completion of the study required under section 6102(e)(3) of the Omnibus Budget Reconciliation Act of 1989, but not before October 1, 1991, implement a plan under which qualified physician groups could elect annually separate performance standard rates of increase other than the performance standard rate of increase established for the year under paragraph (2) for such physicians. The Secretary shall develop criteria to determine which physician groups are eligible to elect to have applied to such groups separate performance standard rates of increase and the methods by which such group-specific performance standard rates of increase would be accomplished. The Secretary shall report to the Congress on the criteria and methods by April 15, 1991. The Physician Payment Review Commission shall review and comment on such recommendations by May 15, 1991. Before implementing group-specific performance standard rates of increase, the Secretary shall provide for notice and comment in the Federal Register and consult with organizations representing physicians.

[(B) APPROVAL.—The Secretary may not implement the plan described in subparagraph (A), unless specifically approved by law.

[(5) DEFINITIONS.—In this subsection:

[(A) SERVICES INCLUDED IN PHYSICIANS' SERVICES.—The term "physicians' services" includes other items and services (such as clinical diagnostic laboratory tests and radiology services), specified by the Secretary, that are com-

monly performed or furnished by a physician or in a physicians' office, but does not include services furnished to an HMO enrollee under a risk-sharing contract under section 1876.

[(B) HMO ENROLLEE.—The term “HMO enrollee” means, with respect to a fiscal year, an individual enrolled under this part who is enrolled with an entity under a risk-sharing contract under section 1876 in the fiscal year.]

(2) SPECIFICATION OF GROWTH RATE.—*The sustainable growth rate for all physicians' services for a fiscal year (beginning with fiscal year 1998) shall be equal to the product of—*

(A) *1 plus the Secretary's estimate of the weighted average percentage increase (divided by 100) in the fees for all physicians' services in the fiscal year involved,*

(B) *1 plus the Secretary's estimate of the percentage change (divided by 100) in the average number of individuals enrolled under this part (other than MedicarePlus plan enrollees) from the previous fiscal year to the fiscal year involved,*

(C) *1 plus the Secretary's estimate of the projected percentage growth in real gross domestic product per capita (divided by 100) from the previous fiscal year to the fiscal year involved, and*

(D) *1 plus the Secretary's estimate of the percentage change (divided by 100) in expenditures for all physicians' services in the fiscal year (compared with the previous fiscal year) which will result from changes in law and regulations, determined without taking into account estimated changes in expenditures due to changes in the volume and intensity of physicians' services resulting from changes in the update to the conversion factor under subsection (d)(3), minus 1 and multiplied by 100.*

(3) DEFINITIONS.—*In this subsection:*

(A) SERVICES INCLUDED IN PHYSICIANS' SERVICES.—*The term “physicians' services includes other items and services (such as clinical diagnostic laboratory tests and radiology services), specified by the Secretary, that are commonly performed or furnished by a physician or in a physicians' office, but does not include services furnished to a MedicarePlus plan enrollee.*

(B) MEDICAREPLUS PLAN ENROLLEE.—*The term “MedicarePlus plan enrollee” means, with respect to a fiscal year, an individual enrolled under this part who has elected to receive benefits under this title for the fiscal year through a MedicarePlus plan offered under part C, and also includes an individual who is receiving benefits under this part through enrollment with an eligible organization with a risk-sharing contract under section 1876.*

(g) LIMITATION ON BENEFICIARY LIABILITY.—

(1) * * *

* * * * *

(6) MONITORING OF CHARGES.—

(A) * * *

* * * * *

(C) PLAN.—If the Secretary finds that there has been a significant decrease in the proportions described in subclauses (I) and (II) of subparagraph (A)(ii) or an increase in the amounts described in subclause (III) of that subparagraph, the Secretary shall develop a plan to address such a problem and transmit to Congress recommendations regarding the plan. The [Physician Payment Review Commission] Medicare Payment Advisory Commission shall review the Secretary’s plan and recommendations and transmit to Congress its comments regarding such plan and recommendations.

(7) MONITORING OF UTILIZATION AND ACCESS.—

(A) * * *

* * * * *

(C) RECOMMENDATIONS.—The Secretary shall include in each annual report under subparagraph (B) recommendations—

- (i) addressing any identified patterns of inappropriate utilization,
- (ii) on utilization review,
- (iii) on physician education or patient education,
- (iv) addressing any problems of beneficiary access to care made evident by the monitoring process, and
- (v) on such other matters as the Secretary deems appropriate.

The [Physician Payment Review Commission] Medicare Payment Advisory Commission shall comment on the Secretary’s recommendations and in developing its comments, the Commission shall convene and consult a panel of physician experts to evaluate the implications of medical utilization patterns for the quality of and access to patient care.

* * * * *

(i) MISCELLANEOUS PROVISIONS.—

(1) RESTRICTION ON ADMINISTRATIVE AND JUDICIAL REVIEW.—There shall be no administrative or judicial review under section 1869 or otherwise of—

(A) * * *

* * * * *

(C) the determination of [conversion factors] the conversion factor under subsection (d),

* * * * *

(j) DEFINITIONS.—In this section:

(1) CATEGORY.—The term “category” means, with respect to physicians’ services, surgical services (as defined by the Secretary [and including anesthesia services]), primary care services (as defined in section 1842(i)(4)), and all other physicians’ services. The Secretary shall define surgical services and publish such definitions in the Federal Register no later than May

1, 1990, after consultation with organizations representing physicians (*including anesthesia services*).

* * * * *

(3) PHYSICIANS' SERVICES.—The term “physicians’ services” includes items and services described in paragraphs (1),(2)(A), (2)(D), (2)(G), (2)(P) (*with respect to services described in subparagraphs (A) and (C) of section 1861(o), (2)(S), (3), [and (4)], (4), (14) (with respect to services described in section 1861(nn)(2)) and (15) of section 1861(s) (other than clinical diagnostic laboratory tests and, except for purposes of subsections (a)(3), (g), and (h) such other items and services as the Secretary may specify).*

* * * * *

PART C—MEDICAREPLUS PROGRAM

ELIGIBILITY, ELECTION, AND ENROLLMENT

SEC. 1851. (a) CHOICE OF MEDICARE BENEFITS THROUGH MEDICAREPLUS PLANS.—

(1) IN GENERAL.—Subject to the provisions of this section, each MedicarePlus eligible individual (as defined in paragraph (3)) is entitled to elect to receive benefits under this title—

(A) through the medicare fee-for-service program under parts A and B, or

(B) through enrollment in a MedicarePlus plan under this part.

(2) TYPES OF MEDICAREPLUS PLANS THAT MAY BE AVAILABLE.—A MedicarePlus plan may be any of the following types of plans of health insurance:

(A) COORDINATED CARE PLANS.—Coordinated care plans which provide health care services, including health maintenance organization plans and preferred provider organization plans.

(B) PLANS OFFERED BY PROVIDER-SPONSORED ORGANIZATION.—A MedicarePlus plan offered by a provider-sponsored organization, as defined in section 1855(e).

(C) COMBINATION OF MSA PLAN AND CONTRIBUTIONS TO MEDICAREPLUS MSA.—An MSA plan, as defined in section 1859(b)(2), and a contribution into a MedicarePlus medical savings account (MSA).

(3) MEDICAREPLUS ELIGIBLE INDIVIDUAL.—

(A) IN GENERAL.—In this title, subject to subparagraph (B), the term “MedicarePlus eligible individual” means an individual who is entitled to benefits under part A and enrolled under part B.

(B) SPECIAL RULE FOR END-STAGE RENAL DISEASE.—Such term shall not include an individual medically determined to have end-stage renal disease, except that an individual who develops end-stage renal disease while enrolled in a MedicarePlus plan may continue to be enrolled in that plan.

(b) SPECIAL RULES.—

(1) RESIDENCE REQUIREMENT.—

(A) *IN GENERAL.*—Except as the Secretary may otherwise provide, an individual is eligible to elect a MedicarePlus plan offered by a MedicarePlus organization only if the organization serves the geographic area in which the individual resides.

(B) *CONTINUATION OF ENROLLMENT PERMITTED.*—Pursuant to rules specified by the Secretary, the Secretary shall provide that an individual may continue enrollment in a plan, notwithstanding that the individual no longer resides in the service area of the plan, so long as the plan provides benefits for enrollees located in the area in which the individual resides.

(2) *SPECIAL RULE FOR CERTAIN INDIVIDUALS COVERED UNDER FEHBP OR ELIGIBLE FOR VETERANS OR MILITARY HEALTH BENEFITS, VETERANS.*—

(A) *FEHBP.*—An individual who is enrolled in a health benefit plan under chapter 89 of title 5, United States Code, is not eligible to enroll in an MSA plan until such time as the Director of the Office of Management and Budget certifies to the Secretary that the Office of Personnel Management has adopted policies which will ensure that the enrollment of such individuals in such plans will not result in increased expenditures for the Federal Government for health benefit plans under such chapter.

(B) *VA AND DOD.*—The Secretary may apply rules similar to the rules described in subparagraph (A) in the case of individuals who are eligible for health care benefits under chapter 55 of title 10, United States Code, or under chapter 17 of title 38 of such Code.

(3) *LIMITATION ON ELIGIBILITY OF QUALIFIED MEDICARE BENEFICIARIES AND OTHER MEDICAID BENEFICIARIES TO ENROLL IN AN MSA PLAN.*—An individual who is a qualified medicare beneficiary (as defined in section 1905(p)(1)), a qualified disabled and working individual (described in section 1905(s)), an individual described in section 1902(a)(10)(E)(iii), or otherwise entitled to medicare cost-sharing under a State plan under title XIX is not eligible to enroll in an MSA plan.

(4) *COVERAGE UNDER MSA PLANS ON A DEMONSTRATION BASIS.*—

(A) *IN GENERAL.*—An individual is not eligible to enroll in an MSA plan under this part—

(i) on or after January 1, 2003, unless the enrollment is the continuation of such an enrollment in effect as of such date; or

(ii) as of any date if the number of such individuals so enrolled as of such date has reached 500,000. Under rules established by the Secretary, an individual is not eligible to enroll (or continue enrollment) in an MSA plan for a year unless the individual provides assurances satisfactory to the Secretary that the individual will reside in the United States for at least 183 days during the year.

(B) *EVALUATION.*—The Secretary shall regularly evaluate the impact of permitting enrollment in MSA plans under

this part on selection (including adverse selection), use of preventive care, access to care, and the financial status of the Trust Funds under this title.

(C) REPORTS.—The Secretary shall submit to Congress periodic reports on the numbers of individuals enrolled in such plans and on the evaluation being conducted under subparagraph (B). The Secretary shall submit such a report, by not later than March 1, 2002, on whether the time limitation under subparagraph (A)(i) should be extended or removed and whether to change the numerical limitation under subparagraph (A)(ii).

(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) COORDINATION THROUGH MEDICAREPLUS ORGANIZATIONS.—

(A) ENROLLMENT.—Such process shall permit an individual who wishes to elect a MedicarePlus plan offered by a MedicarePlus 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 MedicarePlus plan offered by a MedicarePlus organization and who wishes to terminate such election, to terminate such election through the filing of an appropriate election form with the organization.

(3) 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 medicare fee-for-service program option.

(ii) SEAMLESS CONTINUATION OF COVERAGE.—The Secretary may establish procedures under which an individual who is enrolled in a health plan (other than MedicarePlus plan) offered by a MedicarePlus organization at the time of the initial election period and who fails to elect to receive coverage other than through the organization is deemed to have elected the MedicarePlus plan offered by the organization (or, if the organization offers more than one such plan, such plan or plans as the Secretary identifies under such procedures).

(B) CONTINUING PERIODS.—An individual who has made (or is 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 MedicarePlus plan is discontinued, if the individual had elected such plan at the time of the discontinuation.

(d) PROVIDING INFORMATION TO PROMOTE INFORMED CHOICE.—

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

(2) PROVISION OF NOTICE.—

(A) OPEN SEASON NOTIFICATION.—At least 30 days before the beginning of each annual, coordinated election period (as defined in subsection (e)(3)(B)), the Secretary shall mail to each MedicarePlus eligible individual residing in an area the following:

(i) GENERAL INFORMATION.—The general information described in paragraph (3).

(ii) LIST OF PLANS AND COMPARISON OF PLAN OPTIONS.—A list identifying the MedicarePlus plans that are (or will be) available to residents of the area and information described in paragraph (4) concerning such plans. Such information shall be presented in a comparative form.

(iii) MEDICAREPLUS MONTHLY CAPITATION RATE.—The amount of the monthly MedicarePlus capitation rate for the area.

(iv) ADDITIONAL INFORMATION.—Any other information that the Secretary determines will assist the individual in making the election under this section.

The mailing of such information shall be coordinated with the mailing of any annual notice under section 1804.

(B) NOTIFICATION TO NEWLY MEDICAREPLUS ELIGIBLE INDIVIDUALS.—To the extent practicable, the Secretary shall, not later than 2 months before the beginning of the initial MedicarePlus enrollment period for an individual described in subsection (e)(1)(A), mail to the individual the information described in subparagraph (A).

(C) FORM.—The information disseminated under this paragraph shall be written and formatted using language that is easily understandable by medicare beneficiaries.

(D) PERIODIC UPDATING.—The information described in subparagraph (A) shall be updated on at least an annual basis to reflect changes in the availability of MedicarePlus plans and the benefits and monthly premiums (and net monthly premiums) for such plans.

(3) GENERAL INFORMATION.—General information under this paragraph, with respect to coverage under this part during a year, shall include the following:

(A) BENEFITS UNDER FEE-FOR-SERVICE PROGRAM OPTION.—A general description of the benefits covered (and not covered) under the medicare fee-for-service program under parts A and B, including—

(i) covered items and services,

(ii) beneficiary cost sharing, such as deductibles, co-insurance, and copayment amounts, and

(iii) any beneficiary liability for balance billing.

(B) *PART B PREMIUM.*—The part B premium rates that will be charged for part B coverage.

(C) *ELECTION PROCEDURES.*—Information and instructions on how to exercise election options under this section.

(D) *RIGHTS.*—The general description of procedural rights (including grievance and appeals procedures) of beneficiaries under the medicare fee-for-service program and the MedicarePlus program and right to be protected against discrimination based on health status-related factors under section 1852(b).

(E) *INFORMATION ON MEDIGAP AND MEDICARE SELECT.*—A general description of the benefits, enrollment rights, and other requirements applicable to medicare supplemental policies under section 1882 and provisions relating to medicare select policies described in section 1882(t).

(F) *POTENTIAL FOR CONTRACT TERMINATION.*—The fact that a MedicarePlus organization may terminate or refuse to renew its contract under this part and the effect the termination or nonrenewal of its contract may have on individuals enrolled with the MedicarePlus plan under this part.

(4) *INFORMATION COMPARING PLAN OPTIONS.*—Information under this paragraph, with respect to a MedicarePlus plan for a year, shall include the following:

(A) *BENEFITS.*—The benefits covered (and not covered) under the plan, including—

(i) covered items and services beyond those provided under the medicare fee-for-service program,

(ii) any beneficiary cost sharing,

(iii) any maximum limitations on out-of-pocket expenses, and

(iv) in the case of an MSA plan, differences in cost sharing under such a plan compared to under other MedicarePlus plans.

(B) *PREMIUMS.*—The monthly premium (and net monthly premium), if any, for the plan.

(C) *SERVICE AREA.*—The service area of the plan.

(D) *QUALITY AND PERFORMANCE.*—To the extent available, plan quality and performance indicators for the benefits under the plan (and how they compare to such indicators under the medicare fee-for-service program under parts A and B in the area involved), including—

(i) disenrollment rates for medicare enrollees electing to receive benefits through the plan for the previous 2 years (excluding disenrollment due to death or moving outside the plans service area),

(ii) information on medicare enrollee satisfaction,

(iii) information on health outcomes, and

(iv) the recent record regarding compliance of the plan with requirements of this part (as determined by the Secretary).

(E) *SUPPLEMENTAL COVERAGE OPTIONS.*—Whether the organization offering the plan offers optional supplemental coverage and the terms and conditions (including premiums) for such coverage.

(5) *MAINTAINING A TOLL-FREE NUMBER AND INTERNET SITE.*—The Secretary shall maintain a toll-free number for inquiries regarding MedicarePlus options and the operation of this part in all areas in which MedicarePlus plans are offered and an Internet site through which individuals may electronically obtain information on such options and MedicarePlus plans.

(6) *USE OF NONFEDERAL ENTITIES.*—The Secretary may enter into contracts with non-Federal entities to carry out activities under this subsection.

(7) *PROVISION OF INFORMATION.*—A MedicarePlus organization shall provide the Secretary with such information on the organization and each MedicarePlus plan it offers as may be required for the preparation of the information referred to in paragraph (2)(A).

(e) *COVERAGE ELECTION PERIODS.*—

(1) *INITIAL CHOICE UPON ELIGIBILITY TO MAKE ELECTION IF MEDICAREPLUS PLANS AVAILABLE TO INDIVIDUAL.*—If, at the time an individual first becomes entitled to benefits under part A and enrolled under part B, there is one or more MedicarePlus plans offered in the area in which the individual resides, 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 such time. Such period shall be specified in a manner so that, in the case of an individual who elects a MedicarePlus plan during the period, coverage under the plan becomes effective as of the first date on which the individual may receive such coverage.

(2) *OPEN ENROLLMENT AND DISENROLLMENT OPPORTUNITIES.*—Subject to paragraph (5)—

(A) *CONTINUOUS OPEN ENROLLMENT AND DISENROLLMENT THROUGH 2000.*—At any time during 1998, 1999, and 2000, a MedicarePlus eligible individual may change the election under subsection (a)(1).

(B) *CONTINUOUS OPEN ENROLLMENT AND DISENROLLMENT FOR FIRST 6 MONTHS DURING 2001.*—

(i) *IN GENERAL.*—Subject to clause (ii), at any time during the first 6 months of 2001, or, if the individual first becomes a MedicarePlus eligible individual during 2001, during the first 6 months during 2001 in which the individual is a MedicarePlus eligible individual, a MedicarePlus eligible individual may change the election under subsection (a)(1).

(ii) *LIMITATION OF ONE CHANGE PER YEAR.*—An individual may exercise the right under clause (i) only once during 2001. The limitation under this clause shall not apply to changes in elections effected during an annual, coordinated election period under paragraph (3) or during a special enrollment period under paragraph (4).

(C) CONTINUOUS OPEN ENROLLMENT AND DISENROLLMENT FOR FIRST 3 MONTHS IN SUBSEQUENT YEARS.—

(i) *IN GENERAL.*—Subject to clause (ii), at any time during the first 3 months of a year after 2001, or, if the individual first becomes a MedicarePlus eligible individual during a year after 2001, during the first 3 months of such year in which the individual is a MedicarePlus eligible individual, a MedicarePlus eligible individual may change the election under subsection (a)(1).

(ii) *LIMITATION OF ONE CHANGE PER YEAR.*—An individual may exercise the right under clause (i) only once a year. The limitation under this clause shall not apply to changes in elections effected during an annual, coordinated election period under paragraph (3) or during a special enrollment period under paragraph (4).

(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 an annual, coordinated election period.

(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 2001), the month of October before such year.

(C) *MEDICAREPLUS HEALTH FAIRS.*—In the month of October of each year (beginning with 1998), the Secretary shall provide for a nationally coordinated educational and publicity campaign to inform MedicarePlus eligible individuals about MedicarePlus plans and the election process provided under this section.

(4) *SPECIAL ELECTION PERIODS.*—Effective as of January 1, 2001, an individual may discontinue an election of a MedicarePlus plan offered by a MedicarePlus organization other than during an annual, coordinated election period and make a new election under this section if—

(A) the organization’s or plan’s certification under this part has been terminated or the organization has terminated or otherwise discontinued providing the plan;

(B) the individual is no longer eligible to elect the plan 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 the individual’s enrollment on the basis described in clause (i) or (ii) subsection (g)(3)(B));

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

(i) the organization offering the plan substantially violated a material provision of the organization’s contract under this part in relation to the individual (including the failure to provide an enrollee on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide such

covered care in accordance with applicable quality standards); or

(ii) the organization (or an agent or other entity acting on the organizations behalf) materially misrepresented the plans provisions in marketing the plan to the individual; or

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

(5) *SPECIAL RULES FOR MSA PLANS.*—Notwithstanding the preceding provisions of this subsection, an individual—

(A) may elect an MSA plan only during—

(i) an initial open enrollment period described in paragraph (1),

(ii) an annual, coordinated election period described in paragraph (3)(B), or

(iii) the months of October 1998 and October 1999; and

(B) may not discontinue an election of an MSA plan except during the periods described in clause (ii) or (iii) of subparagraph (A) and under paragraph (4).

(f) *EFFECTIVENESS OF ELECTIONS AND CHANGES OF ELECTIONS.*—

(1) *DURING INITIAL COVERAGE ELECTION PERIOD.*—An election of coverage made during the initial coverage election period under subsection (e)(1) 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 CONTINUOUS OPEN ENROLLMENT PERIODS.*—An election or change of coverage made under subsection (e)(2) shall take effect with the first day of the first calendar month following the date on which the election is made.

(3) *ANNUAL, COORDINATED ELECTION PERIOD.*—An election or change 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 or change of coverage made during any other period under subsection (e)(4) 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) *GUARANTEED ISSUE AND RENEWAL.*—

(1) *IN GENERAL.*—Except as provided in this subsection, a MedicarePlus organization shall provide that at any time during which elections are accepted under this section with respect to a MedicarePlus plan 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 MedicarePlus organization, in relation to a MedicarePlus plan it offers, has a capacity limit and the number of MedicarePlus eligible individuals who elect the plan under this section exceeds the capacity limit, the organization may limit the election of individuals of the plan under this section but only if priority in election is provided—

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

(B) then to other such individuals in such a manner that does not discriminate, on a basis described in section 1852(b), among the individuals (who seek to elect the plan). The preceding sentence shall not apply if it would result in the enrollment of enrollees substantially nonrepresentative, as determined in accordance with regulations of the Secretary, of the medicare population in the service area of the plan.

(3) LIMITATION ON TERMINATION OF ELECTION.—

(A) IN GENERAL.—Subject to subparagraph (B), a MedicarePlus organization may not for any reason terminate the election of any individual under this section for a MedicarePlus plan it offers.

(B) BASIS FOR TERMINATION OF ELECTION.—A MedicarePlus organization may terminate an individuals election under this section with respect to a MedicarePlus plan it offers if—

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

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

(iii) the plan is terminated with respect to all individuals under this part in the area in which the individual resides.

(C) CONSEQUENCE OF TERMINATION.—

(i) TERMINATIONS FOR CAUSE.—Any individual whose election is terminated under clause (i) or (ii) of subparagraph (B) is deemed to have elected the medicare fee-for-service program option described in subsection (a)(1)(A).

(ii) TERMINATION BASED ON PLAN TERMINATION OR SERVICE AREA REDUCTION.—Any individual whose election is terminated under subparagraph (B)(iii) shall have a special election period under subsection (e)(4)(A) in which to change coverage to coverage under another MedicarePlus plan. Such an individual who fails to make an election during such period is deemed to have chosen to change coverage to the medicare fee-for-service program option described in subsection (a)(1)(A).

(C) ORGANIZATION OBLIGATION WITH RESPECT TO ELECTION FORMS.—Pursuant to a contract under section 1857, each MedicarePlus organization receiving an election form under subsection (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.

(h) APPROVAL OF MARKETING MATERIAL AND APPLICATION FORMS.—

(1) *SUBMISSION.*—No marketing material may be distributed by a MedicarePlus organization to (or for the use of) MedicarePlus eligible individuals 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 or form.

(2) *REVIEW.*—The standards established under section 1856 shall include guidelines for the review of all such material or form submitted and under such guidelines the Secretary shall disapprove (or later require the correction of) such material or form 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 or form 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 or form under paragraph (1)(B) with respect to a MedicarePlus plan in an area, the Secretary is deemed not to have disapproved such distribution in all other areas covered by the plan and organization except to the extent that such material or form is specific only to an area involved.

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

(i) *EFFECT OF ELECTION OF MEDICAREPLUS PLAN OPTION.*—Subject to sections 1852(a)(5), 1857(f)(2), and 1857(g)—

(1) payments under a contract with a MedicarePlus organization under section 1853(a) with respect to an individual electing a MedicarePlus plan offered by the organization 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, and

(2) subject to subsections (e) and (f) of section 1853, only the MedicarePlus organization shall be entitled to receive payments from the Secretary under this title for services furnished to the individual.

BENEFITS AND BENEFICIARY PROTECTIONS

SEC. 1852. (a) *BASIC BENEFITS.*—

(1) *IN GENERAL.*—Except as provided in section 1859(b)(2) for MSA plans, each MedicarePlus plan shall provide to members enrolled under this part, through providers and other persons that meet the applicable requirements of this title and part A of title XI—

(A) those items and services for which benefits are available under parts A and B to individuals residing in the area served by the plan, and

(B) additional benefits required under section 1854(f)(1)(A).

(2) **SATISFACTION OF REQUIREMENT.**—A MedicarePlus plan (other than an MSA plan) offered by a MedicarePlus organization satisfies paragraph (1)(A), with respect to benefits for items and services furnished other than through a provider that has a contract with the organization offering the plan, if the plan provides (in addition to any cost sharing provided for under the plan) for at least the total dollar amount of payment for such items and services as would otherwise be authorized under parts A and B (including any balance billing permitted under such parts).

(3) **SUPPLEMENTAL BENEFITS.**—

(A) **BENEFITS INCLUDED SUBJECT TO SECRETARY'S APPROVAL.**—Each MedicarePlus organization may provide to individuals enrolled under this part, other than under an MSA plan, (without affording those individuals an option to decline the coverage) supplemental health care benefits that the Secretary may approve. The Secretary shall approve any such supplemental benefits unless the Secretary determines that including such supplemental benefits would substantially discourage enrollment by MedicarePlus eligible individuals with the organization.

(B) **AT ENROLLEES' OPTION.**—A MedicarePlus organization may provide to individuals enrolled under this part, other than under an MSA plan, supplemental health care benefits that the individuals may elect, at their option, to have covered.

(4) **ORGANIZATION AS SECONDARY PAYER.**—Notwithstanding any other provision of law, a MedicarePlus organization may (in the case of the provision of items and services to an individual under a MedicarePlus plan 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 a law, plan, 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.

(5) **NATIONAL COVERAGE DETERMINATIONS.**—If there is a national coverage determination made in the period beginning on the date of an announcement under section 1853(b) and ending on the date of the next announcement under such section and the Secretary projects that the determination will result in a significant change in the costs to a MedicarePlus organization of providing the benefits that are the subject of such national coverage determination and that such change in costs was not incorporated in the determination of the annual MedicarePlus

capitation rate under section 1853 included in the announcement made at the beginning of such period—

(A) such determination shall not apply to contracts under this part until the first contract year that begins after the end of such period, and

(B) if such coverage determination provides for coverage of additional benefits or coverage under additional circumstances, section 1851(i) shall not apply to payment for such additional benefits or benefits provided under such additional circumstances until the first contract year that begins after the end of such period,

unless otherwise required by law.

(b) **ANTIDISCRIMINATION.**—

(1) **IN GENERAL.**—A MedicarePlus organization may not deny, limit, or condition the coverage or provision of benefits under this part, for individuals permitted to be enrolled with the organization under this part, based on any health status-related factor described in section 2702(a)(1) of the Public Health Service Act.

(2) **CONSTRUCTION.**—Paragraph (1) shall not be construed as requiring a MedicarePlus organization to enroll individuals who are determined to have end-stage renal disease, except as provided under section 1851(a)(3)(B).

(c) **DETAILED DESCRIPTION OF PLAN PROVISIONS.**—A MedicarePlus organization shall disclose, in clear, accurate, and standardized form to each enrollee with a MedicarePlus plan offered by the organization under this part at the time of enrollment and at least annually thereafter, the following information regarding such plan:

(1) **SERVICE AREA.**—The plans service area.

(2) **BENEFITS.**—Benefits offered (and not offered) under the plan offered, including information described in section 1851(d)(3)(A) and exclusions from coverage and, if it is an MSA plan, a comparison of benefits under such a plan with benefits under other MedicarePlus plans.

(3) **ACCESS.**—The number, mix, and distribution of plan providers.

(4) **OUT-OF-AREA COVERAGE.**—Out-of-area coverage provided by the plan.

(5) **EMERGENCY COVERAGE.**—Coverage of emergency services and urgently needed care, including—

(A) the appropriate use of emergency services, including use of the 911 telephone system or its local equivalent in emergency situations and an explanation of what constitutes an emergency situation;

(B) the process and procedures of the plan for obtaining emergency services; and

(C) the locations of (i) emergency departments, and (ii) other settings, in which plan physicians and hospitals provide emergency services and post-stabilization care..

(6) **SUPPLEMENTAL BENEFITS.**—Supplemental benefits available from the organization offering the plan, including—

(A) whether the supplemental benefits are optional,

(B) the supplemental benefits covered, and

(C) the premium price for the supplemental benefits.

(7) *PRIOR AUTHORIZATION RULES.*—Rules regarding prior authorization or other review requirements that could result in nonpayment.

(8) *PLAN GRIEVANCE AND APPEALS PROCEDURES.*—Any appeal or grievance rights and procedures.

(9) *QUALITY ASSURANCE PROGRAM.*—A description of the organizations quality assurance program under subsection (e).

(d) *ACCESS TO SERVICES.*—

(1) *IN GENERAL.*—A MedicarePlus organization offering a MedicarePlus plan may select the providers from whom the benefits under the plan are provided so long as—

(A) the organization makes such benefits available and accessible to each individual electing the plan within the plan 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 plan 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 it was not reasonable given the circumstances to obtain the services through the organization,

(ii) the services were renal dialysis services and were provided other than through the organization because the individual was temporarily out of the plans service area, or

(iii) the services are maintenance care or post-stabilization care covered under the guidelines established under paragraph (2);

(D) the organization provides access to appropriate providers, including credentialed specialists, for medically necessary treatment and services; and

(E) coverage is provided for emergency services (as defined in paragraph (3)) without regard to prior authorization or the emergency care providers contractual relationship with the organization.

(2) *GUIDELINES RESPECTING COORDINATION OF POST-STABILIZATION CARE.*—A MedicarePlus plan shall comply with such guidelines as the Secretary may prescribe relating to promoting efficient and timely coordination of appropriate maintenance and post-stabilization care of an enrollee after the enrollee has been determined to be stable under section 1867.

(3) *DEFINITION OF EMERGENCY SERVICES.*—In this subsection—

(A) *IN GENERAL.*—The term “emergency services” means, with respect to an individual enrolled with an organization, covered inpatient and outpatient services that—

(i) are furnished by a provider that is qualified to furnish such services under this title, and

(ii) are needed to evaluate or stabilize an emergency medical condition (as defined in subparagraph (B)).

(B) **EMERGENCY MEDICAL CONDITION BASED ON PRUDENT LAYPERSON.**—The term “emergency medical condition” means a medical condition manifesting itself by acute symptoms of sufficient severity such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in—

(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,

(ii) serious impairment to bodily functions, or

(iii) serious dysfunction of any bodily organ or part.

(e) **QUALITY ASSURANCE PROGRAM.**—

(1) **IN GENERAL.**—Each MedicarePlus organization must have arrangements, consistent with any regulation, for an ongoing quality assurance program for health care services it provides to individuals enrolled with MedicarePlus plans of the organization.

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

(A) stress health outcomes and provide for the collection, analysis, and reporting of data (in accordance with a quality measurement system that the Secretary recognizes) that will permit measurement of outcomes and other indices of the quality of MedicarePlus plans and organizations;

(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) monitor and evaluate high volume and high risk services and the care of acute and chronic conditions;

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

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

(G) after identifying areas for improvement, establish or alter practice parameters;

(H) take action to improve quality and assesses the effectiveness of such action through systematic followup;

(I) make 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) be evaluated on an ongoing basis as to its effectiveness;

(K) include measures of consumer satisfaction; and

(L) provide the Secretary with such access to information collected as may be appropriate to monitor and ensure the quality of care provided under this part.

(3) *EXTERNAL REVIEW.*—Each MedicarePlus organization shall, for each MedicarePlus plan it operates, have an agreement with an independent quality review and improvement organization approved by the Secretary to perform functions of the type described in sections 1154(a)(4)(B) and 1154(a)(14) with respect to services furnished by MedicarePlus plans for which payment is made under this title.

(4) *TREATMENT OF ACCREDITATION.*—The Secretary shall provide that a MedicarePlus organization is deemed to meet requirements of paragraphs (1) through (3) of this subsection and subsection (h) (relating to confidentiality and accuracy of enrollee records) if the organization is accredited (and periodically reaccredited) by a private organization under a process that the Secretary has determined assures that the organization, as a condition of accreditation, applies and enforces standards with respect to the requirements involved that are no less stringent than the standards established under section 1856 to carry out the respective requirements.

(f) *COVERAGE DETERMINATIONS.*—

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

(2) *RECONSIDERATIONS.*—

(A) *IN GENERAL.*—Subject to subsection (g)(4), a reconsideration of a determination of an organization denying coverage shall be made within 30 days of the date of receipt of medical information, but not later than 60 days after the date of the determination.

(B) *PHYSICIAN DECISION ON CERTAIN RECONSIDERATIONS.*—A reconsideration relating to a determination to deny coverage based on a lack of medical necessity shall be made only by a physician other than a physician involved in the initial determination.

(g) *GRIEVANCES AND APPEALS.*—

(1) *GRIEVANCE MECHANISM.*—Each MedicarePlus 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 with MedicarePlus plans of the organization under this part.

(2) *APPEALS.*—An enrollee with a MedicarePlus plan of a MedicarePlus 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 paragraph, 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) *INDEPENDENT REVIEW OF CERTAIN COVERAGE DENIALS.*—The Secretary shall contract with an independent, outside entity to review and resolve reconsiderations that affirm denial of coverage.

(4) *EXPEDITED DETERMINATION AND RECONSIDERATION.*—

(A) *RECEIPT OF REQUESTS.*—An enrollee in a MedicarePlus plan may request, either in writing or orally, an expedited determination or reconsideration by the MedicarePlus organization regarding a matter described in paragraph (2). The organization shall also permit the acceptance of such requests by physicians.

(B) *ORGANIZATION PROCEDURES.*—

(i) *IN GENERAL.*—The MedicarePlus organization shall maintain procedures for expediting organization determinations and reconsiderations when, upon request of an enrollee, the organization determines that the application of normal time frames for making a determination (or a reconsideration involving a determination) could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

(ii) *TIMELY RESPONSE.*—In an urgent case described in clause (i), the organization shall notify the enrollee (and the physician involved, as appropriate) of the determination (or determination on the reconsideration) as expeditiously as the enrollee's health condition requires, but not later than 72 hours (or 24 hours in the case of a reconsideration) of the time of receipt of the request for the determination or reconsideration (or receipt of the information necessary to make the determination or reconsideration), or such longer period as the Secretary may permit in specified cases.

(h) *CONFIDENTIALITY AND ACCURACY OF ENROLLEE RECORDS.*—Each MedicarePlus organization shall establish procedures—

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

(2) to maintain accurate and timely medical records and other health information for enrollees, and

(3) to assure timely access of enrollees to their medical information.

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

(j) *RULES REGARDING PHYSICIAN PARTICIPATION.*—

(1) *PROCEDURES.*—Each MedicarePlus organization shall establish reasonable procedures relating to the participation (under an agreement between a physician and the organization) of physicians under MedicarePlus plans 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 such adverse decisions, including the presentation of information and views of the physician regarding such decision.

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

(3) *PROHIBITING INTERFERENCE WITH PROVIDER ADVICE TO ENROLLEES.*—

(A) *IN GENERAL.*—Subject to subparagraphs (B) and (C), a MedicarePlus organization (in relation to an individual enrolled under a MedicarePlus plan offered by the organization under this part) shall not prohibit or otherwise restrict a covered health care professional (as defined in subparagraph (D)) from advising such an individual who is a patient of the professional about the health status of the individual or medical care or treatment for the individual's condition or disease, regardless of whether benefits for such care or treatment are provided under the plan, if the professional is acting within the lawful scope of practice.

(B) *CONSCIENCE PROTECTION.*—Subparagraph (A) shall not be construed as requiring a MedicarePlus plan to provide, reimburse for, or provide coverage of a counseling or referral service if the MedicarePlus organization offering the plan—

(i) objects to the provision of such service on moral or religious grounds; and

(ii) in the manner and through the written instrumentalities such MedicarePlus organization deems appropriate, makes available information on its policies regarding such service to prospective enrollees before or during enrollment and to enrollees within 90 days after the date that the organization or plan adopts a change in policy regarding such a counseling or referral service.

(C) *CONSTRUCTION.*—Nothing in subparagraph (B) shall be construed to affect disclosure requirements under State law or under the Employee Retirement Income Security Act of 1974.

(D) *HEALTH CARE PROFESSIONAL DEFINED.*—For purposes of this paragraph, the term “health care professional” means a physician (as defined in section 1861(r)) or other health care professional if coverage for the professional's services is provided under the MedicarePlus plan for the

services of the professional. Such term includes a podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist and therapy assistant, speech-language pathologist, audiologist, registered or licensed practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified nurse-midwife), licensed certified social worker, registered respiratory therapist, and certified respiratory therapy technician.

(4) *LIMITATIONS ON PHYSICIAN INCENTIVE PLANS.—*

(A) *IN GENERAL.—*No MedicarePlus organization may 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 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 MedicarePlus 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.

(5) *LIMITATION ON PROVIDER INDEMNIFICATION.—*A MedicarePlus organization may not provide (directly or indirectly) for a provider (or group of providers) to indemnify the organization against any liability resulting from a civil action brought for any damage caused to an enrollee with a

MedicarePlus plan of the organization under this part by the organizations denial of medically necessary care.

(k) *TREATMENT OF SERVICES FURNISHED BY CERTAIN PROVIDERS.—A physician or other entity (other than a provider of services) that does not have a contract establishing payment amounts for services furnished to an individual enrolled under this part with a MedicarePlus organization (other than under an MSA plan) shall accept as payment in full for covered services under this title that are furnished to such an individual the amounts that the physician or other entity could collect if the individual were not so enrolled. Any penalty or other provision of law that applies to such a payment with respect to an individual entitled to benefits under this title (but not enrolled with a MedicarePlus organization under this part) also applies with respect to an individual so enrolled.*

(l) *DISCLOSURE OF USE OF DSH AND TEACHING HOSPITALS.—Each MedicarePlus organization shall provide the Secretary with information on—*

(1) *the extent to which the organization provides inpatient and outpatient hospital benefits under this part—*

(A) *through the use of hospitals that are eligible for additional payments under section 1886(d)(5)(F)(i) (relating to so-called DSH hospitals), or*

(B) *through the use of teaching hospitals that receive payments under section 1886(h); and*

(2) *the extent to which differences between payment rates to different hospitals reflect the disproportionate share percentage of low-income patients and the presence of medical residency training programs in those hospitals.*

PAYMENTS TO MEDICAREPLUS ORGANIZATIONS

SEC. 1853. (a) *PAYMENTS TO ORGANIZATIONS.—*

(1) *MONTHLY PAYMENTS.—*

(A) *IN GENERAL.—Under a contract under section 1857 and subject to subsections (e) and (f), the Secretary shall make monthly payments under this section in advance to each MedicarePlus organization, with respect to coverage of an individual under this part in a MedicarePlus payment area for a month, in an amount equal to $\frac{1}{12}$ of the annual MedicarePlus capitation rate (as calculated under subsection (c)) with respect to that individual for that area, adjusted for such risk factors as age, disability status, gender, institutional status, 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 factors, if such changes will improve the determination of actuarial equivalence.*

(B) *SPECIAL RULE FOR END-STAGE RENAL DISEASE.—The Secretary shall establish separate rates of payment to a MedicarePlus organization with respect to classes of individuals determined to have end-stage renal disease and enrolled in a MedicarePlus plan of the organization. Such rates of payment shall be actuarially equivalent to rates paid to other enrollees in the MedicarePlus payment area (or such other area as specified by the Secretary). In ac-*

cordance with regulations, the Secretary shall provide for the application of the seventh sentence of section 1881(b)(7) to payments under this section covering the provision of renal dialysis treatment in the same manner as such sentence applies to composite rate payments described in such sentence.

(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 MedicarePlus organization under a plan 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 information required to be disclosed under section 1852(c) at the time the individual enrolled with the organization.

(3) ESTABLISHMENT OF RISK ADJUSTMENT FACTORS.—

(A) REPORT.—The Secretary shall develop, and submit to Congress by not later than October 1, 1999, a report on a method of risk adjustment of payment rates under this section that accounts for variations in per capita costs based on health status. Such report shall include an evaluation of such method by an outside, independent actuary of the actuarial soundness of the proposal.

(B) DATA COLLECTION.—In order to carry out this paragraph, the Secretary shall require MedicarePlus organizations (and eligible organizations with risk-sharing contracts under section 1876) to submit, for periods beginning on or after January 1, 1998, data regarding inpatient hospital services and other services and other information the Secretary deems necessary.

(C) INITIAL IMPLEMENTATION.—The Secretary shall first provide for implementation of a risk adjustment methodology that accounts for variations in per capita costs based on health status and other demographic factors for payments by no later than January 1, 2000.

(b) ANNUAL ANNOUNCEMENT OF PAYMENT RATES.—

(1) *ANNUAL ANNOUNCEMENT.*—The Secretary shall annually determine, and shall announce (in a manner intended to provide notice to interested parties) not later than August 1 before the calendar year concerned—

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

(B) the risk and other factors to be used in adjusting such rates under subsection (a)(1)(A) for payments for months in that year.

(2) *ADVANCE NOTICE OF METHODOLOGICAL CHANGES.*—At least 45 days before making the announcement under paragraph (1) for a year, the Secretary shall provide for notice to MedicarePlus organizations of proposed changes to be made in the methodology from the methodology and assumptions used in the previous announcement and shall provide such organizations an opportunity to comment on such proposed changes.

(3) *EXPLANATION OF ASSUMPTIONS.*—In each announcement made under paragraph (1), the Secretary shall include an explanation of the assumptions and changes in methodology used in the announcement in sufficient detail so that MedicarePlus organizations can compute monthly adjusted MedicarePlus capitation rates for individuals in each MedicarePlus payment area which is in whole or in part within the service area of such an organization.

(c) *CALCULATION OF ANNUAL MEDICAREPLUS CAPITATION RATES.*—

(1) *IN GENERAL.*—For purposes of this part, each annual MedicarePlus capitation rate, for a MedicarePlus payment area for a contract year consisting of a calendar year, is equal to the largest of the amounts specified in the following subparagraphs (A), (B), or (C):

(A) *BLENDED CAPITATION RATE.*—The sum of—

(i) area-specific percentage for the year (as specified under paragraph (2) for the year) of the annual area-specific MedicarePlus capitation rate for the year for the MedicarePlus payment area, as determined under paragraph (3), and

(ii) national percentage (as specified under paragraph (2) for the year) of the input-price-adjusted annual national MedicarePlus capitation rate for the year, as determined under paragraph (4), multiplied by the payment adjustment factors described in subparagraphs (A) and (B) of paragraph (5).

(B) *MINIMUM AMOUNT.*—12 multiplied by the following amount:

(i) For 1998, \$350 (but not to exceed, in the case of an area outside the 50 States and the District of Columbia, 150 percent of the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) for the area).

(ii) For a succeeding year, the minimum amount specified in this clause (or clause (i)) for the preceding year increased by the national per capita MedicarePlus

growth percentage, specified under paragraph (6) for that succeeding year.

(C) *MINIMUM PERCENTAGE INCREASE.*—

(i) For 1998, 102 percent of the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) for the MedicarePlus payment area.

(ii) For a subsequent year, 102 percent of the annual MedicarePlus capitation rate under this paragraph for the area for the previous year.

(2) *AREA-SPECIFIC AND NATIONAL PERCENTAGES.*—For purposes of paragraph (1)(A)—

(A) for 1998, the “area-specific percentage” is 90 percent and the “national percentage” is 10 percent,

(B) for 1999, the “area-specific percentage” is 80 percent and the “national percentage” is 20 percent,

(C) for 2000, the “area-specific percentage” is 70 percent and the “national percentage” is 30 percent,

(D) for 2001, the “area-specific percentage” is 60 percent and the “national percentage” is 40 percent, and

(E) for a year after 2001, the “area-specific percentage” is 50 percent and the “national percentage” is 50 percent.

(3) *ANNUAL AREA-SPECIFIC MEDICAREPLUS CAPITATION RATE.*—For purposes of paragraph (1)(A), the annual area-specific MedicarePlus capitation rate for a MedicarePlus payment area—

(A) for 1998 is the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) for the area, increased by the national per capita MedicarePlus growth percentage for 1998 (as defined in paragraph (6)); or

(B) for a subsequent year is the annual area-specific MedicarePlus capitation rate for the previous year determined under this paragraph for the area, increased by the national per capita MedicarePlus growth percentage for such subsequent year.

(4) *INPUT-PRICE-ADJUSTED ANNUAL NATIONAL MEDICAREPLUS CAPITATION RATE.*—

(A) *IN GENERAL.*—For purposes of paragraph (1)(A), the input-price-adjusted annual national MedicarePlus capitation rate for a MedicarePlus 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 service) of—

(i) the national standardized annual MedicarePlus 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 ANNUAL MEDICAREPLUS CAPITATION RATE.—In subparagraph (A)(i), the “national standardized annual MedicarePlus capitation rate” for a year is equal to—

(i) the sum (for all MedicarePlus payment areas) of the product of—

(I) the annual area-specific MedicarePlus capitation rate for that year for the area under paragraph (3), and

(II) the average number of medicare beneficiaries residing in that area in the year, multiplied by the average of the risk factor weights used to adjust payments under subsection (a)(1)(A) for such beneficiaries in such area; divided by

(ii) the sum of the products described in clause (i)(II) for all areas for that year.

(C) SPECIAL RULES FOR 1998.—In applying this paragraph for 1998—

(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)—

(I) for part A services shall be the ratio (expressed as a percentage) of the national average annual per capita rate of payment for part A for 1997 to the total national average annual per capita rate of payment for parts A and B for 1997, and

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

(iii) for 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, 40 percent shall be adjusted by the index described in clause (iii); and

(v) the index values shall be computed based only on the beneficiary population who are 65 years of age or older and who are not determined to have end stage renal disease.

The Secretary may continue to apply the rules described in this subparagraph (or similar rules) for 1999.

(5) PAYMENT ADJUSTMENT BUDGET NEUTRALITY FACTORS.—For purposes of paragraph (1)(A)—

(A) *BLENDED RATE PAYMENT ADJUSTMENT FACTOR.*—For each year, the Secretary shall compute a blended rate payment adjustment factor such that, not taking into account subparagraphs (B) and (C) of paragraph (1) and the application of the payment adjustment factor described in subparagraph (B), the aggregate of the payments that would be made under this part is equal to the aggregate payments that would have been made under this part (not taking into account such subparagraphs and such other adjustment factor) if the area-specific percentage under paragraph (1) for the year had been 100 percent and the national percentage had been 0 percent.

(B) *FLOOR-AND-MINIMUM-UPDATE PAYMENT ADJUSTMENT FACTOR.*—For each year, the Secretary shall compute a floor-and-minimum-update payment adjustment factor so that, taking into account the application of the blended rate payment adjustment factor under subparagraph (A) and subparagraphs (B) and (C) of paragraph (1) and the application of the adjustment factor under this subparagraph, the aggregate of the payments under this part shall not exceed the aggregate payments that would have been made under this part if subparagraphs (B) and (C) of paragraph (1) did not apply and if the floor-and-minimum-update payment adjustment factor under this subparagraph was 1.

(6) *NATIONAL PER CAPITA MEDICAREPLUS GROWTH PERCENTAGE DEFINED.*—

(A) *IN GENERAL.*—In this part, the “national per capita MedicarePlus growth percentage for a year is the percentage determined by the Secretary, by April 30th before the beginning of the year involved, to reflect the Secretary’s estimate of the projected per capita rate of growth in expenditures under this title for an individual entitled to benefits under part A and enrolled under part B, reduced by the number of percentage points specified in subparagraph (B) for the year. Separate determinations may be made for aged enrollees, disabled enrollees, and enrollees with end-stage renal disease. Such percentage shall include an adjustment for over or under projection in the growth percentage for previous years.

(B) *ADJUSTMENT.*—The number of percentage points specified in this subparagraph is—

- (i) for 1998, 0.5 percentage points,
- (ii) for 1999, 0.5 percentage points,
- (iii) for 2000, 0.5 percentage points,
- (iv) for 2001, 0.5 percentage points,
- (v) for 2002, 0.5 percentage points, and
- (vi) for a year after 2002, 0 percentage points.

(d) *MEDICAREPLUS PAYMENT AREA DEFINED.*—

(1) *IN GENERAL.*—In this part, except as provided in paragraph (3), the term “MedicarePlus payment area” means a county, or equivalent area specified by the Secretary.

(2) *RULE FOR ESRD BENEFICIARIES.*—In the case of individuals who are determined to have end stage renal disease, the

MedicarePlus payment area shall be a State or such other payment area as the Secretary specifies.

(3) GEOGRAPHIC ADJUSTMENT.—

(A) IN GENERAL.—*Upon written request of the chief executive officer of a State for a contract year (beginning after 1998) made at least 7 months before the beginning of the year, the Secretary shall make a geographic adjustment to a MedicarePlus payment area in the State otherwise determined under paragraph (1)—*

- (i) to a single statewide MedicarePlus payment area,*
- (ii) to the metropolitan based system described in subparagraph (C), or*
- (iii) to consolidating into a single MedicarePlus payment area noncontiguous counties (or equivalent areas described in paragraph (1)) within a State.*

Such adjustment shall be effective for payments for months beginning with January of the year following the year in which the request is received.

(B) BUDGET NEUTRALITY ADJUSTMENT.—*In the case of a State requesting an adjustment under this paragraph, the Secretary shall adjust the payment rates otherwise established under this section for MedicarePlus payment areas in the State in a manner so that the aggregate of the payments under this section in the State shall not exceed the aggregate payments that would have been made under this section for MedicarePlus payment areas in the State in the absence of the adjustment under this paragraph.*

(C) METROPOLITAN BASED SYSTEM.—*The metropolitan based system described in this subparagraph is one in which—*

- (i) all the portions of each metropolitan statistical area in the State or in the case of a consolidated metropolitan statistical area, all of the portions of each primary metropolitan statistical area within the consolidated area within the State, are treated as a single MedicarePlus payment area, and*
- (ii) all areas in the State that do not fall within a metropolitan statistical area are treated as a single MedicarePlus payment area.*

(D) AREAS.—*In subparagraph (C), the terms “metropolitan statistical area,” “consolidated metropolitan statistical area, and “primary metropolitan statistical area mean any area designated as such by the Secretary of Commerce.*

(e) SPECIAL RULES FOR INDIVIDUALS ELECTING MSA PLANS.—

(1) IN GENERAL.—*If the amount of the monthly premium for an MSA plan for a MedicarePlus payment area for a year is less than $\frac{1}{12}$ of the annual MedicarePlus capitation rate applied under this section for the area and year involved, the Secretary shall deposit an amount equal to 100 percent of such difference in a MedicarePlus MSA established (and, if applicable, designated) by the individual under paragraph (2).*

(2) ESTABLISHMENT AND DESIGNATION OF MEDICAREPLUS MEDICAL SAVINGS ACCOUNT AS REQUIREMENT FOR PAYMENT OF CONTRIBUTION.—*In the case of an individual who has elected*

coverage under an MSA plan, no payment shall be made under paragraph (1) 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 MedicarePlus MSA (as defined in section 138(b)(2) of the Internal Revenue Code of 1986), and

(B) if the individual has established more than one such MedicarePlus MSA, has designated one of such accounts as the individual's MedicarePlus 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 an MSA plan effective beginning with a month in a year, the amount of the contribution to the MedicarePlus 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.

(f) PAYMENTS FROM TRUST FUND.—The payment to a MedicarePlus organization under this section for individuals enrolled under this part with the organization and payments to a MedicarePlus MSA under subsection (e)(1) 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. Monthly payments otherwise payable under this section for October 2001 shall be paid on the last business day of September 2001.

(g) SPECIAL RULE FOR CERTAIN INPATIENT HOSPITAL STAYS.—In the case of an individual who is receiving inpatient hospital services from a subsection (d) hospital (as defined in section 1886(d)(1)(B)) as of the effective date of the individual's—

(1) election under this part of a MedicarePlus plan offered by a MedicarePlus organization—

(A) payment for such services until the date of the individual's discharge shall be made under this title through the MedicarePlus plan or the medicare fee-for-service program option described in section 1851(a)(1)(A) (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 MedicarePlus 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 individuals discharge,

(B) payment for such services during the stay shall not be made under section 1886(d) or by any succeeding MedicarePlus 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.

PREMIUMS

SEC. 1854. (a) SUBMISSION AND CHARGING OF PREMIUMS.—

(1) IN GENERAL.—Subject to paragraph (3), each MedicarePlus 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 premium for coverage for services under section 1852(a) under each MedicarePlus plan it offers under this part in each MedicarePlus payment area (as defined in section 1853(d)) in which the plan is being offered; and

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

(2) TERMINOLOGY.—In this part—

(A) the term “monthly premium means, with respect to a MedicarePlus plan offered by a MedicarePlus organization, the monthly premium filed under paragraph (1), not taking into account the amount of any payment made toward the premium under section 1853; and

(B) the term “net monthly premium means, with respect to such a plan and an individual enrolled with the plan, the premium (as defined in subparagraph (A)) for the plan reduced by the amount of payment made toward such premium under section 1853.

(b) MONTHLY PREMIUM CHARGED.—The monthly amount of the premium charged by a MedicarePlus organization for a MedicarePlus plan offered in a MedicarePlus payment area to an individual under this part shall be equal to the net monthly premium plus any monthly premium charged in accordance with subsection (e)(2) for supplemental benefits.

(c) UNIFORM PREMIUM.—The monthly premium and monthly amount charged under subsection (b) of a MedicarePlus organization under this part may not vary among individuals who reside in the same MedicarePlus payment area.

(d) TERMS AND CONDITIONS OF IMPOSING PREMIUMS.—Each MedicarePlus organization shall permit the payment of net monthly premiums on a monthly basis and may terminate election of individuals for a MedicarePlus plan for failure to make premium payments only in accordance with section 1851(g)(3)(B)(i). A MedicarePlus organization is not authorized to provide for cash or other monetary rebates as an inducement for enrollment or otherwise.

(e) LIMITATION ON ENROLLEE COST-SHARING.—

(1) *FOR BASIC AND ADDITIONAL BENEFITS.*—Except as provided in paragraph (2), in no event may—

(A) the net monthly premium (multiplied by 12) and the actuarial value of the deductibles, coinsurance, and copayments applicable on average to individuals enrolled under this part with a MedicarePlus plan of an organization with respect to required benefits described in section 1852(a)(1) and additional benefits (if any) required under subsection (f)(1) for a year, exceed

(B) the actuarial value of the deductibles, coinsurance, and copayments that would be applicable on average to individuals entitled to benefits under part A and enrolled under part B if they were not members of a MedicarePlus organization for the year.

(2) *FOR SUPPLEMENTAL BENEFITS.*—If the MedicarePlus organization provides to its members enrolled under this part supplemental benefits described in section 1852(a)(3), the sum of the monthly premium rate (multiplied by 12) charged for such supplemental benefits and the actuarial value of its deductibles, coinsurance, and copayments charged with respect to such benefits may not exceed the adjusted community rate for such benefits (as defined in subsection (f)(4)).

(3) *EXCEPTION FOR MSA PLANS.*—Paragraphs (1) and (2) do not apply to an MSA plan.

(4) *DETERMINATION ON OTHER BASIS.*—If the Secretary determines that adequate data are not available to determine the actuarial value under paragraph (1)(A) or (2), the Secretary may determine such amount with respect to all individuals in the MedicarePlus payment area, the State, or in the United States, eligible to enroll in the MedicarePlus plan involved under this part or on the basis of other appropriate data.

(f) *REQUIREMENT FOR ADDITIONAL BENEFITS.*—

(1) *REQUIREMENT.*—

(A) *IN GENERAL.*—Each MedicarePlus organization (in relation to a MedicarePlus plan it offers) shall provide that if there is an excess amount (as defined in subparagraph (B)) for the plan 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) in a 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 plan, is the amount (if any) by which—

(i) the average of the capitation payments made to the organization under section 1853 for the plan at the beginning of contract year, exceeds

(ii) the actuarial value of the required benefits described in section 1852(a)(1) under the plan 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 plan, is the excess amount reduced to reflect any amount withheld and reserved for the organization for the year under paragraph (3).

(D) *NO APPLICATION TO MSA PLANS.*—Subparagraph (A) shall not apply to an MSA plan.

(E) *UNIFORM APPLICATION.*—This paragraph shall be applied uniformly for all enrollees for a plan in a MedicarePlus payment area.

(F) *CONSTRUCTION.*—Nothing in this subsection shall be construed as preventing a MedicarePlus 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) *STABILIZATION FUND.*—A MedicarePlus organization may provide that a part of the value of an excess 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 offered in those subsequent periods by the organization in accordance with such paragraph. Any of such value of the amount reserved which is not provided as additional benefits described in paragraph (1)(A) to individuals electing the MedicarePlus plan of the organization in accordance with such paragraph prior to the end of such periods, shall revert for the use of such trust funds.

(3) *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.

(4) *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 MedicarePlus organization, either—

(i) the rate of payment for that service or services which the Secretary annually determines would apply to an individual electing a MedicarePlus plan 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 plan (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 MedicarePlus coverage, or MedicarePlus eligible individuals in the area, in the State, or in the United States, eligible to elect MedicarePlus 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 MedicarePlus organization that is a provider-sponsored organization, the adjusted community rate under subparagraph (A) for a MedicarePlus plan of the organization 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 plan.

(g) PERIODIC AUDITING.—The Secretary shall provide for the annual auditing of the financial records (including data relating to medicare utilization, costs, and computation of the adjusted community rate) of at least one-third of the MedicarePlus organizations offering MedicarePlus plans under this part. The Comptroller General shall monitoring auditing activities conducted under this subsection.

(h) PROHIBITION OF STATE IMPOSITION OF PREMIUM TAXES.—No State may impose a premium tax or similar tax with respect to premiums on MedicarePlus plans or the offering of such plans.

ORGANIZATIONAL AND FINANCIAL REQUIREMENTS FOR MEDICAREPLUS ORGANIZATIONS; PROVIDER-SPONSORED ORGANIZATIONS

SEC. 1855. (a) ORGANIZED AND LICENSED UNDER STATE LAW.—

(1) IN GENERAL.—Subject to paragraphs (2) and (3), a MedicarePlus organization shall be organized and licensed under State law as a risk-bearing entity eligible to offer health insurance or health benefits coverage in each State in which it offers a MedicarePlus plan.

(2) SPECIAL EXCEPTION FOR PROVIDER-SPONSORED ORGANIZATIONS.—

(A) IN GENERAL.—In the case of a provider-sponsored organization that seeks to offer a MedicarePlus plan in a State, the Secretary shall waive the requirement of paragraph (1) that the organization be licensed in that State if—

(i) the organization files an application for such waiver with the Secretary, and

(ii) the Secretary determines, based on the application and other evidence presented to the Secretary, that

any of the grounds for approval of the application described in subparagraph (B), (C), or (D) has been met.

(B) *FAILURE TO ACT ON LICENSURE APPLICATION ON A TIMELY BASIS.*—A ground for approval of such a waiver application is that the State has failed to complete action on a licensing application of the organization within 90 days of the date of the State's receipt of the completed application. No period before the date of the enactment of this section shall be included in determining such 90-day period.

(C) *DENIAL OF APPLICATION BASED ON DISCRIMINATORY TREATMENT.*—A ground for approval of such a waiver application is that the State has denied such a licensing application and—

(i) the State has imposed documentation or information requirements not related to solvency requirements that are not generally applicable to other entities engaged in substantially similar business, or

(ii) the standards or review process imposed by the State as a condition of approval of the license imposes any material requirements, procedures, or standards (other than requirements and standards relating to solvency) to such organizations that are not generally applicable to other entities engaged in substantially similar business.

(D) *DENIAL OF APPLICATION BASED ON APPLICATION OF SOLVENCY REQUIREMENTS.*—A ground for approval of such a waiver application is that the State has denied such a licensing application based (in whole or in part) on the organization's failure to meet applicable solvency requirements and—

(i) such requirements are not the same as the solvency standards established under section 1856(a); or

(ii) the State has imposed as a condition of approval of the license any documentation or information requirements relating to solvency or other material requirements, procedures, or standards relating to solvency that are different from the requirements, procedures, and standards applied by the Secretary under subsection (d)(2).

For purposes of this subparagraph, the term “solvency requirements means requirements relating to solvency and other matters covered under the standards established under section 1856(a).

(E) *TREATMENT OF WAIVER.*—In the case of a waiver granted under this paragraph for a provider-sponsored organization—

(i) the waiver shall be effective for a 36-month period, except it may be renewed based on a subsequent application filed during the last 6 months of such period, and

(ii) any provisions of State law which relate to the licensing of the organization and which prohibit the organization from providing coverage pursuant to a contract under this part shall be superseded.

Nothing in this subparagraph shall be construed as limiting the number of times such a waiver may be renewed.

(F) PROMPT ACTION ON APPLICATION.—The Secretary shall grant or deny such a waiver application within 60 days after the date the Secretary determines that a substantially complete application has been filed. Nothing in this section shall be construed as preventing an organization which has had such a waiver application denied from submitting a subsequent waiver application. “

(3) EXCEPTION IF REQUIRED TO OFFER MORE THAN MEDICAREPLUS PLANS.—Paragraph (1) shall not apply to a MedicarePlus organization in a State if the State requires the organization, as a condition of licensure, to offer any product or plan other than a MedicarePlus plan.

(4) LICENSURE DOES NOT SUBSTITUTE FOR OR CONSTITUTE CERTIFICATION.—The fact that an organization is licensed in accordance with paragraph (1) does not deem the organization to meet other requirements imposed under this part.

(b) PREPAID PAYMENT.—A MedicarePlus organization shall be compensated (except for premiums, deductibles, coinsurance, and copayments) for the provision of health care services to enrolled members under the contract under this part 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.

(c) ASSUMPTION OF FULL FINANCIAL RISK.—The MedicarePlus organization shall assume full financial risk on a prospective basis for the provision of the health care services (except, at the election of the organization, 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.

(d) CERTIFICATION OF PROVISION AGAINST RISK OF INSOLVENCY FOR UNLICENSED PSOS.—

(1) IN GENERAL.—Each MedicarePlus organization that is a provider-sponsored organization, that is not licensed by a State under subsection (a), and for which a waiver application has

been approved under subsection (a)(2), shall meet standards established under section 1856(a) relating to the financial solvency and capital adequacy of the organization.

(2) *CERTIFICATION PROCESS FOR SOLVENCY STANDARDS FOR PSOS.*—The Secretary shall establish a process for the receipt and approval of applications of a provider-sponsored organization described in paragraph (1) for certification (and periodic recertification) of the organization as meeting such solvency standards. Under such process, the Secretary shall act upon such an application not later than 60 days after the date the application has been received.

(e) *PROVIDER-SPONSORED ORGANIZATION DEFINED.*—

(1) *IN GENERAL.*—In this part, the term “provider-sponsored organization” means a public or private entity—

(A) that is established or organized by a health care provider, or group of affiliated health care providers,

(B) that provides a substantial proportion (as defined by the Secretary in accordance with paragraph (2)) of the health care items and services under the contract under this part directly through the provider or affiliated group of providers, and

(C) with respect to which those affiliated providers that share, directly or indirectly, substantial financial risk with respect to the provision of such items and services have at least a majority financial interest in the entity.

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

(A) shall take into account (i) the need for such an organization to assume responsibility for a substantial proportion of services in order to assure financial stability and (ii) 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) both providers are part of a controlled group of corporations under section 1563 of the Internal Revenue Code of 1986, or

(C) 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.

(5) *HEALTH CARE PROVIDER DEFINED.*—In this subsection, the term “health care provider” means—

(A) any individual who is engaged in the delivery of health care services in a State and who 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, and

(B) any entity that is engaged in the delivery of health care services in a State and that, if it 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, is so licensed.

(6) *REGULATIONS.*—The Secretary shall issue regulations to carry out this subsection.

ESTABLISHMENT OF STANDARDS

SEC. 1856. (a) ESTABLISHMENT OF SOLVENCY STANDARDS FOR PROVIDER-SPONSORED ORGANIZATIONS.—

(1) ESTABLISHMENT.—

(A) *IN GENERAL.*—The Secretary shall establish, on an expedited basis and using a negotiated rulemaking process under subchapter III of chapter 5 of title 5, United States Code, standards described in section 1855(d)(1) (relating to the financial solvency and capital adequacy of the organization) that entities must meet to qualify as provider-sponsored organizations under this part.

(B) *FACTORS TO CONSIDER FOR SOLVENCY STANDARDS.*—In establishing solvency standards under subparagraph (A) for provider-sponsored organizations, the Secretary shall consult with interested parties and shall take into account—

(i) the delivery system assets of such an organization and ability of such an organization to provide services directly to enrollees through affiliated providers, and

(ii) alternative means of protecting against insolvency, including reinsurance, unrestricted surplus, letters of credit, guarantees, organizational insurance coverage, partnerships with other licensed entities, and valuation attributable to the ability of such an organization to meet its service obligations through direct delivery of care.

(C) *ENROLLEE PROTECTION AGAINST INSOLVENCY.*—Such standards shall include provisions to prevent enrollees from being held liable to any person or entity for the MedicarePlus organization's debts in the event of the organization's insolvency.

(2) *PUBLICATION OF NOTICE.*—In carrying out the rulemaking process under this subsection, the Secretary, after consultation with the National Association of Insurance Commissioners, the American Academy of Actuaries, organizations representative of medicare beneficiaries, and other interested parties, shall publish the notice provided for under section 564(a) of title 5, United States Code, by not later than 45 days after the date of the enactment of this section.

(3) *TARGET DATE FOR PUBLICATION OF RULE.*—As part of the notice under paragraph (2), and for purposes of this subsection, the “target date for publication” (referred to in section 564(a)(5) of such title) shall be April 1, 1998.

(4) *ABBREVIATED PERIOD FOR SUBMISSION OF COMMENTS.*—In applying section 564(c) of such title under this subsection, “15 days” shall be substituted for “30 days”.

(5) *APPOINTMENT OF NEGOTIATED RULEMAKING COMMITTEE AND FACILITATOR.*—The Secretary shall provide for—

(A) the appointment of a negotiated rulemaking committee under section 565(a) of such title by not later than 30 days after the end of the comment period provided for under section 564(c) of such title (as shortened under paragraph (4)), and

(B) the nomination of a facilitator under section 566(c) of such title by not later than 10 days after the date of appointment of the committee.

(6) *PRELIMINARY COMMITTEE REPORT.*—The negotiated rulemaking committee appointed under paragraph (5) shall report to the Secretary, by not later than January 1, 1998, regarding the committee’s progress on achieving a consensus with regard to the rulemaking proceeding and whether such consensus is likely to occur before one month before the target date for publication of the rule. If the committee reports that the committee has failed to make significant progress towards such consensus or is unlikely to reach such consensus by the target date, the Secretary may terminate such process and provide for the publication of a rule under this subsection through such other methods as the Secretary may provide.

(7) *FINAL COMMITTEE REPORT.*—If the committee is not terminated under paragraph (6), the rulemaking committee shall submit a report containing a proposed rule by not later than one month before the target date of publication.

(8) *INTERIM, FINAL EFFECT.*—The Secretary shall publish a rule under this subsection in the Federal Register by not later than the target date of publication. Such rule shall be effective and final immediately on an interim basis, but is subject to change and revision after public notice and opportunity for a period (of not less than 60 days) for public comment. In connection with such rule, the Secretary shall specify the process for the timely review and approval of applications of entities to be certified as provider-sponsored organizations pursuant to such rules and consistent with this subsection.

(9) *PUBLICATION OF RULE AFTER PUBLIC COMMENT.*—The Secretary shall provide for consideration of such comments and republication of such rule by not later than 1 year after the target date of publication.

(b) *ESTABLISHMENT OF OTHER STANDARDS.*—

(1) *IN GENERAL.*—The Secretary shall establish by regulation other standards (not described in subsection (a)) for MedicarePlus organizations and plans consistent with, and to carry out, this part.

(2) *USE OF CURRENT STANDARDS.*—Consistent with the requirements of this part, standards established under this subsection shall be based on standards established under section 1876 to carry out analogous provisions of such section.

(3) *USE OF INTERIM STANDARDS.*—For the period in which this part is in effect and standards are being developed and es-

established under the preceding provisions of this subsection, the Secretary shall provide by not later than June 1, 1998, for the application of such interim standards (without regard to any requirements for notice and public comment) as may be appropriate to provide for the expedited implementation of this part. Such interim standards shall not apply after the date standards are established under the preceding provisions of this subsection.

(4) *APPLICATION OF NEW STANDARDS TO ENTITIES WITH A CONTRACT.*—In the case of a MedicarePlus 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).

(5) *RELATION TO STATE LAWS.*—The standards established under this subsection shall supersede any State law or regulation with respect to MedicarePlus plans which are offered by MedicarePlus organizations under this part to the extent such law or regulation is inconsistent with such standards.

CONTRACTS WITH MEDICAREPLUS ORGANIZATIONS

SEC. 1857. (a) IN GENERAL.—The Secretary shall not permit the election under section 1851 of a MedicarePlus plan offered by a MedicarePlus organization under this part, and no payment shall be made under section 1853 to an organization, unless the Secretary has entered into a contract under this section with the organization with respect to the offering of such plan. Such a contract with an organization may cover more than one MedicarePlus plan. 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) *MINIMUM ENROLLMENT REQUIREMENTS.*—

(1) *IN GENERAL.*—Subject to paragraphs (2) and (3), the Secretary may not enter into a contract under this section with a MedicarePlus organization 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.

(2) *EXCEPTION FOR MSA PLAN.*—Paragraph (1) shall not apply with respect to a contract that relates only to an MSA plan.

(3) *ALLOWING TRANSITION.*—The Secretary may waive the requirement of paragraph (1) during the first 3 contract years with respect to an organization.

(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 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;

or

(C) 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, except that in no case shall a contract under this section which provides for coverage under an MSA plan be effective before January 1999 with respect to such coverage.

(4) *PREVIOUS TERMINATIONS.*—The Secretary may not enter into a contract with a MedicarePlus 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 MedicarePlus 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 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 MedicarePlus 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 MedicarePlus 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 MedicarePlus 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 MedicarePlus 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.

(e) ADDITIONAL CONTRACT TERMS.—

(1) IN GENERAL.—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.

(2) COST-SHARING IN ENROLLMENT-RELATED COSTS.—The contract with a MedicarePlus organization shall require the payment to the Secretary for the organizations pro rata share (as determined by the Secretary) of the estimated costs to be incurred by the Secretary in carrying out section 1851 (relating to enrollment and dissemination of information). Such payments are appropriated to defray the costs described in the preceding sentence, to remain available until expended.

(f) PROMPT PAYMENT BY MEDICAREPLUS ORGANIZATION.—

(1) REQUIREMENT.—A contract under this part shall require a MedicarePlus organization to provide prompt payment (consistent with the provisions of sections 1816(c)(2) and 1842(c)(2)) of claims submitted for services and supplies furnished to individuals pursuant to the contract, if the services or supplies are not furnished under a contract between the organization and the provider or supplier.

(2) SECRETARYS OPTION TO BYPASS NONCOMPLYING ORGANIZATION.—In the case of a MedicarePlus eligible organization which the Secretary determines, after notice and opportunity for a hearing, has failed to make payments of amounts in compliance with paragraph (1), the Secretary may provide for direct payment of the amounts owed to providers and suppliers for covered services and supplies furnished to individuals enrolled under this part under the contract. If the Secretary provides for the direct payments, the Secretary shall provide for an appropriate reduction in the amount of payments otherwise made to the organization under this part to reflect the amount of the Secretarys payments (and the Secretarys costs in making the payments).

(g) INTERMEDIATE SANCTIONS.—

(1) IN GENERAL.—If the Secretary determines that a MedicarePlus 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 net monthly premiums on individuals enrolled under this part in excess of the net monthly 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(j)(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 para-

graph (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 MedicarePlus 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 organizations 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 (g) during which the deficiency that is the basis of a determination under subsection (c)(2) exists.

(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.

(h) *PROCEDURES FOR TERMINATION.*—

(1) *IN GENERAL.*—The Secretary may terminate a contract with a MedicarePlus organization under this section in accordance with formal investigation and compliance procedures established by the Secretary under which—

(A) the Secretary provides the organization with the reasonable 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);

(B) the Secretary provides the organization with reasonable notice and opportunity for hearing (including the right to appeal an initial decision) before terminating the contract.

(2) *CIVIL MONEY PENALTIES.*—The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under subsection (f) or under paragraph (2) or (3) of subsection (g) in the same manner as they apply to a civil money penalty or proceeding under section 1128A(a).

(3) *EXCEPTION FOR IMMINENT AND SERIOUS RISK TO HEALTH.*—Paragraph (1) shall not apply if the Secretary determines that a delay in termination, resulting from compliance with the procedures specified in such paragraph prior to termination, would pose an imminent and serious risk to the health of individuals enrolled under this part with the organization.

DEFINITIONS; MISCELLANEOUS PROVISIONS

SEC. 1859. (a) *DEFINITIONS RELATING TO MEDICAREPLUS ORGANIZATIONS.*—In this part—

(1) **MEDICAREPLUS ORGANIZATION.**—The term “MedicarePlus organization” means a public or private entity that is certified under section 1856 as meeting the requirements and standards of this part for such an organization.

(2) **PROVIDER-SPONSORED ORGANIZATION.**—The term “provider-sponsored organization” is defined in section 1855(e)(1).

(b) **DEFINITIONS RELATING TO MEDICAREPLUS PLANS.**—

(1) **MEDICAREPLUS PLAN.**—The term “MedicarePlus plan” means health benefits coverage offered under a policy, contract, or plan by a MedicarePlus organization pursuant to and in accordance with a contract under section 1857.

(2) **MSA PLAN.**—

(A) **IN GENERAL.**—The term “MSA plan” means a MedicarePlus plan that—

(i) 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 plan) equal to the amount of an annual deductible (described in subparagraph (B));

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

(iii) provides, after such deductible is met for a year and for all subsequent expenses for items and services referred to in clause (i) 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.

(B) **DEDUCTIBLE.**—The amount of annual deductible under an MSA plan—

(i) for contract year 1999 shall be not more than \$6,000; and

(ii) for a subsequent contract year shall be not more than the maximum amount of such deductible for the previous contract year under this subparagraph increased by the national per capita MedicarePlus growth percentage under section 1853(c)(6) for the year.

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

(c) **OTHER REFERENCES TO OTHER TERMS.**—

(1) **MEDICAREPLUS ELIGIBLE INDIVIDUAL.**—The term “MedicarePlus eligible individual” is defined in section 1851(a)(3).

(2) **MEDICAREPLUS PAYMENT AREA.**—The term “MedicarePlus payment area” is defined in section 1853(d).

(3) NATIONAL PER CAPITA MEDICAREPLUS GROWTH PERCENTAGE.—The “national per capita MedicarePlus growth percentage” is defined in section 1853(c)(6).

(4) MONTHLY PREMIUM; NET MONTHLY PREMIUM.—The terms “monthly premium and “net monthly premium” are defined in section 1854(a)(2).

(d) COORDINATED ACUTE AND LONG-TERM CARE BENEFITS UNDER A MEDICAREPLUS PLAN.—Nothing in this part shall be construed as preventing a State from coordinating benefits under a medicaid plan under title XIX with those provided under a MedicarePlus plan 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 plan.

(e) RESTRICTION ON ENROLLMENT FOR CERTAIN MEDICAREPLUS PLANS.—

(1) IN GENERAL.—In the case of a MedicarePlus religious fraternal benefit society plan described in paragraph (2), notwithstanding any other provision of this part to the contrary and in accordance with regulations of the Secretary, the society offering the plan may restrict the enrollment of individuals under this part to individuals who are members of the church, convention, or group described in paragraph (3)(B) with which the society is affiliated.

(2) MEDICAREPLUS RELIGIOUS FRATERNAL BENEFIT SOCIETY PLAN DESCRIBED.—For purposes of this subsection, a MedicarePlus religious fraternal benefit society plan described in this paragraph is a MedicarePlus plan described in section 1851(a)(2)(A) that—

(A) is offered by a religious fraternal benefit society described in paragraph (3) only to members of the church, convention, or group described in paragraph (3)(B); and

(B) permits all such members to enroll under the plan without regard to health status-related factors.

Nothing in this subsection shall be construed as waiving any plan requirements relating to financial solvency. In developing solvency standards under section 1856, the Secretary shall take into account open contract and assessment features characteristic of fraternal insurance certificates.

(3) RELIGIOUS FRATERNAL BENEFIT SOCIETY DEFINED.—For purposes of paragraph (2)(A), a “religious fraternal benefit society described in this section is an organization that—

(A) is exempt from Federal income taxation under section 501(c)(8) of the Internal Revenue Code of 1986;

(B) is affiliated with, carries out the tenets of, and shares a religious bond with, a church or convention or association of churches or an affiliated group of churches;

(C) offers, in addition to a MedicarePlus religious fraternal benefit society plan, health coverage to individuals not entitled to benefits under this title who are members of such church, convention, or group; and

(D) does not impose any limitation on membership in the society based on any health status-related factor.

(4) PAYMENT ADJUSTMENT.—Under regulations of the Secretary, in the case of individuals enrolled under this part under

a MedicarePlus religious fraternal benefit society plan described in paragraph (2), the Secretary shall provide for such adjustment to the payment amounts otherwise established under section 1854 as may be appropriate to assure an appropriate payment level, taking into account the actuarial characteristics and experience of such individuals.

PART **[C]** *D*—MISCELLANEOUS PROVISIONS
 DEFINITIONS OF SERVICES, INSTITUTIONS, ETC.

SEC. 1861. For purposes of this title—

Spell of Illness

(a) * * *

* * * * *

Inpatient Hospital Services

(b) The term “inpatient hospital services” means the following items and services furnished to an inpatient of a hospital and (except as provided in paragraph (3)) by the hospital—

(1) * * *

* * * * *

excluding, however—

(4) medical or surgical services provided by a physician, resident, or intern, services described by **[**clauses (i) or (iii) of subsection (s)(2)(K)**]** *subsection (s)(2)(K)*, certified nurse-midwife services, qualified psychologist services, and services of a certified registered nurse anesthetist; and

* * * * *

Extended Care Services

(h) The term “extended care services” means the following items and services furnished to an inpatient of a skilled nursing facility and (except as provided in **[**paragraphs (3) and (6)**]** *paragraphs (3), (6), and (7)*) by such skilled nursing facility—

(1) * * *

* * * * *

(7) such other services necessary to the health of the patients as are generally provided by skilled nursing facilities, *or by others under arrangements with them made by the facility*; excluding, however, any item or service if it would not be included under subsection (b) if furnished to an inpatient of a hospital.

* * * * *

Home Health Services

(m) The term “home health services” means the following items and services furnished to an individual, who is under the care of a physician, by a home health agency or by others under arrangements with them made by such agency, under a plan (for furnishing such items and services to such individual) established and pe-

riodically reviewed by a physician, which items and services are, except as provided in paragraph (7), provided on a visiting basis in a place of residence used as such individual's home—

(1) * * *

* * * * *

excluding, however, any item or service if it would not be included under subsection (b) if furnished to an inpatient of a hospital. *For purposes of paragraphs (1) and (4), the term "part-time or intermittent services" means skilled nursing and home health aide services furnished any number of days per week as long as they are furnished (combined) less than 8 hours each day and 28 or fewer hours each week (or, subject to review on a case-by-case basis as to the need for care, less than 8 hours each day and 35 or fewer hours per week). For purposes of sections 1814(a)(2)(C) and 1835(a)(2)(A), "intermittent" means skilled nursing care that is either provided or needed on fewer than 7 days each week, or less than 8 hours of each day of skilled nursing and home health aide services combined for periods of 21 days or less (with extensions in exceptional circumstances when the need for additional care is finite and predictable).*

Durable Medical Equipment

(n) The term "durable medical equipment" includes iron lungs, oxygen tents, hospital beds, and wheelchairs (which may include a power-operated vehicle that may be appropriately used as a wheelchair, but only where the use of such a vehicle is determined to be necessary on the basis of the individuals medical and physical condition and the vehicle meets such safety requirements as the Secretary may prescribe) used in the patients home (including an institution used as his home other than an institution that meets the requirements of subsection (e)(1) of this section or section 1819(a)(1)), whether furnished on a rental basis or purchased, *and includes blood-testing strips and blood glucose monitors for individuals with diabetes without regard to whether the individual has Type I or Type II diabetes or to the individuals use of insulin (as determined under standards established by the Secretary in consultation with the appropriate organizations);* except that such term does not include such equipment furnished by a supplier who has used, for the demonstration and use of specific equipment, an individual who has not met such minimum training standards as the Secretary may establish with respect to the demonstration and use of such specific equipment. With respect to a seat-lift chair, such term includes only the seat-lift mechanism and does not include the chair.

Home Health Agency

(o) The term "home health agency" means a public agency or private organization, or a subdivision of such an agency or organization, which—

(1) * * *

* * * * *

(7) meets such additional requirements (including conditions relating to bonding or establishing of escrow accounts as the Secretary finds necessary for the financial security of the program *and including providing the Secretary on a continuing basis with a surety bond in a form specified by the Secretary and in an amount that is not less than \$50,000*) as the Secretary finds necessary for the effective and efficient operation of the program;

except that for purposes of part A such term shall not include any agency or organization which is primarily for the care and treatment of mental diseases. *The Secretary may waive the requirement of a bond under paragraph (7) in the case of an agency or organization that provides a comparable surety bond under State law.*

Outpatient Physical Therapy Services

(p) The term “outpatient physical therapy services” means physical therapy services furnished by a provider of services, a clinic, rehabilitation agency, or a public health agency, or by others under an arrangement with, and under the supervision of, such provider, clinic, rehabilitation agency, or public health agency to an individual as an outpatient—

(1) * * *

* * * * *

(4) any such service—

(A) if furnished by a clinic or rehabilitation agency, or by others under arrangements with such clinic or agency, unless such clinic or rehabilitation agency—

(i) * * *

* * * * *

(v) meets such other conditions relating to the health and safety of individuals who are furnished services by such clinic or agency on an outpatient basis, as the Secretary may find necessary, *and provides the Secretary, to the extent required by the Secretary, on a continuing basis with a surety bond in a form specified by the Secretary and in an amount that is not less than \$50,000, or*

The term “outpatient physical therapy services” also includes physical therapy services furnished an individual by a physical therapist (in his office or in such individual’s home) who meets licensing and other standards prescribed by the Secretary in regulations, otherwise than under an arrangement with and under the supervision of a provider of services, clinic, rehabilitation agency, or public health agency, if the furnishing of such services meets such conditions relating to health and safety as the Secretary may find necessary. In addition, such terms includes physical therapy services which meet the requirements of the first sentence of this subsection except that they are furnished to an individual as an inpatient of a hospital or extended care facility. The term “outpatient physical therapy services” also includes speech-language pathology services furnished by a provider of services, a clinic, rehabilitation agency, or by a public health agency, or by others under an arrange-

ment with, and under the supervision of, such provider, clinic, rehabilitation agency, or public health agency to an individual as an outpatient, subject to the conditions prescribed in this subsection. Nothing in this subsection shall be construed as requiring with respect to outpatients who are not entitled to benefits under this title, a physical therapist to provide outpatient physical therapy services only to outpatients are under the care of a physician or pursuant to a plan of care established by a physician. *Secretary may waive the requirement of a bond under paragraph (4)(A)(v) in the case of a clinic or agency that provides a comparable surety bond under State law.*

* * * * *

Physician

(r) The term “physician”, when used in connection with the performance of any function or action, means (1) a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he performs such function or action (including a physician within the meaning of section 1101(a)(7)), (2) a doctor of dental surgery or of dental medicine who is legally authorized to practice dentistry by the State in which he performs such function and who is acting within the scope of his license when he performs such functions, (3) a doctor of podiatric medicine for the purposes of subsections (k), (m), (p)(1), and (s) of this section and sections 1814(a), 1832(a)(2)(F)(ii), and 1835 but only with respect to functions which he is legally authorized to perform as such by the State in which he performs them, (4) a doctor of optometry, but only with respect to the provision of items or services described in subsection (s) which he is legally authorized to perform as a doctor of optometry by the State in which he performs them, or (5) a chiropractor who is licensed as such by the State (or in a State which does not license chiropractors as such, is legally authorized to perform the services of a chiropractor in the jurisdiction in which he performs such services), and who meets uniform minimum standards promulgated by the Secretary, but only for the purpose of sections 1861(s)(1) and 1861(s)(2)(A) and only with respect to treatment by means of manual manipulation of the spine (to correct a subluxation [demonstrated by X-ray to exist]) which he is legally authorized to perform by the State or jurisdiction in which such treatment is provided. For the purposes of section 1862(a)(4) and subject to the limitations and conditions provided in the previous sentence, such term includes a doctor of one of the arts, specified in such previous sentence, legally authorized to practice such art in the country in which the inpatient hospital services (referred to in such section 1862(a)(4)) are furnished.

Medical and Other Health Services

(s) The term “medical and other health services” means any of the following items or services:

- (1) physicians’ services;
- (2)(A) * * *

* * * * *

(K)(i) services which would be physicians' services if furnished by a physician (as defined in subsection (r)(1)) and which are performed by a physician assistant (as defined in subsection (aa)(5)) under the supervision of a physician (as so defined) **[(I) in a hospital, skilled nursing facility, or nursing facility (as defined in section 1919(a)), (II) as an assistant at surgery, or (III) in a rural area (as defined in section 1886(d)(2)(D)) that is designated, under section 332(a)(1)(A) of the Public Health Service Act, as a health professional shortage area,]** and which the physician assistant is legally authorized to perform by the State in which the services are performed, *and such services and supplies furnished as incident to such services as would be covered under subparagraph (A) if furnished as an incident to a physicians professional service, but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services,*

[(ii) services which would be physicians' services if furnished by a physician (as defined in subsection (r)(1)) and which are performed by a nurse practitioner (as defined in subsection (aa)(5)) working in collaboration (as defined in subsection (aa)(6)) with a physician (as defined in subsection (r)(1)) in a skilled nursing facility or nursing facility (as defined in section 1919(a)) which the nurse practitioner is legally authorized to perform by the State in which the services are performed,

[(iii) services which would be physicians' services, if furnished by a physician (as defined in subsection (r)(1)) and which are performed by a nurse practitioner or clinical nurse specialist (as defined in subsection (aa)(5)) working in collaboration (as defined in subsection (aa)(6)) with a physician (as defined in subsection (r)(1)) in a rural area (as defined in section 1886(d)(2)(D)) which the nurse practitioner or clinical nurse specialist is authorized to perform by the State in which the services are performed, and such services and supplies furnished as an incident to such services as would be covered under subparagraph (A) if furnished as an incident to a physicians professional service, and

[(iv) such services and supplies furnished as an incident to services described in clause (i) or (ii) as would be covered under subparagraph (A) if furnished as an incident to a physicians' professional service;]

(ii) services which would be physicians' services if furnished by a physician (as defined in subsection (r)(1)) and which are performed by a nurse practitioner or clinical nurse specialist (as defined in subsection (aa)(5)) working in collaboration (as defined in subsection (aa)(6)) with a physician (as defined in subsection (r)(1)) which the nurse practitioner or clinical nurse specialist is legally authorized to perform by the State in which the services are performed, and such services and supplies furnished as an incident to such services as would be covered under subparagraph (A) if furnished incident to a physician's professional service, but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services;

(N) clinical social worker services (as defined in subsection (hh)(2)); **[and]**

(O) erythropoietin for dialysis patients competent to use such drug without medical or other supervision with respect to the administration of such drug, subject to methods and standards established by the Secretary by regulation for the safe and effective use of such drug, and items related to the administration of such drug; **[and]**

(P) prostate cancer screening tests (as defined in subsection (oo));

(Q) an oral drug (which is approved by the Federal Food and Drug Administration) prescribed for use as an anticancer chemotherapeutic agent for a given indication, and containing an active ingredient (or ingredients), which is the same indication and active ingredient (or ingredients) as a drug which the carrier determines would be covered pursuant to subparagraph (A) or (B) if the drug could not be self-administered;

(R) colorectal cancer screening tests (as defined in subsection (pp));

(S) diabetes outpatient self-management training services (as defined in subsection (qq)); and

(T) an oral drug (which is approved by the Federal Food and Drug Administration) prescribed for use as an acute anti-emetic used as part of an anticancer chemotherapeutic regimen if the drug is administered by a physician (or under the supervision of a physician)—

(i) for use immediately before, immediately after, or at the time of the administration of the anticancer chemotherapeutic agent; and

(ii) as a full replacement for the anti-emetic therapy which would otherwise be administered intravenously.

* * * * *

(12) subject to section 4072(e) of the Omnibus Budget Reconciliation Act of 1987, extra-depth shoes with inserts or custom molded shoes with inserts for an individual with diabetes, if—

(A) * * *

* * * * *

(C) the shoes are fitted and furnished by a podiatrist or other qualified individual (such as a pedorthist or orthotist, as established by the Secretary) who is not the physician described in subparagraph (A) (unless the Secretary finds that the physician is the only such qualified individual in the area); **[and]**

(13) screening mammography (as defined in subsection (jj));

(14) screening pap smear **[.]** and screening pelvic exam; and

No diagnostic tests performed in any laboratory, including a laboratory that is part of a rural health clinic, or a hospital (which, for purposes of this sentence, means an institution considered a hospital for purposes of section 1814(d)) shall be included within paragraph (3) unless such laboratory—

(15) bone mass measurement (as defined in subsection (rr)).

[(15)] (16) if situated in any State in which State or applicable local law provides for licensing of establishments of this nature, (A) is licensed pursuant to such law, or (B) is approved, by the agency of such State or locality responsible for licensing establishments of this nature, as meeting the standards established for such licensing; and

[(16)] (17)(A) meets the certification requirements under section 353 of the Public Health Service Act; and

(B) meets such other conditions relating to the health and safety of individuals with respect to whom such tests are performed as the Secretary may find necessary.

There shall be excluded from the diagnostic services specified in paragraph (2)(C) any item or service (except services referred to in paragraph (1)) which would not be included under subsection (b) if it were furnished to an inpatient of a hospital. None of the items and services referred to in the preceding paragraphs (other than paragraphs (1) and (2)(A)) of this subsection which are furnished to a patient of an institution which meets the definition of a hospital for purposes of section 1814(d) shall be included unless such other conditions are met as the Secretary may find necessary relating to health and safety of individuals with respect to whom such items and services are furnished.

* * * * *

Reasonable Cost

(v)(1)(A) * * *

* * * * *

(H) In determining such reasonable cost with respect to home health agencies, the Secretary may not include—

(i) any costs incurred in connection with bonding or establishing an escrow account by any such agency as a result of **the financial security requirement** the financial security and surety bond requirements described in subsection (o)(7);

(ii) in the case of home health agencies to which **the financial security requirement described in subsection (o)(7) applies** the financial security and surety bond requirements described in subsection (o)(7) apply, any costs attributed to interest charged such an agency in connection with amounts borrowed by the agency to repay overpayments made under this title to the agency, except that such costs may be included in reasonable cost if the Secretary determines that the agency was acting in good faith in borrowing the amounts;

* * * * *

(L)(i) The Secretary, in determining the amount of the payments that may be made under this title with respect to services furnished by home health agencies, may not recognize as reasonable (in the efficient delivery of such services) costs for the provision of such services by an agency to the extent these costs exceed (on the aggregate for the agency) for cost reporting periods beginning on or after—

(I) July 1, 1985, and before July 1, 1986, 120 percent of the mean of the labor-related and nonlabor per visit costs for free-standing home health agencies,

(II) July 1, 1986, and before July 1, 1987, 115 percent[, or] of such mean,

(III) July 1, 1987, and before October 1, 1997, 112 percent[,] of such mean, or

[of the mean of the labor-related and nonlabor per visit costs for free standing home health agencies.]

(IV) October 1, 1997, 105 percent of the median of the labor-related and nonlabor per visit costs for freestanding home health agencies.

* * * * *

(iii) Not later than July 1, 1991, and annually thereafter (but not for cost reporting periods beginning on or after July 1, 1994, and before July 1, 1996, or on or after July 1, 1997, and before October 1, 1997), the Secretary shall establish limits under this subparagraph for cost reporting periods beginning on or after such date by utilizing the area wage index applicable under section 1886(d)(3)(E) and determined using the survey of the most recent available wages and wage-related costs of hospitals located in the geographic area in which the home health [agency is located] service is furnished (determined without regard to whether such hospitals have been reclassified to a new geographic area pursuant to section 1886(d)(8)(B), a decision of the Medicare Geographic Classification Review Board under section 1886(d)(10), or a decision of the Secretary).

(iv) In establishing limits under this subparagraph for cost reporting periods beginning after September 30, 1997, the Secretary shall not take into account any changes in the home health market basket, as determined by the Secretary, with respect to cost reporting periods which began on or after July 1, 1994, and before July 1, 1996.

(v) For services furnished by home health agencies for cost reporting periods beginning on or after October 1, 1997, the Secretary shall provide for an interim system of limits. Payment shall not exceed the costs determined under the preceding provisions of this subparagraph or, if lower, the product of—

(I) an agency-specific per beneficiary annual limitation calculated based 75 percent on the reasonable costs (including nonroutine medical supplies) for the agency's 12-month cost reporting period ending during 1994, and based 25 percent on the standardized regional average of such costs for the agency's region, as applied to such agency, for cost reporting periods ending during 1994, such costs updated by the home health market basket index; and

(II) the agency's unduplicated census count of patients (entitled to benefits under this title) for the cost reporting period subject to the limitation.

(vi) For services furnished by home health agencies for cost reporting periods beginning on or after October 1, 1997, the following rules apply:

(I) For new providers and those providers without a 12-month cost reporting period ending in calendar year 1994, the per ben-

eficiary limitation shall be equal to the median of these limits (or the Secretary's best estimates thereof) applied to other home health agencies as determined by the Secretary. A home health agency that has altered its corporate structure or name shall not be considered a new provider for this purpose.

(II) For beneficiaries who use services furnished by more than one home health agency, the per beneficiary limitations shall be prorated among the agencies.

* * * * *

(O)(i) In establishing an appropriate allowance for depreciation and for interest on capital indebtedness [and (if applicable) a return on equity capital] with respect to an asset of a [hospital or skilled nursing facility] *provider of services* which has undergone a change of ownership, such regulations shall provide, except as provided in clause [(iv)] *(iii)*, that the valuation of the asset after such change of ownership shall be [the lesser of the allowable acquisition cost of such asset to the owner of record as of the date of the enactment of this subparagraph (or, in the case of an asset not in existence as of such date, the first owner of record of the asset after such date), or the acquisition cost of such asset to the new owner.] *the historical cost of the asset, as recognized under this title, less depreciation allowed, to the owner of record as of the date of enactment of the Balanced Budget Act of 1997 (or, in the case of an asset not in existence as of that date, the first owner of record of the asset after that date).*

[(ii) Such regulations shall provide for recapture of depreciation in the same manner as provided under the regulations in effect on June 1, 1984.]

[(iii)] *(ii)* Such regulations shall not recognize, as reasonable in the provision of health care services, costs (including legal fees, accounting and administrative costs, travel costs, and the costs of feasibility studies) attributable to the negotiation or settlement of the sale or purchase of any capital asset (by acquisition or merger) for which any payment has previously been made under this title.

[(iv)] *(iii)* In the case of the transfer of a hospital from ownership by a State to ownership by a nonprofit corporation without monetary consideration, the basis for capital allowances to the new owner shall be the book value of the hospital to the State at the time of the transfer.

* * * * *

(S)(i) Such regulations shall not include provision for specific recognition of any return on equity capital with respect to hospital outpatient departments.

(ii)(I) Such regulations shall provide that, in determining the amount of the payments that may be made under this title with respect to all the capital-related costs of outpatient hospital services, the Secretary shall reduce the amounts of such payments otherwise established under this title by 15 percent for payments attributable to portions of cost reporting periods occurring during fiscal year 1990, by 15 percent for payments attributable to portions of cost reporting periods occurring during fiscal year 1991, and by 10 percent for payments attributable to portions of cost reporting

periods occurring during fiscal years 1992 **through 1998** *through 1999 and during fiscal year 2000 before January 1, 2000.*

(II) The Secretary shall reduce the reasonable cost of outpatient hospital services (other than the capital-related costs of such services) otherwise determined pursuant to section 1833(a)(2)(B)(i)(I) by 5.8 percent for payments attributable to portions of cost reporting periods occurring during fiscal years 1991 **through 1998** *through 1999 and during fiscal year 2000 before January 1, 2000.*

* * * * *

(T) *In determining such reasonable costs for hospitals, the amount of bad debts otherwise treated as allowable costs which are attributable to the deductibles and coinsurance amounts under this title shall be reduced—*

- (i) *for cost reporting periods beginning during fiscal year 1998, by 25 percent, of such amount otherwise allowable,*
- (ii) *for cost reporting periods beginning during fiscal year 1999, by 40 percent of such amount otherwise allowable, and*
- (iii) *for cost reporting periods beginning during a subsequent fiscal year, by 50 percent of such amount otherwise allowable.*

(U) *In determining the reasonable cost of ambulance services (as described in section (s)(7)) provided during a fiscal year (beginning with fiscal year 1998 and ending with fiscal year 2002), the Secretary shall not recognize any costs in excess of costs recognized as reasonable for ambulance services provided during the previous fiscal year after application of this subparagraph, increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) as estimated by the Secretary for the 12-month period ending with the midpoint of the fiscal year involved reduced (in the case of each of fiscal years 1998 and 1999) by 1 percentage point.*

* * * * *

Rural Health Clinic Services and Federally Qualified Health Center Services

(aa)(1) * * *

(2) The term “rural health clinic” means a facility which—

(A) * * *

* * * * *

[(I) has appropriate procedures for review of utilization of clinic services to the extent that the Secretary determines to be necessary and feasible;]

(I) has a quality assessment and performance improvement program, and appropriate procedures for review of utilization of clinic services, as the Secretary may specify,

* * * * *

For the purposes of this title, such term includes only a facility which (i) is located in an area that is not an urbanized area (as defined by the Bureau of the Census) *and in which there are insufficient numbers of needed health care practitioners (as determined by the Secretary),* **[and that is designated]** *and that, within the previous three-year period, has been designated by the chief executive*

officer of the State and certified by the Secretary as an area with a shortage of personal health services [, or that is designated] or designated by the Secretary either (I) as an area with a shortage of personal health services under section 330(b)(3) or 1302(7) of the Public Health Service Act, (II) as a health professional shortage area described in section 332(a)(1)(A) of that Act because of its shortage of primary medical care manpower, (III) as a high impact area described in section 329(a)(5) of that Act, or (IV) as an area which includes a population group which the Secretary determines has a health manpower shortage under section 332(a)(1)(B) of that Act, (ii) has filed an agreement with the Secretary by which it agrees not to charge any individual or other person for items or services for which such individual is entitled to have payment made under this title, except for the amount of any deductible or coinsurance amount imposed with respect to such items or services (not in excess of the amount customarily charged for such items and services by such clinic), pursuant to subsections (a) and (b) of section 1833, (iii) employs a physician assistant or nurse practitioner, and (iv) is not a rehabilitation agency or a facility which is primarily for the care and treatment of mental diseases. A facility that is in operation and qualifies as a rural health clinic under this title or title XIX and that subsequently fails to satisfy the requirement of clause (i) shall be considered, for purposes of this title and title XIX, as still satisfying the requirement of such clause *if it is determined, in accordance with criteria established by the Secretary in regulations, to be essential to the delivery of primary care services that would otherwise be unavailable in the geographic area served by the clinic.* If a State agency has determined under section 1864(a) that a facility is a rural health clinic and the facility has applied to the Secretary for approval as such a clinic, the Secretary shall notify the facility of the Secretary's approval or disapproval not later than 60 days after the date of the State agency determination or the application (whichever is later).

* * * * *

(5) [The term "physician assistant, the term "nurse practitioner, and the term "clinical nurse specialist mean, for purposes of this title, a physician assistant, nurse practitioner, or clinical nurse specialist who performs](A) *The term 'physician assistant and the term 'nurse practitioner mean, for purposes of this title, a physician assistant or nurse practitioner who performs such services as such individual is legally authorized to perform (in the State in which the individual performs such services) in accordance with State law (or the State regulatory mechanism provided by State law), and who meets such training, education, and experience requirements (or any combination thereof) as the Secretary may prescribe in regulations.*

(B) *The term "clinical nurse specialist means, for purposes of this title, an individual who—*

(i) is a registered nurse and is licensed to practice nursing in the State in which the clinical nurse specialist services are performed; and

(ii) holds a masters degree in a defined clinical area of nursing from an accredited educational institution.

* * * * *

(7)(A) * * *

(B) The Secretary may not grant such a waiver under subparagraph (A) to a facility if the request for the waiver is made less than 6 months after the date of the expiration of any previous such waiver for the facility, or if the facility has not yet been determined to meet the requirements (including subparagraph (J) of the first sentence of paragraph (2)) of a rural health clinic.

* * * * *

Comprehensive Outpatient Rehabilitation Facility Services

(cc)(1) * * *

(2) The term “comprehensive outpatient rehabilitation facility means a facility which—

(A) * * *

* * * * *

(I) meets such other conditions of participation as the Secretary may find necessary in the interest of the health and safety of individuals who are furnished services by such facility, including conditions concerning qualifications of personnel in these facilities and providing the Secretary on a continuing basis with a surety bond in a form specified by the Secretary and in an amount that is not less than \$50,000.

The Secretary may waive the requirement of a bond under subparagraph (I) in the case of a facility that provides a comparable surety bond under State law.

* * * * *

Hospice Care; Hospice Program

(dd)(1) The term “hospice care means the following items and services provided to a terminally ill individual by, or by others under arrangements made by, a hospice program under a written plan (for providing such care to such individual) established and periodically reviewed by the individuals attending physician and by the medical director (and by the interdisciplinary group described in paragraph (2)(B)) of the program—

(A) * * *

* * * * *

(G) short-term inpatient care (including both respite care and procedures necessary for pain control and acute and chronic symptom management) in an inpatient facility meeting such conditions as the Secretary determines to be appropriate to provide such care, but such respite care may be provided only on an intermittent, nonroutine, and occasional basis and may not be provided consecutively over longer than five days, [and]

(H) counseling (including dietary counseling) with respect to care of the terminally ill individual and adjustment to his death[.], and

(I) any other item or service which is specified in the plan and for which payment may otherwise be made under this title.
 The care and services described in subparagraphs (A) and (D) may be provided on a 24-hour, continuous basis only during periods of crisis (meeting criteria established by the Secretary) and only as necessary to maintain the terminally ill individual at home.

(2) The term "hospice program means a public agency or private organization (or a subdivision thereof) which—

(A)(i) is primarily engaged in providing the care and services described in paragraph (1) and makes such services available (as needed) on a 24-hour basis and which also provides bereavement counseling for the immediate family of terminally ill individuals,

(ii) provides for such care and services in individuals' homes, on an outpatient basis, and on a short-term inpatient basis, directly or under arrangements made by the agency or organization, except that—

(I) the agency or organization must routinely provide directly substantially all of each of the services described in subparagraphs (A), (C), **[(F),]** and (H) of paragraph (1), except as otherwise provided in paragraph (5), and

* * * * *

(B) has an interdisciplinary group of personnel which—

(i) includes at least—

(I) one physician (as defined in subsection (r)(1)),

(II) one registered professional nurse, and

(III) one social worker,

employed by *or, in the case of a physician described in subclause (I), under contract with* the agency or organization, and also includes at least one pastoral or other counselor,

* * * * *

(5)(A) * * *

(B) Any waiver, which is in such form and containing such information as the Secretary may require and which is requested by an agency or organization under subparagraph (A) *or (C)*, shall be deemed to be granted unless such request is denied by the Secretary within 60 days after the date such request is received by the Secretary. The granting of a waiver under subparagraph (A) *or (C)* shall not preclude the granting of any subsequent waiver request should such a waiver again become necessary.

(C) *The Secretary may waive the requirements of paragraph (2)(A)(i) and (2)(A)(ii) for an agency or organization with respect to the services described in paragraph (1)(B) and, with respect to dietary counseling, paragraph (1)(H), if such agency or organization—*

(i) is located in an area which is not an urbanized area (as defined by the Bureau of Census), and

(ii) demonstrates to the satisfaction of the Secretary that the agency or organization has been unable, despite diligent efforts, to recruit appropriate personnel.

* * * * *

Rural Primary Care Hospital; Rural Primary Care Hospital
Services

(mm)(1) The term “rural primary care hospital means a facility designated by the Secretary as a rural primary care hospital under section [1820(i)(2).] 1820(c), and includes a facility designated by the Secretary under section 1820(i)(2) as in effect on September 30, 1997.

* * * * *

Screening Pap [Smear] Smear; Screening Pelvic Exam

(nn)(1) The term “screening pap smear means a diagnostic laboratory test consisting of a routine exfoliative cytology test (Papanicolaou test) provided to a woman for the purpose of early detection of cervical cancer and includes a physicians interpretation of the results of the test, if the individual involved has not had such a test during the preceding [3 years (or such shorter period as the Secretary may specify in the case of a woman who is at high risk of developing cervical cancer (as determined pursuant to factors identified by the Secretary)).] 3 years, or during the preceding year in the case of a woman described in paragraph (3).

(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).

* * * * *

Prostate Cancer Screening Tests

(oo)(1) The term “prostate cancer screening test means a test that consists of any (or all) of the procedures described in paragraph (2) provided for the purpose of early detection of prostate cancer to a man over 50 years of age who has not had such a test during the preceding year.

(2) The procedures described in this paragraph are as follows:

(A) A digital rectal examination.

(B) A prostate-specific antigen blood test.

(C) For years beginning after 2001, such other procedures as the Secretary finds appropriate for the purpose of early detection of prostate cancer, taking into account changes in technology and standards of medical practice, availability, effectiveness, costs, and such other factors as the Secretary considers appropriate.

Colorectal Cancer Screening Tests

(pp)(1) The term “colorectal cancer screening test means any of the following procedures furnished to an individual for the purpose of early detection of colorectal cancer:

(A) Screening fecal-occult blood test.

(B) Screening flexible sigmoidoscopy.

(C) In the case of an individual at high risk for colorectal cancer, screening colonoscopy.

(D) Screening barium enema, if found by the Secretary to be an appropriate alternative to screening flexible sigmoidoscopy under subparagraph (B) or screening colonoscopy under subparagraph (C).

(E) For years beginning after 2002, such other procedures as the Secretary finds appropriate for the purpose of early detection of colorectal cancer, taking into account changes in technology and standards of medical practice, availability, effectiveness, costs, and such other factors as the Secretary considers appropriate.

(2) In paragraph (1)(C), an “individual at high risk for colorectal cancer is an individual who, because of family history, prior experience of cancer or precursor neoplastic polyps, a history of chronic digestive disease condition (including inflammatory bowel disease, Crohns Disease, or ulcerative colitis), the presence of any appropriate recognized gene markers for colorectal cancer, or other predisposing factors, faces a high risk for colorectal cancer.

Diabetes Outpatient Self-Management Training Services

(qq)(1) The term “diabetes outpatient self-management training services means educational and training services furnished to an individual with diabetes by 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 individuals diabetic condition certifies that such services are needed under a comprehensive plan of care related to the individuals 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 individuals condition.

(2) In paragraph (1)—

(A) a “certified provider is a physician, or other individual or entity designated by the Secretary, 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) a physician, or such other individual or entity, meets the quality standards described in this paragraph if the physician, or individual or entity, meets quality standards established by the Secretary, except that the physician or other individual or entity shall be deemed to have met such standards if the physician or other 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 an organization that represents individuals (including individuals under this title) with diabetes as meeting standards for furnishing the services.

Post-Institutional Home Health Services; Home Health Spell of Illness

(rr)(1) The term “post-institutional home health services” means home health services furnished to an individual—

(A) after discharge from a hospital or rural primary care hospital in which the individual was an inpatient for not less than 3 consecutive days before such discharge if such home health services were initiated within 14 days after the date of such discharge; or

(B) after discharge from a skilled nursing facility in which the individual was provided post-hospital extended care services if such home health services were initiated within 14 days after the date of such discharge.

(2) The term “home health spell of illness” with respect to any individual means a period of consecutive days—

(A) beginning with the first day (not included in a previous home health spell of illness) (i) on which such individual is furnished post-institutional home health services, and (B) which occurs in a month for which the individual is entitled to benefits under part A, and

(B) ending with the close of the first period of 60 consecutive days thereafter on each of which the individual is neither an inpatient of a hospital or rural primary care hospital nor an inpatient of a facility described in section 1819(a)(1) or subsection (y)(1) nor provided home health services.

BONE MASS MEASUREMENT

(ss)(1) The term “bone mass measurement” means a radiologic or radioisotopic procedure or other procedure approved by the Food and Drug Administration performed on a qualified individual (as defined in paragraph (2)) for the purpose of identifying bone mass or detecting bone loss of determining bone quality, and includes a physician’s interpretation of the results of the procedure.

(2) For purposes of this subsection, the term “qualified individual” means an individual who is (in accordance with regulations prescribed by the Secretary)—

(A) an estrogen-deficient woman at clinical risk for osteoporosis;

(B) an individual with vertebral abnormalities;

(C) an individual receiving long-term glucocorticoid steroid therapy;

(D) an individual with primary hyperparathyroidism; or

(E) an individual being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy.

(3) The Secretary shall establish such standards regarding the frequency with which a qualified individual shall be eligible to be provided benefits for bone mass measurement under this title.

EXCLUSIONS FROM COVERAGE AND MEDICARE AS SECONDARY PAYER

SEC. 1862. (a) Notwithstanding any other provision of this title, no payment may be made under part A or part B for any expenses incurred for items or services—

(1)(A) * * *

* * * * *

(D) in the case of clinical care items and services provided with the concurrence of the Secretary and with respect to research and experimentation conducted by, or under contract with, the [Prospective Payment Assessment Commission] Medicare Payment Advisory Commission or the Secretary, which are not reasonable and necessary to carry out the purposes of section 1886(e)(6),

(E) in the case of research conducted pursuant to section 1142, which is not reasonable and necessary to carry out the purposes of that section, [and]

(F) in the case of screening mammography, which is performed more frequently than is covered under section 1834(c)(2) or which is not conducted by a facility described in section 1834(c)(1)(B), and, in the case of screening pap smear and screening pelvic exam, which is performed more frequently than is provided under section 1861(nn)[;],

(G) in the case of prostate cancer screening tests (as defined in section 1861(oo)), which are performed more frequently than is covered under such section,

(H) in the case of colorectal cancer screening tests, which are performed more frequently than is covered under section 1834(d); and

(I) the frequency and duration of home health services which are in excess of normative guidelines that the Secretary shall establish by regulation;

* * * * *

(7) where such expenses are for routine physical checkups, eyeglasses (other than eyewear described in section 1861(s)(8)) or eye examinations for the purpose of prescribing, fitting, or changing eyeglasses, procedures performed (during the course of any eye examination) to determine the refractive state of the eyes, hearing aids or examinations therefor, or immunizations (except as otherwise allowed under section 1861(s)(10) and [paragraph (1)(B) or under paragraph (1)(F)] subparagraphs (B), (F), (G), or (H) of paragraph (I));

* * * * *

(14) which are other than physicians services (as defined in regulations promulgated specifically for purposes of this paragraph), services described by [section 1861(s)(2)(K)(i) or 1861(s)(2)(K)(iii)] section 1861(s)(2)(K), certified nurse-midwife services, qualified psychologist services, and services of a certified registered nurse anesthetist, and which are furnished to an individual who is a patient of a hospital or rural primary care hospital by an entity other than the hospital or rural primary care hospital, unless the services are furnished under ar-

rangements (as defined in section 1861(w)(1)) with the entity made by the hospital or rural primary care hospital; “

(15)(A) which are for services of an assistant at surgery in a cataract operation (including subsequent insertion of an intraocular lens) unless, before the surgery is performed, the appropriate utilization and quality control peer review organization (under part B of title XI) or a carrier under section 1842 has approved of the use of such an assistant in the surgical procedure based on the existence of a complicating medical condition, or

(B) which are for services of an assistant at surgery to which section 1848(i)(2)(B) applies; **[or]**

(16) in the case in which funds may not be used for such items and services under the Assisted Suicide Funding Restriction Act of 1997**[.]**;

(17) which are covered skilled nursing facility services described in section 1888(e)(2)(A)(i)(II) and which are furnished to an individual who is a resident of a skilled nursing facility by an entity other than the skilled nursing facility, unless the services are furnished under arrangements (as defined in section 1861(w)(1)) with the entity made by the skilled nursing facility;

(18) in the case of outpatient occupational therapy services or outpatient physical therapy services furnished as an incident to a physicians professional services (as described in section 1861(s)(2)(A)), that do not meet the standards and conditions under the second sentence of section 1861(g) or 1861(p) as such standards and conditions would apply to such therapy services if furnished by a therapist; or

(19) where such expenses are for home health services furnished to an individual who is under a plan of care of the home health agency if the claim for payment for such services is not submitted by the agency.

Paragraph (7) shall not apply to Federally qualified health center services described in section 1861(aa)(3)(B).

(b) MEDICARE AS SECONDARY PAYER.—

(1) REQUIREMENTS OF GROUP HEALTH PLANS.—

(A) * * *

(B) DISABLED INDIVIDUALS IN LARGE GROUP HEALTH PLANS.—

(i) IN GENERAL.—A large group health plan (as defined in clause **[(iv)] (iii)**) may not take into account that an individual (or a member of the individuals family) who is covered under the plan by virtue of the individuals current employment status with an employer is entitled to benefits under this title under section 226(b).

(ii) EXCEPTION FOR INDIVIDUALS WITH END STAGE RENAL DISEASE.—Subparagraph (C) shall apply instead of clause (i) to an item or service furnished in a month to an individual if for the month the individual is, or (without regard to entitlement under section 226) would upon application be, entitled to benefits under section 226A.

[(iii) SUNSET.—Clause (i) shall only apply to items and services furnished on or after January 1, 1987, and before October 1, 1998.]

[(iv)] (iii) LARGE GROUP HEALTH PLAN DEFINED.—In this subparagraph, the term “large group health plan has the meaning given such term in section 5000(b)(2) of the Internal Revenue Code of 1986, without regard to section 5000(d) of such Code.

(C) INDIVIDUALS WITH END STAGE RENAL DISEASE.—A group health plan (as defined in subparagraph (A)(v))—

(i) may not take into account that an individual is entitled to or eligible for benefits under this title under section 226A during the [12-month] 30-month period which begins with the first month in which the individual becomes entitled to benefits under part A under the provisions of section 226A, or, if earlier, the first month in which the individual would have been entitled to benefits under such part under the provisions of section 226A if the individual had filed an application for such benefits; and

(ii) may not differentiate in the benefits it provides between individuals having end stage renal disease and other individuals covered by such plan on the basis of the existence of end stage renal disease, the need for renal dialysis, or in any other manner;

except that clause (ii) shall not prohibit a plan from paying benefits secondary to this title when an individual is entitled to or eligible for benefits under this title under section 226A after the end of the [12-month] 30-month period described in clause (i). [Effective for items and services furnished on or after February 1, 1991, and before October 1, 1998 (with respect to periods beginning on or after February 1, 1990), this subparagraph shall be applied by substituting “18-month for “12-month each place it appears.]

* * * * *

(F) LIMITATION ON BENEFICIARY LIABILITY.—*An individual who is entitled to benefits under this title and is furnished an item or service for which such benefits are incorrectly paid is not liable for repayment of such benefits under this paragraph unless payment of such benefits was made to the individual.*

(2) MEDICARE SECONDARY PAYER.—

(A) * * *

(B) CONDITIONAL PAYMENT.—

(i) * * *

(ii) ACTION BY UNITED STATES.—In order to recover payment under this title for such an item or service, the United States may bring an action against any entity which is required or responsible [under this subsection to pay] (*directly, as a third-party administrator, or otherwise*) to make payment with respect to such item or service (or any portion thereof) under a primary plan (and may, in accordance with paragraph (3)(A) collect double damages against that entity), or

against any other entity (including any physician or provider) that has received payment from that entity with respect to the item or service, and may join or intervene in any action related to the events that gave rise to the need for the item or service. *The United States may not recover from a third-party administrator under this clause in cases where the third-party administrator would not be able to recover the amount at issue from the employer or group health plan for whom it provides administrative services due to the insolvency or bankruptcy of the employer or plan.*

* * * * *

(v) *CLAIMS-FILING PERIOD.—Notwithstanding any other time limits that may exist for filing a claim under an employer group health plan, the United States may seek to recover conditional payments in accordance with this subparagraph where the request for payment is submitted to the entity required or responsible under this subsection to pay with respect to the item or service (or any portion thereof) under a primary plan within the 3-year period beginning on the date on which the item or service was furnished.*

* * * * *

(e)(1) * * *

[(2) Where an individual eligible for benefits under this title submits a claim for payment for items or services furnished by an individual or entity excluded from participation in the programs under this title, pursuant to section 1128, 1128A, 1156, 1160 (as in effect on September 2, 1982), 1842(j)(2), 1862(d) (as in effect on the date of the enactment of the Medicare and Medicaid Patient and Program Protection Act of 1987), or 1866, and such beneficiary did not know or have reason to know that such individual or entity was so excluded, then, to the extent permitted by this title, and notwithstanding such exclusion, payment shall be made for such items or services. In each such case the Secretary shall notify the beneficiary of the exclusion of the individual or entity furnishing the items or services. Payment shall not be made for items or services furnished by an excluded individual or entity to a beneficiary after a reasonable time (as determined by the Secretary in regulations) after the Secretary has notified the beneficiary of the exclusion of that individual or entity.]

(2) No individual or entity may bill (or collect any amount from) any individual for any item or service for which payment is denied under paragraph (1). No person is liable for payment of any amounts billed for such an item or service in violation of the previous sentence.

* * * * *

(i) In order to supplement the activities of the [Prospective Payment Assessment Commission] *Medicare Payment Advisory Commission* under section 1886(e) in assessing the safety, efficacy, and cost-effectiveness of new and existing medical procedures, the Secretary may carry out, or award grants or contracts for, original re-

search and experimentation of the type described in clause (ii) of section 1886(e)(6)(E) with respect to such a procedure if the Secretary finds that—

(1) * * *

* * * * *

USE OF STATE AGENCIES TO DETERMINE COMPLIANCE BY PROVIDERS OF SERVICES WITH CONDITIONS OF PARTICIPATION

SEC. 1864. (a) The Secretary shall make an agreement with any State which is able and willing to do so under which the services of the State health agency or other appropriate State agency (or the appropriate local agencies) will be utilized by him for the purpose of determining whether an institution therein is a hospital or skilled nursing facility, or whether an agency therein is a home health agency, or whether an agency is a hospice program or whether a facility therein is a rural health clinic as defined in section 1861(aa)(2), a rural primary care hospital, as defined in section 1861(mm)(1), or a comprehensive outpatient rehabilitation facility as defined in section 1861(cc)(2), or whether a laboratory meets the requirements of paragraphs [(15) and 16)] (16) and (17) of section 1861(s) or whether a clinic, rehabilitation agency or public health agency meets the requirements of subparagraph (A) or (B), as the case may be, of section 1861(p)(4), or whether an ambulatory surgical center meets the standards specified under section 1832(a)(2)(F)(i). To the extent that the Secretary finds it appropriate, an institution or agency which such a State (or local) agency certifies is a hospital, skilled nursing facility, rural health clinic, comprehensive outpatient rehabilitation facility, home health agency, or hospice program (as those terms are defined in section 1861) may be treated as such by the Secretary. Any State agency which has such an agreement may (subject to approval of the Secretary) furnish to a skilled nursing facility, after proper request by such facility, such specialized consultative services (which such agency is able and willing to furnish in a manner satisfactory to the Secretary) as such facility may need to meet one or more of the conditions specified in section 1819(a). Any such services furnished by a State agency shall be deemed to have been furnished pursuant to such agreement. Within 90 days following the completion of each survey of any health care facility, ambulatory surgical center, rural health clinic, comprehensive outpatient rehabilitation facility, laboratory, clinic, agency, or organization by the appropriate State or local agency described in the first sentence of this subsection, the Secretary shall make public in readily available form and place, and require (in the case of skilled nursing facilities) the posting in a place readily accessible to patients (and patients' representatives), the pertinent findings of each such survey relating to the compliance of each such health care facility, ambulatory surgical center, rural health clinic, comprehensive outpatient rehabilitation facility, laboratory, clinic, agency, or organization with (1) the statutory conditions of participation imposed under this title and (2) the major additional conditions which the Secretary finds necessary in the interest of health and safety of individuals who are furnished care or services by any such health care facility, ambulatory

surgical center, rural health clinic, comprehensive outpatient rehabilitation facility, laboratory, clinic, agency, or organization. Any agreement under this subsection shall provide for the appropriate State or local agency to maintain a toll-free hotline (1) to collect, maintain, and continually update information on home health agencies located in the State or locality that are certified to participate in the program established under this title (which information shall include in the most recent deficiencies found with respect to patient care in the most recent certification survey conducted by a State agency or accreditation survey conducted by a private accreditation agency under section 1865 with respect to the home health agency, when that survey was completed, whether corrective actions have been taken or are planned, and the sanctions, if any, imposed under this title with respect to the agency) and (2) to receive complaints (and answer questions) with respect to home health agencies in the State or locality. Any such agreement shall provide for such State or local agency to maintain a unit for investigating such complaints that possesses enforcement authority and has access to survey and certification reports, information gather by any private accreditation agency utilized by the Secretary under section 1865, and consumer medical records (but only with the consent of the consumer or his or her legal representative).

AGREEMENTS WITH PROVIDERS OF SERVICES

SEC. 1866. (a)(1) Any provider of services (except a fund designated for purposes of section 1814(g) and section 1835(e)) shall be qualified to participate under this title and shall be eligible for payments under this title if it files with the Secretary an agreement—

(A) * * *

* * * * *

(H)(i) in the case of hospitals which provide services for which payment may be made under this title and in the case of rural primary care hospitals which provide rural primary care hospital services, to have all items and services (other than physicians services as defined in regulations for purposes of section 1862(a)(14), and other than services described by [section 1861(s)(2)(K)(i) or 1861(s)(2)(K)(iii)] *section 1861(s)(2)(K)*, certified nurse-midwife services, qualified psychologist services, and services of a certified registered nurse anesthetist [(i)] *(I)* that are furnished to an individual who is a patient of the hospital, and [(ii)] *(II)* for which the individual is entitled to have payment made under this title, furnished by the hospital or otherwise under arrangements (as defined in section 1861(w)(1)) made by the hospital,

(ii) in the case of skilled nursing facilities which provide covered skilled nursing facility services—

(I) that are furnished to an individual who is a resident of the skilled nursing facility, and

(II) for which the individual is entitled to have payment made under this title,

furnished by the skilled nursing facility or otherwise under arrangements (as defined in section 1861(w)(1)) made by the skilled nursing facility,

* * * * *

(O) **in the case of hospitals and skilled nursing facilities,** to accept as payment in full for **inpatient hospital and extended care services that are covered under this title and are furnished to any individual enrolled with a MedicarePlus organization under part C with an eligible organization (i) with a risk-sharing contract under section 1876, under section 1876(i)(2)(A) (as in effect before February 1, 1985), under section 402(a) of the Social Security Amendments of 1967, or under section 222(a) of the Social Security Amendments of 1972, and (ii) which does not have a contract establishing payment amounts for services furnished to members of the organization the amounts [(in the case of hospitals) or limits (in the case of skilled nursing facilities)] that would be made as a payment in full under this title if the individuals were not so enrolled;**

* * * * *

In the case of a hospital which has an agreement in effect with an organization described in subparagraph (F), which organizations contract with the Secretary under part B of title XI is terminated on or after October 1, 1984, the hospital shall not be determined to be out of compliance with the requirement of such subparagraph during the six month period beginning on the date of the termination of that contract.

(2)(A) A provider of services may charge such individual or other person (i) the amount of any deduction or coinsurance amount imposed pursuant to section 1813(a)(1), (a)(3), or (a)(4), section 1833(b), or section 1861(y)(3) with respect to such items and services (not in excess of the amount customarily charged for such items and services by such provider), and (ii) an amount equal to 20 per centum of the reasonable charges for such items and services (not in excess of 20 per centum of the amount customarily charged for such items and services by such provider) for which payment is made under part B or which are durable medical equipment furnished as home health services (but in the case of items and services furnished to individuals with end-stage renal disease, an amount equal to 20 percent of the estimated amounts for such items and services calculated on the basis established by the Secretary). In the case of items and services described in section 1833(c), clause (ii) of the preceding sentence shall be applied by substituting for 20 percent the proportion which is appropriate under such section. A provider of services may not impose a charge under clause (ii) of the first sentence of this subparagraph with respect to items and services described in section 1861(s)(10)(A) and with respect to clinical diagnostic laboratory tests for which payment is made under part B. Notwithstanding the first sentence of this subparagraph, a home health agency may charge such an individual or person, with respect to covered items subject to payment under section 1834(a), the amount of any deduction imposed under section 1833(b) and 20 percent of the payment basis described in

section 1834(a)(1)(B). *In the case of items and services for which payment is made under part B under the prospective payment system established under section 1833(t), clause (ii) of the first sentence shall be applied by substituting for 20 percent of the reasonable charge, the applicable copayment amount established under section 1833(t)(5).*

* * * * *

(b)(1)

(2) The Secretary may refuse to enter into an agreement under this section or, upon such reasonable notice to the provider and the public as may be specified in regulations, may refuse to renew or may terminate such an agreement after the Secretary—

(A) * * *

(B) has determined that the provider fails substantially to meet the applicable provisions of section 1861, **[or]**

(C) has excluded the provider from participation in a program under this title pursuant to section 1128 or section 1128A**[.],** or

(D) has ascertained that the provider has been convicted of a felony under Federal or State law for an offense which the Secretary determines is inconsistent with the best interests of program beneficiaries.

* * * * *

(f)(1) For purposes of subsection (a)(1)(Q) and sections 1819(c)(2)(E), 1833(s), 1855(i), 1876(c)(8), and 1891(a)(6), the requirement of this subsection is that a provider of services, *MedicarePlus organization*, or prepaid or eligible organization (as the case may be) maintain written policies and procedures with respect to all adult individuals receiving medical care by or through the provider or organization—

(A) * * *

* * * * *

(2) The written information described in paragraph (1)(A) shall be provided to an adult individual—

(A) * * *

* * * * *

(E) in the case of an eligible organization (as defined in section 1876(b)) or an organization provided payments under section 1833(a)(1)(A) or a *MedicarePlus organization*, at the time of enrollment of the individual with the organization.

* * * * *

DETERMINATIONS; APPEALS

SEC. 1869. (a) * * *

(b)(1) * * *

(2) Notwithstanding paragraph (1)(C) and(1)(D), in the case of a claim arising—

(A) under part A, a hearing shall not be available to an individual under paragrph(1)(C) and (1)(D) if he amount in controversy is less than \$100 and judicial review shall not be

available to the individual under that paragraph if the amount in controversy is less than \$1,000; or—

(B) under part B, a hearing shall not be available to an individual under paragraph (1)(C) and (1)(D) if the amount in controversy is less than \$500 or (\$100 in the case of home health services) and judicial review shall not be available to the individual under that paragraph if the aggregate amount in controversy is less than \$1,000.

* * * * *

PAYMENTS TO HEALTH MAINTENANCE ORGANIZATIONS AND COMPETITIVE MEDICAL PLANS

SEC. 1876. (a) * * *

* * * * *

(f)(1) * * *

(2) **【The Secretary】** *Subject to paragraph (4), the Secretary may modify or waive the requirement imposed by paragraph (1) only—*

(A) * * *

* * * * *

(4) Effective for contract periods beginning after December 31, 1996, the Secretary may waive or modify the requirement imposed by paragraph (1) to the extent the Secretary finds that it is in the public interest.

* * * * *

(k)(1) Except as provided in paragraph (3), the Secretary shall not enter into, renew, or continue any risk-sharing contract under this section with an eligible organization for any contract year beginning on or after—

(A) the date standards for MedicarePlus organizations and plans are first established under section 1856 with respect to MedicarePlus organizations that are insurers or health maintenance organizations, or

(B) in the case of such an organization with such a contract in effect as of the date such standards were first established, 1 year after such date.

(2) The Secretary shall not enter into, renew, or continue any risk-sharing contract under this section with an eligible organization for any contract year beginning on or after January 1, 2000.

(3) An individual who is enrolled in part B only and is enrolled in an eligible organization with a risk-sharing contract under this section on December 31, 1998, may continue enrollment in such organization in accordance with regulations issued by not later than July 1, 1998.

(4) Notwithstanding subsection (a), the Secretary shall provide that payment amounts under risk-sharing contracts under this section for months in a year (beginning with January 1998) shall be computed—

(A) with respect to individuals entitled to benefits under both parts A and B, by substituting payment rates under section 1853(a) for the payment rates otherwise established under subsection 1876(a), and

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

For purposes of carrying out this paragraph for payments for months in 1998, the Secretary shall compute, announce, and apply the payment rates under section 1853(a) (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 under this section not in accordance with such rates.

LIMITATION ON CERTAIN PHYSICIAN REFERRALS

SEC. 1877. (a) * * *

* * * * *

(g) SANCTIONS.—

(1) * * *

* * * * *

(6) ADVISORY OPINIONS.—

(A) IN GENERAL.—The Secretary shall issue written advisory opinions concerning whether a referral relating to designated health services (other than clinical laboratory services) is prohibited under this section.

(B) BINDING AS TO SECRETARY AND PARTIES INVOLVED.—Each advisory opinion issued by the Secretary shall be binding as to the Secretary and the party or parties requesting the opinion.

(C) APPLICATION OF CERTAIN PROCEDURES.—The Secretary shall, to the extent practicable, apply the regulations promulgated under section 1128D(b)(5) to the issuance of advisory opinions under this paragraph.

(D) APPLICABILITY.—This paragraph shall apply to requests for advisory opinions made during the period described in section 1128D(b)(6).

* * * * *

LIMITATION ON LIABILITY OF BENEFICIARY WHERE MEDICARE CLAIMS ARE DISALLOWED

SEC. 1879.(a) * * *

* * * * *

(g) The coverage denial described in this subsection [is,] is—

(1) with respect to the provision of home health services to an individual, a failure to meet the requirements of section 1814(a)(2)(C) or section 1835(a)(2)(A) in that the individual—

[(1)] (A) is or was not confined to his home, or

[(2)] (B) does or did not need skilled nursing care on an intermittent basis[.]; and

(2) with respect to the provision of hospice care to an individual, a determination that the individual is not terminally ill.

* * * * *

CERTIFICATION OF MEDICARE SUPPLEMENTAL HEALTH INSURANCE POLICIES

SEC. 1882. (a) * * *

* * * * *

(d)(1) * * *

* * * * *

(3)(A)(i) It is unlawful for a person to sell or issue to an individual entitled to benefits under part A or enrolled under part B of this title (including an individual electing a MedicarePlus plan under section 1851)—

(I) a health insurance policy with knowledge that the policy duplicates health benefits to which the individual is otherwise entitled under this title or title XIX,

(II) in the case of an individual not electing a MedicarePlus plan a medicare supplemental policy with knowledge that the individual is entitled to benefits under another medicare supplemental policy or in the case of an individual electing a MedicarePlus plan, a medicare supplemental policy with knowledge that the policy duplicates health benefits to which the individual is otherwise entitled under the MedicarePlus plan or under another medicare supplemental policy, or

(III) a health insurance policy (other than a medicare supplemental policy) with knowledge that the policy duplicates health benefits to which the individual is otherwise entitled, other than benefits to which the individual is entitled under a requirement of State or Federal law.

(B)(i) It is unlawful for a person to issue or sell a medicare supplemental policy to an individual entitled to benefits under part A or enrolled under part B, whether directly, through the mail, or otherwise, unless—

(I) the person obtains from the individual, as part of the application for the issuance or purchase and on a form described in clause (II), a written statement signed by the individual stating, to the best of the individuals knowledge, what health insurance policies (including any MedicarePlus plan) the individual has, from what source, and whether the individual is entitled to any medical assistance under title XIX, whether as a qualified medicare beneficiary or otherwise, and

* * * * *

(g)(1) For purposes of this section, a medicare supplemental policy is a health insurance policy or other health benefit plan offered by a private entity to individuals who are entitled to have payment made under this title, which provides reimbursement for expenses incurred for services and items for which payment may be made under this title but which are not reimbursable by reason of the applicability of deductibles, coinsurance amounts, or other limitations imposed pursuant to this title; but does not include or a MedicarePlus plan or any such policy or plan of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations (or combination thereof), for employees or former employees (or combination thereof) or for members or former members (or combination

thereof) of the labor organizations and does not include a policy or plan of an eligible organization (as defined in section 1876(b)) if the policy or plan provides benefits pursuant to a contract under section 1876 or an approved demonstration project described in section 603(c) of the Social Security Amendments of 1983, section 2355 of the Deficit Reduction Act of 1984, or section 9412(b) of the Omnibus Budget Reconciliation Act of 1986, or, during the period beginning on the date specified in subsection (p)(1)(C) and ending on December 31, 1995, a policy or plan of an organization if the policy or plan provides benefits pursuant to an agreement under section 1833(a)(1)(A). For purposes of this section, the term "policy includes a certificate issued under such policy.

* * * * *

(s)(1) * * *
(2)(A) * * *

(B) Subject to [subparagraph (C)] *subparagraphs (C) and (D)*, subparagraph (A) shall not be construed as preventing the exclusion of benefits under a policy, during its first 6 months, based on a pre-existing condition for which the policyholder received treatment or was otherwise diagnosed during the 6 months before the policy became effective.

* * * * *

(D) *In the case of a policy issued during the 6-month period described in subparagraph (A) to an individual who is 65 years of age or older as of the date of issuance and who as of the date of the application for enrollment has a continuous period of creditable coverage (as defined in 2701(c) of the Public Health Service Act) of—*

(i) at least 6 months, the policy may not exclude benefits based on a pre-existing condition; or

(ii) of less than 6 months, if the policy excludes benefits based on a preexisting condition, the policy shall reduce the period of any preexisting condition exclusion by the aggregate of the periods of creditable coverage (if any, as so defined) applicable to the individual as of the enrollment date.

The Secretary shall specify the manner of the reduction under clause (ii), based upon the rules used by the Secretary in carrying out section 2701(a)(3) of such Act.

(3)(A) *The issuer of a medicare supplemental policy—*

(i) may not deny or condition the issuance or effectiveness of a medicare supplemental policy described in subparagraph (C) that is offered and is available for issuance to new enrollees by such issuer;

(ii) may not discriminate in the pricing of the policy, because of health status, claims experience, receipt of health care, or medical condition; and

(iii) may not impose an exclusion of benefits based on a pre-existing condition under such policy,

in the case of an individual described in subparagraph (B) who seeks to enroll under the policy not later than 63 days after the date of the termination of enrollment described in such subparagraph and who submits evidence of the date of termination or disenrollment along with the application for such medicare supplemental policy.

(B) *An individual described in this subparagraph is an individual described in any of the following clauses:*

(i) *The individual is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under this title and the plan terminates or ceases to provide any such supplemental health benefits to the individual.*

(ii) *The individual is enrolled with a MedicarePlus organization under a MedicarePlus plan under part C, and there are circumstances permitting discontinuance of the individual's election of the plan under section 1851(c)(4).*

(iii) *The individual is enrolled with an eligible organization under a contract under section 1876, a similar organization operating under demonstration project authority, with an organization under an agreement under section 1833(a)(1)(A), or with an organization under a policy described in subsection (t), and such enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under section 1851(c)(4) and, in the case of a policy described in subsection (t) there is no provision under applicable State law for the continuation of coverage under such policy.*

(iv) *The individual is enrolled under a medicare supplemental policy under this section and such enrollment ceases because—*

(I) of the bankruptcy or insolvency of the issuer or because of other involuntary termination of coverage or enrollment under such policy and there is no provision under applicable State law for the continuation of such coverage;

(II) the issuer of the policy substantially violated a material provision of the policy; or

(III) the issuer (or an agent or other entity acting on the issuer's behalf) misrepresented the policy's provisions in marketing the policy to the individual.

(v) *The individual—*

(I) was enrolled under a medicare supplemental policy under this section,

(II) subsequently terminates such enrollment and enrolls, for the first time, with any MedicarePlus organization under a MedicarePlus plan under part C, any eligible organization under a contract under section 1876, any similar organization operating under demonstration project authority, any organization under an agreement under section 1833(a)(1)(A), or any policy described in subsection (t), and

(III) the subsequent enrollment under subclause (II) is terminated by the enrollee during the first 6 months (or 3 months for terminations occurring on or after January 1, 2003) of such enrollment.

(C)(i) *Subject to clauses (ii) and (iii), a medicare supplemental policy described in this subparagraph has a benefit package classified as "A", "B", "C", or "F" under the standards established under subsection (p)(2).*

(ii) *Only for purposes of an individual described in subparagraph (b)(v), a medicare supplemental policy described in this subparagraph also includes (if available from the same issuer) the same medicare supplemental policy referred to in such sub-*

paragraph in which the individual was most recently previously enrolled.

(iii) For purposes of applying this paragraph in the case of a State that provides for offering of benefit packages other than under the classification referred to in clause (i), the references to benefit packages in such clause are deemed references to comparable benefit packages offered in such State.

(D) At the time of an event described in subparagraph (B) because of which an individual ceases enrollment or loses coverage or benefits under a contract or agreement, policy, or plan, the organization that offers the contract or agreement, the insurer offering the policy, or the administrator of the plan, respectively, shall notify the individual of the rights of the individual, and obligations of issuers of medicare supplemental policies, under subparagraph (A).

[(3)] *(4) Any issuer of a medicare supplemental policy that fails to meet the requirements of [paragraphs (1) and (2)] this subsection is subject to a civil money penalty of not to exceed \$5,000 for each such failure. The provisions of section 1128A (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).*

* * * * *

(u)(1) It is unlawful for a person to sell or issue a policy described in paragraph (2) to an individual with knowledge that the individual has in effect under section 1851 an election of an MSA plan.

(2) A policy described in this subparagraph is a health insurance policy that provides for coverage of expenses that are otherwise required to be counted toward meeting the annual deductible amount provided under the MSA plan.

* * * * *

HOSPITAL PROVIDERS OF EXTENDED CARE SERVICES

SEC. 1883. (a)(1) Any hospital or rural primary care hospital (other than a hospital which has in effect a waiver under subparagraph (A) of the last sentence of section 1861(e)) which has an agreement under section 1866 may (subject to subsection (b)) enter into an agreement with the Secretary under which its inpatient hospital facilities may be used for the furnishing of services of the type which, if furnished by a skilled nursing facility, would constitute extended care services.

* * * * *

PAYMENT TO HOSPITALS FOR INPATIENT HOSPITAL SERVICES

SEC. 1886. (a) * * *

(b)(1) Notwithstanding section 1814(b) but subject to the provisions of section 1813, if the operating costs of inpatient hospital services (as defined in subsection (a)(4)) of a hospital (other than a subsection (d) hospital, as defined in subsection (d)(1)(B) and other than a rehabilitation facility described in subsection (j)(1)) for a cost reporting period subject to this paragraph—

(A) are less than or equal to the target amount (as defined in paragraph (3)) for that hospital for that period, the amount of the payment with respect to such operating costs payable under part A on a per discharge or per admission basis (as the case may be) shall be equal to the amount of such operating costs, plus—

[(i) 50 percent of the amount by which the target amount exceeds the amount of the operating costs, or

[(ii) 5 percent of the target amount, whichever is less; or]

(i) 10 percent of the amount by which the target amount exceeds the amount of the operating costs, or

(ii) 1 percent of the operating costs, whichever is less;

(B) are greater than the target amount but do not exceed 110 percent of the target amount, the amount of the payment with respect to those operating costs payable under part A on a per discharge basis shall equal the target amount; or

[(B)] (C) are [greater than the target amount] greater than 110 percent of the target amount, the amount of the payment with respect to such operating costs payable under part A on a per discharge or per admission basis (as the case may be) shall be equal to (i) the target amount, plus (ii) in the case of cost reporting periods beginning on or after October 1, 1991, an additional amount equal to 50 percent of the amount by which the operating costs [exceed the target amount] exceed 110 percent of the target amount (except that such additional amount may not exceed [10] 20 percent of the target amount) after any exceptions or adjustments are made to such target amount for the cost reporting period;

except that in no case may the amount payable under this title (other than on the basis of a DRG prospective payment rate determined under subsection (d)) with respect to operating costs of inpatient hospital services exceed the maximum amount payable with respect to such costs pursuant to subsection (a).

(2)(A) Notwithstanding paragraph (1), in the case of a hospital or unit that is within a class of hospital described in subparagraph (B) which first receives payments under this section on or after October 1, 1997—

(i) for each of the first 2 full or partial cost reporting periods, the amount of the payment with respect to operating costs described in paragraph (1) under part A on a per discharge or per admission basis (as the case may be) is equal to the lesser of—

(I) the amount of operating costs for such respective period, or

(II) 150 percent of the national median of the operating costs for hospitals in the same class as the hospital for cost reporting periods beginning during the same fiscal year, as adjusted under subparagraph (C); and

(ii) for purposes of computing the target amount for the subsequent cost reporting period, the target amount for the preceding cost reporting period is equal to the amount determined under clause (i) for such preceding period.

(B) For purposes of this paragraph, each of the following shall be treated as a separate class of hospital:

(i) Hospitals described in clause (i) of subsection (d)(1)(B) and psychiatric units described in the matter following clause (v) of such subsection.

(ii) Hospitals described in clause (ii) of such subsection and rehabilitation units described in the matter following clause (v) of such subsection.

(iii) A class of hospitals described in subsection (d)(1)(B)(iv) that the Secretary shall establish based upon a measure of case mix that takes into account acuity.

(iv) Hospitals described in subsection (d)(1)(B)(iv) that are not within the class described in clause (iii).

(C) In applying subparagraph (A)(i)(II) in the case of a hospital or unit, the Secretary shall provide for an appropriate adjustment to the labor-related portion of the amount determined under such subparagraph to take into account differences between average wage-related costs in the area of the hospital and the national average of such costs within the same class of hospital.

(3)(A) Except as provided in [subparagraphs (C), (D), and (E)] subparagraph (C) and succeeding subparagraphs and in paragraph (2)(A)(ii), for purposes of this subsection, the term "target amount" means, with respect to a hospital for a particular 12-month cost reporting period—

(i) * * *

* * * * *

(B)(i) For purposes of subsection (d) and subsection (j) for discharges occurring during a fiscal year, the "applicable percentage increase shall be—

(I) * * *

* * * * *

(XII) for fiscal year 1997, the market basket percentage increase minus 0.5 percentage point for hospitals in all areas, [and]

[(XIII) for fiscal year 1998 and each subsequent fiscal year, the market basket percentage increase for hospitals in all areas.]

(XIII) for fiscal year 1998, 0 percent,

(XIV) for each of the fiscal years 1999 through 2002, the market basket percentage increase minus 1.0 percentage point for hospitals in all areas, and

(XV) for fiscal year 2003 and each subsequent fiscal year, the market basket percentage increase for hospitals in all areas.

(ii) For purposes of subparagraphs (A) and (E), the "applicable percentage increase" for 12-month cost reporting periods beginning during—

(I) * * *

* * * * *

(V) fiscal years 1994 through 1997, is the market basket percentage increase minus the applicable reduction (as defined in clause (v)(II)), or in the case of a hospital for a fiscal year for

which the hospitals update adjustment percentage (as defined in clause (v)(I)) is at least 10 percent, the market basket percentage increase, **[and]**

(VI) for fiscal year 1998, is 0 percent;

(VII) for fiscal years 1999 through 2002, is the applicable update factor specified under clause (vi) for the fiscal year; and

[(VI)] (VIII) subsequent fiscal years is the market basket percentage increase.

(vi) For purposes of clause (ii)(VII) for a fiscal year, if a hospitals allowable operating costs of inpatient hospital services recognized under this title for the most recent cost reporting period for which information is available—

(I) is equal to, or exceeds, 110 percent of the hospitals target amount (as determined under subparagraph (A)) for such cost reporting period, the applicable update factor specified under this clause is the market basket percentage;

(II) exceeds 100 percent, but is less than 110 percent, of such target amount for the hospital, the applicable update factor specified under this clause is 0 percent or, if greater, the market basket percentage minus 0.25 percentage points for each percentage point by which such allowable operating costs (expressed as a percentage of such target amount) is less than 110 percent of such target amount;

(III) is equal to, or less than 100 percent, but exceeds $\frac{2}{3}$ of such target amount for the hospital, the applicable update factor specified under this clause is 0 percent or, if greater, the market basket percentage minus 2.5 percentage points; or

(IV) does not exceed $\frac{2}{3}$ of such target amount for the hospital, the applicable update factor specified under this clause is 0 percent.

* * * * *

(D) For cost reporting periods ending on or before **[September 30, 1994,]** *September 30, 1994, and for cost reporting periods beginning on or after October 1, 1997, and before October 1, 2001,* in the case of a hospital that is a medicare-dependent, small rural hospital (as defined in subsection (d)(5)(G)), the term “target amount means—

(i) * * *

(ii) with respect to a later cost reporting period beginning before fiscal year 1994, the target amount for the preceding 12-month cost reporting period, increased by the applicable percentage increase under subparagraph (B)(iv) for discharges occurring in the fiscal year in which that later cost reporting period begins, **[and]**

(iii) with respect to discharges occurring in fiscal year 1994, the target amount for the cost reporting period beginning in fiscal year 1993 increased by the applicable percentage increase under subparagraph (B)(iv)**[,] and**

(iv) with respect to discharges occurring during fiscal year 1998 through fiscal year 2000, the target amount for the preceding year increased by the applicable percentage increase under subparagraph (B)(iv).

There shall be substituted for the base cost reporting period described in clause (i) a hospitals cost reporting period (if any) begin-

ning during fiscal year 1987 if such substitution results in an increase in the target amount for the hospital.

* * * * *

(F)(i) In the case of a hospital or unit that is within a class of hospital described in clause (ii), for cost reporting periods beginning on or after October 1, 1997, and before October 1, 2002, such target amount may not be greater than the 90th percentile of the target amounts for such hospitals within such class for cost reporting periods beginning during that fiscal year.

(ii) For purposes of this subparagraph, each of the following shall be treated as a separate class of hospital:

(I) Hospitals described in clause (i) of subsection (d)(1)(B) and psychiatric units described in the matter following clause (v) of such subsection.

(II) Hospitals described in clause (ii) of such subsection and rehabilitation units described in the matter following clause (v) of such subsection.

(III) Hospitals described in clause (iv) of such subsection.

(G)(i) In the case of a hospital (or unit described in the matter following clause (v) of subsection (d)(1)(B)) that received payment under this subsection for inpatient hospital services furnished before January 1, 1990, that is within a class of hospital described in clause (iii), and that elects (in a form and manner determined by the Secretary) this subparagraph to apply to the hospital, the target amount for the hospitals 12-month cost reporting period beginning during fiscal year 1998 is equal to the average described in clause (ii).

(ii) The average described in this clause for a hospital or unit shall be determined by the Secretary as follows:

(I) The Secretary shall determine the allowable operating costs for inpatient hospital services for the hospital or unit for each of the 5 cost reporting periods for which the Secretary has the most recent settled cost reports as of the date of the enactment of this subparagraph.

(II) The Secretary shall increase the amount determined under subclause (I) for each cost reporting period by the applicable percentage increase under subparagraph (B)(ii) for each subsequent cost reporting period up to the cost reporting period described in clause (i).

(III) The Secretary shall identify among such 5 cost reporting periods the cost reporting periods for which the amount determined under subclause (II) is the highest, and the lowest.

(IV) The Secretary shall compute the averages of the amounts determined under subclause (II) for the 3 cost reporting periods not identified under subclause (III).

(iii) For purposes of this subparagraph, each of the following shall be treated as a separate class of hospital:

(I) Hospitals described in clause (i) of subsection (d)(1)(B) and psychiatric units described in the matter following clause (v) of such subsection.

(II) Hospitals described in clause (ii) of such subsection and rehabilitation units described in the matter following clause (v) of such subsection.

(III) Hospitals described in clause (iii) of such subsection.

(IV) Hospitals described in clause (iv) of such subsection.

(V) Hospitals described in clause (v) of such subsection.

(H)(i) In the case of a qualified long-term care hospital (as defined in clause (ii)) that elects (in a form and manner determined by the Secretary) this subparagraph to apply to the hospital, the target amount for the hospitals 12-month cost reporting period beginning during fiscal year 1998 is equal to the allowable operating costs of inpatient hospital services (as defined in subsection (a)(4)) recognized under this title for the hospital for the 12-month cost reporting period beginning during fiscal year 1996, increased by the applicable percentage increase for the cost reporting period beginning during fiscal year 1997.

(ii) In clause (i), a “qualified long-term care hospital means, with respect to a cost reporting period, a hospital described in clause (iv) of subsection (d)(1)(B) during each of the 2 cost reporting periods for which the Secretary has the most recent settled cost reports as of the date of the enactment of this subparagraph for each of which—

(I) the hospitals allowable operating costs of inpatient hospital services recognized under this title exceeded 115 percent of the hospitals target amount, and

(II) the hospital would have a disproportionate patient percentage of at least 70 percent (as determined by the Secretary under subsection (d)(5)(F)(vi)) if the hospital were a subsection (d) hospital.

(4)(A)(i) The Secretary shall provide for an [exemption from, or an exception and adjustment to,] *an exception and adjustment to* the method under this subsection for determining the amount of payment to a hospital where events beyond the hospitals control or extraordinary circumstances, including changes in the case mix of such hospital, create a distortion in the increase in costs for a cost reporting period (including any distortion in the costs for the base period against which such increase is measured). The Secretary may provide for such other exemptions from, and exceptions and adjustments to, such method as the Secretary deems appropriate, including the assignment of a new base period which is more representative, as determined by the Secretary, of the reasonable and necessary cost of inpatient services and including those which he deems necessary to take into account a decrease in the inpatient hospital services that a hospital provides and that are customarily provided directly by similar hospitals which results in a significant distortion in the operating costs of inpatient hospital services. The Secretary shall announce a decision on any request for an exemption, exception, or adjustment under this paragraph not later than 180 days after receiving a completed application from the intermediary for such exemption, exception, or adjustment, and shall include in such decision a detailed explanation of the grounds on which such request was approved or denied.

(ii) The payment reductions under paragraph (3)(B)(ii)(V) shall not be considered by the Secretary in making adjustments pursuant to clause (i). *In making such reductions, the Secretary shall treat the applicable update factor described in paragraph (3)(B)(vi) for a fiscal year as being equal to the market basket percentage for that year.*

* * * * *

(d)(1)(A) * * *

(B) As used in this section, the term “subsection (d) hospital” means a hospital located in one of the fifty States or the District of Columbia other than—

- (i) a psychiatric hospital (as defined in section 1861(f)),
- (ii) a rehabilitation hospital (as defined by the Secretary),
- (iii) a hospital whose inpatients are predominantly individuals under 18 years of age,
- (iv) a hospital which has an average inpatient length of stay (as determined by the Secretary) of greater than 25 days, or a hospital that first received payment under this subsection in 1986 which has an average inpatient length of stay (as determined by the Secretary) of greater than 20 days and that has 80 percent or more of its annual total inpatient discharges with a principal diagnosis that reflects a finding of neoplastic disease, or
- (v) a hospital that the Secretary has classified, at any time on or before December 31, 1990, (or, in the case of a hospital that, as of the date of the enactment of this clause, is located in a State operating a demonstration project under section 1814(b), on or before December 31, 1991) for purposes of applying exceptions and adjustments to payment amounts under this subsection, as a hospital involved extensively in treatment for or research on cancer;

and, in accordance with regulations of the Secretary, does not include a psychiatric or rehabilitation unit of the hospital which is a distinct part of the hospital (as defined by the Secretary). A hospital that was classified by the Secretary on or before September 30, 1995, as a hospital described in clause (iv) shall continue to be so classified notwithstanding that it is located in the same building as, or on the same campus as, another hospital.

(2) The Secretary shall determine a national adjusted DRG prospective payment rate, for each inpatient hospital discharge in fiscal year 1984 involving inpatient hospital services of a subsection (d) hospital in the United States, and shall determine a regional adjusted DRG prospective payment rate for such discharges in each region, for which payment may be made under part A of this title. Each such rate shall be determined for hospitals located in urban or rural areas within the United States or within each such region, respectively, as follows:

(A) * * *

* * * * *

(C) STANDARDIZING AMOUNTS.—The Secretary shall standardize the amount updated under subparagraph (B) for each hospital by—

- (i) excluding an estimate of indirect medical education costs (taking into account, for discharges occurring after September 30, 1986, the amendments made by section 9104(a) of the Medicare and Medicaid Budget Reconciliation Amendments of 1985), *except that the Secretary shall not take into account any reductions in the amount of additional payments under paragraph (5)(B)(ii) resulting from*

the amendments made by section 10506(a) of the Balanced Budget Act of 1997,

* * * * *

(5)(A)(i) * * *

(ii) For cases which are not included in clause (i), a subsection (d) hospital may request additional payments in any case where charges, adjusted to cost, exceed a fixed multiple of the applicable DRG prospective payment rate, or exceed such other fixed dollar amount, whichever is greater, or for discharges in fiscal years beginning on or after October 1, 1994, [exceed the applicable DRG prospective payment rate] *exceed the sum of the applicable DRG prospective payment rate plus any amounts payable under paragraphs (d)(5)(B) and (d)(5)(F) plus a fixed dollar amount determined by the Secretary.*

(B) The Secretary shall provide for an additional payment amount for subsection (d) hospitals with indirect costs of medical education, in an amount computed in the same manner as the adjustment for such costs under regulations (in effect as of January 1, 1983) under subsection (a)(2), except as follows:

(i) The amount of such additional payment shall be determined by multiplying (I) the sum of the amount determined under paragraph (1)(A)(ii)(II) (or, if applicable, the amount determined under paragraph (1)(A)(iii)) and, *for cases qualifying for additional payment under subparagraph (A)(i), the amount paid to the hospital under subparagraph (A), by (II) the indirect teaching adjustment factor described in clause (ii).*

[(ii) For purposes of clause (i)(II), the indirect teaching adjustment factor for discharges occurring on or after October 1, 1988, is equal to $1.89 \times (((1+r) \text{ to the } n\text{th power}) - 1)$, where "r" is the ratio of the hospitals full-time equivalent interns and residents to beds and "n" equals .405.]

(ii) *For purposes of clause (i)(II), the indirect teaching adjustment factor for discharges occurring—*

(I) *on or after October 1, 1988 and before October 1, 1997, is equal to $1.89 \times (((1+r) \text{ to the } n\text{th power}) - 1)$,*

(II) *during fiscal year 1998, is equal to $1.62 \times (((1+r) \text{ to the } n\text{th power}) - 1)$, and*

(III) *during or after fiscal year 1999, is equal to $1.35 \times (((1+r) \text{ to the } n\text{th power}) - 1)$,*

where "r" is the ratio of the hospital's full-time equivalent interns and residents to beds and "n" equals 0.405, subject to clause (vi).

* * * * *

(v) *In determining the adjustment with respect to a hospital for discharges occurring on or after October 1, 1997, the total number of interns and residents in either a hospital or non-hospital setting may not exceed the number of interns and residents in the hospital with respect to the hospital's cost reporting period beginning on or before December 31, 1996.*

(vi) *For purposes of clause (ii)—*

(I) *"r" may not exceed the ratio of the number of interns and residents as determined under clause (v) with respect to the hospital for its most recent cost reporting period, to*

the hospital's available beds (as defined by the Secretary) during that cost reporting period,

(II) for the hospital's first cost reporting period beginning on or after October 1, 1997, subject to the limits described in clauses (iv) and (v), the total number of full-time equivalent residents for payment purposes shall equal the average of the actual full-time equivalent resident count for the hospital's most recent cost reporting period and the preceding cost reporting period, and

(III) for the cost reporting period beginning on or after October 1, 1998, and each subsequent cost reporting period, subject to the limits described in clauses (iv) and (v), the total number of full-time equivalent residents for payment purposes shall equal the average of the actual full-time equivalent resident count for the cost reporting period and the preceding two cost reporting periods.

(vii) If the hospital's fiscal year 1998 or later cost reporting period is not equal to twelve months, the Secretary shall make appropriate modifications to ensure that the average full-time equivalent residency count pursuant to subclauses (II) and (III) of clause (vi) is based on the equivalent of full twelve month cost reporting periods.

(viii) The Secretary may establish rules, consistent with the policies in clauses (v) through (vii) and in subsection (h)(6)(A)(ii), with respect to the application of clauses (v) through (vii) in the case of medical residency training programs established on or after January 1, 1997.

* * * * *
 (D)(i) * * *

* * * * *
 (iii) For purposes of this title, the term "sole community hospital means any hospital—

(I) * * *

* * * * *
 (III) that is located in a rural area and designated by the Secretary as an essential access community hospital under section 1820(i)(1) *as in effect on September 30, 1997.*

(v) If the Secretary determines that, in the case of a hospital located in a rural area and designated by the Secretary as an essential access community hospital under section 1820(i)(1) *as in effect on September 30, 1997*, the hospital has incurred increases in reasonable costs during a cost reporting period as a result of becoming a member of a rural health network (as defined in section 1820(g) *as in effect on September 30, 1997*) in the State in which it is located, and in incurring such increases, the hospital will increase its costs for subsequent cost reporting periods, the Secretary shall increase the hospitals target amount under subsection (b)(3)(C) to account for such incurred increases.

* * * * *
 (F)(i) * * *

(ii) The amount of such payment for each discharge shall be determined by multiplying (I) the sum of the amount determined

under paragraph (1)(A)(ii)(II) (or, if applicable, the amount determined under paragraph (1)(A)(iii)) and, *for cases qualifying for additional payment under subparagraph (A)(i)*, the amount paid to the hospital under subparagraph (A) for that discharge, by (II) the disproportionate share adjustment percentage established under clause (iii) or (iv) for the cost reporting period in which the discharge occurs. *For discharges occurring on or after October 1, 1997, the sum described in subclause (I) shall be determined as if the applicable percentage increase described in subsection (b)(3)(B)(i) for discharges for fiscal years 1998 and 1999 were zero percent.*

* * * * *

(G)(i) For any cost reporting period beginning on or after April 1, 1990, and before ~~October 1, 1994,~~ *October 1, 1994, or beginning on or after October 1, 1997, and before October 1, 2001*, in the case of a subsection (d) hospital which is a medicare-dependent, small rural hospital, payment under paragraph (1)(A) shall be equal to the sum of the amount determined under clause (ii) and the amount determined under paragraph (1)(A)(iii).

(ii) The amount determined under this clause is—

(I) * * *

(II) for discharges occurring during any subsequent cost reporting period (or portion thereof) and before ~~October 1, 1994,~~ *October 1, 1994, or beginning on or after October 1, 1997, and before October 1, 2001*, 50 percent of the amount by which the hospitals target amount for the cost reporting period (as defined in subsection (b)(3)(D)) exceeds the amount determined under paragraph (1)(A)(iii).

(I)(i) * * *

* * * * *

(iii) *In carrying out this subparagraph, the Secretary shall treat the term “transfer case as including the case of an individual who, upon discharge from a subsection (d) hospital—*

(I) *is admitted as an inpatient to a hospital or hospital unit that is not a subsection (d) hospital for the receipt of inpatient hospital services;*

(II) *is admitted to a skilled nursing facility or facility described in section 1861(y)(1) for the receipt of extended care services; or*

(III) *receives home health services from a home health agency, if such services directly relate to the condition or diagnosis for which such individual received inpatient hospital services from the subsection (d) hospital, and if such services are provided within an appropriate period as determined by the Secretary in regulations promulgated not later than April 1, 1998.*

* * * * *

(9)(A) Notwithstanding section 1814(b) but subject to the provisions of section 1813, the amount of the payment with respect to the operating costs of inpatient hospital services of a subsection (d) Puerto Rico hospital for inpatient hospital discharges ~~in a fiscal year beginning on or after October 1, 1987,~~ is equal to the sum of—

(i) **75 percent** for discharges beginning on or after October 1, 1997, 50 percent (and for discharges between October 1, 1987, and September 30, 1997, 75 percent) of the Puerto Rico adjusted DRG prospective payment rate (determined under subparagraph (B) or (C)) for such discharges, and

(ii) **25 percent** for discharges beginning in a fiscal year beginning on or after October 1, 1997, 50 percent (and for discharges between October 1, 1997 and September 30, 1997, 25 percent) of the discharge-weighted average of—

(I) the national adjusted DRG prospective payment rate (determined under paragraph (3)(D)) for hospitals located in a large urban area,

(II) such rate for hospitals located in other urban areas, and

(III) such rate for hospitals located in a rural area, for such discharges, adjusted in the manner provided in paragraph (3)(E) for different area wage levels. As used in this section, the term “subsection (d) Puerto Rico hospital” means a hospital that is located in Puerto Rico and that would be a subsection (d) hospital (as defined in paragraph (1)(B)) if it were located in one of the fifty States.

* * * * *
 (10)(A) * * *

* * * * *
 (C)(i) The Board shall consider the application of any subsection (d) hospital requesting that the Secretary change the hospitals geographic classification for purposes of determining for a fiscal year—

(I) the hospitals average standardized amount under paragraph (2)(D), **or**

(II) the factor used to adjust the DRG prospective payment rate for area differences in hospital wage levels that applies to such hospital under paragraph (3)(E)**or**, or

(III) eligibility for and amount of additional payment amounts under paragraph (5)(F).

(D)(i) * * * * *

(iii) Under the guidelines published by the Secretary under clause (i), in the case of a hospital which has ever been classified by the Secretary as a rural referral center under paragraph (5)(C), the Board may not reject the application of the hospital under this paragraph on the basis of any comparison between the average hourly wage of the hospital and the average hourly wage of hospitals in the area in which it is located.

(iii) (iv) The Secretary shall publish the guidelines described in clause (i) by July 1, 1990.

* * * * *
 (e)(1) * * *

(2)(A) The Director of the Congressional Office of Technology Assessment (hereinafter in this subsection referred to as the “Director” and the “Office”, respectively) shall provide for appointment of a Prospective Payment Assessment Commission (hereinafter in this subsection referred to as the “Commission”), to be composed of

independent experts appointed by the Director (without regard to the provisions of title 5, United States Code, governing appointments in the competitive service). The Commission shall review the applicable percentage increase factor described in subsection (b)(3)(B) and make recommendations to the Secretary on the appropriate percentage change which should be effected for hospital inpatient discharges under subsections (b) and (d) for fiscal years beginning with fiscal year 1986. In making its recommendations, the Commission shall take into account changes in the hospital market-basket described in subsection (b)(3)(B), hospital productivity, technological and scientific advances, the quality of health care provided in hospitals (including the quality and skill level of professional nursing required to maintain quality care), and long-term cost-effectiveness in the provision of inpatient hospital services.

[(B) In order to promote the efficient and effective delivery of high-quality health care services, the Commission shall, in addition to carrying out its functions under subparagraph (A), study and make recommendations for each fiscal year regarding changes in each existing reimbursement policy under this title under which payments to an institution are based upon prospectively determined rates and the development of new institutional reimbursement policies under this title, including recommendations relating to payments during such fiscal year under the prospective payment system established under this section for determining payments for the operating costs of inpatient hospital services, including changes in the number of diagnosis-related groups used to classify inpatient hospital discharges under subsection (d), adjustments to such groups to reflect severity of illness, and changes in the methods by which hospitals are reimbursed for capital-related costs, together with general recommendations on the effectiveness and quality of health care delivery systems in the United States and the effects on such systems of institutional reimbursements under this title.

[(C) By not later than June 1 of each year, the Commission shall submit a report to Congress containing an examination of issues affecting health care delivery in the United States, including issues relating to—

[(i) trends in health care costs;

[(ii) the financial condition of hospitals and the effect of the level of payments made to hospitals under this title on such condition;

[(iii) trends in the use of health care services; and

[(iv) new methods used by employers, insurers, and others to constrain growth in health care costs.]

(3)[(A) The Commission, not later than the March 1 before the beginning of each fiscal year (beginning with fiscal year 1986), shall report its recommendations to Congress on an appropriate change factor which should be used for inpatient hospital services for discharges in that fiscal year, together with its general recommendations under paragraph (2)(B) regarding the effectiveness and quality of health care delivery systems in the United States.

[(B)] The Secretary, not later than April 1, 1987, for fiscal year 1988 and not later than March 1 before the beginning of each fiscal year (beginning with fiscal year 1989), shall report to the Congress the Secretary's initial estimate of the percentage change that the

Secretary will recommend under paragraph (4) with respect to that fiscal year.

* * * * *

[(6)(A) The Commission shall consist of 17 individuals. Members of the Commission shall first be appointed no later than April 1, 1984, for a term of three years, except that the Director may provide initially for such shorter terms as will insure that (on a continuing basis) the terms of no more than seven members expire in any one year.

[(B) The membership of the Commission shall include individuals with national recognition for their expertise in health economics, health facility management, reimbursement of health facilities or other providers of services which reflect the scope of the Commission's responsibilities, 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 registered professional nurses, employers, third party payors, individuals skilled in the conduct and interpretation of biomedical, health services, and health economics research, and individuals having expertise in the research and development of technological and scientific advances in health care.

[(C) Subject to such review as the Office deems necessary to assure the efficient administration of the Commission, the Commission may—

[(i) employ and fix the compensation of an Executive Director (subject to the approval of the Director of the Office) and such other personnel (not to exceed 25) 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);

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

[(iii) 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));

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

[(v) provide transportation and subsistence for persons serving without compensation; and

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

Section 10(a)(1) of the Federal Advisory Committee Act shall not apply to any portion of a Commission meeting if the Commission, by majority vote, determines that such portion of such meeting should be closed.

[(D) 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 his regular place of business, a member may be allowed travel expenses, as au-

thorized 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.

[(E) In order to identify medically appropriate patterns of health resources use in accordance with paragraph (2), the Commission shall collect and assess information on medical and surgical procedures and services, including information on regional variations of medical practice and lengths of hospitalization and on other patient-care data, giving special attention to treatment patterns for conditions which appear to involve excessively costly or inappropriate services not adding to the quality of care provided. In order to assess the safety, efficacy, and cost-effectiveness of new and existing medical and surgical procedures, the Commission shall, in coordination to the extent possible with the Secretary, collect and assess factual information, giving special attention to the needs of updating existing diagnosis-related groups, establishing new diagnosis-related groups, and making recommendations on relative weighting factors for such groups to reflect appropriate differences in resource consumption in delivering safe, efficacious, and cost-effective care. In collecting and assessing information, the Commission shall—

[(i) 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 paragraph;

[(ii) carry out, or award grants or contracts for, original research and experimentation, including clinical research, where existing information is inadequate for the development of useful and valid guidelines by the Commission; and

[(iii) adopt procedures allowing any interested party to submit information with respect to medical and surgical procedures and services (including new practices, such as the use of new technologies and treatment modalities), which information the Commission shall consider in making reports and recommendations to the Secretary and Congress.

[(F) The Commission shall have access to such relevant information and data as may be available from appropriate Federal agencies and shall assure that its activities, especially the conduct of original research and medical studies, are coordinated with the activities of Federal agencies.

[(G)(i) The Office shall have unrestricted access to all deliberations, records, and data of the Commission, immediately upon its request.

[(ii) In order to carry out its duties under this paragraph, the Office is authorized to expend reasonable and necessary funds as mutually agreed upon by the Office and the Commission. The Of-

office shall be reimbursed for such funds by the Commission from the appropriations made with respect to the Commission.

[(H) The Commission shall be subject to periodic audit by the General Accounting Office.

[(I)(i) There are authorized to be appropriated such sums as may be necessary to carry out the provisions of this paragraph.

[(ii) Eighty-five percent of such appropriation shall be payable from the Federal Hospital Insurance Trust Fund, and 15 percent of such appropriation shall be payable from the Federal Supplementary Medical Insurance Trust Fund.

[(J) The Commission shall submit requests for appropriations in the same manner as the Office submits requests for appropriations, but amounts appropriated for the Commission shall be separate from amounts appropriated for the Office.]

* * * * *

(g)(1)(A) Notwithstanding section 1861(v), instead of any amounts that are otherwise payable under this title with respect to the reasonable costs of subsection (d) hospitals and subsection (d) Puerto Rico hospitals for capital-related costs of inpatient hospital services, the Secretary shall, for hospital cost reporting periods beginning on or after October 1, 1991, provide for payments for such costs in accordance with a prospective payment system established by the Secretary. Aggregate payments made under subsection (d) and this subsection during fiscal years 1992 through 1995 shall be reduced in a manner that results in a reduction (as estimated by the Secretary) in the amount of such payments equal to a 10 percent reduction in the amount of payments attributable to capital-related costs that would otherwise have been made during such fiscal year had the amount of such payments been based on reasonable costs (as defined in section 1861(v)). For discharges occurring after September 30, 1993, the Secretary shall reduce by 7.4 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 1993) and shall (for hospital cost reporting periods beginning on or after October 1, 1993) redetermine which payment methodology is applied to the hospital under such system to take into account such reduction. *In addition to the reduction described in the preceding sentence, for discharges occurring on or after October 1, 1997, the Secretary shall apply the budget neutrality adjustment factor used to determine the Federal capital payment rate in effect on September 30, 1995 (as described in section 412.352 of title 42 of the Code of Federal Regulations), to (i) the unadjusted standard Federal capital payment rate (as described in section 412.308(c) of that title, as in effect on September 30, 1997), and (ii) the unadjusted hospital-specific rate (as described in section 412.328(e)(1) of that title, as in effect on September 30, 1997).*

(B) Such system—

(i) * * *

* * * * *

(iii) [may provide] shall provide (in accordance with subparagraph (D)) for such exceptions (including appropriate ex-

ceptions to reflect capital obligations) as the Secretary determines to be appropriate, and

* * * * *

(C) *The exceptions under the system provided by the Secretary under subparagraph (B)(iii) shall include the provision of exception payments under the special exceptions process provided under section 412.348(g) of title 42, Code of Federal Regulations (as in effect on September 1, 1995), except that the Secretary shall revise such process, effective for discharges occurring after September 30, 1997, as follows:*

(i) *A hospital with at least 100 beds which is located in an urban area shall be eligible under such process without regard to its disproportionate patient percentage under subsection (d)(5)(F) or whether it qualifies for additional payment amounts under such subsection.*

(ii) *The minimum payment level for qualifying hospitals shall be 85 percent (or such lower percentage, but no lower than 75 percent, as the Secretary may provide to comply with subparagraph (E)).*

(iii) *A hospital shall be considered to meet the requirement that it complete the project involved no later than the end of the hospitals last cost reporting period beginning before October 1, 2002, if—*

(I) *the hospital has obtained a certificate of need for the project approved by the State or a local planning authority by September 1, 1995, and*

(II) *by September 1, 1995, the hospital has expended on the project at least \$750,000 or 10 percent of the estimated cost of the project.*

(iv) *Offsetting amounts, as described in section 412.348(g)(8)(ii) of title 42, Code of Federal Regulations, shall apply except that subparagraph (B) of such section shall be revised to require that the additional payment that would otherwise be payable for the cost reporting period shall be reduced by the amount (if any) by which the hospital's current year medicare capital payments (excluding, if applicable, 75 percent of the hospital's capital-related disproportionate share payments) exceeds its medicare capital costs for such year.*

(D) *The Secretary may reduce the percent specified under subparagraph (C)(ii) (but not below 75 percent) and shall reduce the Federal capital rate for a fiscal year by such percentage as the Secretary determines to be necessary to ensure that the application of subparagraph (C) does not result in an increase in the total amount that would have been paid under this subsection in the fiscal year if such subparagraph did not apply.*

(E) *The Secretary shall provide for publication in the Federal Register each year (beginning with 1999) a description of the distributional impact of the application of subparagraph (C) on hospitals which receive and do not receive, an exception payment under such subparagraph.*

[(C)] (F) *In this paragraph, the term "capital-related costs" has the meaning given such term by the Secretary under subsection*

(a)(4) as of September 30, 1987, and does not include a return on equity capital.

* * * * *

(4) *In determining the amount of the payments that are attributable to portions of cost reporting periods occurring during fiscal years 1998 through 2002 and that may be made under this title with respect to capital-related costs of inpatient hospital services of a hospital which is described in clause (i), (ii), or (iv) of subsection (d)(1)(B) or a unit described in the matter after clause (v) of such subsection, the Secretary shall reduce the amounts of such payments otherwise determined under this title by 10 percent.*

(h) PAYMENTS FOR DIRECT GRADUATE MEDICAL EDUCATION COSTS.—

(1) * * *

* * * * *

(3) HOSPITAL PAYMENT AMOUNT PER RESIDENT.—

(A) * * *

(B) AGGREGATE APPROVED AMOUNT.—As used in subparagraph (A) *subject to subparagraph (D)*, the term “aggregate approved amount” means, for a hospital cost reporting period, the product of—

(i) the hospital’s approved FTE resident amount (determined under paragraph (2)) for that period, and

(ii) the weighted average number of full-time-equivalent residents (as determined under paragraph (4)) in the hospitals approved medical residency training programs in that period.

The Secretary shall reduce the aggregate approved amount to the extent payment is made under subsection (k) for residents included in the hospital’s count of full-time equivalent residents and, in the case of residents not included in any such count, the Secretary shall provide for such a reduction in aggregate approved amounts under this subsection as will assure that the application of subsection (k) does not result in any increase in expenditures under this title in excess of those that would have occurred if subsection (k) were not applicable.

* * * * *

(D) PHASED-IN LIMITATION ON HOSPITAL OVERHEAD AND SUPERVISORY PHYSICIAN COMPONENT.—

(i) *IN GENERAL.—In the case of a hospital for which the overhead GME amount (as defined in clause (ii)) for the base period exceeds an amount equal to the 75th percentile of the overhead GME amounts in such period for all hospitals (weighted to reflect the full-time equivalent resident counts for all approved medical residency training programs), subject to clause (iv), the hospital’s approved FTE resident amount (for periods beginning on or after October 1, 1997) shall be reduced from the amount otherwise applicable (as previously reduced under this subparagraph) by an overhead reduc-*

tion amount. The overhead reduction amount is equal to the lesser of—

(I) 20 percent of the reference reduction amount (described in clause (iii)) for the period, or

(II) 15 percent of the hospital's overhead GME amount for the period (as otherwise determined before the reduction provided under this subparagraph for the period involved).

(ii) OVERHEAD GME AMOUNT.—For purposes of this subparagraph, the term “overhead GME amount” means, for a hospital for a period, the product of—

(I) the percentage of the hospital's approved FTE resident amount for the base period that is not attributable to resident salaries and fringe benefits, and

(II) the hospital's approved FTE resident amount for the period involved.

(iii) REFERENCE REDUCTION AMOUNT.—

(I) IN GENERAL.—The reference reduction amount described in this clause for a hospital for a cost reporting period is the base difference (described in subclause (II)) updated, in a compounded manner for each period from the base period to the period involved, by the update applied for such period to the hospital's approved FTE resident amount.

(II) BASE DIFFERENCE.—The base difference described in this subclause for a hospital is the amount by which the hospital's overhead GME amount in the base period exceeded the 75th percentile of such amounts (as described in clause (i)).

(iv) MAXIMUM REDUCTION TO 75TH PERCENTILE.—In no case shall the reduction under this subparagraph effected for a hospital for a period (below the amount that would otherwise apply for the period if this subparagraph did not apply for any period) exceed the reference reduction amount for the hospital for the period.

(v) BASE PERIOD.—For purposes of this subparagraph, the term “base period” means the cost reporting period beginning in fiscal year 1984 or the period used to establish the hospital's approved FTE resident amount for hospitals that did not have approved residency training programs in fiscal year 1984.

(vi) RULES FOR HOSPITALS INITIATING RESIDENCY TRAINING PROGRAMS.—The Secretary shall establish rules for the application of this subparagraph in the case of a hospital that initiates medical residency training programs during or after the base period.

(4) DETERMINATION OF FULL-TIME-EQUIVALENT RESIDENTS.—

(A) * * *

* * * * *

(F) LIMITATION ON NUMBER OF RESIDENTS FOR CERTAIN FISCAL YEARS.—Such rules shall provide that for purposes of a cost reporting period beginning on or after October 1,

1997, the total number of full-time equivalent residents before application of weighting factors (as determined under this paragraph) with respect to a hospital's approved medical residency training program may not exceed the number of full-time equivalent residents with respect to the hospital's most recent cost reporting period ending on or before December 31, 1996. The Secretary may establish rules, consistent with the policies in the previous sentence and paragraph (6), with respect to the application of the previous sentence in the case of medical residency training programs established on or after January 1, 1997.

(G) COUNTING INTERNS AND RESIDENTS FOR FY 1998 AND SUBSEQUENT YEARS.—

(i) FY 1998.—For the hospital's first cost reporting period beginning during fiscal year 1998, subject to the limit described in subparagraph (F), the total number of full-time equivalent residents, for determining the hospital's graduate medical education payment, shall equal the average of the full-time equivalent resident counts for the cost reporting period and the preceding cost reporting period.

(ii) SUBSEQUENT YEARS.—For each subsequent cost reporting period, subject to the limit described in subparagraph (F), the total number of full-time equivalent residents, for determining the hospital's graduate medical education payment, shall equal the average of the actual full-time equivalent resident counts for the cost reporting period and preceding two cost reporting periods.

(iii) ADJUSTMENT FOR SHORT PERIODS.—If a hospital's cost reporting period beginning on or after October 1, 1997, is not equal to twelve months, the Secretary shall make appropriate modifications to ensure that the average full-time equivalent resident counts pursuant to clause (ii) are based on the equivalent of full 12-month cost reporting periods.

(5) DEFINITIONS AND SPECIAL RULES.—As used in this subsection:

(A) * * *

* * * * *

(G) PERIOD OF BOARD ELIGIBILITY.—

(i) GENERAL RULE.—Subject to clauses (ii) [and (iii)], (iii), and (iv), the term “period of board eligibility” means, for a resident, the minimum number of years of formal training necessary to satisfy the requirements for initial board eligibility in the particular specialty for which the resident is training.

* * * * *

(iv) SPECIAL RULE FOR CERTAIN COMBINED RESIDENCY PROGRAMS.—(I) In the case of a resident enrolled in a combined medical residency training program in which all of the individual programs (that are combined) are for training a primary care resident (as

defined in subparagraph (H)), the period of board eligibility shall be the minimum number of years of formal training required to satisfy the requirements for initial board eligibility in the longest of the individual programs plus one additional year.

(II) A resident enrolled in a combined medical residency training program that includes an obstetrics and gynecology program shall qualify for the period of board eligibility under subclause (I) if the other programs such resident combines with such obstetrics and gynecology program are for training a primary care resident.

(6) INCENTIVE PAYMENT UNDER PLANS FOR VOLUNTARY REDUCTION IN NUMBER OF RESIDENTS.—

(A) IN GENERAL.—In the case of a voluntary residency reduction plan for which an application is approved under subparagraph (B), the qualifying entity submitting the plan shall be paid an applicable hold harmless percentage (as specified in subparagraph (E)) of the sum of—

(i) the amount (if any) by which—

(I) the amount of payment which would have been made under this subsection if there had been a 5 percent reduction in the number of full-time equivalent residents in the approved medical education training programs of the qualifying entity as of June 30, 1997, exceeds

(II) the amount of payment which is made under this subsection, taking into account the reduction in such number effected under the reduction plan; and

(ii) the amount of the reduction in payment under 1886(d)(5)(B) (for hospitals participating in the qualifying entity) that is attributable to the reduction in number of residents effected under the plan below 95 percent of the number of full-time equivalent residents in such programs of such entity as of June 30, 1997.

(B) APPROVAL OF PLAN APPLICATIONS.—The Secretary may not approve the application of an qualifying entity unless—

(i) the application is submitted in a form and manner specified by the Secretary and by not later than March 1, 2000,

(ii) the application provides for the operation of a plan for the reduction in the number of full-time equivalent residents in the approved medical residency training programs of the entity consistent with the requirements of subparagraph (D);

(iii) the entity elects in the application whether such reduction will occur over—

(I) a period of not longer than 5 residency training years, or

(II) a period of 6 residency training years,

except that a qualifying entity described in subparagraph (C)(i)(III) may not make the election described in subclause (II); and

(iv) the Secretary determines that the application and the entity and such plan meet such other requirements as the Secretary specifies in regulations.

(C) QUALIFYING ENTITY.—

(i) **IN GENERAL.**—For purposes of this paragraph, any of the following may be a qualifying entity:

(I) Individual hospitals operating one or more approved medical residency training programs.

(II) Subject to clause (ii), two or more hospitals that operate such programs and apply for treatment under this paragraph as a single qualifying entity.

(III) Subject to clause (iii), a qualifying consortium (as described in section 10735 of the Balanced Budget Act of 1997).

(ii) **ADDITIONAL REQUIREMENT FOR JOINT PROGRAMS.**—In the case of an application by a qualifying entity described in clause (i)(II), the Secretary may not approve the application unless the application represents that the qualifying entity either—

(I) in the case of an entity that meets the requirements of clause (v) of subparagraph (E) will not reduce the number of full-time equivalent residents in primary care during the period of the plan, or

(II) in the case of another entity will not reduce the proportion of its residents in primary care (to the total number of residents) below such proportion as in effect as of the applicable time described in subparagraph (D)(vi).

(iii) **ADDITIONAL REQUIREMENT FOR CONSORTIA.**—In the case of an application by a qualifying entity described in clause (i)(III), the Secretary may not approve the application unless the application represents that the qualifying entity will not reduce the proportion of its residents in primary care (to the total number of residents) below such proportion as in effect as of the applicable time described in subparagraph (D)(vi).

(D) RESIDENCY REDUCTION REQUIREMENTS.—

(i) **INDIVIDUAL HOSPITAL APPLICANTS.**—In the case of a qualifying entity described in subparagraph (A)(i)(I), the number of full-time equivalent residents in all the approved medical residency training programs operated by or through the entity shall be reduced as follows:

(I) If base number of residents exceeds 750 residents, by a number equal to at least 20 percent of such base number.

(II) Subject to subclause (IV), if base number of residents exceeds 500, but is less than 750, residents, by 150 residents.

(III) Subject to subclause (IV), if base number of residents does not exceed 500 residents, by a number equal to at least 25 percent of such base number.

(IV) In the case of a qualifying entity which is described in clause (v) and which elects treatment under this subclause, by a number equal to at least 20 percent of such base number.

(ii) JOINT APPLICANTS.—In the case of a qualifying entity described in subparagraph (C)(i)(II), the number of full-time equivalent residents in all the approved medical residency training programs operated by or through the entity shall be reduced as follows:

(I) Subject to subclause (II), by a number equal to at least 25 percent of such base number.

(II) In the case of a qualifying entity which is described in clause (v) and which elects treatment under this subclause, by a number equal to at least 20 percent of such base number.

(iii) CONSORTIA.—In the case of a qualifying entity described in subparagraph (A)(i)(III), the number of full-time equivalent residents in all the approved medical residency training programs operated by or through the entity shall be reduced by a number equal to at least 20 percent of such base number.

(iv) MANNER OF REDUCTION.—The reductions specified under the preceding provisions of this subparagraph for a qualifying entity shall be below the base number of residents for that entity and shall be fully effective not later than—

(I) the 5th residency training year in which the application under subparagraph (B) is effective, in the case of an entity making the election described in subparagraph (B)(iii)(I), or

(II) the 6th such residency training year, in the case of an entity making the election described in subparagraph (B)(iii)(II).

(v) ENTITIES PROVIDING ASSURANCE OF MAINTENANCE OF PRIMARY CARE RESIDENTS.—An entity is described in this clause if—

(I) the base number of residents for the entity is less than 750;

(II) the number of full-time equivalent residents in primary care included in the base number of residents for the entity is at least 10 percent of such base number; and

(III) the entity represents in its application under subparagraph (B) that there will be no reduction under the plan in the number of full-time equivalent residents in primary care.

If a qualifying entity fails to comply with the representation described in subclause (III), the entity shall be subject to repayment of all amounts paid under this

paragraph, in accordance with procedures established to carry out subparagraph (F).

(vi) *BASE NUMBER OF RESIDENTS DEFINED.*—For purposes of this paragraph, the term “base number of residents” means, with respect to a qualifying entity operating approved medical residency training programs, the number of full-time equivalent residents in such programs (before application of weighting factors) of the entity as of the most recent cost reporting period ending before June 30, 1997, or, if less, for any subsequent cost reporting period that ends before the date the entity makes application under this paragraph.

(E) *APPLICABLE HOLD HARMLESS PERCENTAGE.*—

(i) *IN GENERAL.*—For purposes of subparagraph (A), the “applicable hold harmless percentage” is the percentages specified in clause (ii) or clause (iii), as elected by the qualifying entity in the application submitted under subparagraph (B).

(ii) *5-YEAR REDUCTION PLAN.*—In the case of an entity making the election described in subparagraph (B)(ii)(I), the percentages specified in this clause are, for the—

- (I) first and second residency training years in which the reduction plan is in effect, 100 percent,
- (II) third such year, 75 percent,
- (III) fourth such year, 50 percent, and
- (IV) fifth such year, 25 percent.

(iii) *6-YEAR REDUCTION PLAN.*—In the case of an entity making the election described in subparagraph (B)(iii)(II), the percentages specified in this clause are, for the—

- (I) first residency training year in which the reduction plan is in effect, 100 percent,
- (II) second such year, 95 percent,
- (III) third such year, 85 percent,
- (IV) fourth such year, 70 percent,
- (V) fifth such year, 50 percent, and
- (VI) sixth such year, 25 percent.

(F) *PENALTY FOR INCREASE IN NUMBER OF RESIDENTS IN SUBSEQUENT YEARS.*—If payments are made under this paragraph to a qualifying entity, if the entity (or any hospital operating as part of the entity) increases the number of full-time equivalent residents above the number of such residents permitted under the reduction plan as of the completion of the plan, then, as specified by the Secretary, the entity is liable for repayment to the Secretary of the total amounts paid under this paragraph to the entity.

(G) *TREATMENT OF ROTATING RESIDENTS.*—In applying this paragraph, the Secretary shall establish rules regarding the counting of residents who are assigned to institutions the medical residency training programs in which are not covered under approved applications under this paragraph.

* * * * *

(j) *PROSPECTIVE PAYMENT FOR INPATIENT REHABILITATION SERVICES.*—

(1) *PAYMENT DURING TRANSITION PERIOD.*—

(A) *IN GENERAL.*—Notwithstanding section 1814(b), but subject to the provisions of section 1813, the amount of the payment with respect to the operating and capital costs of inpatient hospital services of a rehabilitation hospital or a rehabilitation unit (in this subsection referred to as a “rehabilitation facility”), in a cost reporting period beginning on or after October 1, 2000, and before October 1, 2003, is equal to the sum of—

(i) the TEFRA percentage (as defined in subparagraph (C)) of the amount that would have been paid under part A with respect to such costs if this subsection did not apply, and

(ii) the prospective payment percentage (as defined in subparagraph (C)) of the product of (I) the per unit payment rate established under this subsection for the fiscal year in which the payment unit of service occurs, and (II) the number of such payment units occurring in the cost reporting period.

(B) *FULLY IMPLEMENTED SYSTEM.*—Notwithstanding section 1814(b), but subject to the provisions of section 1813, the amount of the payment with respect to the operating and capital costs of inpatient hospital services of a rehabilitation facility for a payment unit in a cost reporting period beginning on or after October 1, 2003, is equal to the per unit payment rate established under this subsection for the fiscal year in which the payment unit of service occurs.

(C) *TEFRA AND PROSPECTIVE PAYMENT PERCENTAGES SPECIFIED.*—For purposes of subparagraph (A), for a cost reporting period beginning—

(i) on or after October 1, 2000, and before October 1, 2001, the “TEFRA percentage” is 75 percent and the “prospective payment percentage” is 25 percent;

(ii) on or after October 1, 2001, and before October 1, 2002, the “TEFRA percentage” is 50 percent and the “prospective payment percentage” is 50 percent; and

(iii) on or after October 1, 2002, and before October 1, 2003, the “TEFRA percentage” is 25 percent and the “prospective payment percentage” is 75 percent.

(D) *PAYMENT UNIT.*—For purposes of this subsection, the term “payment unit” means a discharge, day of inpatient hospital services, or other unit of payment defined by the Secretary.

(2) *PATIENT CASE MIX GROUPS.*—

(A) *ESTABLISHMENT.*—The Secretary shall establish—

(i) classes of patients of rehabilitation facilities (each in this subsection referred to as a “case mix group”, based on such factors as the Secretary deems appropriate, which may include impairment, age, related prior hospitalization, comorbidities, and functional capability of the patient; and

(ii) a method of classifying specific patients in rehabilitation facilities within these groups.

(B) *WEIGHTING FACTORS.*—For each case mix group the Secretary shall assign an appropriate weighting which reflects the relative facility resources used with respect to patients classified within that group compared to patients classified within other groups.

(C) *ADJUSTMENTS FOR CASE MIX.*—

(i) *IN GENERAL.*—The Secretary shall from time to time adjust the classifications and weighting factors established under this paragraph as appropriate to reflect changes in treatment patterns, technology, case mix, number of payment units for which payment is made under this title, and other factors which may affect the relative use of resources. Such adjustments shall be made in a manner so that changes in aggregate payments under the classification system are a result of real changes and are not a result of changes in coding that are unrelated to real changes in case mix.

(ii) *ADJUSTMENT.*—Insofar as the Secretary determines that such adjustments for a previous fiscal year (or estimates that such adjustments for a future fiscal year) did (or are likely to) result in a change in aggregate payments under the classification system during the fiscal year that are a result of changes in the coding or classification of patients that do not reflect real changes in case mix, the Secretary shall adjust the per payment unit payment rate for subsequent years so as to discount the effect of such coding or classification changes.

(D) *DATA COLLECTION.*—The Secretary is authorized to require rehabilitation facilities that provide inpatient hospital services to submit such data as the Secretary deems necessary to establish and administer the prospective payment system under this subsection.

(3) *PAYMENT RATE.*—

(A) *IN GENERAL.*—The Secretary shall determine a prospective payment rate for each payment unit for which such rehabilitation facility is entitled to receive payment under this title. Subject to subparagraph (B), such rate for payment units occurring during a fiscal year shall be based on the average payment per payment unit under this title for inpatient operating and capital costs of rehabilitation facilities using the most recent data available (as estimated by the Secretary as of the date of establishment of the system) adjusted—

(i) by updating such per-payment-unit amount to the fiscal year involved by the weighted average of the applicable percentage increases provided under subsection (b)(3)(B)(ii) (for cost reporting periods beginning during the fiscal year) covering the period from the midpoint of the period for such data through the midpoint of fiscal year 2000 and by an increase factor (described in

subparagraph (C)) specified by the Secretary for subsequent fiscal years up to the fiscal year involved;

(ii) by reducing such rates by a factor equal to the proportion of payments under this subsection (as estimated by the Secretary) based on prospective payment amounts which are additional payments described in paragraph (4) (relating to outlier and related payments) or paragraph (7);

(iii) for variations among rehabilitation facilities by area under paragraph (6);

(iv) by the weighting factors established under paragraph (2)(B); and

(v) by such other factors as the Secretary determines are necessary to properly reflect variations in necessary costs of treatment among rehabilitation facilities.

(B) **BUDGET NEUTRAL RATES.**—The Secretary shall establish the prospective payment amounts under this subsection for payment units during fiscal years 2001 through 2004 at levels such that, in the Secretary's estimation, the amount of total payments under this subsection for such fiscal years (including any payment adjustments pursuant to paragraphs (4), (6), and (7)) shall be equal to 99 percent of the amount of payments that would have been made under this title during the fiscal years for operating and capital costs of rehabilitation facilities had this subsection not been enacted. In establishing such payment amounts, the Secretary shall consider the effects of the prospective payment system established under this subsection on the total number of payment units from rehabilitation facilities and other factors described in subparagraph (A).

(C) **INCREASE FACTOR.**—For purposes of this subsection for payment units in each fiscal year (beginning with fiscal year 2001), the Secretary shall establish an increase factor. Such factor shall be based on an appropriate percentage increase in a market basket of goods and services comprising services for which payment is made under this subsection, which may be the market basket percentage increase described in subsection (b)(3)(B)(iii).

(4) **OUTLIER AND SPECIAL PAYMENTS.**—

(A) **OUTLIERS.**—

(i) **IN GENERAL.**—The Secretary may provide for an additional payment to a rehabilitation facility for patients in a case mix group, based upon the patient being classified as an outlier based on an unusual length of stay, costs, or other factors specified by the Secretary.

(ii) **PAYMENT BASED ON MARGINAL COST OF CARE.**—The amount of such additional payment under clause (i) shall be determined by the Secretary and shall approximate the marginal cost of care beyond the cutoff point applicable under clause (i).

(iii) **TOTAL PAYMENTS.**—The total amount of the additional payments made under this subparagraph for payment units in a fiscal year may not exceed 5 percent

of the total payments projected or estimated to be made based on prospective payment rates for payment units in that year.

(B) ADJUSTMENT.—The Secretary may provide for such adjustments to the payment amounts under this subsection as the Secretary deems appropriate to take into account the unique circumstances of rehabilitation facilities located in Alaska and Hawaii.

(5) PUBLICATION.—The Secretary shall provide for publication in the Federal Register, on or before September 1 before each fiscal year (beginning with fiscal year 2001, of the classification and weighting factors for case mix groups under paragraph (2) for such fiscal year and a description of the methodology and data used in computing the prospective payment rates under this subsection for that fiscal year.

(6) AREA WAGE ADJUSTMENT.—The Secretary shall adjust the proportion (as estimated by the Secretary from time to time) of rehabilitation facilities' costs which are attributable to wages and wage-related costs, of the prospective payment rates computed under paragraph (3) for area differences in wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the rehabilitation facility compared to the national average wage level for such facilities. Not later than October 1, 2001 (and at least every 36 months thereafter), the Secretary shall update the factor under the preceding sentence on the basis of a survey conducted by the Secretary (and updated as appropriate) of the wages and wage-related costs incurred in furnishing rehabilitation services. Any adjustments or updates made under this paragraph for a fiscal year shall be made in a manner that assures that the aggregated payments under this subsection in the fiscal year are not greater or less than those that would have been made in the year without such adjustment.

(7) ADDITIONAL ADJUSTMENTS.—The Secretary may provide by regulation for—

(A) an additional payment to take into account indirect costs of medical education and the special circumstances of hospitals that serve a significantly disproportionate number of low-income patients in a manner similar to that provided under subparagraphs (B) and (F), respectively, of subsection (d)(5); and

(B) such other exceptions and adjustments to payment amounts under this subsection in a manner similar to that provided under subsection (d)(5)(I) in relation to payments under subsection (d).

(8) LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1878 or otherwise of—

(A) the establishment of case mix groups, of the methodology for the classification of patients within such groups, and of the appropriate weighting factors thereof under paragraph (2),

(B) the establishment of the prospective payment rates under paragraph (3),

- (C) the establishment of outlier and special payments under paragraph (4),
- (D) the establishment of area wage adjustments under paragraph (6), and
- (E) the establishment of additional adjustments under paragraph (7).

(k) PAYMENT TO NON-HOSPITAL PROVIDERS.—

(1) REPORT.—The Secretary shall submit to Congress, not later than 18 months after the date of the enactment of this subsection, a proposal for payment to qualified non-hospital providers for their direct costs of medical education, if those costs are incurred in the operation of an approved medical residency training program described in subsection (h). Such proposal shall specify the amounts, form, and manner in which such payments will be made and the portion of such payments that will be made from each of the trust funds under this title.

(2) EFFECTIVENESS.—Except as otherwise provided in law, the Secretary may implement such proposal for residency years beginning not earlier than 6 months after the date of submittal of the report under paragraph (1).

(3) QUALIFIED NON-HOSPITAL PROVIDERS.—For purposes of this subsection, the term “qualified non-hospital provider” means—

- (A) a Federally qualified health center, as defined in section 1861(aa)(4);
- (B) a rural health clinic, as defined in section 1861(aa)(2);
- (C) MedicarePlus organizations; and
- (D) such other providers (other than hospitals) as the Secretary determines to be appropriate.

* * * * *

PAYMENT TO SKILLED NURSING FACILITIES FOR ROUTINE SERVICE COSTS

SEC. 1888. (a) * * *

* * * * *

(e) PROSPECTIVE PAYMENT.—

(1) PAYMENT PROVISION.—Notwithstanding any other provision of this title, subject to paragraph (7), the amount of the payment for all costs (as defined in paragraph (2)(B)) of covered skilled nursing facility services (as defined in paragraph (2)(A)) for each day of such services furnished—

- (A) in a cost reporting period during the transition period (as defined in paragraph (2)(E)), is equal to the sum of—
 - (i) the non-Federal percentage of the facility-specific per diem rate (computed under paragraph (3)), and
 - (ii) the Federal percentage of the adjusted Federal per diem rate (determined under paragraph (4)) applicable to the facility; and
- (B) after the transition period is equal to the Federal per diem rate applicable to the facility.

(2) DEFINITIONS.—For purposes of this subsection:

- (A) COVERED SKILLED NURSING FACILITY SERVICES.—

(i) *IN GENERAL.*—The term “covered skilled nursing facility services—

(I) means post-hospital extended care services as defined in section 1861(i) for which benefits are provided under part A; and

(II) includes all items and services (other than services described in clause (ii)) for which payment may be made under part B and which are furnished to an individual who is a resident of a skilled nursing facility during the period in which the individual is provided covered post-hospital extended care services.

(ii) *SERVICES EXCLUDED.*—Services described in this clause are physicians’ services, services described by clauses (i) through (ii) of section 1861(s)(2)(K), certified nurse-midwife services, qualified psychologist services, services of a certified registered nurse anesthetist, items and services described in subparagraphs in (F) and (O) of section 1861(s)(2), and, only with respect to services furnished during 1998, the transportation costs of electrocardiogram equipment for electrocardiogram tests services (HCPCS Code R0076). Services described in this clause do not include any physical, occupational, or speech-language therapy services regardless of whether or not the services are furnished by, or under the supervision of, a physician or other health care professional.

(B) *ALL COSTS.*—The term “all costs” means routine service costs, ancillary costs, and capital-related costs of covered skilled nursing facility services, but does not include costs associated with approved educational activities.

(C) *NON-FEDERAL PERCENTAGE; FEDERAL PERCENTAGE—FOR—*

(i) the first cost reporting period (as defined in subparagraph (D)) of a facility, the “non-Federal percentage” is 75 percent and the “Federal percentage” is 25 percent;

(ii) the next cost reporting period of such facility, the “non-Federal percentage” is 50 percent and the “Federal percentage” is 50 percent; and

(iii) the subsequent cost reporting period of such facility, the “non-Federal percentage” is 25 percent and the “Federal percentage” is 75 percent.

(D) *FIRST COST REPORTING PERIOD.*—The term “first cost reporting period” means, with respect to a skilled nursing facility, the first cost reporting period of the facility beginning on or after July 1, 1998.

(E) *TRANSITION PERIOD.*—

(i) *IN GENERAL.*—The term “transition period” means, with respect to a skilled nursing facility, the 3 cost reporting periods of the facility beginning with the first cost reporting period.

(ii) *TREATMENT OF NEW SKILLED NURSING FACILITIES.*—In the case of a skilled nursing facility that does

not have a settled cost report for a cost reporting period before July 1, 1998, payment for such services shall be made under this subsection as if all services were furnished after the transition period.

(3) *DETERMINATION OF FACILITY SPECIFIC PER DIEM RATES.*—The Secretary shall determine a facility-specific per diem rate for each skilled nursing facility for a cost reporting period as follows:

(A) *DETERMINING BASE PAYMENTS.*—The Secretary shall determine, on a per diem basis, the total of—

(i) the allowable costs of extended care services for the facility for cost reporting periods beginning in 1995 with appropriate adjustments (as determined by the Secretary) to non-settled cost reports, and

(ii) an estimate of the amounts that would be payable under part B (disregarding any applicable deductibles, coinsurance and copayments) for covered skilled nursing facility services described in paragraph (2)(A)(i)(II) furnished during such period to an individual who is a resident of the facility, regardless of whether or not the payment was made to the facility or to another entity.

(B) *UPDATE TO COST REPORTING PERIOD BEFORE FIRST COST REPORTING PERIOD.*—The Secretary shall update the amount determined under subparagraph (A), for each cost reporting period after the cost reporting period described in subparagraph (A)(i) and up to the cost reporting period immediately preceding the first cost reporting period, by the skilled nursing facility historical trend factor.

(C) *UPDATING TO APPLICABLE COST REPORTING PERIOD.*—The Secretary shall further update such amount for each cost reporting period beginning with the first cost reporting period and up to and including the cost reporting period involved by a factor equal to the skilled nursing facility market basket percentage increase.

(4) *FEDERAL PER DIEM RATE.*—

(A) *DETERMINATION OF HISTORICAL PER DIEM FOR FREE-STANDING FACILITIES.*—For each freestanding skilled nursing facility that received payments for post-hospital extended care services during a cost reporting period beginning in fiscal year 1995 and that was subject to (and not exempted from) the per diem limits referred to in paragraph (1) or (2) of subsection (a) (and facilities described in subsection (d), if appropriate), the Secretary shall estimate, on a per diem basis for such cost reporting period, the total of—

(i) the allowable costs of extended care services for the facility for cost reporting periods beginning in 1995 with appropriate adjustments (as determined by the Secretary) to non-settled cost reports, and

(ii) an estimate of the amounts that would be payable under part B (disregarding any applicable deductibles, coinsurance and copayments) for covered skilled nursing facility services described in paragraph

(2)(A)(i)(II) furnished during such period to an individual who is a resident of the facility, regardless of whether or not the payment was made to the facility or to another entity.

(B) UPDATE TO FISCAL YEAR 1998.—The Secretary shall update the amount determined under subparagraph (A), for each cost reporting period after the cost reporting period described in subparagraph (A)(i) and up to the cost reporting period immediately preceding the first cost reporting period, by the skilled nursing facility historical trend factor for such period.

(C) COMPUTATION OF STANDARDIZED PER DIEM RATE.—The Secretary shall standardize the amount updated under subparagraph (B) for each facility by—

(i) adjusting for variations among facility by area in the average facility wage level per diem, and

(ii) adjusting for variations in case mix per diem among facilities.

(D) COMPUTATION OF WEIGHTED AVERAGE PER DIEM RATE.—The Secretary shall compute a weighted average per diem rate by computing an average of the standardized amounts computed under subparagraph (C), weighted for each facility by number of days of extended care services furnished during the cost reporting period referred to in subparagraph (A). The Secretary may compute and apply such average separately for facilities located in urban and rural areas (as defined in section 1886(d)(2)(D)).

(E) UPDATING.—

(i) FISCAL YEAR 1998.—For fiscal year 1998, the Secretary shall compute for each skilled nursing facility an unadjusted Federal per diem rate equal to the weighted average per diem rate computed under subparagraph (D) and applicable to the facility increased by skilled nursing facility market basket percentage change for the fiscal year involved.

(ii) SUBSEQUENT FISCAL YEARS.—For each subsequent fiscal year the Secretary shall compute for each skilled nursing facility an unadjusted Federal per diem rate equal to the Federal per diem rate computed under this subparagraph for the previous fiscal year and applicable to the facility increased by the skilled nursing facility market basket percentage change for the fiscal year involved.

(F) ADJUSTMENT FOR CASE MIX CREEP.—Insofar as the Secretary determines that such adjustments under subparagraph (G)(i) for a previous fiscal year (or estimates that such adjustments for a future fiscal year) did (or are likely to) result in a change in aggregate payments under this subsection during the fiscal year that are a result of changes in the coding or classification of residents that do not reflect real changes in case mix, the Secretary may adjust unadjusted Federal per diem rates for subsequent years so as to discount the effect of such coding or classification changes.

(G) *APPLICATION TO SPECIFIC FACILITIES.*—The Secretary shall compute for each skilled nursing facility for each fiscal year (beginning with fiscal year 1998) an adjusted Federal per diem rate equal to the unadjusted Federal per diem rate determined under subparagraph (E)) adjusted as follows:

(i) *ADJUSTMENT FOR CASE MIX.*—The Secretary shall provide for an appropriate adjustment to account for case mix. Such adjustment shall be based on a resident classification system, established by the Secretary, that accounts for the relative resource utilization of different patient types. The case mix adjustment shall be based on resident assessment data and other data that the Secretary considers appropriate.

(ii) *ADJUSTMENT FOR GEOGRAPHIC VARIATIONS IN LABOR COSTS.*—The Secretary shall adjust the portion of such per diem rate attributable to wages and wage-related costs for the area in which the facility is located compared to the national average of such costs using an appropriate wage index as determined by the Secretary. Such adjustment shall be done in a manner that does not result in aggregate payments under this subsection that are greater or less than those that would otherwise be made if such adjustment had not been made.

(H) *PUBLICATION OF INFORMATION ON PER DIEM RATES.*—The Secretary shall provide for publication in the Federal Register, before the July 1 preceding each fiscal year (beginning with fiscal year 1999), of—

(i) the unadjusted Federal per diem rates to be applied to days of covered skilled nursing facility services furnished during the fiscal year,

(ii) the case mix classification system to be applied under subparagraph (G)(i) with respect to such services during the fiscal year, and

(iii) the factors to be applied in making the area wage adjustment under subparagraph (G)(ii) with respect to such services.

(5) *SKILLED NURSING FACILITY MARKET BASKET INDEX, PERCENTAGE, AND HISTORICAL TREND FACTOR.*—For purposes of this subsection:

(A) *SKILLED NURSING FACILITY MARKET BASKET INDEX.*—The Secretary shall establish a skilled nursing facility market basket index that reflects changes over time in the prices of an appropriate mix of goods and services included in covered skilled nursing facility services.

(B) *SKILLED NURSING FACILITY MARKET BASKET PERCENTAGE.*—The term “skilled nursing facility market basket percentage” means, for a fiscal year or other annual period and as calculated by the Secretary, the percentage change in the skilled nursing facility market basket index (established under subparagraph (A)) from the midpoint of the prior fiscal year (or period) to the midpoint of the fiscal year (or other period) involved.

(C) *SKILLED NURSING FACILITY HISTORICAL TREND FACTOR.*—The term “skilled nursing facility historical trend factor” means, for a fiscal year or other annual period and as calculated by the Secretary, the percentage change in the skilled nursing facility routine cost index (used in applying per diem routine cost limits under subsection (a)) from the midpoint of the prior fiscal year (or period) to the midpoint of the fiscal year (or other period) involved, reduced (on an annualized basis) by 1 percentage point.

(6) *SUBMISSION OF RESIDENT ASSESSMENT DATA.*—A skilled nursing facility shall provide the Secretary, in a manner and within the timeframes prescribed by the Secretary, the resident assessment data necessary to develop and implement the rates under this subsection. For purposes of meeting such requirement, a skilled nursing facility may submit resident assessment data required under section 1819(b)(3), using the standard instrument designated by the State under section 1819(e)(5).

(7) *TRANSITION FOR MEDICARE LOW VOLUME SKILLED NURSING FACILITIES AND SWING BED HOSPITALS.*—

(A) *IN GENERAL.*—The Secretary shall determine an appropriate manner in which to apply this subsection to the facilities described in subparagraph (B), taking into account the purposes of this subsection, and shall provide that at the end of the transition period (as defined in paragraph (2)(E)) such facilities shall be paid only under this subsection. Payment shall not be made under this subsection to such facilities for cost reporting periods beginning before such date (not earlier than July 1, 1999) as the Secretary specifies.

(B) *FACILITIES DESCRIBED.*—The facilities described in this subparagraph are—

(i) skilled nursing facilities for which payment is made for routine service costs during a cost reporting period, ending prior to the date of the implementation of this paragraph, on the basis of prospective payments under section 1888(d), or

(ii) facilities that have in effect an agreement described in section 1883, for which payment is made for the furnishing of extended care services on a reasonable cost basis under section 1814(l) (as in effect on and after such date).

(8) *LIMITATION ON REVIEW.*—There shall be no administrative or judicial review under section 1869, 1878 or otherwise of—

(A) the establishment of facility specific per diem rates under paragraph (3);

(B) the establishment of Federal per diem rates under paragraph (4), including the computation of the standardized per diem rates under paragraph (4)(C), adjustments and corrections for case mix under paragraphs (4)(F) and (4)(G)(i), and adjustments for variations in labor-related costs under paragraph (4)(G)(ii); and

(C) the establishment of transitional amounts under paragraph (7).

(9) *PAYMENT FOR CERTAIN SERVICES.*—In the case of an item or service furnished by a skilled nursing facility (or by others under arrangement with them made by a skilled nursing facility or under any other contracting or consulting arrangement or otherwise) for which payment would otherwise (but for this paragraph) be made under part B in an amount determined in accordance with section 1833(a)(2)(B), the amount of the payment under such part shall be based on such existing or other fee schedules as the Secretary establishes.

(10) *REQUIRED CODING.*—No payment may be made under part B for items and services (other than services described in paragraph (2)(A)(ii)) furnished to an individual who is a resident of a skilled nursing facility unless the claim for such payment includes a code (or codes) under a uniform coding system specified by the Secretary that identifies the items or services delivered.

CENTERS OF EXCELLENCE

SEC. 1889. (a) *IN GENERAL.*—The Secretary shall use a competitive process to contract with specific hospitals or other entities for furnishing services related to surgical procedures, and for furnishing services (unrelated to surgical procedures) to hospital inpatients that the Secretary determines to be appropriate. The services may include any services covered under this title that the Secretary determines to be appropriate, including post-hospital services.

(b) *QUALITY STANDARDS.*—Only entities that meet quality standards established by the Secretary shall be eligible to contract under this section. Contracting entities shall implement a quality improvement plan approved by the Secretary.

(c) *PAYMENT.*—Payment under this section shall be made on the basis of negotiated all-inclusive rates. The amount of payment made by the Secretary to an entity under this title for services covered under a contract shall be less than the aggregate amount of the payments that the Secretary would have otherwise made for the services.

(d) *CONTRACT PERIOD.*—A contract period shall be 3 years (subject to renewal), so long as the entity continues to meet quality and other contractual standards.

(e) *INCENTIVES FOR USE OF CENTERS.*—Entities under a contract under this section may furnish additional services (at no cost to an individual entitled to benefits under this title) or waive cost-sharing, subject to the approval of the Secretary.

(f) *LIMIT ON NUMBER OF CENTERS.*—The Secretary shall limit the number of centers in a geographic area to the number needed to meet projected demand for contracted services.

CONDITIONS OF PARTICIPATION FOR HOME HEALTH AGENCIES; HOME HEALTH QUALITY “

SEC. 1891. (a) * * *

* * * * *

(g) *PAYMENT ON BASIS OF LOCATION OF SERVICE.*—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, as determined by the Secretary.

* * * * *

PAYMENTS TO, AND COVERAGE OF BENEFITS UNDER, PROGRAMS OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)

SEC. 1894. (a) RECEIPT OF BENEFITS THROUGH ENROLLMENT IN PACE PROGRAM; DEFINITIONS FOR PACE PROGRAM RELATED TERMS.—

(1) BENEFITS THROUGH ENROLLMENT IN A PACE PROGRAM.—In accordance with this section, in the case of an individual who is entitled to benefits under part A or enrolled under part B and who is a PACE program eligible individual (as defined in paragraph (5)) with respect to a PACE program offered by a PACE provider under a PACE program agreement—

(A) the individual may enroll in the program under this section; and

(B) so long as the individual is so enrolled and in accordance with regulations—

(i) the individual shall receive benefits under this title solely through such program, and

(ii) the PACE provider is entitled to payment under and in accordance with this section and such agreement for provision of such benefits.

(2) PACE PROGRAM DEFINED.—For purposes of this section and section 1932, the term “PACE program means a program of all-inclusive care for the elderly that meets the following requirements:

(A) OPERATION.—The entity operating the program is a PACE provider (as defined in paragraph (3)).

(B) COMPREHENSIVE BENEFITS.—The program provides comprehensive health care services to PACE program eligible individuals in accordance with the PACE program agreement and regulations under this section.

(C) TRANSITION.—In the case of an individual who is enrolled under the program under this section and whose enrollment ceases for any reason (including the individual no longer qualifies as a PACE program eligible individual, the termination of a PACE program agreement, or otherwise), the program provides assistance to the individual in obtaining necessary transitional care through appropriate referrals and making the individuals medical records available to new providers.

(3) PACE PROVIDER DEFINED.—

(A) IN GENERAL.—For purposes of this section, the term “PACE provider means an entity that—

(i) subject to subparagraph (B), is (or is a distinct part of) a public entity or a private, nonprofit entity organized for charitable purposes under section 501(c)(3) of the Internal Revenue Code of 1986, and

(ii) has entered into a PACE program agreement with respect to its operation of a PACE program.

(B) *TREATMENT OF PRIVATE, FOR-PROFIT PROVIDERS.*—*Clause (i) of subparagraph (A) shall not apply—*

(i) to entities subject to a demonstration project waiver under subsection (h); and

(ii) after the date the report under section 10014(b) of the Medicare Amendments Act of 1997 is submitted, unless the Secretary determines that any of the findings described in subparagraph (A), (B), (C) or (D) of paragraph (2) of such section are true.

(4) *PACE PROGRAM AGREEMENT DEFINED.*—*For purposes of this section, the term “PACE program agreement means, with respect to a PACE provider, an agreement, consistent with this section, section 1932 (if applicable), and regulations promulgated to carry out such sections, between the PACE provider and the Secretary, or an agreement between the PACE provider and a State administering agency for the operation of a PACE program by the provider under such sections.*

(5) *PACE PROGRAM ELIGIBLE INDIVIDUAL DEFINED.*—*For purposes of this section, the term “PACE program eligible individual means, with respect to a PACE program, an individual who—*

(A) is 55 years of age or older;

(B) subject to subsection (c)(4), is determined under subsection (c) to require the level of care required under the State medicaid plan for coverage of nursing facility services;

(C) resides in the service area of the PACE program; and

(D) meets such other eligibility conditions as may be imposed under the PACE program agreement for the program under subsection (e)(2)(A)(ii).

(6) *PACE PROTOCOL.*—*For purposes of this section, the term “PACE protocol means the Protocol for the Program of All-inclusive Care for the Elderly (PACE), as published by On Lok, Inc., as of April 14, 1995.*

(7) *PACE DEMONSTRATION WAIVER PROGRAM DEFINED.*—*For purposes of this section, the term “PACE demonstration waiver program means a demonstration program under either of the following sections (as in effect before the date of their repeal):*

(A) Section 603(c) of the Social Security Amendments of 1983 (Public Law 98–21), as extended by section 9220 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99–272).

(B) Section 9412(b) of the Omnibus Budget Reconciliation Act of 1986 (Public Law 99–509).

(8) *STATE ADMINISTERING AGENCY DEFINED.*—*For purposes of this section, the term “State administering agency means, with respect to the operation of a PACE program in a State, the agency of that State (which may be the single agency responsible for administration of the State plan under title XIX in the State) responsible for administering PACE program agreements under this section and section 1932 in the State.*

(9) *TRIAL PERIOD DEFINED.*—

(A) IN GENERAL.—*For purposes of this section, the term “trial period” means, with respect to a PACE program oper-*

ated by a PACE provider under a PACE program agreement, the first 3 contract years under such agreement with respect to such program.

(B) *TREATMENT OF ENTITIES PREVIOUSLY OPERATING PACE DEMONSTRATION WAIVER PROGRAMS.*—Each contract year (including a year occurring before the effective date of this section) during which an entity has operated a PACE demonstration waiver program shall be counted under subparagraph (A) as a contract year during which the entity operated a PACE program as a PACE provider under a PACE program agreement.

(10) *REGULATIONS.*—For purposes of this section, the term “regulations” refers to interim final or final regulations promulgated under subsection (f) to carry out this section and section 1932.

(b) *SCOPE OF BENEFITS; BENEFICIARY SAFEGUARDS.*—

(1) *IN GENERAL.*—Under a PACE program agreement, a PACE provider shall—

(A) provide to PACE program eligible individuals, regardless of source of payment and directly or under contracts with other entities, at a minimum—

(i) all items and services covered under this title (for individuals enrolled under this section) and all items and services covered under title XIX, but without any limitation or condition as to amount, duration, or scope and without application of deductibles, copayments, coinsurance, or other cost-sharing that would otherwise apply under this title or such title, respectively; and

(ii) all additional items and services specified in regulations, based upon those required under the PACE protocol;

(B) provide such enrollees access to necessary covered items and services 24 hours per day, every day of the year;

(C) provide services to such enrollees through a comprehensive, multidisciplinary health and social services delivery system which integrates acute and long-term care services pursuant to regulations; and

(D) specify the covered items and services that will not be provided directly by the entity, and to arrange for delivery of those items and services through contracts meeting the requirements of regulations.

(2) *QUALITY ASSURANCE; PATIENT SAFEGUARDS.*—The PACE program agreement shall require the PACE provider to have in effect at a minimum—

(A) a written plan of quality assurance and improvement, and procedures implementing such plan, in accordance with regulations, and

(B) written safeguards of the rights of enrolled participants (including a patient bill of rights and procedures for grievances and appeals) in accordance with regulations and with other requirements of this title and Federal and State law designed for the protection of patients.

(c) *ELIGIBILITY DETERMINATIONS.*—

(1) *IN GENERAL.*—*The determination of whether an individual is a PACE program eligible individual—*

(A) *shall be made under and in accordance with the PACE program agreement, and*

(B) *who is entitled to medical assistance under title XIX, shall be made (or who is not so entitled, may be made) by the State administering agency.*

(2) *CONDITION.*—*An individual is not a PACE program eligible individual (with respect to payment under this section) unless the individual's health status has been determined, in accordance with regulations, to be comparable to the health status of individuals who have participated in the PACE demonstration waiver programs. Such determination shall be based upon information on health status and related indicators (such as medical diagnoses and measures of activities of daily living, instrumental activities of daily living, and cognitive impairment) that are part of a uniform minimum data set collected by PACE providers on potential eligible individuals.*

(3) *ANNUAL ELIGIBILITY RECERTIFICATIONS.*—

(A) *IN GENERAL.*—*Subject to subparagraph (B), the determination described in subsection (a)(5)(B) for an individual shall be reevaluated at least once a year.*

(B) *EXCEPTION.*—*The requirement of annual reevaluation under subparagraph (A) may be waived during a period in accordance with regulations in those cases where the State administering agency determines that there is no reasonable expectation of improvement or significant change in an individual's condition during the period because of the advanced age, severity of the advanced age, severity of chronic condition, or degree of impairment of functional capacity of the individual involved.*

(4) *CONTINUATION OF ELIGIBILITY.*—*An individual who is a PACE program eligible individual may be deemed to continue to be such an individual notwithstanding a determination that the individual no longer meets the requirement of subsection (a)(5)(B) if, in accordance with regulations, in the absence of continued coverage under a PACE program the individual reasonably would be expected to meet such requirement within the succeeding 6-month period.*

(5) *ENROLLMENT; DISENROLLMENT.*—*The enrollment and disenrollment of PACE program eligible individuals in a PACE program shall be pursuant to regulations and the PACE program agreement and shall permit enrollees to voluntarily disenroll without cause at any time.*

(d) *PAYMENTS TO PACE PROVIDERS ON A CAPITATED BASIS.*—

(1) *IN GENERAL.*—*In the case of a PACE provider with a PACE program agreement under this section, except as provided in this subsection or by regulations, the Secretary shall make prospective monthly payments of a capitation amount for each PACE program eligible individual enrolled under the agreement under this section in the same manner and from the same sources as payments are made to a MedicarePlus organization under section 1854 (or, for periods beginning before January 1, 1999, to an eligible organization under a risk-sharing*

contract under section 1876). Such payments shall be subject to adjustment in the manner described in section 1854(a)(2) or section 1876(a)(1)(E), as the case may be.

(2) *CAPITATION AMOUNT.*—The capitation amount to be applied under this subsection for a provider for a contract year shall be an amount specified in the PACE program agreement for the year. Such amount shall be based upon payment rates established for purposes of payment under section 1854 (or, for periods before January 1, 1999, for purposes of risk-sharing contracts under section 1876) and shall be adjusted to take into account the comparative frailty of PACE enrollees and such other factors as the Secretary determines to be appropriate. Such amount under such an agreement shall be computed in a manner so that the total payment level for all PACE program eligible individuals enrolled under a program is less than the projected payment under this title for a comparable population not enrolled under a PACE program. “

(e) *PACE PROGRAM AGREEMENT.*—

(1) *REQUIREMENT.*—

(A) *IN GENERAL.*—The Secretary, in close cooperation with the State administering agency, shall establish procedures for entering into, extending, and terminating PACE program agreements for the operation of PACE programs by entities that meet the requirements for a PACE provider under this section, section 1932, and regulations.

(B) *NUMERICAL LIMITATION.*—

(i) *IN GENERAL.*—The Secretary shall not permit the number of PACE providers with which agreements are in effect under this section or under section 9412(b) of the Omnibus Budget Reconciliation Act of 1986 to exceed—

(I) 40 as of the date of the enactment of this section, or

(II) as of each succeeding anniversary of such date, the numerical limitation under this subparagraph for the preceding year plus 20.

Subclause (II) shall apply without regard to the actual number of agreements in effect as of a previous anniversary date.

(ii) *TREATMENT OF CERTAIN PRIVATE, FOR-PROFIT PROVIDERS.*—The numerical limitation in clause (i) shall not apply to a PACE provider that—

(I) is operating under a demonstration project waiver under subsection (h), or

(II) was operating under such a waiver and subsequently qualifies for PACE provider status pursuant to subsection (a)(3)(B)(ii).

(2) *SERVICE AREA AND ELIGIBILITY.*—

(A) *IN GENERAL.*—A PACE program agreement for a PACE program—

(i) shall designate the service area of the program;

(ii) may provide additional requirements for individuals to qualify as PACE program eligible individuals with respect to the program;

(iii) shall be effective for a contract year, but may be extended for additional contract years in the absence of a notice by a party to terminate and is subject to termination by the Secretary and the State administering agency at any time for cause (as provided under the agreement);

(iv) shall require a PACE provider to meet all applicable State and local laws and requirements; and

(v) shall have such additional terms and conditions as the parties may agree to consistent with this section and regulations.

(B) *SERVICE AREA OVERLAP.*—In designating a service area under a PACE program agreement under subparagraph (A)(i), the Secretary (in consultation with the State administering agency) may exclude from designation an area that is already covered under another PACE program agreement, in order to avoid unnecessary duplication of services and avoid impairing the financial and service viability of an existing program.

(3) *DATA COLLECTION.*—

(A) *IN GENERAL.*—Under a PACE program agreement, the PACE provider shall—

(i) collect data,

(ii) maintain, and afford the Secretary and the State administering agency access to, the records relating to the program, including pertinent financial, medical, and personnel records, and

(iii) make to the Secretary and the State administering agency reports that the Secretary finds (in consultation with State administering agencies) necessary to monitor the operation, cost, and effectiveness of the PACE program under this title and title XIX.

(B) *REQUIREMENTS DURING TRIAL PERIOD.*—During the first three years of operation of a PACE program (either under this section or under a PACE demonstration waiver program), the PACE provider shall provide such additional data as the Secretary specifies in regulations in order to perform the oversight required under paragraph (4)(A).

(4) *OVERSIGHT.*—

(A) *ANNUAL, CLOSE OVERSIGHT DURING TRIAL PERIOD.*—During the trial period (as defined in subsection (a)(9)) with respect to a PACE program operated by a PACE provider, the Secretary (in cooperation with the State administering agency) shall conduct a comprehensive annual review of the operation of the PACE program by the provider in order to assure compliance with the requirements of this section and regulations. Such a review shall include—

(i) an on-site visit to the program site;

(ii) comprehensive assessment of a provider's fiscal soundness;

(iii) comprehensive assessment of the provider's capacity to provide all PACE services to all enrolled participants;

(iv) detailed analysis of the entity's substantial compliance with all significant requirements of this section and regulations; and

(v) any other elements the Secretary or State agency considers necessary or appropriate.

(B) CONTINUING OVERSIGHT.—After the trial period, the Secretary (in cooperation with the State administering agency) shall continue to conduct such review of the operation of PACE providers and PACE programs as may be appropriate, taking into account the performance level of a provider and compliance of a provider with all significant requirements of this section and regulations.

(C) DISCLOSURE.—The results of reviews under this paragraph shall be reported promptly to the PACE provider, along with any recommendations for changes to the providers program, and shall be made available to the public upon request.

(5) TERMINATION OF PACE PROVIDER AGREEMENTS.—

(A) IN GENERAL.—Under regulations—

(i) the Secretary or a State administering agency may terminate a PACE program agreement for cause, and

(ii) a PACE provider may terminate such an agreement after appropriate notice to the Secretary, the State agency, and enrollees.

(B) CAUSES FOR TERMINATION.—In accordance with regulations establishing procedures for termination of PACE program agreements, the Secretary or a State administering agency may terminate a PACE program agreement with a PACE provider for, among other reasons, the fact that—

(i) the Secretary or State administering agency determines that—

(I) there are significant deficiencies in the quality of care provided to enrolled participants; or

(II) the provider has failed to comply substantially with conditions for a program or provider under this section or section 1932; and

(ii) the entity has failed to develop and successfully initiate, within 30 days of the date of the receipt of written notice of such a determination, and continue implementation of a plan to correct the deficiencies.

(C) TERMINATION AND TRANSITION PROCEDURES.—An entity whose PACE provider agreement is terminated under this paragraph shall implement the transition procedures required under subsection (a)(2)(C).

(6) SECRETARY'S OVERSIGHT; ENFORCEMENT AUTHORITY.—

(A) IN GENERAL.—Under regulations, if the Secretary determines (after consultation with the State administering agency) that a PACE provider is failing substantially to comply with the requirements of this section and regulations, the Secretary (and the State administering agency) may take any or all of the following actions:

(i) Condition the continuation of the PACE program agreement upon timely execution of a corrective action plan.

(ii) Withhold some or all further payments under the PACE program agreement under this section or section 1932 with respect to PACE program services furnished by such provider until the deficiencies have been corrected.

(iii) Terminate such agreement.

(B) APPLICATION OF INTERMEDIATE SANCTIONS.—Under regulations, the Secretary may provide for the application against a PACE provider of remedies described in section 1857(f)(2) (or, for periods before January 1, 1999, section 1876(i)(6)(B)) or 1903(m)(5)(B) in the case of violations by the provider of the type described in section 1857(f)(1) (or 1876(i)(6)(A) for such periods) or 1903(m)(5)(A), respectively (in relation to agreements, enrollees, and requirements under this section or section 1932, respectively).

(7) PROCEDURES FOR TERMINATION OR IMPOSITION OF SANCTIONS.—Under regulations, the provisions of section 1857(g) (or for periods before January 1, 1999, section 1876(i)(9)) shall apply to termination and sanctions respecting a PACE program agreement and PACE provider under this subsection in the same manner as they apply to a termination and sanctions with respect to a contract and a MedicarePlus organization under part C (or for such periods an eligible organization under section 1876).

(8) TIMELY CONSIDERATION OF APPLICATIONS FOR PACE PROGRAM PROVIDER STATUS.—In considering an application for PACE provider program status, the application shall be deemed approved unless the Secretary, within 90 days after the date of the submission of the application to the Secretary, either denies such request in writing or informs the applicant in writing with respect to any additional information that is needed in order to make a final determination with respect to the application. After the date the Secretary receives such additional information, the application shall be deemed approved unless the Secretary, within 90 days of such date, denies such request.

(f) REGULATIONS.—

(1) IN GENERAL.—The Secretary shall issue interim final or final regulations to carry out this section and section 1932.

(2) USE OF PACE PROTOCOL.—

(A) IN GENERAL.—In issuing such regulations, the Secretary shall, to the extent consistent with the provisions of this section, incorporate the requirements applied to PACE demonstration waiver programs under the PACE protocol.

(B) FLEXIBILITY.—The Secretary (in close consultation with State administering agencies) may modify or waive such provisions of the PACE protocol in order to provide for reasonable flexibility in adapting the PACE service delivery model to the needs of particular organizations (such as those in rural areas or those that may determine it appropriate to use non-staff physicians accordingly to State licensing law requirements) under this section and section

1932 where such flexibility is not inconsistent with and would not impair the essential elements, objectives, and requirements of the this section, including—

(i) the focus on frail elderly qualifying individuals who require the level of care provided in a nursing facility;

(ii) the delivery of comprehensive, integrated acute and long-term care services;

(iii) the interdisciplinary team approach to care management and service delivery;

(iv) capitated, integrated financing that allows the provider to pool payments received from public and private programs and individuals; and

(v) the assumption by the provider over time of full financial risk.

(3) APPLICATION OF CERTAIN ADDITIONAL BENEFICIARY AND PROGRAM PROTECTIONS.—

(A) IN GENERAL.—In issuing such regulations and subject to subparagraph (B), the Secretary may apply with respect to PACE programs, providers, and agreements such requirements of part C (or, for periods before January 1, 1999, section 1876) and section 1903(m) relating to protection of beneficiaries and program integrity as would apply to MedicarePlus organizations under part C (or for such periods eligible organizations under risk-sharing contracts under section 1876) and to health maintenance organizations under prepaid capitation agreements under section 1903(m).

(B) CONSIDERATIONS.—In issuing such regulations, the Secretary shall—

(i) take into account the differences between populations served and benefits provided under this section and under part C (or, for periods before January 1, 1999, section 1876) and section 1903(m);

(ii) not include any requirement that conflicts with carrying out PACE programs under this section; and

(iii) not include any requirement restricting the proportion of enrollees who are eligible for benefits under this title or title XIX.

(g) WAIVERS OF REQUIREMENTS.—With respect to carrying out a PACE program under this section, the following requirements of this title (and regulations relating to such requirements) are waived and shall not apply:

(1) Section 1812, insofar as it limits coverage of institutional services.

(2) Sections 1813, 1814, 1833, and 1886, insofar as such sections relate to rules for payment for benefits.

(3) Sections 1814(a)(2)(B), 1814(a)(2)(C), and 1835(a)(2)(A), insofar as they limit coverage of extended care services or home health services.

(4) Section 1861(i), insofar as it imposes a 3-day prior hospitalization requirement for coverage of extended care services.

(5) Sections 1862(a)(1) and 1862(a)(9), insofar as they may prevent payment for PACE program services to individuals enrolled under PACE programs.

(h) DEMONSTRATION PROJECT FOR FOR-PROFIT ENTITIES.—

(1) IN GENERAL.—In order to demonstrate the operation of a PACE program by a private, for-profit entity, the Secretary (in close consultation with State administering agencies) shall grant waivers from the requirement under subsection (a)(3) that a PACE provider may not be a for-profit, private entity.

(2) SIMILAR TERMS AND CONDITIONS.—

(A) IN GENERAL.—Except as provided under subparagraph (B), and paragraph (1), the terms and conditions for operation of a PACE program by a provider under this subsection shall be the same as those for PACE providers that are nonprofit, private organizations.

(B) NUMERICAL LIMITATION.—The number of programs for which waivers are granted under this subsection shall not exceed 10. Programs with waivers granted under this subsection shall not be counted against the numerical limitation specified in subsection (e)(1)(B).

(i) CONSTRUCTION.—Nothing in this section or section 1932 shall be construed as preventing a PACE provider from entering into contracts with other governmental or nongovernmental payers for the care of PACE program eligible individuals who are not eligible for benefits under part A, or enrolled under part B, or eligible for medical assistance under title XIX.

PROSPECTIVE PAYMENT FOR HOME HEALTH SERVICES

SEC. 1895. (a) IN GENERAL.—Notwithstanding section 1861(v), the Secretary shall provide, for cost reporting periods beginning on or after October 1, 1999, for payments for home health services in accordance with a prospective payment system established by the Secretary under this section.

(b) SYSTEM OF PROSPECTIVE PAYMENT FOR HOME HEALTH SERVICES.—

(1) IN GENERAL.—The Secretary shall establish under this subsection a prospective payment system for payment for all costs of home health services. Under the system under this subsection all services covered and paid on a reasonable cost basis under the medicare home health benefit as of the date of the enactment of this section, including medical supplies, shall be paid for on the basis of a prospective payment amount determined under this subsection and applicable to the services involved. In implementing the system, the Secretary may provide for a transition (of not longer than 4 years) during which a portion of such payment is based on agency-specific costs, but only if such transition does not result in aggregate payments under this title that exceed the aggregate payments that would be made if such a transition did not occur.

(2) UNIT OF PAYMENT.—In defining a prospective payment amount under the system under this subsection, the Secretary shall consider an appropriate unit of service and the number, type, and duration of visits provided within that unit, potential changes in the mix of services provided within that unit and

their cost, and a general system design that provides for continued access to quality services.

(3) PAYMENT BASIS.—

(A) INITIAL BASIS.—

(i) IN GENERAL.—Under such system the Secretary shall provide for computation of a standard prospective payment amount (or amounts). Such amount (or amounts) shall initially be based on the most current audited cost report data available to the Secretary and shall be computed in a manner so that the total amounts payable under the system for fiscal year 2000 shall be equal to the total amount that would have been made if the system had not been in effect but if the reduction in limits described in clause (ii) had been in effect. Such amount shall be standardized in a manner that eliminates the effect of variations in relative case mix and wage levels among different home health agencies in a budget neutral manner consistent with the case mix and wage level adjustments provided under paragraph (4)(A). Under the system, the Secretary may recognize regional differences or differences based upon whether or not the services or agency are in an urbanized area.

(ii) REDUCTION.—The reduction described in this clause is a reduction by 15 percent in the cost limits and per beneficiary limits described in section 1861(v)(1)(L), as those limits are in effect on September 30, 1999.

(B) ANNUAL UPDATE.—

(i) IN GENERAL.—The standard prospective payment amount (or amounts) shall be adjusted for each fiscal year (beginning with fiscal year 2001) in a prospective manner specified by the Secretary by the home health market basket percentage increase applicable to the fiscal year involved.

(ii) HOME HEALTH MARKET BASKET PERCENTAGE INCREASE.—For purposes of this subsection, the term “home health market basket percentage increase” means, with respect to a fiscal year, a percentage (estimated by the Secretary before the beginning of the fiscal year) determined and applied with respect to the mix of goods and services included in home health services in the same manner as the market basket percentage increase under section 1886(b)(3)(B)(iii) is determined and applied to the mix of goods and services comprising inpatient hospital services for the fiscal year.

(C) ADJUSTMENT FOR OUTLIERS.—*The Secretary shall reduce the standard prospective payment amount (or amounts) under this paragraph applicable to home health services furnished during a period by such proportion as will result in an aggregate reduction in payments for the period equal to the aggregate increase in payments result-*

ing from the application of paragraph (5) (relating to outliers).

(4) PAYMENT COMPUTATION.—

(A) IN GENERAL.—The payment amount for a unit of home health services shall be the applicable standard prospective payment amount adjusted as follows:

(i) CASE MIX ADJUSTMENT.—The amount shall be adjusted by an appropriate case mix adjustment factor (established under subparagraph (B)).

(ii) AREA WAGE ADJUSTMENT.—The portion of such amount that the Secretary estimates to be attributable to wages and wage-related costs shall be adjusted for geographic differences in such costs by an area wage adjustment factor (established under subparagraph (C)) for the area in which the services are furnished or such other area as the Secretary may specify.

(B) ESTABLISHMENT OF CASE MIX ADJUSTMENT FACTORS.—The Secretary shall establish appropriate case mix adjustment factors for home health services in a manner that explains a significant amount of the variation in cost among different units of services.

(C) ESTABLISHMENT OF AREA WAGE ADJUSTMENT FACTORS.—The Secretary shall establish area wage adjustment factors that reflect the relative level of wages and wage-related costs applicable to the furnishing of home health services in a geographic area compared to the national average applicable level. Such factors may be the factors used by the Secretary for purposes of section 1886(d)(3)(E).

(5) OUTLIERS.—The Secretary may provide for an addition or adjustment to the payment amount otherwise made in the case of outliers because of unusual variations in the type or amount of medically necessary care. The total amount of the additional payments or payment adjustments made under this paragraph with respect to a fiscal year may not exceed 5 percent of the total payments projected or estimated to be made based on the prospective payment system under this subsection in that year.

(6) PRORATION OF PROSPECTIVE PAYMENT AMOUNTS.—If a beneficiary elects to transfer to, or receive services from, another home health agency within the period covered by the prospective payment amount, the payment shall be prorated between the home health agencies involved.

(c) REQUIREMENTS FOR PAYMENT INFORMATION.—With respect to home health services furnished on or after October 1, 1998, no claim for such a service may be paid under this title unless—

(1) the claim has the unique identifier (provided under section 1842(r)) for the physician who prescribed the services or made the certification described in section 1814(a)(2) or 1835(a)(2)(A); and

(2) in the case of a service visit described in paragraph (1), (2), (3), or (4) of section 1861(m), the claim has information (coded in an appropriate manner) on the length of time of the service visit, as measured in 15 minute increments.

(d) LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1869 or otherwise of—

- (1) the establishment of a transition period under subsection (b)(1);
- (2) the definition and application of payment units under subsection (b)(2);
- (3) the computation of initial standard prospective payment amounts under subsection (b)(3)(A) (including the reduction described in clause (ii) of such subsection);
- (4) the establishment of the adjustment for outliers under subsection (b)(3)(C);
- (5) the establishment of case mix and area wage adjustments under subsection (b)(4);
- (6) the establishment of any adjustments for outliers under subsection (b)(5); and
- (7) the amounts or types of exceptions or adjustments under subsection (b)(7).

TITLE XIX—GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

* * * * *

STATE PLANS FOR MEDICAL ASSISTANCE

SEC. 1902. (a) A State plan for medical assistance must—

- (1) * * *
- * * * *
- (9) provide—
- (A) * * *

* * * * *

(C) that any laboratory services paid for under such plan must be provided by a laboratory which meets the applicable requirements of section 1861(e)(9) or paragraphs [(15) and (16)] (16) and (17) of section 1861(s), or, in the case of a laboratory which is in a rural health clinic, of section 1861(aa)(2)(G);

* * * * *

(j) Notwithstanding any other requirement of this title, the Secretary may waive or modify any requirement of this title with respect to the medical assistance program in American Samoa and the Northern Mariana Islands, other than a waiver of the Federal medical assistance percentage, the limitation in section 1108(c), or the requirement that payment may be made for medical assistance only with respect to amounts expended by American Samoa or the Northern Mariana Islands for care and services described in paragraphs (1) through [(25)] (26) of section 1905(a).

* * * * *

PAYMENT TO STATES

SEC. 1903. (a) * * *

- * * * *
- (f)(1) * * *
- * * * *

(4) The limitations on payment imposed by the preceding provisions of this subsection shall not apply with respect to any amount expended by a State as medical assistance for any individual described in section 1902(a)(10)(A)(i)(III), 1902(a)(10)(A)(i)(IV), 1902(a)(10)(A)(i)(V), 1902(a)(10)(A)(i)(VI), 1902(a)(10)(A)(i)(VII), 1902(a)(10)(A)(ii)(IX), 1902(a)(10)(A)(ii)(X), or 1905(p)(1) or for any individual—

(A) * * *

* * * * *

(C) with respect to whom there is being paid, or who is eligible, or would be eligible if he were not in a medical institution, to have paid with respect to him, a State supplementary payment and is eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in section 1902(a)(10)(A), or who is a PACE program eligible individual enrolled in a PACE program under section 1932, but only if the income of such individual (as determined under section 1612, but without regard to subsection (b) thereof) does not exceed 300 percent of the supplemental security income benefit rate established by section 1611(b)(1),

at the time of the provision of the medical assistance giving rise to such expenditure.

* * * * *

DEFINITIONS

SEC. 1905. For purposes of this title—

(a) The term “medical assistance means payment of part or all of the cost of the following care and services (if provided in or after the third month before the month in which the recipient makes application for assistance or, in the case of medicare cost-sharing with respect to a qualified medicare beneficiary described in subsection (p)(1), if provided after the month in which the individual becomes such a beneficiary) for individuals, and, with respect to physicians’ or dentists’ services, at the option of the State, to individuals (other than individuals with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in section 1902(a)(10)(A)) not receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A of title IV, and with respect to whom supplemental security income benefits are not being paid under title XVI, who are—

- (i) under the age of 21, or, at the option of the State, under the age of 20, 19, or 18 as the State may choose,
- (ii) relatives specified in section 406(b)(1) with whom a child is living if such child is (or would, if needy, be) a dependent child under part A of title IV,
- (iii) 65 years of age or older,
- (iv) blind, with respect to States eligible to participate in the State plan program established under title XVI,

(v) 18 years of age or older and permanently and totally disabled, with respect to States eligible to participate in the State plan program established under title XVI,

(vi) persons essential (as described in the second sentence of this subsection) to individuals receiving aid or assistance under State plans approved under title I, X, XIV, or XVI,

(vii) blind or disabled as defined in section 1614, with respect to States not eligible to participate in the State plan program established under title XVI,

(viii) pregnant women,

(ix) individuals provided extended benefits under section 1925,

(x) individuals described in section 1902(u)(1), or

(xi) individuals described in section 1902(z)(1),

but whose income and resources are insufficient to meet all of such cost—

(1) * * *

* * * * *

(24) personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are (A) authorized for the individual by a physician in accordance with a plan of treatment or (at the option of the State) otherwise authorized for the individual in accordance with a service plan approved by the State, (B) provided by an individual who is qualified to provide such services and who is not a member of the individuals family, and (C) furnished in a home or other location; **[and]**

(25) services furnished under a PACE program under section 1932 to PACE program eligible individuals enrolled under the program under such section; and

[(25)] (26) any other medical care, and any other type of remedial care recognized under State law, specified by the Secretary.

except as otherwise provided in paragraph (16), such term does not include—

(A) any such payments with respect to care or services for any individual who is an inmate of a public institution (except as a patient in a medical institution); or

(B) any such payments with respect to care or services for any individual who has not attained 65 years of age and who is a patient in an institution for mental diseases.

For purposes of clause (vi) of the preceding sentence, a person shall be considered essential to another individual if such person is the spouse of and is living with such individual, the needs of such person are taken into account in determining the amount of aid or assistance furnished to such individual (under a State plan approved under title I, X, XIV, or XVI), and such person is determined, under such a State plan, to be essential to the well-being of such individual. The payment described in the first sentence may include expenditures for medicare cost-sharing and for premiums under part B of title XVIII for individuals who are eligible for medical assistance under the plan and (A) are receiving aid or assistance under any plan of the State approved under title I, X, XIV,

or XVI, or part A of title IV, or with respect to whom supplemental security income benefits are being paid under title XVI, or (B) with respect to whom there is being paid a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in section 1902(a)(10)(A), and, except in the case of individuals 65 years of age or older and disabled individuals entitled to health insurance benefits under title XVIII who are not enrolled under part B of title XVIII, other insurance premiums for medical or any other type of remedial care or the cost thereof. No service (including counseling) shall be excluded from the definition of "medical assistance solely because it is provided as a treatment service for alcoholism or drug dependency.

* * * * *

PROVISIONS RESPECTING INAPPLICABILITY AND WAIVER OF CERTAIN REQUIREMENTS OF THIS TITLE

SEC. 1915. (a) A State shall not be deemed to be out of compliance with the requirements of paragraphs (1), (10), or (23) of section 1902(a) solely by reason of the fact that the State (or any political subdivision thereof)—

(1) has entered into—

(A) * * *

(B) arrangements through a competitive bidding process or otherwise for the purchase of laboratory services referred to in section 1905(a)(3) or medical devices if the Secretary has found that—

(i) * * *

(ii) any such laboratory services will be provided only through laboratories—

(I) which meet the applicable requirements of section 1861(e)(9) or paragraphs [(15) and (16)] (16) and (17) of section 1861(s), and such additional requirements as the Secretary may require, and

* * * * *

TREATMENT OF INCOME AND RESOURCES FOR CERTAIN INSTITUTIONALIZED SPOUSES

SEC. 1924. (a) SPECIAL TREATMENT FOR INSTITUTIONALIZED SPOUSES.—

(1) * * *

* * * * *

(5) APPLICATION TO INDIVIDUALS RECEIVING SERVICES [FROM ORGANIZATIONS RECEIVING CERTAIN WAIVERS] UNDER PACE PROGRAMS.—This section applies to individuals receiving institutional or noninstitutional services [from any organization receiving a frail elderly demonstration project waiver under section 9412(b) of the Omnibus Budget Reconciliation Act of 1986 or a waiver under section 603(c) of the Social Security Amendments of 1983.] under a PACE demonstration waiver program

(as defined in subsection (a)(7) of section 1894) or under a PACE program under section 1932.

* * * * *

SEC. 1932. PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE).

(a) **OPTION.**—

(1) **IN GENERAL.**—A State may elect to provide medical assistance under this section with respect to PACE program services to PACE program eligible individuals who are eligible for medical assistance under the State plan and who are enrolled in a PACE program under a PACE program agreement. Such individuals need not be eligible for benefits under part A, or enrolled under part B, of title XVIII to be eligible to enroll under this section.

(2) **BENEFITS THROUGH ENROLLMENT IN PACE PROGRAM.**—In the case of an individual enrolled with a PACE program pursuant to such an election—

(A) the individual shall receive benefits under the plan solely through such program, and

(B) the PACE provider shall receive payment in accordance with the PACE program agreement for provision of such benefits.

(3) **APPLICATION OF DEFINITIONS.**—The definitions of terms under section 1894(a) shall apply under this section in the same manner as they apply under section 1894.

(b) **APPLICATION OF MEDICARE TERMS AND CONDITIONS.**—Except as provided in this section, the terms and conditions for the operation and participation of PACE program eligible individuals in PACE programs offered by PACE providers under PACE program agreements under section 1894 shall apply for purposes of this section.

(c) **ADJUSTMENT IN PAYMENT AMOUNTS.**—In the case of individuals enrolled in a PACE program under this section, the amount of payment under this section shall not be the amount calculated under section 1894(d), but shall be an amount, specified under the PACE agreement, which is less than the amount that would otherwise have been made under the State plan if the individuals were not so enrolled. The payment under this section shall be in addition to any payment made under section 1894 for individuals who are enrolled in a PACE program under such section.

(d) **WAIVERS OF REQUIREMENTS.**—With respect to carrying out a PACE program under this section, the following requirements of this title (and regulations relating to such requirements) shall not apply:

(1) Section 1902(a)(1), relating to any requirement that PACE programs or PACE program services be provided in all areas of a State.

(2) Section 1902(a)(10), insofar as such section relates to comparability of services among different population groups.

(3) Sections 1902(a)(23) and 1915(b)(4), relating to freedom of choice of providers under a PACE program.

(4) Section 1903(m)(2)(A), insofar as it restricts a PACE provider from receiving prepaid capitation payments.

(e) *POST-ELIGIBILITY TREATMENT OF INCOME.*—A State may provide for post-eligibility treatment of income for individuals enrolled in PACE programs under this section in the same manner as a State treats post-eligibility income for individuals receiving services under a waiver under section 1915(c).

REFERENCES TO LAWS DIRECTLY AFFECTING MEDICAID PROGRAM

SEC. [1932.] 1933. (a) *AUTHORITY OR REQUIREMENTS TO COVER ADDITIONAL INDIVIDUALS.*—For provisions of law which make additional individuals eligible for medical assistance under this title, see the following:

- (1) * * *
- * * * * *

INTERNAL REVENUE CODE OF 1986

Subtitle A—Income Taxes

* * * * *

CHAPTER 1—NORMAL TAXES AND SURTAXES

* * * * *

PART III—ITEMS SPECIFICALLY EXCLUDED FROM GROSS INCOME

Sec. 101. Certain death benefits.

* * * * *

[Sec. 138. Cross references to other Acts.]

Sec. 138. *MedicarePlus MSA.*

Sec. 139. *Cross references to other Acts.*

* * * * *

SEC. 138. MEDICAREPLUS MSA.

(a) *EXCLUSION.*—Gross income shall not include any payment to the MedicarePlus MSA of an individual by the Secretary of Health and Human Services under part C of title XVIII of the Social Security Act.

(b) *MEDICAREPLUS MSA.*—For purposes of this section, the term “MedicarePlus MSA” means a medical savings account (as defined in section 220(d))—

- (1) which is designated as a MedicarePlus MSA,
- (2) with respect to which no contribution may be made other than—
 - (A) a contribution made by the Secretary of Health and Human Services pursuant to part C of title XVIII of the Social Security Act, or
 - (B) a trustee-to-trustee transfer described in subsection (c)(4),
- (3) the governing instrument of which provides that trustee-to-trustee transfers described in subsection (c)(4) may be made to and from such account, and

(4) which is established in connection with an MSA plan described in section 1859(b)(2) of the Social Security Act.

(c) SPECIAL RULES FOR DISTRIBUTIONS.—

(1) DISTRIBUTIONS FOR QUALIFIED MEDICAL EXPENSES.—In applying section 220 to a MedicarePlus MSA—

(A) qualified medical expenses shall not include amounts paid for medical care for any individual other than the account holder, and

(B) section 220(d)(2)(C) shall not apply.

(2) PENALTY FOR DISTRIBUTIONS FROM MEDICAREPLUS MSA 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 MedicarePlus 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 such 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 MedicarePlus MSA plan covering the account holder as of January 1 of the calendar year in which the taxable year begins.

Section 220(f)(2) shall not apply to any payment or distribution from a MedicarePlus MSA.

(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 MedicarePlus MSAs 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.—Section 220(f)(2) and paragraph (2) of this subsection shall not apply to any payment or distribution from a MedicarePlus MSA to the Secretary of Health and Human Services of an erroneous contribution to such MSA and of the net income attributable to such contribution.

(4) TRUSTEE-TO-TRUSTEE TRANSFERS.—Section 220(f)(2) and paragraph (2) of this subsection shall not apply to any trustee-

to-trustee transfer from a MedicarePlus MSA of an account holder to another MedicarePlus MSA of such account holder. “

(d) SPECIAL RULES FOR TREATMENT OF ACCOUNT AFTER DEATH OF ACCOUNT HOLDER.—In applying section 220(f)(8)(A) to an account which was a MedicarePlus MSA of a decedent, the rules of section 220(f) shall apply in lieu of the rules of subsection (c) of this section with respect to the spouse as the account holder of such MedicarePlus MSA.

(e) REPORTS.—In the case of a MedicarePlus MSA, the report under section 220(h)—

(1) shall include the fair market value of the assets in such MedicarePlus MSA as of the close of each calendar year, and

(2) shall be furnished to the account holder—

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

(B) in such manner as the Secretary prescribes in such regulations.

(f) COORDINATION WITH LIMITATION ON NUMBER OF TAXPAYERS HAVING MEDICAL SAVINGS ACCOUNTS.—Subsection (i) of section 220 shall not apply to an individual with respect to a MedicarePlus MSA, and MedicarePlus MSAs shall not be taken into account in determining whether the numerical limitations under section 220(j) are exceeded.

SEC. [138.] 139. CROSS REFERENCES TO OTHER ACTS.

(a) * * *

* * * * *

PART VII—ADDITIONAL ITEMIZED DEDUCTIONS FOR INDIVIDUALS

* * * * *

SEC. 220. MEDICAL SAVINGS ACCOUNTS.

(a) * * *

(b) LIMITATIONS.—

(1) * * *

* * * * *

(7) MEDICARE ELIGIBLE INDIVIDUALS.—The limitation under this subsection for any month with respect to an individual shall be zero for the first month such individual is entitled to benefits under title XVIII of the Social Security Act and for each month thereafter.

* * * * *

Subchapter F—Exempt Organizations

* * * * *

PART I—GENERAL RULE

* * * * *

SEC. 501. EXEMPTION FROM TAX ON CORPORATIONS, CERTAIN TRUSTS, ETC.

(a) * * *

* * * * *

(o) *TREATMENT OF HOSPITALS PARTICIPATING IN PROVIDER-SPONSORED ORGANIZATIONS.*—An organization shall not fail to be treated as organized and operated exclusively for a charitable purpose for purposes of subsection (c)(3) solely because a hospital which is owned and operated by such organization participates in a provider-sponsored organization (as defined in section 1853(e) of the Social Security Act), whether or not the provider-sponsored organization is exempt from tax. For purposes of subsection (c)(3), any person with a material financial interest in such a provider-sponsored organization shall be treated as a private shareholder or individual with respect to the hospital.

[(o)] (p) CROSS REFERENCE.—

For nonexemption of Communist-controlled organizations, see section 11(b) of the Internal Security Act of 1950 (64 Stat. 997; 50 U.S.C. 790(b)).

* * * * *

Subtitle D—Miscellaneous Excise Taxes

* * * * *

CHAPTER 43—QUALIFIED PENSIONS, ETC., PLANS

* * * * *

SEC. 4973. TAX ON EXCESS CONTRIBUTIONS TO INDIVIDUAL RETIREMENT ACCOUNTS, MEDICAL SAVINGS ACCOUNTS, CERTAIN SECTION 403(B) CONTRACTS, AND CERTAIN INDIVIDUAL RETIREMENT ANNUITIES.

(a) * * *

* * * * *

(d) **EXCESS CONTRIBUTIONS TO MEDICAL SAVINGS ACCOUNTS.**—For purposes of this section, in the case of medical savings accounts (within the meaning of section 220(d)), the term “excess contributions means the sum of—

(1) * * *

* * * * *

For purposes of this subsection, any contribution which is distributed out of the medical savings account in a distribution to which section 220(f)(3) or section 138(c)(3) applies shall be treated as an amount not contributed.

Subtitle F—Procedure and Administration

* * * * *

CHAPTER 61—INFORMATION AND RETURNS

* * * * *

Subchapter B—Miscellaneous Provisions

* * * * *

SEC. 6103. CONFIDENTIALITY AND DISCLOSURE OF RETURNS AND RETURN INFORMATION.

(a) * * *

* * * * *

(1) DISCLOSURE OF RETURNS AND RETURN INFORMATION FOR PURPOSES OTHER THAN TAX ADMINISTRATION.—

(1) * * *

* * * * *

(12) DISCLOSURE OF CERTAIN TAXPAYER IDENTITY INFORMATION FOR VERIFICATION OF EMPLOYMENT STATUS OF MEDICARE BENEFICIARY AND SPOUSE OF MEDICARE BENEFICIARY.—

(A) * * *

* * * * *

[(F) TERMINATION.—Subparagraphs (A) and (B) shall not apply to—

[(i) any request made after September 30, 1998, and

[(ii) any request made before such date for information relating to—

[(I) 1997 or thereafter in the case of subparagraph (A), or

[(II) 1998 or thereafter in the case of subparagraph (B).]

* * * * *

SECTION 9412 OF THE OMNIBUS BUDGET RECONCILIATION ACT OF 1986

SEC. 9412. WAIVER AUTHORITY FOR CHRONICALLY MENTALLY ILL AND FRAIL ELDERLY.

(a) * * *

[(b) FRAIL ELDERLY DEMONSTRATION PROJECT WAIVERS.—

[(1) The Secretary of Health and Human Services shall grant waivers of certain requirements of titles XVIII and XIX of the Social Security Act to not more than 10 public or non-profit private community-based organizations to enable such organizations to provide comprehensive health care services on a capitated basis to frail elderly patients at risk of institutionalization.

[(2)(A) Except as provided in subparagraph (B), the terms and conditions of a waiver granted pursuant to this subsection shall be substantially the same as the terms and conditions of the On Lok waiver (referred to in section 603(c) of the Social Security Amendments of 1983 and extended by section 9220 of the Consolidated Omnibus Budget Reconciliation Act of 1985),

including permitting the organization to assume progressively (over the initial 3-year period of the waiver) the full financial risk.

[(B) In order to receive a waiver under this subsection, an organization must participate in an organized initiative to replicate the findings of the On Lok long-term care demonstration project (described in section 603(c)(1) of the Social Security Amendments of 1983).

[(C) Subject to subparagraph (B), any waiver granted pursuant to this subsection shall be for an initial period of 3 years. The Secretary may extend such waiver beyond such initial period for so long as the Secretary finds that the organization complies with the terms and conditions described in subparagraphs (A) and (B).]

SECTION 603 OF THE SOCIAL SECURITY AMENDMENTS OF 1983

REPORTS, EXPERIMENTS, AND DEMONSTRATION PROJECTS

SEC. 603. (a) * * *

* * * * *

[(c) The Secretary shall approve, with appropriate terms and conditions as defined by the Secretary, within 30 days after the date of enactment of this Act—

[(1) the risk-sharing application of On Lok Senior Health Services (according to terms and conditions as specified by the Secretary), dated July 2, 1982, for waivers, pursuant to section 222 of the Social Security Amendments of 1972 and section 402(a) of the Social Security Amendments of 1967, of certain requirements of title XVIII of the Social Security Act over a period of 36 months in order to carry out a long-term care demonstration project, and

[(2) the application of the Department of Health Services, State of California, dated November 1, 1982, pursuant to section 1115 of the Social Security Act, for the waiver of certain requirements of title XIX of such Act over a period of 36 months in order to carry out a demonstration project for capitated reimbursement for comprehensive long-term care services involving On Lok Senior Health Services.]

* * * * *

THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985

* * * * *

TITLE IX—MEDICARE, MEDICAID, AND MATERNAL AND CHILD HEALTH PROGRAMS

* * * * *

**PART 2—Provisions Relating to Parts A and B of
Medicare**

* * * * *

Subpart B—Other Provisions

* * * * *

SEC. 9215. EXTENSION OF CERTAIN MEDICARE MUNICIPAL HEALTH SERVICES DEMONSTRATION PROJECTS.

(a) *The Secretary of Health and Human Services shall extend through December 31, 1997, approval of four municipal health services demonstration projects (located in Baltimore, Cincinnati, Milwaukee, and San Jose) authorized under section 402(a) of the Social Security Amendments of 1967. The Secretary shall submit a report to Congress on the waiver program with respect to the quality of health care, beneficiary costs, costs to the medicaid program and other payers, access to care, outcomes, beneficiary satisfaction, utilization differences among the different populations served by the projects, and such other factors as may be appropriate. Subject to subsection (c), the Secretary may further extend such demonstration projects through December 31, 2000, but only with respect to individuals are enrolled with such projects before January 1, 1998.*

(b) *The Secretary shall work with each such demonstration project to develop a plan, to be submitted to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate by March 31, 1998, for the orderly transition of demonstration projects and the project enrollees to a non-demonstration project health care delivery system, such as through integration with private or public health plan, including a medicaid managed care or MedicarePlus plan.*

(c) *A demonstration project under subsection (a) which does not develop and submit a transition plan under subsection (b) by March 31, 1998, or, if later, 6 months after the date of the enactment of this Act, shall be discontinued as of December 31, 1998. The Secretary shall provide appropriate technical assistance to assist in the transition so that disruption of medical services to project enrollees may be minimized.*

* * * * *

[SEC. 9220. EXTENSION OF ON LOK WAIVER.

[(a) CONTINUED APPROVAL.—

[(1) MEDICARE WAIVERS.—Notwithstanding any limitations contained in section 222 of the Social Security Amendments of 1972 and section 402(a) of the Social Security Amendments of 1967, the Secretary of Health and Human Services shall continue approval of the risk-sharing application (described in section 603(c)(1) of Public Law 98–21) for waivers of certain requirements of title XVIII of the Social Security Act after the end of the period described in that section.

[(2) MEDICAID WAIVERS.—Notwithstanding any limitations contained in section 1115 of the Social Security Act, the Secretary shall approve any application of the Department of

Health Services, State of California, for a waiver of requirements of title XIX of such Act in order to continue carrying out the demonstration project referred to in section 603(c)(2) of Public Law 98-21 after the end of the period described in that section.

[(b) TERMS, CONDITIONS, AND PERIOD OF APPROVAL.—The Secretary’s approval of an application (or renewal of an application) under this section—

[(1) shall be on the same terms and conditions as applied with respect to the corresponding application under section 603(c) of Public Law 98-21 as of July 1, 1985, except that requirements relating to collection and evaluation of information for demonstration purposes (and not for operational purposes) shall not apply; and

[(2) shall remain in effect until such time as the Secretary finds that the applicant no longer complies with the terms and conditions described in paragraph (1).]

* * * * *

SECTION 4018 OF THE OMNIBUS BUDGET RECONCILIATION ACT OF 1987

SEC. 4018. SPECIAL RULES.

(a) * * *

(b) EXTENSION OF WAIVERS FOR SOCIAL HEALTH MAINTENANCE ORGANIZATIONS.—

(1) The Secretary of Health and Human Services shall extend without interruption, through December 31, [1997] 2000, the approval of waivers granted under subsection (a) of section 2355 of the Deficit Reduction Act of 1984 for the demonstration project described in subsection (b) of that section, subject to the terms and conditions (other than duration of the project) established under that section (as amended by paragraph (2) of this subsection).

(2) * * *

* * * * *

(4) The Secretary of Health and Human Services shall submit a second interim report to the Congress on the project referred to in paragraph (1) not later than March 31, 1993, and shall submit a final report on the demonstration projects conducted under section 2355 of the Deficit Reduction Act of 1984 not later than March 31, [1998] 2001.

* * * * *

THE OMNIBUS BUDGET RECONCILIATION ACT OF 1993

* * * * *

**TITLE XIII—REVENUE, HEALTH CARE,
HUMAN RESOURCES, INCOME SECUR-
ITY, CUSTOMS AND TRADE, FOOD
STAMP PROGRAM, AND TIMBER SALE
PROVISIONS**

* * * * *

**CHAPTER 2—HEALTH CARE, HUMAN RESOURCES, IN-
COME SECURITY, AND CUSTOMS AND TRADE PROVI-
SIONS**

Subchapter A—Medicare

* * * * *

PART I—PROVISIONS RELATING TO PART A

SEC. 13501. PAYMENTS FOR PPS HOSPITALS.

(a) * * *

* * * * *

(e) EXTENSION FOR MEDICARE-DEPENDENT, SMALL RURAL HOS-
PITALS.—

(1) * * *

(2) PERMITTING HOSPITALS TO DECLINE RECLASSIFICATION.—If
any hospital fails to qualify as a medicare-dependent, small
rural hospital under section 1886(d)(5)(G)(i) of the Social Secu-
rity Act as a result of a decision by the Medicare Geographic
Classification Review Board under section 1886(d)(10) of such
Act to reclassify the hospital as being located in an urban area
for fiscal year 1993 [or fiscal year 1994] , *fiscal year 1994, fis-
cal year 1998, fiscal year 1999, or fiscal year 2000*, the Sec-
retary of Health and Human Services shall—

(A) * * *

* * * * *

**PART III—PROVISIONS RELATING TO PARTS A
AND B**

* * * * *

**SEC. 13567. EXTENSION OF SOCIAL HEALTH MAINTENANCE ORGANI-
ZATION DEMONSTRATIONS.**

(a) * * *

* * * * *

(c) EXPANSION OF NUMBER OF MEMBERS PER SITE.—The Sec-
retary of Health and Human Services may not impose a limit of
less than [12,000] 36,000 on the number of individuals that may

participate in a project conducted under section 2355 of the Deficit Reduction Act of 1984.

* * * * *

**SECTION 6011 OF THE OMNIBUS BUDGET
RECONCILIATION ACT OF 1989**

SEC. 6011. PASS THROUGH PAYMENT FOR HEMOPHILIA INPATIENTS.

(a) * * *

* * * * *

(d) **EFFECTIVE DATE.**—The amendments made by subsection (a) shall apply with respect to items furnished 6 months after the date of enactment of this Act **[and shall expire September 30, 1994]**.

MISCELLANEOUS HOUSE REPORT REQUIREMENTS

CONGRESSIONAL BUDGET OFFICE ESTIMATE

Section 403 of the Congressional Budget Act and clause 2(1)(3)(B) of rule XI require reports to include a timely submitted cost estimate by the Congressional Budget Office (CBO). CBO provided separate estimates of the legislation submitted by each of the authorizing committees which are included under the appropriate titles.

CONSTITUTIONAL AUTHORITY STATEMENT

Clause 2(1)(4) of rule XI, as amended by section 13 of H.Res. 5, requires each committee report on a bill or joint resolution of a public character to include a statement citing the specific powers granted to the Congress by the Constitution to enact the proposed law. The Committee on the Budget states that its action in reporting this bill is derived from Article I of the Constitution, Section 5 (“Each House may determine the Rules of its Proceedings”) and Section 8 (“The Congress shall have the power to make all Laws which shall be necessary and proper * * *”).

BUDGET COMMITTEE OVERSIGHT FINDINGS

Clause 2(1)(3)(A) of rule XI requires each committee report to contain oversight findings and recommendations required pursuant to clause (2)(b)(1) of rule X. The Committee on the Budget has examined its activities over the past year and has determined that there are no specific oversight findings on the text of the reported bill.

**OVERSIGHT FINDINGS AND RECOMMENDATIONS OF THE COMMITTEE
ON GOVERNMENT REFORM AND OVERSIGHT**

Clause 2(1)(3)(D) of rule XI requires each committee report to contain a summary of oversight findings and recommendations made by the Government Reform and Oversight Committee pursuant to clause 4(c)(2) of rule X, whenever such findings have been timely submitted. The Committee on the Budget has received no such findings or recommendations from the Committee on Government Reform and Oversight on the text of the reported bill.

COMMITTEE VOTES

Clause 2(1)(2)(B) of rule XI requires each committee report to accompany any bill or resolution of a public character, ordered to include the total number of votes cast for and against on each rollcall vote on a motion to report and any amendment offered to the measure or matter, together with the names of those voting for and against.

On June 20, 1997, the committee met in open session, a quorum being present. The committee ordered reported the text of the Balanced Budget Act of 1997 pursuant to the reconciliation instructions contained in the conference report on H.Con.Res. 84, the Concurrent Resolution on the Budget for Fiscal Year 1998.

The following votes were taken by the committee:

1. Mr. Hobson moved that the committee order reported with a favorable recommendation the text of the Balanced Budget Act of 1997, pursuant to clause 1 of rule XX and authorize the chairman to offer a motion to go to conference. The motion was agreed to by a rollcall vote of 25 ayes, 5 noes, with 2 voting present.

	Aye—	No—	Present—		Aye—	No—	Present
Mr. Kasich, Chairman—	X—	.....	.....	Mr. Spratt, Ranking—	X—	.....	.....
Mr. Hobson—	X	.....	.....	Mr. McDermott—	.....	X	.....
Mr. Shays—	X	.....	.....	Mr. Mollohan—	.....	.....	.....
Mr. Herger—	X	.....	.....	Mr. Costello—	.....	X	.....
Mr. Bunning—	.....	.....	.....	Mrs. Mink—	.....	X	.....
Mr. Smith of Texas—	.....	.....	.....	Mr. Pomeroy—	.....	.....	.....
Mr. Miller—	X	.....	.....	Ms. Woolsey—	.....	X	.....
Mr. Franks—	X	.....	.....	Ms. Roybal-Allard—	.....	.....	.....
Mr. Smith of Michigan—	X	.....	.....	Ms. Rivers—	.....	X	.....
Mr. Inglis—	X	.....	.....	Mr. Doggett—	.....	.....	.....
Ms. Molinari—	X	.....	.....	Mr. Thompson—	.....	.....	.....
Mr. Nussle—	X	.....	.....	Mr. Cardin—	.....	.....	X
Mr. Hoekstra—	X	.....	.....	Mr. Minge—	X	.....	-
Mr. Shadegg—	X	.....	.....	Mr. Baesler—	.....	.....	.....
Mr. Radanovich—	X	.....	.....	Mr. Bentsen—	.....	.....	X
Mr. Bass—	X	.....	.....	Mr. Davis—	X	.....	-
Mr. Neumann—	X	.....	.....	Mr. Sherman—	.....	.....	.....
Mr. Parker—	X	.....	.....	Mr. Weygand—	.....	.....	.....
Mr. Ehrlich—	X	.....	.....	Mrs. Clayton—	.....	.....	.....
Mr. Gutknecht—	X	.....	.....		
Mr. Hilleary—	X	.....	.....		
Ms. Granger—	X	.....	.....		
Mr. Sununu—	X	.....	.....		
Mr. Pitts—	X	.....	.....		

2. Mrs. Mink moved that the Committee on the Budget directs its Chairman to request, on behalf of the committee, that the rule for the floor consideration of the first (spending) reconciliation bill include an amendment to that bill:

- (1) in title V, striking paragraphs (2) and (3) of subsection (f) of section 407 of the Social Security Act, as proposed to be added by section 5002; and striking subsection (k) of the Social Security Act, as proposed to be added by section 5004 (a); and
- (2) in title IX, striking section 403(a)(5)(K)(i)(III) of the Social Security Act, as proposed to be added by section 9001(a), and striking section 9004.

The motion failed by a rollcall vote of 11 ayes and 22 noes.

	Aye—	No—	Present—		Aye—	No—	Present
Mr. Kasich, Chairman—	—	X	.....	Mr. Spratt, Ranking—	X	.....	—
Mr. Hobson	—	X	.....	Mr. McDermott	X	.....	—
Mr. Shays—	—	X—	.....	Mr. Mollohan	.....	.....	—
Mr. Herger—	X	.....	Mr. Costello—	X	.....	—
Mr. Bunning—	Mrs. Mink—	X	.....	—
Mr. Smith of Texas	Mr. Pomeroy	.....	.....	—
Mr. Miller—	X	.....	Ms. Woolsey—	X	.....	—
Mr. Franks	X	.....	Ms. Roybal-Allard—	.....	.....	—
Mr. Smith of Michigan—	X	.....	Ms. Rivers—	X	.....	—
Mr. Inglis—	X	.....	Mr. Doggett—	X	.....	—
Ms. Molinari—	X	.....	Mr. Thompson—	.....	.....	—
Mr. Nussle—	X	.....	Mr. Cardin—	X	.....	—
Mr. Hoekstra—	X	.....	Mr. Minge—	X	.....	—
Mr. Shadegg—	X	.....	Mr. Baesler	.....	.....	—
Mr. Radanovich—	X	.....	Mr. Bentsen—	X	.....	—
Mr. Bass—	X	.....	Mr. Davis—	X	.....	—
Mr. Neumann—	X	.....	Mr. Sherman	.....	.....	—
Mr. Parker—	X	.....	Mr. Weygand	.....	.....	—
Mr. Ehrlich—	X	.....	Mrs. Clayton	.....	.....	—
Mr. Gutknecht—	X	.....			
Mr. Hilleary—	X	.....			
Ms. Granger—	X	.....			
Mr. Sununu—	X	.....			
Mr. Pitts—	X	.....			

3. Mr. McDermott moved that the Committee on the Budget direct its Chairman to request, on behalf of the committee, that the rule for floor consideration of the first (spending) reconciliation bill include an amendment to that bill ensuring that the \$16 billion for children's health is used to provide health insurance coverage for children and not used as an unspecified revenue-sharing grant by the states. The motion failed by a rollcall vote of 11 ayes and 22 noes.

	Aye—	No—	Present—		Aye—	No—	Present
Mr. Kasich, Chairman—	X	.....	Mr. Spratt, Ranking—	X	.....	—
Mr. Hobson	X	.....	Mr. McDermott—	X	.....	—
Mr. Shays—	X	.....	Mr. Mollohan	.....	.....	—
Mr. Herger—	X	.....	Mr. Costello—	X	.....	—
Mr. Bunning	Mrs. Mink—	X	.....	—
Mr. Smith of Texas	Mr. Pomeroy	.....	.....	—
Mr. Miller—	X	.....	Ms. Woolsey—	X	.....	—
Mr. Franks	X—	.....	Ms. Roybal-Allard	.....	.....	—
Mr. Smith of Michigan—	X	.....	Ms. Rivers—	X	.....	—
Mr. Inglis—	X	.....	Mr. Doggett—	X	.....	—
Ms. Molinari—	X	.....			
Mr. Thompson	Mr. Cardin—	X	.....	—
Mr. Nussle—	X—	.....	Mr. Minge—	X	.....	—
Mr. Hoekstra—	X	.....	Mr. Baesler	.....	.....	—
Mr. Shadegg	X	.....	Mr. Bentsen—	X	.....	—
Mr. Radanovich	X	.....	Mr. Davis—	X	.....	—
Mr. Bass—	X	.....	Mr. Sherman	.....	.....	—
Mr. Neumann—	X	.....	Mr. Weygand	.....	.....	—
Mr. Parker—	X	.....	Mrs. Clayton	.....	.....	—
Mr. Ehrlich—	X	.....			
Mr. Gutknecht—	X	.....			
Mr. Hilleary—	X	.....			
Ms. Granger—	X	.....			
Mr. Sununu—	X	.....			
Mr. Pitts—	X	.....			

4. Ms. Woolsey moved that the Committee on the Budget direct its Chairman to request, on behalf of the committee, that the rule for floor consideration of the first (spending) reconciliation bill include an amendment to that bill striking Subtitle D of Title V (entitled "Expansion of Portability and Health Insurance Coverage"), relating to multiple employer welfare associations (MEWAs). The motion failed by a rollcall vote of 11 ayes and 22 noes.

	Aye—	No—	Present—		Aye—	No—	Present
Mr. Kasich, Chairman—		X	—	Mr. Spratt, Ranking—	X		—
Mr. Hobson—		X	—	Mr. McDermott—	X		—
Mr. Shays—		X	—	Mr. Mollohan—			—
Mr. Herger—		X	—	Mr. Costello—	X		—
Mr. Bunning—			—	Mrs. Mink—	X		—
Mr. Smith of Texas—			—	Mr. Pomeroy—			—
Mr. Miller—		X	—	Ms. Woolsey—	X		—
Mr. Franks—		X	—	Ms. Roybal-Allard—			—
Mr. Smith of Michigan—		X	—	Ms. Rivers—	X		—
Mr. Inglis—		X	—	Mr. Doggett—	X		—
Ms. Molinari—		X	—	Mr. Thompson—			—
Mr. Nussle—		X	—	Mr. Cardin—	X		—
Mr. Hoekstra—		X	—	Mr. Minge—	X		—
Mr. Shadegg—		X	—	Mr. Baesler—			—
Mr. Radanovich—		X	—	Mr. Bentsen—	X		—
Mr. Bass—		X	—	Mr. Davis—	X		—
Mr. Neumann—		X	—	Mr. Sherman—			—
Mr. Parker—		X	—	Mr. Weygand—			—
Mr. Ehrlich—		X	—	Mrs. Clayton—			—
Mr. Gutknecht—		X	—				
Mr. Hilleary—		X	—				
Ms. Granger—		X	—				
Mr. Sununu—		X	—				
Mr. Pitts—		X	—				

5. Mr. Doggett moved that the Committee on the Budget direct its Chairman to request, on behalf of the committee, that the rule for floor consideration of the first (spending) reconciliation bill include an amendment to that bill striking all provisions of the reconciliation bills reported to the House Budget Committee by the House Ways and Means and House Commerce Committees concerning medical liability reform, which provisions should be considered separately since they are unrelated to reform of Medicare. The motion failed by a rollcall vote of 11 ayes and 21 noes.

	Aye—	No—	Present—		Aye—	No—	Present
Mr. Kasich, Chairman—		X	—	Mr. Spratt, Ranking—	X		—
Mr. Hobson—			—	Mr. McDermott—	X		—
Mr. Shays—		X	—	Mr. Mollohan—			—
Mr. Herger—		X	—	Mr. Costello—	X		—
Mr. Bunning—			—	Mrs. Mink—	X		—
Mr. Smith of Texas—			—	Mr. Pomeroy—			—
Mr. Miller—		X	—	Ms. Woolsey—	X		—
Mr. Franks—		X	—	Ms. Roybal-Allard—			—
Mr. Smith of Michigan—		X	—	Ms. Rivers—	X		—
Mr. Inglis—		X	—	Mr. Doggett—	X		—
Ms. Molinari—		X	—	Mr. Thompson—			—
Mr. Nussle—		X	—	Mr. Cardin—	X		—
Mr. Hoekstra—		X	—	Mr. Minge—	X		—
Mr. Shadegg—		X	—	Mr. Baesler—			—
Mr. Radanovich—		X	—	Mr. Bentsen—	X		—
Mr. Bass—		X	—	Mr. Davis—	X		—

	Aye—	No—	Present—		Aye—	No—	Present
Mr. Neumann—		X	—	Mr. Sherman			—
Mr. Parker—		X	—	Mr. Weygand			—
Mr. Ehrlich—		X	—	Mrs. Clayton			—
Mr. Gutknecht—		X	—				
Mr. Hilleary—		X	—				
Ms. Granger—		X	—				
Mr. Sununu—		X	—				
Mr. Pitts—		X	—				

6. Ms. Rivers moved that the Committee on the Budget direct its Chairman to request, on behalf of the committee, that the rule for the floor consideration of the first (spending) reconciliation bill include an amendment to that bill eliminating medical savings accounts as an option under MedicarePlus. The motion failed by a rollcall vote of 11 ayes and 22 noes.

	Aye	No	Present		Aye	No	Present
Mr. Kasich, Chairman		X		Mr. Spratt, Ranking	X		
Mr. Hobson		X		Mr. McDermott	X		
Mr. Shays		X		Mr. Mollohan			
Mr. Herger		X		Mr. Costello	X		
Mr. Bunning				Mrs. Mink	X		
Mr. Smith of Texas				Mr. Pomeroy			
Mr. Miller—		X		Ms. Woolsey	X		
Mr. Franks—		X		Ms. Roybal-Allard			
Mr. Smith of Michigan		X		Ms. Rivers	X		
Mr. Inglis		X		Mr. Doggett	X		
Ms. Molinari		X		Mr. Thompson			
Mr. Nussle		X		Mr. Cardin	X		
Mr. Hoekstra		X		Mr. Minge	X		
Mr. Shadegg—		X		Mr. Baesler			
Mr. Radanovich		X		Mr. Bentsen	X		
Mr. Bass		X		Mr. Davis	X		
Mr. Neumann—		X		Mr. Sherman			
Mr. Parker		X		Mr. Weygand			
Mr. Ehrlich		X		Mrs. Clayton			
Mr. Gutknecht		X					
Mr. Hilleary		X					
Ms. Granger—		X					
Mr. Sununu		X					
Mr. Pitts		X					

7. Mr. Cardin moved, on behalf of Mr. Weygand, that the Committee on the Budget direct its Chairman to request, on behalf of the committee, that the rule for the floor consideration of the first (spending) reconciliation bill include an amendment to that bill providing \$1.5 billion to protect Medicare recipients against the cost of Medicare premiums, as provided in the budget agreement. The motion was withdrawn.

8. Mr. Minge moved that the Committee on the Budget direct its Chairman to request, on behalf of the committee, that the rule for the floor consideration of the first (spending) reconciliation bill permit a floor amendment offered by Mr. Minge, or his designee, regarding balanced budget enforcement procedures which apply to spending and revenues. The motion failed by voice vote.

9. Mr. Bentsen moved that the Committee on the Budget direct its Chairman to request, on behalf of the committee, that the rule for the floor consideration of the first (spending) reconciliation bill include an amendment to that bill that achieves savings in Medic-

aid disproportionate share hospital payments by taking an equal reduction from each state's 1995 DSH spending, up to a limit equal to 12 percent of its total Medicaid spending. In other words, the percentage reduction is to the amount up to 12 percent. The motion was withdrawn.

10. Mr. Franks moved that when the Chairman appears before the Rules Committee that he request that DSH payment reductions not be excessively burdensome to those states with DSH costs greater than 12% of total Medicaid spending. The motion passed by a rollcall vote of 21 ayes and 11 noes.

	Aye	No	Present		Aye	No	Present
Mr. Kasich, Chairman	X			Mr. Spratt, Ranking	X		
Mr. Hobson	X			Mr. McDermott	X		
Mr. Shays	X			Mr. Mollohan			
Mr. Herger	X			Mr. Costello	X		
Mr. Bunning				Mrs. Mink	X		
Mr. Smith of Texas				Mr. Pomeroy			
Mr. Miller		X		Ms. Woolsey		X	
Mr. Franks	X			Ms. Roybal-Allard			
Mr. Smith of Michigan	X			Ms. Rivers		X	
Mr. Inglis	X			Mr. Doggett			
Ms. Molinari		X		Mr. Thompson			
Mr. Nussle		X		Mr. Cardin	X		
Mr. Hoekstra		X		Mr. Minge		X	
Mr. Shadegg		X		Mr. Baesler			
Mr. Radanovich	X			Mr. Bentsen	X		
Mr. Bass	X			Mr. Davis		X	
Mr. Neumann	X			Mr. Sherman			
Mr. Parker	X			Mr. Weygand			
Mr. Ehrlich	X			Mrs. Clayton			
Mr. Gutknecht		X					
Mr. Hilleary	X						
Ms. Granger	X						
Mr. Sununu	X						
Mr. Pitts		X					

11. Mr. McDermott moved that the Committee on the Budget direct its Chairman to request, on behalf of the committee, that the rule for the floor consideration of the first (spending) reconciliation bill include an amendment to that bill restoring the solvency of the Medicare Part A Trust Fund for at least ten years by immediately reallocating all of the home health costs from Part A to Part B. The motion was withdrawn.

12. Mrs. Mink moved, on behalf of Ms. Roybal-Allard, that the Committee on the Budget direct its Chairman request, on behalf of the committee, that the rule for floor consideration of the first (spending) reconciliation bill include an amendment to that bill that adds appropriate language to section 9302 of Subtitle D of Title IX restoring Supplemental Security Income (SSI) and Medicaid benefits to legal immigrants who arrived in the United States on or before August 22, 1996, and become disabled after entry. The motion failed by a rollcall vote of 10 ayes and 20 noes.

	Aye	No	Present		Aye	No	Present
Mr. Kasich, Chairman		X		Mr. Spratt, Ranking	X		
Mr. Hobson		X		Mr. McDermott	X		
Mr. Shays		X		Mr. Mollohan			
Mr. Herger		X		Mr. Costello	X		
Mr. Bunning				Mrs. Mink	X		

	Aye	No	Present		Aye	No	Present
Mr. Smith of Texas				Mr. Pomeroy—			—
Mr. Miller—	X		—	Ms. Woolsey—	X		—
Mr. Franks	X			Ms. Roybal-Allard			—
Mr. Smith of Michigan	X			Ms. Rivers	X		—
Mr. Inglis				Mr. Doggett			—
Ms. Molinari	X		—	Mr. Thompson			—
Mr. Nussle—	X		—	Mr. Cardin	X		—
Mr. Hoekstra	X		—	Mr. Minge	X		—
Mr. Shadegg	X			Mr. Baesler			—
Mr. Radanovich	X			Mr. Bentsen	X		—
Mr. Bass	X			Mr. Davis	X		—
Mr. Neumann	X			Mr. Sherman			—
Mr. Parker	X			Mr. Weygand			—
Mr. Ehrlich				Mrs. Clayton			—
Mr. Gutknecht	X		—				
Mr. Hilleary	X		—				
Ms. Granger	X		—				
Mr. Sununu	X		—				
Mr. Pitts	X		—				

CHANGES IN EXISTING LAW

Clause 3 of rule XIII provides that reports include the text of statutes that are proposed to be repealed and a comparative print of that part of the bill proposed to be amended whenever the bill repeals or amends any statute. The required matter is included in the report language for each title of the legislative recommendations submitted by the appropriate authorization committees and reported to the House by the Committee on the Budget.

UNFUNDED MANDATE STATEMENT

Section 423 of the Congressional Budget and Impoundment Control Act of 1974 requires a statement of whether the provisions of the reported bill include unfunded mandates. The committee received a letter regarding unfunded mandates from the Director of the Congressional Budget Office. [See the Congressional Budget Office Cost Estimate under the appropriate title.]

VIEWS OF THE MEMBERS OF COMMITTEES SUBMITTING RECONCILIATION RECOMMENDATIONS

The views following are from members of committees that have submitted reconciliation recommendations pursuant to H. Con. Res. 84. Although not technically required under rule XI, these views include those submitted by the authorizing committees that submitted the reconciliation recommendations that comprise the text of the bill.

ADDITIONAL VIEWS—AGRICULTURE

The 1997 Budget reconciliation process affords the Congress and the nation enormous opportunities. For the first time in a generation, we stand to realize a balanced Federal budget. The process also gives us the opportunity to fulfill the Bipartisan budget agreement as it relates to the unfinished work for reform of the welfare process. We support these goals and will continue to work to ensure that they are achieved.

The 1997 budget reconciliation also gave the House Agriculture Committee the opportunity to remedy some severe problems which threaten important programs in nutrition, agriculture, and rural economic development while closing a loophole in the 1996 welfare reform law which threatens to cause a dramatic increase in the costs of administering the Food Stamp Program.

The 1996 welfare reform law placed a cap on State's administrative expenditures from the block grant provided under the Temporary Aid for Needy Families program. This created an incentive for States to assign administrative costs to the Food Stamp program which previously would have been assigned to their administration of cash welfare payments. No one in Congress intended this cost reallocation but CBO projects that the result will be a dramatic increase in, the baseline for payments to States for Food Stamp Program administrative expenses. During consideration of the food stamp provisions of the budget reconciliation bill, the House Agriculture Committee rejected our amendment to prevent states from shifting administrative expenses that have historically been funded through the Aid to Families with Dependent Children (AFDC) to the Food Stamp Program. In so doing, we have lost a rare opportunity to prospectively address an incentive for States to reallocate costs in the light of past reforms, and at the same time to address real and immediate problems.

In 1996, total reimbursements to States for administering the Food Stamp Program amounted to \$1.825 billion. Because of changes made to the program in the last Congress, there were reductions in the number of beneficiaries, requirements imposed on the States were simplified. States assured the Congress that they would need fewer resources to administer the welfare programs. The President's FY 1998 budget request for food stamp state administrative expenses is \$1.811 billion. Because of the incentive created by the welfare reform process, however, total reimbursements to states for Food Stamp Program administrative costs in 1998 are estimated by CBO to grow to \$2.372 billion.

So now we have a situation where the food stamp rolls have been reduced the program has been made less costly to administer, the Administration expects state administrative expenses to remain steady, and yet reimbursements to the States are projected by CBO to INCREASE by \$547 million in FY 1998.

Our amendment would have effectively required States to continue allocating administrative expenses in the same manner as they did prior to the enactment of welfare reform, by establishing a cap on food stamp administrative expenses that would increase to reflect inflation and growth in caseload.

If the States do not intend to shift administrative costs from the Temporary Assistance for Needy Families (TANF) Program to food stamps, our amendment would not have had any effect on the funding received by States. Our amendment would reduce a State's funds only to the extent that it takes advantage of an opportunity to attribute costs to the Food Stamp Program—costs which were actually incurred as part of its administration of TANF.

Some said this was an unfunded mandate; and technically it is. But consider this: Under the welfare reform law enacted last year, cash welfare payments which had previously been a Federal entitlement were converted to block grants to States. In addition, each State is to be given a maximum reimbursement for administering the block grants of 15% of the block grant amount. However, the welfare reform law created a strong unintended incentive.

States have an incentive to assign costs to the Food Stamp Program which previously would have been assigned to their administration of cash welfare payments. In fact, the welfare reform law, with its 15% cap on administrative expenses in the block grant, provides the incentive for this cost shifting. No one in Congress intended this but CB has evaluated the incentive and, as a result, has increased the baseline for payments to States for Food Stamp Program administrative expenses significantly. In other words, Congress inadvertently gave States the right to manipulate the Food Stamp Program. And once the States have such a right—even one as absurd as this—any action to correct the situation is deemed to be a Federal intergovernmental mandate.

The Unfunded Mandates Reform Act added to our rules important provisions which properly require that Congress take into account the full impact its actions have on State and local governments. Although the Act technically applies to this amendment, the Mandates Act was never intended to allow States free access to the Federal Treasury. Our amendment would have kept the States whole by ensuring that they would be fully paid their Federal share required under the law for administration of the Food Stamp Program, but it would not allow them to use the Food Stamp Expense Reimbursement Account as a “slush fund.”

The Congressional Budget Office has provided unofficial, preliminary estimates for the provisions of this amendment. The net effect is a reduction of \$32 million in budget authority and \$73 million in outlays in fiscal year 1998 and a reduction of \$183 million in budget authority and \$277 million in outlays over the fiscal year 1998 to 2002 period.

By eliminating the incentive to shift costs that we identified, our amendment would have achieved significant savings that would permit us to solve a number of pressing problems facing needy families and rural America without compromising our common goal of achieving a balanced Federal budget.

Specifically, our amendment included the following provisions: TEFAP—An additional \$30 million FY 1998 and \$50 million in

each of fiscal years 1999–2002 for The Emergency Food Assistance Program.

Fund for rural America.—The proposal also takes advantage of a unique opportunity to provide crucial funds needed for rural economic development and for agricultural research by increasing amounts available for the Fund for Rural America which is established by the FAIR Act.

The amendment provides an additional \$60 million in 1999 and \$70 million in each of fiscal years 2000 through 2002.

Welfare reform research.—The last Congress enacted major changes to the welfare system. Our amendment would have provided \$10 million in each of fiscal years 1998 through 2002 for research to ensure that progress is assessed.

Federal crop insurance.—Reimbursement of crop insurance delivery expenses incurred by approved crop insurance companies would continue to be paid from the Federal Crop Insurance Corporation Fund as it has in each of fiscal years 1995 through 1997 (instead of through annual appropriations) through FY 2002.

Barley Payments Under Production Flexibility Contracts.—The proposal fixes an inequity included in the farm bill by adding \$30 million in fiscal year 1998 to FAIR Act Production Flexibility Contract payments for eligible barley producers.

Suspension of required reduction in crop bases, quotas and allotments under CRP.—The proposal includes a technical change to the CRP statute to put producers of quota crops on the same footing as producers of other crops in regard to requirements imposed under the program. An out-of-date provision requires that the acreage base, quota, or allotment of each participating farm be reduced by the proportion that CRP acreage makes of the farm's total crop acreage. Since acreage bases no longer exist, the provision puts producers of quota and allotment crops at a relative disadvantage. The proposal suspends the effectiveness of this out-of-date reduction requirement with respect to any CRP contract entered into on or after June 1, 1997.

Cotton marketing loans.—The amendment contains changes in the so-called "Step 3" which have been proposed on a unified basis by the cotton industry. The provision eliminates the prohibition on using marketing certificates when prices have risen to levels sufficient to open the cotton import quota. It would also increase the ceiling price under which the marketing certificates could be issued.

Dairy indemnity program.—The proposal fully funds the Dairy Indemnity Program.

We regret that our amendment was defeated in the Agriculture Committee. We do feel that the priorities incorporated in our amendment need to be addressed and we will continue to look forward to opportunities to see them realized.

CHARLES W. STENHOLM.
TIM HOLDEN.
MARION BERRY.
LEONARD L. BOSWELL.
SAM FARR.

ADDITIONAL VIEWS

CONGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,
Washington, DC, June 12, 1997.

I deeply regret that I cannot be here today to vote on the House Agriculture Committee provisions in the FY98 budget reconciliation agreement. I appreciate the fact that the budget agreement provides an exemption for certain individuals from the food stamp time limits due to hardship, and increases by \$1.5 billion the amount that can be spent on employment and training programs. I am concerned, however, that while the decisions the committee makes today may strengthen the food safety net, we could also allow needy recipients to fall through the cracks.

I represent a district whose economic base is dependent on agriculture and tourism, two industries that are not notable for high-paying salaries. Unfortunately, the unemployment rate for Monterey, Santa Cruz and San Benito Counties is more than double the national unemployment rate. So, I am constantly reminded of the need to increase the number of work slots for childless 18–50 year olds in my district, principally migrant workers who have not been able to find a labor intensive job in the fields picking strawberries or harvesting lettuce. It is important to note that almost half of these food stamp beneficiaries are women.

We must also be clear in our intent—our reconciliation instructions must ensure that this new funding supplements state funding for employment and training services to food stamp recipients, and not allow the states to reduce their fiscal commitment to worker training. If our welfare reform restructuring is to be effective, it must be based on a partnership with the states and localities, and the federal funding for employment and training for food stamp beneficiaries should be matched by the state.

Finally, on the issue of privatizing the certification of food stamp applicants, I think this proposal puts us on a slippery slope. Shifting the critical functions for determining eligibility and allotment of nutrition assistance cannot be left to private sector employees whose job performance may be driven by cost performance and not in trying to determine the very real nutritional needs of their clients. Contracting out these vital jobs may only result in an undermining of the nutritional safety net for these truly in need and I would oppose such a provision.

SAM FARR.

MINORITY, ADDITIONAL, AND DISSENTING VIEWS—
COMMERCE

MINORITY VIEWS WITH REGARD TO PROCEDURES ON
RECONCILIATION OF THE HONORABLE JOHN D. DINGELL

The Budget Resolution for Fiscal Year 1998 provided just one week for the Commerce Committee to report reconciliation legislation that will determine how more than \$3.6 trillion of the American taxpayer's money is spent over the next five years. The Committee worked diligently during that period and completed its action late on Thursday, June 12. The minority was informed that all Minority Views would be required to be submitted by close of business on Friday, June 13, when the House was in recess.

Obviously such a timetable creates problems in both the drafting of legislation, but also in the drafting of the report and Minority Views. It was virtually impossible to circulate any Minority Views for Members' signatures on Friday, a day that the House was in recess.

The Minority Views contained in this report are currently being circulated to Members. I urge my colleagues on the Budget Committee to include the names of all who subsequently sign these views, along with any additional views submitted by Members prior to the filing of the report by the Budget Committee on this legislation.

JOHN D. DINGELL.

MINORITY VIEWS ON TITLE III, SUBTITLE C—SALE OF DOE
ASSETS

The provision directing the Department of Energy to sell uranium is fatally flawed because it fails to include the sort of fundamental protections the Committee historically has included in legislation requiring the sale of federal assets. As a result, the legislation could force DOE to sell stocks of surplus uranium at pennies on the dollar, depriving the taxpayer of a reasonable return on the value of this material.

Current law authorizes the Department to sell surplus uranium at fair market prices upon a finding that doing so will not adversely affect the market. However, under this authority DOE retains discretion to time sales so as to maximize proceeds. Thus, under current law, the Department would not be compelled to conduct a uranium fire sale in a depressed market.

The Committee Print denies DOE this common sense, necessary discretion. It requires DOE to sell specific amounts of uranium on a set schedule, at whatever the “fair market” price is at the specified time. While requiring fair market value is an element of a sound asset disposition program, it is not sufficient in and of itself. The Dingell-Pallone-Strickland amendment addressed this deficiency through a failsafe provision which would permit deferral of the sale if the Secretary and the Director of O.M.B. jointly determine that the sale would not achieve a price that reflects the full value of the uranium, or is not in the best interests of the United States. This is the same protection included in the 1996 Defense Authorization bill provision directing DOE to sell the Elk Hills Naval Petroleum Reserve. Similarly, the statute requiring privatization of the United States Enrichment Corporation provides a “failsafe” for unanticipated market conditions in the form of a final Presidential approval of the sale.

One other deficiency in the majority's approach warrants comment. The Committee has not held hearings or built any type of record in support of a policy to make mandatory DOE's existing discretionary statutory authority to sell uranium. Nonetheless, the majority report is replete with references to what the Committee "expects" with respect to implementation of this provision, what market conditions "are not expected", and what the Department "has indicated" it "projects" may occur in the future. There is no Committee record in support of these conclusions, or with respect to other conclusions the majority draws concerning the Elk Hills sale. In the absence of any Committee activity or record on these matters, such statements are unfounded, inappropriate, and inconsistent with the goal of a balanced budget.

JOHN D. DINGELL.
EDOLPHUS TOWNS.
DIANA DEGETTE.
BOBBY RUSH.
RICK BOUCHER.
THOMAS J. MANTON.
TOM SAWYER.
ANNA G. ESHOO.
ELIZABETH FURSE.
FRANK PALLONE, JR.
SHERROD BROWN.
PETE DEUTSCH.
RON KLINK.
ED MARKEY.
BART GORDON.
HENRY A. WAXMAN.
TED STRICKLAND.
KAREN MCCARTHY.
BART STUPAK.

MINORITY VIEWS ON TITLE III, SUBTITLE D—
COMMUNICATIONS

The majority has perpetrated a ruse on the American people. At a hearing on spectrum auctions earlier this year Chairman Tom Bliley stated, “The annual budget cycle has begun once again and this means that quick-fix proposals involving the sale of spectrum emerge like snake oil salesmen at a local carnival.”

Unfortunately, the Chairman was all too prescient. The Budget Resolution included reconciliation instructions to our committee to report legislation requiring spectrum auctions to raise \$26.3 billion in revenues. There was not the slightest basis for such an estimate. At the hearing on spectrum auctions no testimony supported such a market for spectrum. Even worse, in order for the committee to seek auction revenues that can be “scored,” the committee passed legislation which will actually reduce revenues flowing to the nation’s taxpayers.

The rules of budget scoring have forced the Majority to write a bill that unnecessarily requires massive amounts of spectrum to be auctioned during the budget “window” of 1998–2002. Unfortunately, in order to achieve value for frequencies, there must be appropriate technologies available and ready to utilize the frequencies. The development and availability of emerging technologies is, however, not dictated by budget windows.

The recent Congressionally mandated auction of certain frequencies for wireless communications systems should give the Congress pause. That auction was estimated by CBO to achieve \$1.8 billion in revenue, but the winning bids totaled just \$13 million, or less than one percent of the estimate. One winning bidder bought the rights to market in 4 states with a population of 15 million for just 4 dollars. The reason for this spectacular failure was clear. First, the Commission failed to indicate more precisely the type of services the auctioned frequencies were to be for and this led to great uncertainty on the part of manufacturers as to what equipment to order. Second, the budget-drive timetable for holding the WCS auction did not allow potential bidders sufficient time to assess the markets, develop business plans, and find partners or financial backing. Third, the Commission was forced to auction specific frequencies and lacked the discretion to exercise its expertise to tailor the frequencies to be put out for bid to further serve the public interest. Finally, there was also a saturation of competitors and frequencies available in the marketplace.

It might have been easy for Members of our committee to ignore these facts, and report the proposals contained in the budget resolution, despite our doubts. However, many of us believed that we had a responsibility to inform our colleagues that a portion of the balanced budget agreement was built on assumptions that could not be met. Other parts of the budget, whether they are spending

increases or tax cuts, are real. In the case of spectrum auctions, the dollars to pay for them are as ephemeral as the airwaves themselves.

We now turn to the individual proposals in the spectrum auction legislation that are of particular concern.

Requirement to sell 120 megahertz of spectrum

The bill requires the Commission to identify 120 MHz of additional spectrum to auction over the next five years. The proposal raises several fundamental problems. First, as the failed auction described above proved, it is unwise for Congress to specify the frequencies to be auctioned years from now. That is a decision best left to the Commission. Second, the timing of auctions must be dictated by the marketplace. Unless there are new and valuable uses for the frequencies, the auctions will fail. Specifying a mandatory date for the sales will likely result in irrevocable losses to the taxpayer.

Third, the assumption that valuable frequencies are available was challenged in a letter to the committee from Commission Chairman Reed Hundt. He wrote on June 9, 1997, "Our engineers, in an extended effort, have been unable to identify that amount [100 MHz] of spectrum below 3 Gigahertz which could be auctioned for significantly more valuable uses." If the agency with expertise cannot find the spectrum, we do not understand the basis for the Budget Committee's assumption. Even CBO has now backed off of its estimates of the value of the 120 MHz. In response to questions from Ranking Member John D. Dingell, CBO Director June E. O'Neill wrote in a letter dated June 5, 1997, "Based on information from the FCC and the National Technology and Information Administration, however, we are concerned that it may be very difficult to identify 120 megahertz (MHz) of spectrum under 3 gigahertz (GHz) that could be reallocated and auctioned, as proposed by the President. . . . Subsequently, we received draft language prepared by the Administration for the spectrum proposals in the President's budget. We have not prepared an estimate for that draft language, but we have concluded that the portion of the language dealing with directed reallocation of 120 MHz is not specific enough to warrant the \$9.7 billion in estimated receipts that we attributed to the President's budget."

Fourth, the mandatory reallocation of certain Federal frequencies without any testimony concerning the uses and the ability to reallocate the frequency raises further concerns. For example, it appears that some of the frequencies contained in section 3301(b)(1)(E) may be important for use by the FAA in airline safety.

Auction of analog spectrum

The legislation would establish a statutory date for the return of the analog broadcast spectrum of December 31, 2006. The date would be extended indefinitely, if in a given year more than 5% of households are not capable of receiving digital signals. The auction of the anticipated returned spectrum would begin in 2001.

This portion of the legislation creates the most serious problems. We do not oppose the auction of the returned analog spectrum.

However, the procedures in this legislation virtually guarantee that the taxpayer will be shortchanged. There is no logic to requiring the auction of the returned spectrum in the year 2001, more than 5 years in advance of the availability of the spectrum for use. The only justification for this arbitrary date is to meet a budget "window" of five years.

The Majority has chosen to establish a statutory date for the return of the spectrum, rather than leaving regulatory flexibility to the Commission, which has established a similar "target" date, which could be adjusted, as circumstances dictate. Recognizing the problem in setting a statutory date, the Majority included a statutory rule for delaying the return of the spectrum indefinitely, if five percent of households are incapable of receiving digital signals. This exception would likely result in the spectrum never being returned. It is almost certain to spark virtually no interest by bidders in 2001 for spectrum which may never be returned.

Sale and labeling of analog sets

During the consideration of the legislation, two amendments were offered relating to the sale of television sets. Ranking Member Edward J. Markey offered an amendment that would have prohibited the sale of sets that were incapable of receiving digital transmissions three years before the anticipated change to digital broadcasting. Rep. Elizabeth Furse subsequently offered an amendment to require that the Commission at least establish labeling requirements for new televisions that were unable to receive digital transmissions to inform purchasers that the set would not be capable of receiving transmissions without the addition of a converter when broadcasters converted to digital transmissions.

The bill approved by the Majority includes for the first time a statutory requirement that the analog spectrum be returned by December 31, 2006. This deadline may be extended, if 5% of households are not capable of receiving digital transmissions. It is only fair to the consumer that the consequences of this law be disclosed when they purchase a set that is not capable of receiving the digital signal mandated by this law. Otherwise, dealers could sell sets that could be obsolete in just months or a few years after they are sold.

The situation in no way resembles that of a technology becoming obsolete through market forces, such as eight-track tapes, as alleged by some opponents of these amendments. Analog televisions, in the absence of a converter, will become obsolete due to the government mandate contained in this law requiring the return of the analog spectrum, not due to market forces. If the Majority desires to establish a date upon which analog televisions should become obsolete, they should at least be willing to disclose their decision to buyers of television sets. Apparently, if consumers buy a television that soon becomes obsolete, the Majority intends, in Mission Impossible style, to "disavow any knowledge of its actions" on this legislation.

There is another budgetary consequence to the decision not to adopt these amendments. If manufacturers continue to sell sets not capable of receiving digital transmissions, and also fail even to inform purchasers of the potential obsolescence of the equipment, the

likelihood that more than 95% of households will be digitally-capable is reduced. Under the bill, the spectrum would not be returned under such conditions, and bidders at an auction occurring in 2001 will be less likely to bid anything for such spectrum.

Spectrum penalty

One of the more questionable instructions, based upon the Bipartisan Budget Agreement, and incorporated into the Budget Resolution, was entitled "Spectrum Penalty." The Budget Agreement stated, "As authorized by current law, a penalty fee would be levied against those entities who received 'free' spectrum for advanced, advertiser-based television services, but failed to utilize it fully." According to the Budget Agreement, this provision would be scored at \$2 billion. The Budget Agreement also stated with respect to spectrum auctions, "Estimates for 1998-2002 were developed by the Congressional Budget Office."

Both the Majority and Minority were skeptical about how a provision already in current law could be scored by CBO as part of reconciliation. In response to questions by Ranking Member John D. Dingell concerning this provision, CBO Director June E. O'Neill on June 5, 1997 wrote concerning this "Spectrum Penalty," "CBO has not seen any legislative language regarding a spectrum penalty, and therefore we cannot comment on what the spectrum penalty would be and how much it would raise. In order to result in savings, it would have to mandate fees that would not be assessed under current law."

It therefore appears that the attribution of the Budget Agreement and Budget Resolution of \$2 billion in scorable savings for fees authorized under current law to estimates by CBO was erroneous. There is no provision for such a Spectrum Penalty in the bill.

Tauzin amendment on target

During the consideration of the legislation, Subcommittee Chairman W.J. "Billy" Tauzin offered an amendment that would require the Commission to establish methodologies to carry out the auctions required under each section to achieve approximately 50% of the original CBO estimates for each category of auction. If the Commission failed to convince itself that such targets were achievable the auctions could be canceled. The amendment also gave the Commission the authority to establish minimum bids.

We agree that the Commission should have the authority to establish minimum bids and to cancel auctions if they are not in the public interest or will not achieve estimated revenue targets. The minority offered amendments on these matters that were defeated by the Majority. Our amendments, however, did not accept the arbitrary dates for auctions contained in the Majority bill. The target approach in the Tauzin amendment, while providing some flexibility to cancel auctions if they cannot achieve the unrealistic budget estimates, appears designed more to "pretend" that revenue estimates can be met than to provide true flexibility to the Commission.

Duopoly and joint-ownership rules

The Majority has also decided to use the Reconciliation legislation as an opportunity to reopen the bipartisan Telecommunications Act passed in the last Congress. Specifically, the legislation was amended to repeal the Commission's duopoly and cross-ownership rules with respect to the purchase of the returned analog spectrum for digital uses, an approach rejected in the conference on the Telecommunications legislation last year. Not only do we disagree with the merits of such an approach, but this decision is based upon no hearings or other testimony that the repeal of these rules is in the public interest. The committee has received no testimony in this Congress on the impact of this provision on various broadcasters, including minority broadcasters, nor was there testimony on the impact on the viewing public.

Summary

We preach the virtues of thinking and planning for the future, yet the forced sale of spectrum contained in this bill sets just the opposite example. We are squandering a scarce and valuable public resource by providing more spectrum for those services that are here and now, at the expense of emerging technologies that will be in higher demand and, not incidentally, more valuable to the public purse in the future.

During the consideration of this legislation the Minority sought to provide the Commission with the necessary flexibility to protect the taxpayers and auction the spectrum in the public interest. Our amendments would have achieved the maximum benefit for taxpayers and users of the spectrum, both in the short term and long term. Spectrum auctions must be based upon sound communications policy and should not be mandated to fill budget holes. The success of auctions based upon the 1993 reconciliation provisions, and the failure of the most recent auction on wireless communications, are proof that market conditions, and not government mandates establish the amount of revenues that can be achieved. Neither our proposals nor those of the Majority will provide \$26.3 billion. Our proposals, however, would have provided a better opportunity to maximize the spectrum's value. We strongly encourage the Budget Committee to review its assumptions concerning spec-

trum auctions, as the legislative process continues. Otherwise, a balanced budget will be as real as the phantom revenues from spectrum auctions.

JOHN D. DINGELL.
ED MARKEY.
DIANA DEGETTE.
BOBBY RUSH.
RICK BOUCHER.
THOMAS J. MANTON.
GENE GREEN.
TOM SAWYER.
ANNA G. ESHOO.
ELIZABETH FURSE.
FRANK PALLONE, JR.
SHERROD BROWN.
PETE DEUTSCH.
RON KLINK.
HENRY A. WAXMAN.
EDOLPHUS TOWNS.
KAREN MCCARTHY.
BART STUPAK.

DISSENTING VIEWS ON TITLE 3, SUBTITLE D—
TELECOMMUNICATIONS RECONCILIATION

It is with regret that I was not able to vote with the rest of my colleagues to support the telecommunications portion of the budget reconciliation bill that passed out of the Commerce Committee earlier this week. However, I could not support a bill that contained such unrealistic savings goals. It is not rational to believe that additional spectrum auctions will net \$26.3 billion when the last spectrum auctions created a \$2.886 billion shortfall.

JOE BARTON.

MINORITY VIEWS ON TITLE III, SUBTITLE E—MEDICAID

We applaud the majority for rejecting the ill-conceived notion of a block grant for Medicaid. Since Medicaid is America's second largest health care program, covering almost as many Americans as Medicare, it would have been irresponsible for Congress to support a program that had virtually no protections for the 36.8 million poor senior citizens, disabled people, women, and children that rely on Medicaid for their health and long term care services. We believe that the Republicans have once again learned that the approach of the last Congress—putting America's children, the elderly and disabled at risk—was the wrong way to go.

This year's Medicaid proposal maintains a number of the existing protections of current law for these important and vulnerable beneficiaries including: an appropriate benefits package for the 70 million children who need early preventive care, diagnosis and treatment. This is a sound investment because it saves on more expensive longer term adult care and treatment later; protections for the 6 million disabled individuals and approximately 7.4 million low-income women who are eligible for Medicaid; and protections for the elderly against impoverishment in their last years of life when they need nursing home care and cannot afford it themselves.

In addition, as the Republican proposal moved through the committee process several bi-partisan amendments adopted improved on the initial proposal: women will have direct access to their ob/gyn as their primary care provider; women and children will be guaranteed important quality standards for managed care plans; children who suffer from cerebral palsy, cystic fibrosis, cancer and a range of other debilitating diseases will have access to the specialized pediatric services they vitally need; and the public will have important fraud and abuse provisions for managed care plans in the areas of marketing and contract negotiations.

The minority is very disappointed, however, that the Republicans failed to live up to the budget agreement.

First, the budget agreement included an understanding that \$1.5 billion would pay for premiums for low-income Medicare beneficiaries. This protection was vital to securing the over-all agreement that the costs of maintaining the Part B premium at 25% of program costs and the costs of switching home health to part B of Medicare would be phased into the premium payment. Because of these two provisions the part B premium for Seniors will increase by as much as \$23.00 a month from 1997 to 2002. When this increase is added to the other increases incorporated into the budget agreement, the average elderly woman with an income less than \$12,000 a year will see her Part B premium rise from \$43.80 a month in 1997 to \$66.70 a month in 2002. This extra cost of approximately \$800 a year represents a substantial sum for those with incomes less than 150 percent of the poverty line. The com-

mittee included the savings from increasing the Part B premium, but did not include the agreed upon protections for low-income Seniors. Instead of providing \$1.5 billion in protection, it provides only \$600 million. To add insult to injury, the bill actually spends an additional \$2.2 billion in Medicare funds on MSAs, which will hardly help low-income Seniors. Most MSAs include deductibles of up to \$6,000, approximately half the annual income of a senior at 150 percent of poverty. The majority failed abjectly in this matter. The minority attempted several times in subcommittee and full committee to circumscribe this through amendments, and we intend to see that the terms of the agreement are honored as this legislation proceeds.

Second, the majority took direct action to refuse to provide health care services for disabled children eligible for SSI who were covered under terms of the agreement. At a time when the majority was attempting to proclaim that they were providing additional coverage to millions of uninsured children, they were at the same time taking away health insurance coverage from 20,000 disabled children. This is beyond our comprehension, and causes us to wonder whether the majority's idea is to provide insurance to the healthy but not the sick.

Finally, the majority repealed the so-called "Boren amendment," which provides payment protections for hospitals and nursing homes. The Boren amendment simply says that Governors must pay hospitals and nursing homes a "reasonable and adequate" payment to ensure the adequate provision of services. This provision is crucial to ensuring that we do not have a return to the disgraceful conditions that existed before our 1987 nursing home reforms when we found frail elderly and disabled individuals warehoused and abused in chronically substandard facilities. The Democratic minority worked successfully in subcommittee to restore this vital provision only to see it replaced by the Republicans in full committee with a meaningless public process.

For these reasons, the Medicaid provisions of budget reconciliation ultimately falls short in several key areas and fail to honor the terms of the budget agreement.

JOHN D. DINGELL.
SHERROD BROWN.
DIANA DEGETTE.
BOBBY RUSH.
RICK BOUCHER.
THOMAS J. MANTON.
GENE GREEN.
TOM SAWYER.
ANNA G. ESHOO.
ELIZABETH FURSE.
FRANK PALLONE, JR.
PETE DEUTSCH.
RON KLINK.
ED MARKEY.
BART GORDON.
HENRY A. WAXMAN.
EDOLPHUS TOWNS.
TED STRICKLAND.
KAREN MCCARTHY.
BART STUPAK.

ADDITIONAL VIEWS: GREENWOOD WAXMAN TITLE III(E)
AND TITLE

In both the Medicare Plus and the Medicaid provisions of the bill, the Committee has adopted language ensuring that managed care organizations cannot limit the scope of the information and advice that physicians may give to patients.

This provision is, however, limited by a construction clause contained within it. In that clause, it is made clear that the provision is not to be interpreted to require a health maintenance organization to "provide, reimburse for, or provide coverage of" any counseling or referral service if the HMO has moral or religious grounds for doing so and if the HMO gives its enrollees and prospective enrollees advance notice of its unwillingness to provide such counseling and referral.

In our view, the intention of the Committee in adopting this language was to make clear that health plans that are religiously controlled do not have to disregard their religious or moral beliefs in order to participate in Medicare Plus or Medicaid. Further, we believe there is no rationale for extending the reach of this provision to include HMOs that are public, non-profit secular, or for-profit secular organizations. We believe the committee does not intend to allow such organizations to assert such religious or moral objections in order to side step what is required of them by the statute, regulations or contract.

JAMES GREENWOOD.
HENRY A. WAXMAN.

TITLE III—SUBTITLE E

ADDITIONAL VIEWS ON DISPROPORTIONATE SHARE HOSPITAL (DSH) FORMULA

The undersigned members of the Commerce Committee strongly protest the Committee-approved formula on disproportionate share hospital (DSH) payments.

We are compelled to do so because the formula contained in the Committee bill—intended to produce \$15.7 billion in savings over five years—will lead to punitive cuts in those states defined as “high-DSH” states; that is, states that send 12% or more of medical assistance payments on DSH.

There is no one approach that we would favor or that we would deem fair. Low-DSH states have a legitimate point when arguing against taking the same percentage cuts as high-DSH states. However, the approach we favored at the Committee mark-up has the merit of recognizing that some high-DSH states are particularly dependent on DSH funding and they should not bear the entire impact of these cuts.

The argument that the burden of DSH cuts squarely on the backs of high DSH states cannot be denied. The formula passed by the Committee will start with modest cuts of two and five percent respectively in 1998 and 1999. Beginning in 2000, however, high-DSH states will receive 20 percent less than they received in 1997; in 2001, 30 percent less; and in 2002, 40 percent less. Low-DSH states, on the other hand, will face cuts at only half the yearly rate of high-DSH states.

In addition to higher yearly percentage cuts, high-DSH states are further burdened by the way the Committee has defined high-DSH states. The Clinton Administration originally proposed a formula using FY 1995 DSH payments to states as the basis for determining the starting point of reductions. During the development of the Committee bill, a change was made to the proposed formula that established FY 1997 as the starting point from which to classify high-DSH states. This change served to reduce the number of states that were classified as high-DSH and concentrated a higher level of reductions in fewer states. We believe that this change unfairly penalizes our states and confers advantages to other states. To address this inequity, we offered an amendment to change the DSH formula.

Our alternative, sponsored by Rep. Gene Green, was nearly identical to the Administration’s proposal, the only change being a slight increase in the yearly percentage cuts. This change was made to achieve the same budget savings as the Committee version. The amendment exempted (as did the Committee-approved version) those states whose DSH spending was below 1 percent of medical assistance payments as of FY 1995. Then, for the years be-

ginning in 1999 and ending in 2002, it applied annual cuts of 10, 20, 25, and 35 percent respectively.

Notably, our amendment would apply those percentage cuts on a state's first 12 percent of DSH spending, the percentage spending level distinguishing high and low-DSH states. The Committee's version on the other hand, contains deeper cuts on the whole amount of DSH spending. This is a double blow to high-DSH states and demonstrates the one-sided nature of the Committee formula.

In summary, we do not regard the provision passed by the Commerce Committee as a sound way to manage the DSH program and we will continue to work to see that it is changed.

GENE GREEN.
DAN SCHAEFER.
DIANA DEGETTE.
JOE BARTON.
FRANK PALLONE, JR.
KAREN MCCARTHY.

ADDITIONAL VIEWS

CONGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,

TITLE IV—COMMITTEE ON COMMERCE—MEDICARE

The Medicare program is one of the cornerstones of the public safety net that our Seniors and disabled citizens rely upon for critical health care services. During the development of the balanced budget agreement, Congress had the opportunity to address the fundamental structural problems associated with Medicare that have helped create the short and long-term solvency problems of the program. The budget agreement has been criticized on many fronts, but one of my primary concerns is that it fails to address the underlying structural problems of our major entitlement programs, opting instead for a short-term fix.

In the Commerce committee Medicare restructuring legislation, a commission was authorized to make specific recommendations to Congress on the financial impact to the program of the generation of Americans which will begin eligibility around 2010. I was pleased to see that the language establishing this commission was structured along similar lines to legislation I introduced, H.R. 75, the Medicare Commission Act of 1997.

Authorizing commissions, expert panels, and other entities to study and make recommendations has helped to guide past Congresses on difficult issues in the past. The most successful examples are the Base Closure Commission and the Social Security Commission of the early 1980s, from which a specific set of recommendations were developed and acted upon by Congress.

Congressional action must also occur on the recommendations of the Medicare Solvency Commission when it makes the report called for in this legislation during 1999. The future of the Medicare program requires us to address these problems in a timely manner, before the demographics of the Baby Boomer generation retirement are upon us. We should not require the emergence of a national crisis to spur Congress to action, and we should act to address the long-term solvency of the Medicare program in a deliberate manner as soon as practicable.

TITLE III SUBTITLE E—MEDICAID

Furthermore, my support for the repeal of the Boren amendment reflects the need to provide the states maximum flexibility in the administration of the Medicaid program. In addition to being consistent with the support of the President, the severe reductions in the Disproportionate Share programs necessitate additional flexibility for states.

KAREN MCCARTHY.

MINORITY VIEWS ON TITLE III, SUBTITLE F—STATE CHILD HEALTH COVERAGE

The Commerce Committee has taken important steps toward helping needy children get access to health care.

We are pleased to see that the Committee adopted, on voice vote, Rep. DeGette's proposal on presumptive eligibility for children. This is a valuable component of outreach for children. Allowing selected sites and providers to determine children to be presumptively eligible for Medicaid for one month, until their application can be completed and reviewed, is an important step to reaching the 3 million children who are currently eligible for Medicaid but are not enrolled. Presumptive eligibility cuts through some of the difficulties parents face in obtaining health insurance for their children through Medicaid.

We were also pleased to see the Committee adopt Rep. Strickland's amendment on exempting special needs children from mandatory enrollment in managed care. While the exemption is included in the Medicaid title, it protects all children with special needs. This exemption is particularly important because managed care systems have not been tested for their ability to serve those with chronic and disabling conditions.

However, while we have bipartisan agreement on those two items, we have a number of concerns with the approach taken to target the 5 million low-income children who are currently uninsured. We would have preferred to see another approach. In fact, the Democrats offered two alternatives.

We were particularly disappointed that the Republicans did not adhere to the budget agreement that specifically said that \$16 billion for children's health must be spent on programs that provide *health insurance coverage* for low-income children. Under the Committee proposal as it now stands, States are not required to provide health insurance coverage for children. They could choose to do this, but there is no requirement in clear violation of the agreement between the Republican leadership and the Administration.

On this matter, we are particularly concerned with a large loophole that says that children's health money can be spent on "direct provision of services." Our experience with the disproportionate share hospital program (DSH) tells us that sometimes the funds that Congress turns over to the states do not always reach the intended beneficiaries. Congress did not intend for DSH moneys to fund state psychiatric hospitals, or roads, or prisons, but in some states that is exactly what happened. With the direct provision of services clause in the current bill, States could use all of their block grant money to buy drugs for sick children, or pay for psychiatric care in a state mental hospital, or pay for residential substance abuse treatment services for children in the juvenile justice system. These individuals who are receiving services through these programs and institutions are certainly worthy of federal support. But, we already have a number of federal programs that purchase direct services for children in this manner.

In fact, the block grant proposal, coupled with the large disproportionate share hospital cuts, provides incentives for states not to use their money to cover children but to invest it in particular

services. The states could target this children's health money directly to the facilities that will be losing DSH money through the cuts in the budget package.

The Commerce Committee Minority believes that there are options available to make sure that we are getting what we are intending to pay for: health insurance coverage for children. We believe that we put forth two solid proposals that would direct the funds for this purpose expressly: the Dingell-Brown proposal, and the Democratic Caucus proposal offered by Mr. Pallone.

The Dingell-Brown Child Health Insurance Provides Security Act, H.R. 1491, builds on the Medicaid program to expand health insurance coverage to children up to 150% of poverty. Three important points about this proposal should be kept in mind as the package moves towards conference.

First, the Dingell-Brown bill builds on an existing program that insures 22 million children and has succeeded at getting children access to medically necessary services. The beauty of this approach is in its simplicity. There is no need to create another complicated program layer with eligibility standards and benefits that differ from the current Medicaid program. This can only create confusion for states and beneficiaries alike, and could reduce access to care and services for children.

More importantly however, are the second two points; the Dingell-Brown approach targets children who most need help, and the Dingell-Brown approach would provide children with a comprehensive package of medically necessary benefits. The Dingell-Brown bill would reach children in families at or below 150% of poverty more than 75% of whom do not have private health insurance coverage.

Also, the Medicaid program provides a comprehensive package of medically necessary services for children, something the Committee-posed bill does not offer. Given that the money we have to spend is limited, to best reach our goal of covering 5 million currently uninsured children, the \$16 billion must be targeted to the children who have the greatest need—those in families at or below 150% of poverty. We also believe that it is important to provide these children with true health insurance coverage, not "direct provision of services."

The Pallone approach contains a number of components that could help provide health insurance to children. First, it builds on the Medicaid program and adds the 'Medikids' grant program, similar to the Hatch-Kennedy proposal requiring states provide to benefits for children comparable to the Medicaid benefits package. This approach requires maintenance of effort, but gives states the flexibility: grant money could purchase private insurance, for example, but not the direct provision of services. This approach also contains private insurance reforms advocated by Rep. Furse which would make kids-only health insurance policies more accessible, especially for children in families with parents who were between jobs.

Either of these approaches would be preferable to the Committee bill.

Another issue of special concern is the majority's proposal to allow states to cap the number of children they enroll through the Medicaid program. All children who fall within a given eligibility

category should be allowed to receive benefits. Limiting the entitlement for Medicaid, even if it is only for a small population, is a dangerous precedent. The Commerce Minority would like to see this corrected.

A final issue in the area of children's health concerns is that money designated to restoring Medicaid eligibility for disabled children losing SSI because the new, stricter definition of childhood eligibility was not included in the package. The proposal was removed in favor of a block grant for certain, selected states to help with the unreimbursed cost of emergency services for immigrants. In a bill that was designed to increase health insurance coverage for up to 5 million children, we are taking away health insurance for 20,000 poor or near-poor disabled children.

We look forward to continuing to work in a bipartisan manner on the remaining outstanding issues that we have highlighted here.

JOHN D. DINGELL.
SHERROD BROWN.
DIANA DEGETTE.
BOBBY RUSH.
RICK BOUCHER.
THOMAS J. MANTON.
GENE GREEN.
TOM SAWYER.
ANNA G. ESHOO.
ELIZABETH FURSE.
FRANK PALLONE, JR.
PETE DEUTSCH.
RON KLINK.
ED MARKEY.
BART GORDON.
HENRY A. WAXMAN.
EDOLPHUS TOWNS.
TED STRICKLAND.
KAREN MCCARTHY.
BART STUPAK.

MINORITY VIEWS ON TITLE IV—MEDICARE

If the Medicare provisions of this budget reconciliation could be considered in isolation, a number of positive statements could be made about them.

For example, the provisions expand Medicare health care choices by allowing beneficiaries to enroll in a variety of managed health care plans, and also provide significant consumer protections within most of these plans. We applaud our Republican colleagues for recognizing the wisdom of carefully defining the terms of managed care for senior citizens who choose to receive their health care this way. The success of managed care in the Medicare market ultimately hinges on whether seniors are well served by the system: whether they have quality care, access to appropriate providers, bona fide appeals and grievance mechanisms, and honest marketing. Another protection, expanded by a Democratic amendment, allowing seniors to move into the managed care market without the penalty of losing forever their right to purchase a Medigap policy. In short, the majority wisely turned its back to the last Congress' approach of leaving America's seniors to the mercy of the health insurance marketplace.

The Committee's Medicare proposal also properly acknowledges the need to make both short-term payment changes and longer term policy modifications to address escalating Medicare costs and the solvency of the Medicare Trust Funds. The provisions attempt to provide judicious balance among payment reductions affecting various providers and to allow the establishment of new payment methodologies that provide for greater control and accountability. In addition, a number of important fraud and abuse protections, as proposed by the President, are contained in the legislation. Additional components of the President's proposal should be included, and we will pursue that goal as the bill moves forward.

However, the legislation continues penny- and pound-foolish: namely, including Medical Savings Accounts in the MedicarePlus program. Although the proposal is structured as a demonstration project, we continue to question the wisdom of spending over \$2 billion to toss Medicare beneficiaries into totally uncharted waters, as an experiment. We already are testing MSAs in the younger, healthier general population through a demonstration program established under the Kassebaum-Kennedy legislation. That project is due to end, and to be evaluated, in 4 years. Why not wait until that evaluation concludes to begin an expansion of the experiment to Medicare beneficiaries?

Many differences of opinion on MSAs were expressed during Subcommittee and Committee deliberations. We argued that MSAs would appeal to and thus enroll younger, healthier Medicare beneficiaries—those who cost the Medicare program less—leaving older, less healthy people in “traditional” Medicare and increasing Medi-

care costs. This is one of the reasons that the Congressional Budget Office believes MSAs will cost, not save money. But the truth is, nobody knows about risk selection in MSAs. Thus, nobody can predict with any accuracy that MSAs will not have an enormous and adverse affect on Medicare costs over the long term. The Kassebaum-Kennedy demonstration will be the first opportunity to answer that question. We believe it would be prudent to wait for the results of that program. Alternatively, and at a minimum, we believe that any MSA demonstration program in Medicare must be much more limited than 500,000 lives. We attempted to circumscribe this through amendments, and intend to pursue a reduction in scope, or the elimination of the MSAs, as the legislation proceeds.

Our additional point: medical malpractice reforms—regardless of their substantive merits or lack thereof—do not belong in this legislation. Congressional decisions about federal malpractice liability standards that would pre-empt state laws and prerogatives deserve to be made in the light of separate deliberations. Committee hearings have not been held on this matter. We have not had an opportunity to mark up legislation. We have not had an opportunity for Members to debate their differing perspectives on this issue. We intend to continue our objection to including malpractice provisions in budget reconciliation.

In summary, we cannot isolate the Medicare provisions of budget reconciliation and look at their positive features separately. Indeed, we must look at the changes in this critically important program in the total context of a budget agreement that places America's senior citizens in the last car of a train and pulled by an engine of "balancing" the federal budget loaded with tax cuts for the wealthy. Many agree that Medicare spending needs to be curtailed, and the program needs to be changed—for its long-term good. And many would agree that savings of \$115 billion improves upon the Republican proposal of the last Congress. However, reasonable senior citizens, and reasonable Democrats, continue to puzzle over a scheme that cuts Medicare while at the same time providing tax breaks for businesses and for higher-income individuals.

We are told that tax cuts will help the "middle class"—those whose incomes are \$100,000 per year, or more. Since the majority of Medicare beneficiaries have incomes one-quarter of that amount—less than \$25,000 per year—we are understandably skeptical of the trade-offs. Furthermore, the budget agreement between the President and the Republican leadership—for all of its flaws—included a "fail-safe" for the lowest income Medicare beneficiaries. It specifically included a commitment to spend \$1.5 billion on helping these seniors pay their Medicare Part B premiums. The bills reported by this Committee do not honor that commitment. That failure colors all of what otherwise might be viewed as positive aspects of the Medicare portions of this package.

JOHN D. DINGELL.
SHERROD BROWN.
DIANA DEGETTE.
BOBBY RUSH.
RICK BOUCHER.

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THOMAS J. MANTON.
GENE GREEN.
TOM SAWYER.
ANNA G. ESHOO.
ELIZABETH FURSE.
FRANK PALLONE, JR.
PETE DEUTSCH.
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MINORITY VIEWS ON WELFARE AND HIGHER EDUCATION RECONCILIATION RECOMMENDATIONS

I. CHANGES MADE TO WELFARE REFORM

The Reconciliation recommendations that have been reported by the Committee are a pernicious attack on the poor.

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (herein referred to as the "Act" or the "new welfare law") increased emphasis on the need to move welfare recipients from welfare to work. Under the Act, the Aid to Families with Dependent Children (AFDC) program was replaced with the Temporary Assistance for Needy Families (TANF) program. The law also established specific work requirements that States and tribal governments must meet to qualify for the full Federal share of funds supporting the TANF program.

The new welfare law requires 25 percent of all TANF families (excluding families in which there are no adults) and 75 percent of two-parent TANF families to have an adult engaged in work activities in FY 1997. States may exempt single parents of children under the age of one from the work requirement. The required participation rates increase each year, culminating at 50 percent for all families with an adult and 90 percent for two-parent families in FY 2002.

In order to be counted toward the work participation rate, a single parent is required to be engaged in a work activity for an average of 20 hours a week per month in FY 1997, for an average of 25 hours a week per month in FY 1999, and for an average of 30 hours a week per month in FY 2000. An adult in a two-parent family is required to be engaged in work activity for an average of 35 hours a week per month.

Work activity is defined in the Act to include (1) unsubsidized employment; (2) subsidized private sector employment; (3) subsidized public sector employment; (4) work experience (including work associated with the refurbishing of publicly-assisted housing) if sufficient private sector employment is not available; (5) on-the-job training; (6) job search and job readiness assistance; (7) community service programs; (8) vocational education training (not to exceed 12 months with respect to any individual); (9) job skills training directly related to employment; (10) education directly related to employment, in the case of a recipient who has not received a high school diploma or a certificate of high school equivalency; (11) satisfactory attendance at secondary school or in a course of study leading to a certificate of general equivalence, in the case of a recipient who has not completed secondary school or received such a certificate; and (12) the provision of child care services to an individual who is participating in a community service program."

Under the new welfare law, not more than 20 percent of individuals in all families receiving TANF assistance may be determined to be engaged in work in the State for a month by reason of participating in vocational education or, in the case of a single parent teenager, maintaining satisfactory school attendance.

Further, the public sector must provide "workfare jobs" when the private sector does not meet the demand for labor. But what must those "workfare jobs" be like? Under the Reconciliation recommendations adopted by the Committee, they could be like indentured servitude. Perhaps we will return to the days of the company town, where workers did not receive cash wages, but were "compensated" by their bosses with food, clothing, and shelter.

Under the Committee's Reconciliation recommendations, a public agency or nonprofit employer will not be required to pay workfare workers any cash wages at all. In some States, workfare workers could be required to work in excess of 40 hours a week and would still not be entitled to cash wages.

The Committee's Reconciliation recommendations provide that a State may not require a recipient to be assigned to on-the-job training, and to a work experience or community service position with a public agency or nonprofit organization for more than the value of includible benefits provided by the State divided by the minimum wage. Includible benefits include TANF benefits, food stamps, and at the option of the State, child care assistance, Medicaid, and housing benefits. For a family of two, the value of TANF benefits and food stamps, alone, exceeds the value of twenty hours of work at the minimum wage in 42 of 50 States. For a family of three, the value of TANF benefits and food stamps exceeds the value of twenty hours of work at the minimum wage in every State except one. For a family of four, the value of TANF and food stamps exceeds the value of twenty hours of work at the minimum wage in every State and, in fourteen States, exceeds the value of forty hours of work at the minimum wage. If the value of child care assistance, Medicaid, and housing benefits are included in the calculation of includible benefits, virtually no recipient employed by a public or nonprofit employer will be entitled to cash for that work.

The Committee recommendations further provide a recipient will be determined to be sufficiently employed if the recipient is employed for a number of hours that is not less than the sum of the dollar value of the TANF and food stamp benefits provided by the recipient divided by the minimum wage. In fourteen States, a recipient in a family of four may be required to work excessive overtime and would still not be entitled to any cash wages for that work. Finally, no remedy is provided for a recipient where the recipient is required to work a greater number of hours than permissible under the Fair Labor Standards Act (FLSA), because the recipients are "not considered employees."

Beyond effectively repealing minimum wage overtime, overtime, child labor, and other FLSA protections for recipients working for public or nonprofit employers, these recipients will be denied the rights and protections afforded by labor and employment-based civil rights laws to all other workers. The Committee's recommendations provide:

A recipient of assistance under a State program funded under this part who is engaged in work experience or community service with a public agency or nonprofit organization *shall not be considered an employee* of the public agency or the nonprofit organization. (Proposed section 470(K) of the Social Security Act, emphasis added)

By specifically relegating these workers to “non-employee” status, this proposal also denies them protections of the Family and Medical Leave Act, the Equal Pay Act, Title VII of the Civil Rights Act, the National Labor Relations Act, the Age Discrimination in Employment Act, and all other laws designed to protect working people from unsafe workplaces, racial and sexual harassment, and unfair wages. It is patently unfair to say to these workfare workers that their employers may require them to work in a workplace environment where they are less protected than the workers working next to them who enjoy employee status.

The Republican Reconciliation recommendations provide weak health and safety protections to workfare workers. The proposal provides that health and safety “standards” established under Federal and State law will be applicable to the working conditions of workfare workers. However, the Republicans have failed to provide any means by which workfare workers may meaningfully invoke the protections afforded by those standards. The skeletal grievance procedure established in the proposal—which are the exclusive remedial procedures extended to these workers—are no match for OSHA’s grievance procedures and remedies. The most important provision of OSHA, the “General Duty Clause”, requiring that employers ensure that the workplace is free from recognized hazards likely to cause death or serious injury, may not be applicable to workfare workers. A workfare worker may have no right to request an inspection of the workplace and may be subject to employer retaliation for engaging in safety-related activities. While a workfare worker may be able to invoke the grievance procedures where the workfare worker believes a specific health and safety standard has been violated, the exclusive grievance procedure under this proposal may take up to 180 days to complete. For the workfare worker who is faced with an imminent hazard, the grievance procedure has the effect of prolonging the recipient’s jeopardy. This proposal pays lip service to the issue of worker health and safety while jeopardizing the health and safety of that worker. It also would eliminate the deterrent effect of OSHA by not applying OSHA’s civil and penalties imposed on employers guilty of health and safety violations.

The cavalier disregard shown for the health and safety of workfare workers is repeated with regard to the civil rights of workfare workers. The new welfare law extends certain non-employment based civil rights protections to workfare workers (Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and the Americans with Disabilities Act of 1990). The Majority has included coverage for sex discrimination in its recommendations, however, the discrimination provision provides only a minimalist grievance procedure as the exclusive remedy for gender discrimination. As Representative Robert E. Andrews (D-NJ) pointed out during the

markup, the grievance process contemplated by the Republicans will be established by the public agency, the employer of the workfare worker. In effect, that agency will be charged with establishing a process for judging the allegations of unpaid welfare recipients against the supervisors and employees of the agency. Nowhere in the grievance procedures the Republicans have put forward is there a requirement that the grievance hearing officer be an impartial arbiter. Rather, the grievance hearing officer is likely to also be an employee of the public agency. There are no protections in the grievance procedures the Republicans are proposing to ensure that the grievance process itself is fair and impartial, and not a kangaroo court.

In what appears to be either a Freudian slip or a particularly cruel hoax, the Republican proposal provides that the workfare worker is entitled to, "where applicable, reinstatement of the employee, payment of lost wages and benefits, and reestablishment of other relevant terms, conditions, and privileges of employment." By definition, those workfare workers who work for public or nonprofit employers are not employees and, therefore, are not entitled to reinstatement, may not be entitled to payment of lost wages and benefits, and are not entitled to the reestablishment of other relevant terms, conditions, and privileges of employment. In sum, there is no coherent remedy for sexual harassment against a workfare worker under the Republican proposal. What have poor women done to deserve such second-class treatment?

In addition to the full panoply of civil rights protections, workfare workers who are "employees" must be protected under the Age Discrimination in Employment Act, Title VII of the Civil Rights Act, the Equal Pay Act, and other employment based civil rights laws such as the Equal Pay Act. Further, the scope of protection under the employment-based civil rights laws is generally broader than that provided by Federal financial assistance civil rights laws. Title VI also applies to religious discrimination. Insofar as workfare workers may be employed by nonprofit employers without receiving Title VII protection, the absence of any protection against religious discrimination is another glaring omission.

There are additional examples of the second-class treatment of workfare workers. If denied employee-status, workfare cannot receive the civil rights protections under Executive Order 11246, Section 503 of the Rehabilitation Act, and the affirmative action provisions of the Vietnam Era Veterans' Readjustment Assistance Act. Vietnam veterans who have the misfortune of landing on welfare forfeit the obligation the Federal Government has to try assist those who risked their lives in the service of their country.

The patchwork of remedies the Republican proposal concocts provides far less for workfare workers than the damages and relief those recipients would receive if they were not arbitrarily denied status. The Federal civil rights financial assistance laws (Title VI, the Age Discrimination Act, and Section 504) and the non-employee provisions of the Americans with Disabilities Act offer injunctive relief and back pay, but generally do not provide for punitive damages as are available under Title VII and the employment provisions of the Americans with Disabilities Act. Since a workfare worker may be likely to be required to work for no pay at all, limit-

ing remedies to back pay, as the Republican proposal does, may be a wholly meaningless exercise.

Even if the recipient can obtain a back pay award, it is very unlikely that the award will make the recipient whole for the damage the recipient has suffered. A workfare worker who has been discriminated against on the basis of sex, may have lost his or her job as a consequence of that discrimination. As a result of losing that job, the workfare worker is liable to have lost all benefits as well. Even paying the worker retroactively for the benefits he or she should have received is not likely to begin to compensate for the damage that worker's family suffered as a result of losing their safety net.

Further, Federal financial assistance laws are enforced primarily through termination of financial assistance. In this case, termination of financial assistance may mean nothing more than the loss of benefits for the workfare worker. What incentive does that provide for the workfare worker to seek enforce his or her rights?

During Committee markup, the Majority opposed our efforts to reverse these unconscionable limits on worker and civil rights protections. If it is true that a workfare worker's labor is not even worth the minimum wage, a supposition with which we strongly disagree, then it is pointless to place that recipient in a work program, because the value of the recipient's labor will never be sufficient to enable the recipient to obtain a job that would eliminate the need for assistance. Instead, that recipient should be in some form of education or skill enhancement program, in which case the recipient would not meet the definition of "employee" under the labor laws. And, yet in another bizarre irony, at the same time that the Republicans are contending that the labor of workfare workers is not worth the minimum wage, they propose to restrict the number of workfare workers who may be placed in vocational education programs. Whereas, the new welfare law provided that not more than 20 percent of individuals in all families receiving TANF assistance may be determined to be engaged in work in the State for a month by reason of participating in vocational education, the Republicans proposed that those participating in vocational education may not exceed 20 percent of those workfare workers who are engaged in work. Apparently, in the Republican view, workfare workers are not worthy of training either.

We do not regard poverty as a sin, nor do we see the misfortune of living on welfare as a crime. Those who can work should work, and our nation has an obligation to make sure they have jobs at livable wages and under safe conditions. And, where a workfare worker meets the test applicable to all other individuals for determining whether that individual is an employee, the workfare worker must and should be entitled to the all of the rights and protections afforded any other similarly situated worker.

Last year, with strong public support, the Congress, overrode the objections of the House Republican Leadership and enacted an increase in the minimum wage. Now, even before that law has been fully implemented, the Republicans are seeking to effectively repeal the minimum wage and all other workplace protections for workfare workers. There is no justification for carving out one group of workers and denying them the protection afforded all

other workers. This is not just a matter of fairness and equity for workfare workers, though it is certainly that. The treatment of workfare workers, however, has inevitable consequences for other workers as well. For instance, New York City operates the largest workfare program in the country. In 1991, the City employed 7,000 workers who earned wages that kept themselves and their families off of welfare to keep its parks clean. Now, the City only employs 4,600 workers for the same purpose. Seven thousand and seven hundred additional workfare workers are also employed for the same purpose. The workfare workers work for the city in return only on their welfare grants and carfare. Where once 7,000 workers were able to earn wages keeping the city's parks clean, now 7,700 workers cannot.

There are parts of the Committee's reconciliation proposal that were developed on a bipartisan basis and that we strongly support. The reconciliation proposal includes a \$3 billion welfare-to-work program substantially similar to that requested by President Clinton. We commend our Republican colleagues for their efforts in developing this program and for ensuring that funding is directed to local communities where it will do the most good. We also commend our Republican colleagues for working with us to ensure that this proposal includes strong displacement protections for current employees. However, as strongly as we support these provisions, we cannot support legislation that denies basic labor and discrimination protections to as many as 500,000 to 1 million citizens.

Throughout the long and fractious debate on welfare reform, many Republicans have talked about how welfare recipients need to be put to work, that work is dignity. What dignity is afforded to workfare workers when they are denied the protections that are afforded all other workers? Where is the dignity in being denied a wage for your work? Where is the dignity in being discriminated against on the basis of your race, sex, or religion? Workfare workers, no less than any other citizen, deserve a fair wage; they deserve a safe workplace; they deserve to be protected from unfair discrimination. They deserve respect and dignity.

Four specific amendments were offered by Democrats to address the egregious inequities in the Republican proposal. Our Ranking Member, Representative William L. Clay (D-MO), and other offered an amendment providing that those participating in work experience, on-the-job training, community service, or on the provision of child care—in addition to those in unsubsidized employment, subsidized private sector employment, subsidized public sector employment as provided in the Republican proposal—would be entitled to the same compensation at the same rates applicable to other similar employees or trainees of the employer. In addition, the amendment sought to strike provisions of the Republican proposal that exclude workfare workers from the definition of employee and that permit States to court child care, housing assistance, and Medicaid against the wages owed a workfare worker. The effect of the Clay amendment would have been to ensure that, to the extent that a workfare worker meets the same test of employee status applicable to any other individual, the workfare worker will receive the same protection in law. The amendment was defeated on a party-line vote.

Representative Lynn C. Woolsey (D-CA) and other offered an amendment to protect the civil rights of workfare worker. The amendment provided that no workfare worker shall be discriminated against on the basis of race, color, religion, sex, national origin, age, political affiliation or belief, or status as a disabled individual. In addition, the amendment extended the protection of Title IX of the Education Amendments of 1972 and, to ensure coverage under the employment-based civil rights laws, struck the "non-employee" language. Finally, to ensure that there were not conflicting remedies and that workfare workers would have the full protection of the employment-based civil rights laws, the amendment deleted those provisions of the exclusive grievance procedures in the Republican proposal related to discrimination. That amendment was also defeated on a party-line vote.

Representative Time Roemer (D-IN), along with Ranking Member Clay, offered an amendment that retained the welfare to work provisions and the anti-displacement provisions of the Republican proposal, but incorporated the changes contained in the Clay and Woolsey amendments. In addition, the amendment struck that provision of the Republican proposal limiting the number of workfare workers who may receive vocational education and still be counted for meeting work requirements. That amendment was defeated on a party-line vote.

Finally, Representative Patsy T. Mink (D-HI) offered an amendment that provided that work performed by a workfare worker would be counted as if the workfare worker had received wages equal to the minimum wage for each hour worked for purposes of calculating the Earned Income Tax Credit (EITC). The amendment was ruled "non-germane" on grounds that we found unpersuasive. And, notwithstanding that procedural ruling, the Majority should have permitted debate on the merits of the Mink amendment.

II. CHANGES MADE TO THE HIGHER EDUCATION ACT

Reducing student fees

We are disappointed that the majority voted against the amendment offered by Representative Andrews to cut student loan origination fees in half. The proposal would save students \$1 billion over five years. The fee reduction would have provided students money when they need it the most, while they are still in school. For the typical student, it would have paid for a new textbook, school supplies, or a month's worth of utility bills. The loan origination fees were imposed on students in the 1980's as a temporary revenue measure—they were never intended to be permanent.

Students are currently required to pay a 4% loan origination fee that is deducted off the top of loan proceeds they receive (technically under the FFEL program the loan origination fee is 3% and there is a 1% guaranty agency insurance fee). The amendment defeated by the majority would have reduced the origination fee from 4% to 2% on the Direct Loan side, and on the FFEL side reduced the origination fee from 3% to 2% and repealed the 1% guaranty agency insurance fee. These reductions applied to loans that go to students who have the greatest financial need.

To pay for reduction in loan origination fees, the Andrews' amendment reduced the amount the federal government reimburses lenders on defaulted loans from 98% to 95%. Also, the amendment would have reduced the amount guaranty agencies may collect on defaulted loans from 27% to 18.5%. The two offsets save approximately \$1.080 billion from 1997–2002.

Reducing the percentage a lender can be reimbursed for defaulted loans not only produces saving for the federal government, but encourages lenders to work with borrowers to prevent them from defaulting on their loans. The offset is included in the Administration's budget and was included by the Republicans in the 1995 budget reconciliation bill vetoed by President Clinton.

The reduction in the amount a guaranty agency may retain on defaulted loans from 27% to 18.5% was designed to reflect the real cost of default loan collections. The Department of Education pays an average of 18.5% to vendors on loans it collects for defaulted borrowers. The size of this collection "bonus" for guaranty agencies has been criticized by the GAO. In a report prepared in 1993 it concluded the following: "[With such a high fee] guaranty agencies have more financial incentive to expend resources collecting on defaulted loans than working with borrowers to prevent defaults because they can earn additional revenue from default collections but not from performing due diligence procedures."

New entitlements for guaranty agencies

We find it appalling that at the same time the majority voted to deny students a cut in student fees, it created two new entitlements for guaranty agencies to receive administrative payments. The Committee mark entitles guaranty agencies to receive a mandatory cost allowance under section 458 of the Higher Education Act at a rate of .85% of new loan volume. Currently, the Higher Education Act authorizes the Secretary of Education to establish the cost allowance administratively (although the Labor/HHS appropriation's bill for the last two years has required payment at the .85% rate).

In June 10, 1997, letter to the Committee's Chairman William F. Goodling and Ranking Minority Member William L. Clay, OMB Director Franklin D. Raines wrote in opposition to the new entitlement for guaranty agencies:

The Administration opposes the provision regarding administrative cost allowances (ACAs) to guaranty agencies in the Federal Family Education Loan Program (FFELP) . . . [It] represents a new entitlement to these agencies not included in the budget agreement. Moreover, any allowance to these agencies should bear some relationship to the cost these agencies incur and not be based on an arbitrary formula.

We regret that the majority has put special interest ahead of the public interest.

We also opposed an amendment that was offered by Representative Howard P. McKeon (R-CA). The amendment establishes a statutory right for guaranty agencies to retain 18.5% of payments made to it on defaulted loans that are subsequently consolidated. Currently, the Department pays up to 18.5%, but is considering reducing the amount the agencies may retain to reflect the actual

cost of collection. Other than fixed costs, most accounts collected through a subsequent loan consolidation require little work by the guaranty agency and does not merit a high level of compensation.

An earlier version of the McKeon amendment would have allowed guaranty agencies who had improperly retained 27% of consolidated defaulted loans—to the tune of tens of millions of dollars—to keep these funds retroactively to 1992. However, those guaranty agencies who played by the rules and complied with the law could only retain 18.5%. We vigorously opposed this change. Marshall S. Smith, Acting Deputy Secretary of the Department of Education, also expressed the Department of Education's opposition to the proposal:

The Department strongly opposes the proposed amendment under which guaranty agencies would be allowed to retain 27 percent of collection resulting from consolidations of defaulted loans made between the passage of the Higher Education Amendments of 1992 and July 1, 1997. We also oppose provisions in the amendment that would set agency retention on consolidations from defaults made after July 1, 1997, at 18.5%.

This proposal exemplifies the major structural flaw of the FFEL program: payments to the program participants are decided arbitrarily through the political process rather than by the competitive forces of the marketplace. For the last few years, agencies have been allowed to retain their actual collection costs on consolidations from default, up to 18.5%. The proposal would require the Department to repay retroactively agencies 27 percent on these loans. We estimate that these payments would total \$110 million in FY 1997. Based on actual reported collection cost of guaranty agencies, this level is clearly excessive [June 11, 1997 letter to Committee Chairman Goodling and Ranking Minority Member Clay].

The McKeon amendment accepted by the Committee does *not* retroactively grant guaranty agencies authority to retain more than 18.5% consolidated defaulted loans. The CBO score on the amendment does not include any retroactive change in amount guaranty agencies may retain. The CBO scoring of the amendment, dated June 11, 1997, states that “all provisions are assumed to be effective upon enactment and only apply to future collections except where specifically specified.”

During the Committee mark-up, Representative McKeon criticized a Department of Education regulation scheduled to take effect July 1, 1997, that only permits guaranty agencies to retain up to 18.5% on consolidated defaulted loans:

Representative McKeon said, “On July 1 of this year, a new regulation recently put forth by the Department will go into effect. It changes the amount that the guarantors can retain when they collect a defaulted loan through consolidation from 27 percent to 18½ percent of collection since the consolidation option became available in 1992 . . . However, I don't believe the Department should be allowed to change the retention rate through regulation and then go back and retroactively tell guarantors that they now owe the government, everything they collected since July 23rd, 1992, which is about 18½ percent which was being established by regulation in 1997.”

In fact, guaranty agencies were never eligible to retain 27% on consolidated defaulted loans. Those who had retained the 27% would be in violation of Section 428c(6)(A) of the Higher Education Act, which only allows an agency to retain 27% of defaulted payments "made by the borrower." This clearly excludes third party payments made to the agency when a defaulted loan is consolidated. On November 15, 1995, the Department of Education wrote a letter to the guaranty agencies stating that the agencies may retain 18.5%. In no way can the Department of Education's rule be a surprise to guaranty agencies, nor does the rule apply a retention rule retroactively.

WILLIAM L. CLAY.
GEORGE MILLER.
DALE E. KILDEE.
MATTHEW G. MARTINEZ.
MAJOR R. OWENS.
DONALD M. PAYNE.
PATSY T. MINK.
ROBERT E. ANDREWS.
TIM ROEMER.
ROBERT C. SCOTT.
LYNN WOOLSEY.
CARLOS ROMERO-BARCELÓ.
CHAKA FATTAH.
RUBÉN HINOJOSA.
CAROLYN MCCARTHY.
JOHN F. TIERNEY.
RON KIND.
LORETTA SANCHEZ.
HAROLD E. FORD, JR.
DENNIS J. KUCINICH.

EXECUTIVE OFFICE OF THE PRESIDENT,
OFFICE OF MANAGEMENT AND BUDGET,
Washington, DC, June 10, 1997.

Hon. WILLIAM CLAY,
*Ranking Member, Committee on Education and the Workforce,
House of Representatives, Washington, DC.*

DEAR REPRESENTATIVE CLAY: As you know, the Administration and the bipartisan Congressional leadership recently reached agreement on a historic plan to balance the budget by 2002 while investing in the future. The plan is good for America, its people, and its future, and we are committed to working with Congress to see it enacted.

Your Committee will shortly take up important components of that agreement, addressing welfare to work, student loans and the Smith-Hughes Act. We appreciate your efforts to include many provisions consistent with the agreement, which represent valuable policy advances.

Welfare to Work—We are pleased that the Committee is considering provisions that meet many of the Administration's priorities for the program. Specifically, we are pleased that the Committee provides funds for jobs where they are needed most to help long-term recipients in high unemployment-high poverty areas; directs funds to local communities with large numbers of poor people; provides for local administration by chief local elected officials working with private industry councils; gives communities appropriate flexibility to use the funds to create successful job placement and job creation programs; and includes the non-displacement provisions of H.R. 1385, the House-passed job training reform bill.

Student Loans—We are pleased the Committee draft includes \$1.763 billion in outlay savings, including \$1 billion in Federal reserves recalled from guaranty agencies, \$160 million from eliminating a fee paid to institutions in the Direct Student Loan program, and \$603 million in reduced Federal student loan administrative costs. All these savings are being achieved without increasing costs or reducing benefits to students and their families. We appreciate that the Committee has accepted the Administration proposal for an enforcement provision to ensure that the \$1 billion in reserves is recovered by FY 2002. We understand that there are still details to work out on the amounts to be received from each agency. We will continue to work with the Committee on a satisfactory process.

The Administration has the following serious concerns with other aspects of the Committee's proposal:

Welfare-to-Work Grants to Cities—The challenge of welfare reform—moving welfare recipients into work—will be greatest in our Nation's large urban centers. The Administration strongly believes that a substantial amount of all welfare-to-work funds should be managed by cities and other local areas. The welfare-to-work struc-

ture crafted by the Ways and Means Committee accomplishes this goal through its division of funds between formula (50 percent) and competitive (50 percent) grants; its formula grant sub-State allocation factors and method of administration; and its reservation of 65 percent of competitive grants for cities. The Education and Workforce Committee would reduce the competitive funding share from 50 percent to 5 percent, thus severely restricting the amount for which cities can apply directly. The Administration strongly prefers the Ways and Means proposal.

Welfare-to-Work Performance Fund—The Committee's proposal does not include a performance fund. It is essential that welfare to work funds generate greater levels of placement in unsubsidized jobs than States will achieve with TANF and other funds. We hope the Committee will be willing to consider a mechanism to provide needed incentives and rewards for placing more of the hardest-to-serve in lasting, unsubsidized jobs that promote self-sufficiency. We stand ready to provide assistance in this effort.

Minimum Wage and Workfare—The Administration strongly opposes the Committee's proposal on the minimum wage and welfare work requirements. The proposal is not part of the budget agreement and, had it been raised during negotiations, we would have strongly opposed it.

These minimum wage and welfare work requirements proposals would undermine the fundamental goals of welfare reform. The Administration believes strongly that everyone who can work must work, and everyone who works should earn at least the minimum wage—whether they are coming off welfare or not. These proposals do not meet this test. In addition, under the proposal working welfare recipients will be deprived of the protection of laws addressing employment discrimination, child labor, overtime, and family and medical leave.

TANF and Vocational Education—The Administration is concerned with the Committee's proposal on vocational education in TANF. The agreement did not address making changes in the TANF work requirements regarding vocational education and educational services for teen parents.

Student Loans New Entitlement—The Administration opposes the provision regarding administrative cost allowances (ACAs) to guaranty agencies in the Federal Family Education Loan Program (FFELP). The provision would mandate ACAs to be paid at a rate of 0.85% of new loan volume from mandatory funding authorized under Section 458 of the Higher Education Act of 1965 (HEA), up to a cap of \$170 million in FY 1998 and 1999 and \$150 million in FY 2000–2002. It would represent a new entitlement to these agencies not included in the budget agreement. Moreover, any allowance to these agencies should bear some relationship to the costs these agencies incur and not be based on an arbitrary formula. This is an issue for the upcoming HEA reauthorization.

The Committee draft includes a provision that would reduce funds in Section 458 now available to the Secretary to administer the FFEL Program. The Administration strongly opposes this language, enactment of which would prevent the Secretary from effectively administering the FFEL Program.

Smith-Hughes—We understand that the Chairman’s mark would repeal the Smith-Hughes Act of 1917, consistent with the budget agreement. However, there may be an effort made to eliminate this repeal. In light of the \$1.2 billion annual appropriation under the Carl D. Perkins Vocational and Applied Technology Education Act, there is no justification for mandatory spending of \$7 million per year under Smith-Hughes. We urge the Committee to include a provision that is consistent with the budget agreement and achieves the required \$29 million in savings.

MEWAs and Association Health Plans—We share the goal of expanding health insurance coverage for employees and their families. However, as discussed at greater length in a separate letter on the freestanding bill, we cannot support the inclusion in reconciliation of a proposal that would allow business members of multiple employer welfare associations (MEWAs) to form “association health plans,” as provided for in H.R. 1515, the Expansion of Portability and Health Insurance Coverage Act of 1997. The Administration opposed these provisions when they were considered last year, and we believe it would be unfortunate and unwise to introduce this level of controversy into the budget reconciliation process. We believe that the bill as currently drafted has inadequate consumer protections and has the potential to result in premium increases for small businesses and employees who may bear the burden of adverse selection.

We believe that a great deal more work is needed before the provision is ready for consideration. Because we share a number of common goals, including a desire to promote small group purchasing in the small employer marketplace, we look forward to achieving mutually held objectives outside of the budget reconciliation process.

The budget agreement reflects compromise on many important and controversial issues, and challenges the leaders on both sides of the aisle to achieve consensus under difficult circumstances. We must do so on a bipartisan basis.

I look forward to working with you to implement the historic budget agreement.

Sincerely,

FRANKLIN D. RAINES, *Director*.

UNITED STATES DEPARTMENT OF EDUCATION,
OFFICE OF POSTSECONDARY EDUCATION,
Washington, DC, November 1995.

Subject: Guaranty agency retention of payoff amounts of defaulted loans consolidated under the Federal Consolidation Loan Program.

Reference: Sections 428(c)(2)(D) and 428(c)(6) of the HEA, and Dear Guaranty Agency Director Letter of March 29, 1994.

DEAR COLLEAGUE: Section 428C of the Higher Education Act (“HEA”) was amended by the Higher Education Amendments of 1992 (Pub. L. 102–325) to permit a borrower to consolidate the amount of a defaulted Federal Family Education Loan into a Federal Consolidation Loan. This letter reaffirms the Department’s previously announced interpretation of the HEA relating to the ap-

plication of §§ 428(c)(2)(D) and 428(c)(6) of the HEA to payoff amounts received by guaranty agencies on defaulted loans that are being consolidated under this provision.

Section 428(c)(2)(D) of the HEA provides for the Secretary to receive an equitable share of any borrower payments received by the guaranty agency on a defaulted loan on which the Secretary has previously paid a reinsurance claim to a guaranty agency. Under § 428(c)(6) of the HEA, a guaranty agency is authorized to retain an amount of the borrower's payment equal to the sum of the complement of the reinsurance percentage in effect when the Secretary paid the agency's reinsurance claim plus 27 percent of the payment amount for administrative costs related to collection and default prevention.

However, the payoff amount received by a guaranty agency for a defaulted loan included in a Federal Consolidation Loan is not a payment "made by the borrower," as that term is used in § 428(c)(6) of the HEA. The HEA does not specifically authorize guaranty agencies to retain any part of the payoff amount on defaulted loans that are consolidated. Instead, consolidation of the defaulted loan involves a new loan made by another party (the consolidating lender) that is not a party to the borrower's legal obligation to the guaranty agency as holder of the defaulted loan. In most cases, the guaranty agency's collection efforts had little or nothing to do with the borrower's receipt of the Federal Consolidation Loan.

Consolidation loan payoff amounts are similar to amounts received as a result of a tax refund offset by the Internal Revenue Service. The Department has never viewed a payment from a tax refund offset as resulting from the guaranty agency's collection efforts, and a guaranty agency has never been permitted to retain a share of a payment received through that process.

On March 29, 1994, the Department issued a letter to guaranty agencies that provided guidance about the inclusion of collection costs related to an agency's servicing of defaulted loans that are rehabilitated or become eligible for loan consolidation. This guidance, which has been incorporated into 34 CFR 682.401, permits a guaranty agency to charge a defaulter up to 18.5 percent of the outstanding principal and accrued interest as collection costs on the defaulted loan at the time the agency certifies the payoff amount on the loan to the consolidating lender. In providing for this assessment of collection costs, the Department believes it has balanced the statutory requirement that a defaulter pay the costs related to collection of a defaulted loan with the need to allow the borrower to eliminate the default through loan consolidation.

While the HEA does not authorize guaranty agencies to retain a share of consolidation loan payoff amounts, the Department believes that the agencies' retention of 18.5 percent of a consolidation loan payoff amount that includes collection costs is consistent with other provisions of the HEA. In particular, § 428F of the HEA allows an agency to retain 18.5 percent of the principal amount of a defaulted loan which is rehabilitated. This provision reflects the fact that agencies may have some fixed costs related to third party collection contracts that need to be paid. This same consideration applies to defaulted loans which are repaid by a consolidation loan. Therefore, the Secretary decided to permit guaranty agencies to in-

clude up to 18.5 percent in the certified consolidation loan payoff amount to pay for the costs related to the loan that is being consolidated.

PAYOFF AMOUNTS RECEIVED BEFORE MARCH 29, 1994

The Department is aware that some guaranty agencies may have retained collection costs in excess of 18.5 percent on loan consolidation payoff amounts received on defaulted loans before the Department clarified the law on this issue in early 1994. Therefore, we have decided to allow a guaranty agency to retain 18.5 percent of any payoff amount received prior to March 29, 1994, even if it was not included in the agency's calculated payoff amount certified to the consolidating lender. However, any amount retained by the agency in excess of 18.5 percent of the payoff amount must be remitted to the Department. We expect that, since March 29, 1994, all agencies have been in compliance with our directives.

To remit these excess amounts a guaranty agency may request, in writing, that the Department offset excess amounts from the monthly Statement of Account generated by the Guaranty Agency Monthly Claims and Collections Report, ED Form 1189, or the agency can remit the excess amount by check. When remitting these excess amounts by check, the agency should provide the following information: (1) Number of accounts; (2) total outstanding principal and accrued interest at time of payoff; (3) original amount retained; and (4) the refund amount due ED (the difference between the original amount retained and up to 18.5 percent of the payoff amount).

To properly report Federal Consolidation Loan payoff amounts in the future, the Department has provided a suggested format (Attachment A).

All transactions will be shown on the agency's monthly Statement of Account as Department Directed Transactions (DDT's). All correspondence should be addressed to: U.S. Department of Education, Guaranty Agency Reporting, P.O. Box 23457, L'Enfant Plaza Station, Washington, DC 20026.

We trust that this letter clarifies the Department's position on this issue. Please contact Ms. Sandra Simmons of the Loans Financial Management Division, FFELP, if you have any questions related to the reporting instructions provided in this letter. Other questions should be directed to Ms. Pamela Moran, Chief of the Loans Branch, Policy Development Division, or to Ms. Patricia Newcombe, Chief of the FFEL Policy Section, Policy Development Division.

Sincerely,

ELIZABETH M. HICKS,
*Deputy Assistant Secretary for
Student Financial Assistance.*

Attachment

UNITED STATES DEPARTMENT OF EDUCATION,
OFFICE OF POSTSECONDARY EDUCATION,
Washington, DC, March 29, 1994.

DEAR GUARANTY AGENCY DIRECTOR: This letter provides policy guidance on an important default reduction measure implemented as a result of the 1992 Amendments to the HEA.

GUARANTY AGENCIES' INCLUSION OF COLLECTION COSTS IN REHABILITATED LOANS AND ELIGIBLE DEFAULTED LOANS PAID OFF THROUGH LOAN CONSOLIDATION UNDER 428C

Section 484A(b) of the Higher Education Act (HEA) requires a guaranty agency to assess a borrower who has defaulted on a Title IV student loan reasonable collection costs. For purposes of the Federal Family Education Loan (FFEL) Program, 34 CFR § 682.410(b)(2), published on December 18, 1992, provided parameters for what constituted "reasonable" collection costs that would be charged to the borrower on loans for which the agency had paid a default claim. The discussion of this regulation in the preamble of the final rule stated that the collection cost amount to be charged would be a percentage of the principal and interest outstanding on the loan, that it could be calculated annually, and that it would be a flat rate assessed against all borrowers with defaulted loans held by the agency. *57 Fed Reg* 60290, 60311, 60312 (Dec. 18, 1992) Implementation of the requirements of section 682.410(b)(2) of the regulations has resulted in the assessment of significant amounts of collection costs, sometimes as high as 43 percent of the outstanding principal and interest on the defaulted loan.

The Higher Education Amendments of 1992 amended the HEA to add expanded opportunities to allow defaulted borrowers to satisfactorily resolve their default status. Specifically, section 428F(a)(1)(A) of the HEA requires all guaranty agencies to enter into an agreement with the Secretary to "rehabilitate" a borrower's defaulted loan through the sale of the loan, if practicable, to an eligible lender following the borrower's payment of 12 consecutive reasonable and affordable monthly payments to the agency. Section 428C(a)(4) of the HEA also now provides that a defaulted loan would be eligible for consolidation after the borrower pays a series of consecutive reasonable and affordable monthly payments to the agency on the defaulted loan. These sections of the statute did not, however, provide specific guidance on the treatment of collection costs previously assessed the borrower on the defaulted loan.

Shortly after the guaranty agencies began implementation of these provisions of the HEA, the Department of Education (the Department) received several inquiries as to whether, absent specific guidance in the law, outstanding collection costs assessed a borrower on a defaulted loan could be included in the amount of the loan for which the agency arranged the loan rehabilitation purchase or certified as the pay-off amount for consolidation after the borrower has successfully paid the required series of consecutive monthly payments. The Department, in order to effect what it believes was Congressional intent to provide defaulted borrowers with a "fresh start," provided policy guidance that authorized guar-

anty agencies to include all outstanding collection costs on the defaulted loan in the rehabilitated loan amount to be purchased and the Consolidation loan pay-off amount. In many cases, the collection costs have increased significantly the amount of the new rehabilitated or consolidated loan.

After the Department issued this policy guidance, several program participants requested that the Department reconsider its guidance. The program participants expressed concern that including a large amount of collection costs in the borrower's new loan debt would be a disincentive to a borrower attempting to resolve the default status on a loan through rehabilitation and consolidation and would increase the likelihood that the borrower would default on the new increased loan debt.

After further consideration, the Department has decided that, strict application of the requirements of § 484(b) of the HEA would frustrate the intent of the changes to the rehabilitation and consolidation programs. In addition, we have concluded that the amount of the collection costs currently assessed borrowers as reasonable under 34 CFR 682.410(b)(2) is not reasonable when the borrower has shown the initiative to address the default through one of these two programs. Therefore, the Department has decided to modify its earlier policy guidance to restrict the amount of collection costs that will be considered "reasonable" under these circumstances to be an amount that does not exceed 18.5 percent of the outstanding amount of principal and accrued interest on the loan at the time the agency arranges the lender purchase to rehabilitate the loan or certifies the pay-off amount to the consolidating lender. This percentage is consistent with the percentage a guaranty agency is allowed to retain under the loan rehabilitation program at the time of lender purchase.

I trust this information clarifies the Department's position in this area. Please contact us if you have further questions.

Sincerely yours,

ROBERT W. EVANS,
*Director, Division of Policy Development and
Member, Direct Student Loan Task Force.*

GEORGE CONANT'S 6/11/97 7 PM PROPOSED AMENDMENT

PROPOSED CHANGES TO THE STUDENT LOAN PROGRAMS ESTIMATED RELATIVE TO THE CBO POST-POLICY MARCH 1997 BASELINE

[Estimates Reflect an Assumed Enactment Date Prior to October 1, 1997 with all the Provisions Effective Upon Enactment Unless Otherwise Noted.]

	Preliminary staff estimates, by fiscal year, in millions of dollars						1997-2002 Total	1998-2002 Total
	1997	1998	1999	2000	2001	2002		

Stipulate that the guaranty agency retention allowance on defaulted loans which are consolidated is 18.5% rather than current regulatory language which stipulates as amount up to 18.5%. The provision would also clarify that the regulations which are effective July 1, 1997 apply only to new consolidated defaulted loans. In addition, the proposal is also effective for guaranty agencies who have withheld 18.5% since the enactment date of the Higher Education Act Amendments of 1992. All provisions are assumed to be effective upon enactment and only apply to future collections except where specifically specified.

BA	*	*	*	*	*	*	*	*
O	*	*	*	*	*	*	*	*

* Insignificant costs.

Notes:

1. Each proposed program change listed is estimated separately from the CBO Post-Policy Baseline. The provisions are not additive due to programmatic interactions.

2. For most years of the life of loans disbursed between 1997 and 2002, the CBO projection for the 10-Year Treasury Bond Rate is 5.5 percent. This rate used to calculate the variable interest rates and to discount the cash flows.

SEPARATE MINORITY VIEWS CONCERNING H.R. 1515 AND
ITS INCLUSION IN THE COMMITTEE'S RECONCILIATION
RECOMMENDATIONS

We agree that the Congress needs to craft legislation that would help make health care accessible and available to the millions of working parents in this country who live each day under a cloud of health care anxiety, hoping that their children or their spouses will not get seriously ill. However, H.R. 1515, the Expansion of Portability and Health Care Coverage Act of 1997 ("EPHIC") or "Fawell proposal") is not the appropriate vehicle by which we achieve this goal. Instead, this approach represents a very risky gamble with health insurance, and it poses a very real threat to State efforts to protect consumers and make health insurance more accessible and affordable. Furthermore, we object to the manner in which H.R. 1515 was rushed before the committee. The inclusion of H.R. 1515 in Budget Reconciliation is a breach in protocol and procedure.

We recall that H.R. 995 (the ERISA Targeted Health Insurance Reform Act of 1995) was excluded from the final version of the Kennedy-Kassebaum bill. Despite what the Republicans will say in defense of their decision to move this new measure without any previous markup, there was no justification for their haste. There has only been a brief subcommittee hearing on H.R. 1515 thus far this year.

This proposal is complex and controversial. Given the sweeping impact of the bill on the small group coverage infrastructure, this measure should have been subjected to complete scrutiny, including full hearings and a subcommittee markup. As the Administration noted in its June 10, 1997, letter to this Committee "The complexity of the issues raised by H.R. 1515, and the potential harm that could occur in the insurance market under this bill, suggests that a great deal more work is needed before proceeding further."

While on its face, H.R. 1515 appears to be different from H.R. 995, it is actually quite similar. It suffers from many of the fundamental ills that afflicted its predecessor.

The EPHIC bill is ostensibly intended to allow small employers to save money by purchasing health insurance through association-sponsored health plans. This legislation would federalize the regulation and oversight of Association Health Plans (AHPs), which otherwise would be covered under ERISA as multiple employer welfare arrangements. It may create conflicts with HIPAA's newly provisions guaranteeing renewability of health insurance coverage through bona fide associations. This bill has several problems, which taken together, would undermine protections now available to workers and plans under state insurance regulation.

As a result of this new classification of these arrangements, most State laws establishing benefit requirements would not apply to

AHPs. Health insurance issuers and AHPs would have sole discretion in selecting specific items and services, and excluding others from coverage. Moreover, AHPs could offer limited benefit plans, scaling down their coverage of higher cost benefits and avoiding coverage of expensive services, such as certain obstetrical care and well-child care.

Additionally, participants in these plans would be shortchanged on State insurance protections. AHPs would be exempted from provider-mandate laws requiring that certain specialists be included in plans. AHPs' self-insured plans would be exempted from State quality standards, solvency standards, and other consumer protections such as benefit design laws limiting out-of-pocket expenditures or lifetime benefits. The Minority offered several amendments to correct this deficiency designed to maintain States' efforts to protect plan participants, as they proceed with their health reform initiatives. The amendments by Representatives Kildee and Tierney would have ensured that the bill does not supersede State consumer protection laws or medical services required under State law. There is no justification for the Federal law to overturn State regulations that require such health benefits as well-baby care, vaccinations, and regular eye and ear exam.

Because of the Federal preemption of these plans, the solvency requirements under H.R. 1515 are less rigorous than those required by the States. Although the bill specifies reserve standards for self-funded options, reserves are not a substitute for capital requirements. State insurance regulation has evolved beyond minimal fixed capital requirements to risk-based capital requirements that set capital standards based on the level of risk assumed by the plan. The reserve standards in the bill are inadequate because certain types of reserves are not included and may be important in various circumstances. These additional reserves include contract reserves. Also, it is unclear whether incurred, but unreported, reserves are a part of the incurred benefit liability reserves requirements.

Moreover, the bill waives actual reserve requirements if the AHP uses alternative means of compliance, such as letters of credit or assessments of participating employers, that are approved by the Secretary. These alternatives are not cash or cash equivalent options and they may not be appropriate, especially if participating employers are not financially stable. The lack of solvency safeguards has alarming ramifications. Self-insured AHPs have a history of fraud and abuse. Employees and their families enrolled in federally-regulated AHPs will not be protected by State guaranty funds in the event of insolvency.

Further, the Fawell proposal has no provisions comparable to state guaranty funds to address the aftermath of AHP insolvencies. By default, the Federal government may be called upon to bail out defunct AHPs, as it had to bail out bankrupt savings and loan associations in the 1980s. At the markup, the Majority incorporated into their proposal a watered-down version of an amendment offered by Rep. Payne (D-NJ) to establish a guaranty fund to ensure that all claims are paid in the event of plan failure. However, because the fund would not be triggered until after the plan becomes

insolvent, this provision offers too little, too late. Do we really want a repeat of the S&L debacle?

Many States finance high-risk pool shortfalls through an assessment on insured health benefits. Some States have required group insurers to contribute to individual insurer operations where guaranteed availability of individual coverage has been required. The ERISA-preemption blocks the ability of the State to extend such assessments to self-insured AHPs and undo these hard-fought State achievements by allowing lower risk small employers to remove themselves from the small group rating pool, as self-insured AHPs are not required to be open to employers who are not members of the sponsoring association.

These AHP plans could “cherry pick” within the AHP by varying rates among their employers on the basis of claims experience (so long as rates are not varied “significantly”) or by targeting benefits packages to appeal to healthier groups. As a result, the small group risk pool will be fragmented because AHPs would only accept healthy members. Therefore, employers with an unhealthy history would be left in remaining State insurance pools, leading to ever-increasing premiums in the State-regulated small group market.

While the bill’s authors allegedly seek to clarify state and Federal regulatory authority over AHPs, the provisions establish convoluted, illogical conditions under which various AHPs are to be subject to State or Federal regulation. The goal of clarifying AHP regulation is far from realized.

We are very concerned about the ambiguous provisions in the bill defining what individuals or groups may band together to form AHPs. New categories of federally-regulated single employer plans and church plans could seek certification as AHPs, creating additional opportunities for risk selection and exemption from State consumer protections.

Representative George Miller (D–CA) offered an amendment that ensured that AHPs take responsibility for harm caused by abusive cost containment activities. We believe the Chairman was capricious and arbitrary in ruling Representative Miller’s amendment out of order. At the request of the Minority, the Parliamentarian had ruled that the amendment indeed was in order.

The determination by the Chairman that the amendment offered by Representative Miller was nongermane. According to the mark-up transcript, the Chairman stated:

The amendment’s purpose of adding damages to ERISA differs substantially from the purpose of the substitute which is to expand the types of entities eligible to benefit from ERISA. Further, the subject matter of the amendment damage in ERISA differs from the subject matter of the substitute, the applicability of ERISA: An amendment with its purpose or subject matter different from the provision which it amends is not germane. This amendment’s purpose and subject matter differ from the substitute.

Had the amendment sought to impose a new remedy generally applicable under ERISA, that is, had Mr. Miller’s amendment made damages applicable to all ERISA plans, the amendment would have been nongermane. The amendment did not. It simply provided for remedies applicable to the new forms of health plans,

the AHPs, created by H.R. 1515. Furthermore, section 5 of H.R. 1515 establishes enforcement provisions relating to AHPs. The effect of Representative Miller's amendment is to simply make explicit one particular enforcement remedy in cases where an AHP withholds necessary medical treatment. The contention that the amendment is nongermane because it imposes a different remedy than those in H.R. 1515 or current law is wholly ludicrous. As Representative Miller pointed out at the time:

If the point of order is germaneness, originally was scope, clearly this is within the scope and clearly is germane. The fact that you say our bill doesn't have this, this is right, it doesn't, that is why we are offering this. If the only amendment that can be allowed is what is already in the bill, there would never be any amendments. So that is not a rule against germaneness. Saying this introduces something into the bill is a not a rule against germaneness. The question is does the amendment speak to the subject matter.

Again, Representative Miller's amendment had been cleared with the Parliamentarian's office, and we had been advised that the amendment was germane. We understand that the Republican staff were informed of that ruling as well. Nevertheless, Chairman Gooding arbitrarily and capriciously denied due consideration of a germane amendment. We strenuously object and expect the chairman to uphold the rules of the House and protect for the right of Members to offer pertinent amendments to pending legislation.

In conclusion, H.R. 1515 purports to expand access to reliable, affordable health care for employees of small businesses. It sponsors will claim that H.R. 1515 is a solution to the problem of children without insurance. The plight of these children is well-documented. Ten million children in this country are without health coverage. Each day, some 3,300 additional children lose coverage although nearly two-thirds of these children come from working families. Yet, this bill actually threatens State-based efforts to expand access for these families, and it undermines critical protections in the health safety net designed to safeguard and ensure coverage.

We can do better than this. We must. Ten million children and their families are counting on us.

WILLIAM L. CLAY.
DALE E. KILDEE.
MAJOR R. OWENS.
PATSY T. MINK.
TIM ROEMER.
LYNN WOOLSEY.
CHAKA FATTAH.
CAROLYN MCCARTHY.
RON KIND.
HAROLD E. FORD, JR.
GEORGE MILLER.
MATTHEW G. MARTINEZ.
DONALD M. PAYNE.
ROBERT E. ANDREWS.
ROBERT C. SCOTT.
CARLOS ROMERO-BARCELÓ.
RUBÉN HINOJOSA.
JOHN F. TIERNEY.
LORETTA SANCHEZ.
DENNIS J. KUCINICH.

**Dissenting Views of the Democratic Members of the
Committee on Ways and Means
on the Human Resource Provisions
submitted by the Committee on Ways and Means**

During discussions on the fiscal year 1998 budget resolution, the Clinton Administration and Republican congressional leaders entered into good faith negotiations on the steps that would be taken to eliminate the deficit by 2002 and, at the same time, carry out important national initiatives. The final budget agreement included only the following human resource matters that fall within the jurisdiction of the Committee on Ways and Means:

- **Welfare-to-work.**-- A \$3 billion welfare-to-work initiative with capped mandatory spending through 2001 to TANF, allocated to States through a formula and targeted within a State to areas with high poverty and unemployment. A share of funds would go to cities/counties with large poverty populations commensurate with the share of long-term welfare recipients in those jurisdictions.
- **Eligibility for legal immigrants.**-- Restoration of SSI and Medicaid eligibility for all disabled legal immigrants who are or become disabled and who entered the U.S. prior to August 23, 1996.
- **Refugees and asylees.**-- Lengthening the exemption for refugees and asylees from the first 5 years in the country to 7 years in order to provide SSI and Medicaid.
- **SSI fees.**-- An increase in the fees charged by the Social Security Administration for administering State supplemental payments.

- **UI provisions.--** An increase in the ceilings of the Federal FUTA-funded accounts in the Unemployment Trust Fund to increase trust fund solvency and an increase in fraud reduction funds.

Unfortunately, the Republican majority, lead by Subcommittee Chairman Shaw and full Committee Chairman Archer, chose to violate the budget agreement negotiated by their own leaders and deviate from agreed to policy. The Committee report:

- **Violates the budget agreement deal to restore SSI benefits to certain legal immigrants.** Claiming to have proposed a better policy than the budget, the Committee report actually extends benefits to 75,000 *fewer* legal immigrants in 2002 than the budget agreement would. That's not good enough.
- **Creates a subminimum wage**, sending the message that welfare recipients who go to work don't deserve the minimum wage or other important labor protections — for *them*, apparently, a subminimum wage is good enough. It's not good enough for us.
- **Lets States cut back on the SSI benefits of as many as 2.8 million elderly, blind, and disabled Americans**, ending Medicaid for nearly 400,000 of them, even though no Federal savings accrue from this policy. That is unconscionable.

There was one real attempt to be bipartisan in developing the Committee's human resource provisions. This related to the welfare-to-work provisions carrying out the commitment to a \$3 billion program for this purpose. The bipartisan effort worked and needs only minor improvement.

The record of the Democratic Members of the Committee on Ways and Means on deficit reduction is irrefutable. We would like nothing better than to support a budget reconciliation bill that eliminates the deficit while also restoring benefits to needy legal immigrants. Such a bill would be easy to draft. But this is not such a bill. We cannot support legislation that

undermines our commitment to helping welfare recipients find and keep a job, or one that trades one group of human beings for another. The American people expect better of us and they deserve it.

The remainder of these dissenting views explain, in detail, the reasons for our united opposition to this legislation.

The Committee Report Authorizes a Subminimum Wage -- We Cannot Support It

The Committee bill violates the principle that work should pay a decent wage, under decent working conditions. If we want to signal that we expect welfare recipients to move into the workplace — and we must — we must demonstrate that it pays to work. Surely, the best way to do that is to provide a liveable wage and decent working conditions, as *we demand for all other workers*, not by giving welfare recipients moving to work the badge of second class citizenship. This was *not* part of the budget agreement.

The old welfare law — known as Aid to Families with Dependent Children (AFDC) — made clear that only someone placed in a workfare position (also known as community work experience, or CWEP) did not earn wages and could only be required to work in exchange for their benefit for the number of hours that resulted from dividing the welfare benefit by the minimum wage. No mention was made of the Fair Labor Standards Act.

The new welfare law repealed all of AFDC — including the workfare rules — replacing it with the Temporary Assistance to Needy Families (TANF) program. The Department of Labor, as it does routinely, analyzed the new law to determine how the Fair Labor Standards Act applied. In large measure, that conclusion rests on whether or not the individual is an “employee.” DOL concluded that any work activity (except for bona fide training) under TANF is covered by the labor protections of the Fair Labor Standards Act and, as a result, participants must receive the minimum wage for work performed.

The Committee bill includes language designed to override DOL's conclusion that the Fair Labor Standards Act applies. It states that:

- Welfare recipients in placements in the public and nonprofit sectors are not defined as employees.
- States may not require recipients to be employed by a public or private agency for a number of hours greater than the "welfare benefits package" divided by the minimum wage.
- The "welfare benefits package" must include TANF and food stamps, may include the value of housing, child care, and Medicaid, and may include time spent in education, training and job search activities. Two methods are specified for valuing these benefits; States may count the actual value received by the family, or may compute an average.

In our view, **work is work. A worker is a worker.** The Administration is not creating new policy, new rights, or new coverage. All it is saying is that when workfare is work it must be treated as work and welfare recipients treated as employees. That seems clear, simple, and *fair*.

Taking away basic legal protections from workfare workers is a license to exploit the most vulnerable working women and families. It's a statement that some women should work for wages below the minimum wage, tolerate more discrimination and sexual harassment, and have fewer safety protections on the job. If she refuses sexual advances, or dangerous work without proper safety equipment, she will have nowhere to turn — the fig leaf of extending health and safety standards to her is just that, a fig leaf. The Committee bill does not restore to her the same remedies for challenging workplace safety that protect every other American worker.

No other program has ever required workers to work at subminimum wages. Counting child care, health insurance and food stamps against wages means that no matter how many more hours these

women work, their pay will never increase. Such services should keep working families afloat, not drag them down.

And, it unfairly pits welfare recipients against the working poor, who are better off but only marginally so. It opens the door for the conclusion that employers should be permitted to subtract the cost of health benefits from the minimum wage earnings of non-welfare workers or that employer-provided child care now count against the wages of the minimum wage worker not on welfare.

To illustrate the unfairness of the policy, let's consider how it would actually work. Consider two cities — one contracts out its park maintenance work to the private sector, the other pays city employees to do it. Under the Committee bill, a welfare recipient doing park maintenance in one city will get the minimum wage and all labor protections and benefits, while the other welfare recipient does the same job and works off her welfare, housing and Medicaid. How is that equitable?

The Democratic Members of the Committee tried, in vain, to protect workers from this subminimum wage. **Rep. Pete Stark (D-CA)** offered an amendment to strike the offending language. The Republican majority rejected the Stark amendment, by a party-line vote of 16 to 22 (Rep. Jerry Weller (R-IL) was absent).

If payment of a liveable wage is a threat to job placement as the participation requirements increase for States in the later years, we should address these issues through bipartisan discussions with Federal and State officials, not by an across-the-board swing at welfare recipients going to work. Our Republican colleagues have often pointed out that declining caseloads have left most States with a windfall of funds, at least in the early years. It is our view that States should be investing those funds in aggressive education, training and work activities *now* so that recipients are prepared when time limits and tough participation rules take effect.

The Republican Bill Lets States Hurt the Low-Income Elderly and

Disabled — We Cannot Support It

In the 1970's, when the Federal SSI program was created to provide income support to poor elderly, blind, and disabled Americans, some States already provided such benefits. To make certain that the aged, blind, and disabled received the full value of their SSI check — every year — Congress enacted a State maintenance-of-effort requirement, that made certain that States passed on to all SSI recipients any Federal benefit increase. Otherwise, each dollar that the Federal government intended to go into the pocket of the elderly, blind, and disabled would, instead, end up in State treasuries.

The Republican majority — at the urging of California Governor Pete Wilson — decided State flexibility was more important than helping elderly, blind and disabled Americans avoid poverty, so they used the budget reconciliation bill to propose a repeal of the SSI maintenance-of-effort requirement. Worst case, 2.8 million SSI recipients are at risk of becoming poorer from this provision; more than 350,000 of them could lose Medicaid entirely. Of course, that was *not* part of the budget agreement.

The American Association of Retired Persons (AARP) says it best, in their letter to Members of the Committee opposing the Archer and Shaw marks on this point: "If the maintenance of effort requirement is repealed, many of our most vulnerable citizens who are elderly and disabled would face ***serious and irreversible economic hardship***. (Emphasis ours)

Probably the most remarkable aspect of this proposal is that it has absolutely no effect on the Federal budget — or the deficit. There are no federal savings involved because there is no Federal spending on SSI supplements. At issue is ***State spending*** — and the question of whether or not Federal SSI benefit increases will actually reach the elderly and disabled citizens for whom we authorized them, or wind up, instead, in ***State treasuries***. And remember, all we are asking States to do is maintain their SSI supplements at the level they paid in 1983 — fourteen years ago!

The Democratic Members of the committee, led by **Rep. Bob Matsui**

(D-CA), proposed to protect SSI recipients from the potential loss of State SSI supplements. The Republican majority rejected that amendment by a straight party-line vote of 16 to 23.

The Republican Bill Hurts Disabled Legal Immigrants – We Cannot Support It

A cornerstone of the bipartisan budget agreement was the restoration of benefits to certain legal immigrants made ineligible for SSI and Medicaid under the new welfare reform law. President Clinton made clear when he signed the new law that he thought the cuts affecting legal immigrants went too far and vowed to restore them.

The Committee bill violates the bipartisan budget agreement — accepted by House and Senate leaders of both parties — which explicitly states that legal immigrants, who were in our country on August 22, 1996, would be eligible for SSI benefits regardless of when they become disabled.

Instead, Republicans have proposed to trade one group of human beings for another group, offering to “expand” coverage to all elderly legal immigrants currently on SSI, in exchange for eliminating it for those who become disabled in the future. According to the Social Security Administration, this results in the restoration of 75,000 fewer recipients in FY 2002 and 125,000 fewer by FY 2007 than the budget agreement policy. And, it means that any legal immigrants present by August 22 of last year, who qualify as disabled after that date, can *never* get benefits.

To correct this inequity, **Rep. Xavier Becerra (D-CA)** proposed to add the so-called “disabled after entry” to the Republican policy of grandfathering. The Republican majority rejected this amendment, by a vote of 19 -20, *even though the addition of this amendment left the whole legal immigrants package within striking distance of the \$9.7 billion allowed by the budget agreement.* (Three Republicans — Reps. Thomas (R-CA), Johnson (R-CT) and Collins (R-GA) supported the Becerra amendment.) During deliberations by the Subcommittee on Human Resources, Ranking Member **Rep. Sandy Levin (D-MI)** proposed to simply replace the Shaw

legal immigrants policy with what was in the budget agreement. That too was spurned by the Republican majority.

Education and Teen Parents — A Reasonable Middle Ground

There were a few brighter moments during consideration of this legislation. After a spirited debate, the Democratic Members of the Committee managed to convince a majority that it would be a mistake to pit teenagers on welfare who need to go to school against other welfare recipients who haven't finished their basic high school education. The Chairman's mark had proposed to limit (to 30 percent of those subject to the work requirements) the number of TANF recipients who can be in vocational education and still meet the work requirement; teen parents — who *everyone* agrees need to go to school — would have been included in that limitation, making it difficult for the 40 percent of all welfare recipients who lack a high school degree to pursue that goal.

To correct this problem, the Committee adopted, with the support of four Republican Members — Mrs. Johnson, Mr. Bunning, Mr. Houghton, and Mr. Collins — and all 16 Democrats, an amendment by **Rep. Barbara Kennelly (D-CT)** removing teen parents from the calculation of the vocational education limit.

It should be noted that the Republican majority rejected, by a straight party-line vote of 16 to 21 (Mr. Ramstad and Mr. Nussle were absent), what would have been the best approach. **Rep. Pete Stark (D-CA)** proposed to strike the language of the bill and retain the present law limit on vocational education, which is 20 percent of the *total* TANF caseload. This would have given States the most flexibility, enabling them to tailor their work requirements to the actual needs of recipients. The National Governors' Association, the National Conference of State Legislators, and the American Public Welfare Association, all supported the two Democratic amendments.

A Bipartisan Welfare-to-Work Program

The only bipartisan discussions in the human resource area occurred in drafting the welfare-to-work initiative. The budget agreement includes funding for a \$3 billion welfare-to-work program designed to help long-term welfare recipients and those facing an imminent loss of benefits due to a time limit to find work.

To carry out this responsibility, the Democratic Members began by crafting a set of principles by which we would evaluate legislative proposals for the welfare-to-work funds. In summary, we concluded the following:

Purpose.-- The \$3 billion in capped mandatory funds for a welfare-to-work initiative should be used only to expand the supply of jobs for low-skilled workers at high risk of reaching welfare time limits.

Eligible participants.-- For this grant program, eligible participants should be limited to those TANF recipients who have had no significant work experience in the past 3 years, who have received cash assistance for more than 36 months, and who have participated in a structured job search program under TANF without securing employment. Our goal was to assure that the program concentrated its resources to the hardest to employ recipients.

Distribution of funds.-- Grants should be awarded by the Department of Labor, in consultation with the Departments of HHS and HUD, to both States and communities on the basis of merit to those proposing the most innovative and promising approaches to creating job opportunities for hard to employ welfare recipients.

A substantial portion of all grants should be awarded to those areas of a State with the highest combination of poverty, unemployment, and job shortage, without unnecessary duplication of effort between the State and community grants. One percent of available funds should be reserved for evaluation. The remaining funds should be awarded on merit to the entity in the State responsible for meeting the TANF work requirements, with authority for that agency to contract for any allowable activity. Any unused

funds should be reallocated to qualified applicants and grantees.

Allowable activities.-- Under these grants States and communities should be permitted to offer any combination of the following activities (1) wage subsidies to expand the supply of private sector jobs; (2) job creation in private nonprofit or public agencies designed to address pressing community needs; (3) contracts with job placement companies or public job placement programs; (4) job vouchers; and (5) job retention or support services for employment purposes. The program should include strong assurances of nondisplacement and nondiscrimination.

Performance bonuses.-- A portion of the funds should be set aside in later years for performance bonuses to States to reward placement and retention of long-term TANF/AFDC recipients in permanent jobs.

HHS role.-- Grants should be awarded to a State only if the Department of Health and Human Services determines that (1) the State cannot meet its TANF work requirements without additional funds; (2) total State spending on TANF work activities in the prior fiscal year exceeded State spending on JOBS programs in fiscal year 1996; (3) the State has met 100 percent of its maintenance-of-effort requirements under TANF; and (4) the State has the ability and resources to carry out the proposed project.

Nearly all of these Democratic goals were achieved in the version of the welfare-to-work program included in the Committee bill. At the urging of the Administration and the Democratic Members, half the new funds were reserved for competitive grants, the remainder to each State by formula, with instructions that the funds go to sub-State areas with high unemployment, poverty and welfare caseloads. The competitive funds would be spent among rural areas and the 100 poorest cities.

The eligible population was carefully targeted to assure that those *least likely* to find a job on their own will be a priority for these grant funds and that the State and local TANF agencies and JTPA agencies work together to deliver on the job creation promise.

Two important amendments were offered during Committee deliberations on the budget reconciliation bill and should be noted here.

First, **Rep. Ben Cardin (D-MD)** offered an amendment which extends to the new welfare-to-work grant the same basic labor protections, including anti-displacement language, that the House overwhelmingly approved as part of its workforce bill. It was adopted by voice vote. It is the view of the Democratic Members of the Committee that these same protections should be extended to all TANF recipients, whether or not they participate in the welfare-to-work initiative. This would be the fairest and simplest approach.

Second, **Rep. John Tanner (D-TN)** offered an amendment that would have created a performance bonus for the new welfare-to-work block grant, making certain that extra funds are awarded to those projects that do the best job of placing, and retaining, welfare recipients. The Republican majority rejected this amendment, by a vote of 16 to 19 (Rep. Ensign (R-NV) voted for the Tanner amendment; Reps. Neal (D-MA), Thomas (R-CA), Nussle (R-IA), Johnson (R-TX) were absent).

We are especially troubled that the Republican majority would not establish the principle of performance-based funding for this new grant program. Although we understand that it will be difficult to identify precise measures of performance and worry about skewing program design towards those easiest to place and retain in jobs, we believe it is a mistake to miss this opportunity to establish the principle that we expect results for our investment.

We know too little about what works and doesn't and even less about what needs to be done for the hardest to employ. Past program evaluations have usually focused on job retention measures of 18 months, or less, hardly enough time for us to judge placement of long-term welfare recipients to be a true success. Even if the actual bonuses must wait until later in the program, it would be much better, in our view, for work to be underway on such measures now. With continuing scarce resources to invest in these programs, it is all the more important that we be able to distinguish among the best.

Mixed Signals to the Parents of SSI Disabled Kids

Finally, we would like to note that the Committee bill would extend the effective date for the SSI disabled children provision in the 1996 welfare legislation for 6 months, from August 22, 1997 until February 22, 1998. This would give the Social Security Administration needed additional time to do redeterminations of the eligibility of children affected by the 1996 law. This extension received bipartisan support as a part of the Welfare Reform Technical Corrections Act of 1997.

However, the Committee bill also includes language which would effectively eliminate this new February 22, 1998, effective date. By permitting SSA to review any case "as soon as practicable" after the effective date, the language allows SSA to ignore the date and review cases at any time in the future. This review process should not be permitted to go on indefinitely. Not only does it relieve SSA of its duty to comply with the law by the stated effective date, it leaves children and their parents uncertain as to whether they might be cut off at any time in the future.

Parents and children do not know the basis on which they were awarded benefits. Thus, they do not know whether SSA has not reviewed their case because: (1) they are in a category that SSA is not required to review under the new law or (2) SSA has just "missed" their case. Without a specific effective date, every SSI disabled child will be left in indefinite uncertainty as to his or her status. This will include millions of children who would otherwise have nothing to worry about, but for the indefinite nature of this effective date.

Our Conclusion – This Bill is Tough on Women, the Elderly, and Disabled Legal Immigrants – We Cannot Support It

If the Republican majority had been willing to live within the budget agreement it would have been an easy matter to craft a welfare-related budget reconciliation bill that enjoyed broad bipartisan support. The

provisions in the budget agreement with respect to the restoration of benefits for legal immigrants were clear and a bipartisan agreement among our leaders had been reached.

Republicans and Democrats had worked together to design a welfare-to-work initiative that was carefully targeted to those most in need and distributed to those areas of the country experiencing the highest poverty, unemployment, and welfare receipt. Had the majority stopped there, we would have no need for these dissenting views.

But the Republican majority didn't stop there. Instead, they chose to unravel the budget agreement, leaving thousands of disabled legal immigrants without SSI and Medicaid. They chose to reopen the minimum wage debate, establishing a subminimum wage for women on welfare and leaving them unprotected from sexual harassment. And, they chose to let States reduce or eliminate their SSI supplemental payments, potentially leaving millions of elderly and disabled recipients — 60 percent of whom are women — poorer.

That's not what the American people mean when they tell us they want us to balance the budget and reduce their taxes. Along the way, they expect us to also protect children, the elderly and the disabled. Based on this experience, we conclude that the Republicans have abandoned these basic values. It was with a clear conscience that all 16 of us voted "no." We can — and should — do better.

Dissenting Views of Democratic Members
With Respect to Human Resource Provisions

<u>Ed Stumpf</u>	<u>Sander Levin</u>
<u>Jim McCratt</u>	<u>Richard D. Durbin</u>
<u>Paul Kennell</u>	<u>William J. Cuyler</u>
<u>Tom J. Blanton</u>	<u>Anthony S. Brown</u>
<u>John Lewis</u>	<u>Pete Stark</u>
<u>Mike Dwyer</u>	<u>Karen L. Thurman</u>
<u>Jerry Keozka</u>	<u>Jim Duran</u>
<u>Ben Cardin</u>	<u>Yuan Pan</u>

Additional Views of Democratic Members

Thirteen of the sixteen Democratic Members of the Committee on Ways and Means voted in favor of the Medicare title of the reconciliation bill. We did so because it extends the life of the Medicare Hospital Insurance Trust Fund to 2007, makes important payment and provider reforms, improves preventive care for beneficiaries, includes a number of new consumer protections, and includes some anti-fraud initiatives, while avoiding the changes proposed by the Republicans in the 104th Congress, which would have destroyed Medicare. This title of the reconciliation bill makes improvements in Medicare, while maintaining the program as a defined benefit plan serving all eligible enrollees.

We also voted in favor of this proposal because of the manner in which it was drafted.

Unlike the last Congress, when Democrats were totally excluded from the process and where bills were developed in secret and sprung on the Democratic minority, this legislation was developed in a bipartisan atmosphere, with consultation, and with cooperation.

Consequently, we believe the resulting product is better than the failed 104th Congress Medicare legislation. We note, for example, that the proposal includes many bipartisan efforts such as the surety bond anti-fraud proposal of Rep. Thurman, Rep. Becerra's amendment to treat Puerto Rican hospitals more fairly, the Portman-Cardin hospice reforms, and the Thomas-Cardin-Stark preventive care bill (H.R. 15). At the full Committee, an amendment sponsored by Rep. John Lewis and adopted by a bipartisan vote, struck a provision in the Chairman's mark that would have transferred about \$80 million a year from non-profit and charity hospitals to for-profit hospitals. Democratic ideas and proposals are scattered throughout the bill, and are a tribute to the inclusive, cooperative approach taken by Health Subcommittee Chairman Bill Thomas.

In addition, the resulting product is better in large part because of the many things this legislation does not do, that the Republican bill of the 104th Congress tried to do. This proposal does not turn Medicare into a

defined contribution plan that would have gradually shifted more and more costs to beneficiaries through extra charges and that would have gradually forced providers and beneficiaries into managed care plans. It does not sock beneficiaries with extra charges through balance billing. It does not slash payments to the nation's safety net hospitals. In short, it does not destroy Medicare; instead, it extends Medicare's life with the type of traditional and incremental payment changes made in earlier, bipartisan reconciliation bills.

The Majority report will discuss the many good features of the bill at length.

We will focus on improvements that still need to be made to the legislation. There are disappointments. There are bad features. There are provisions we would like to see deleted during the legislative process ahead of us. We hope through the amendment process that this legislation can be made better, so that it will have even wider support.

Medicare Medical Savings Accounts

This provision would spend \$2.2 billion over four years — \$5.7 billion over ten years — on the healthiest, wealthiest seniors. At a time when we are trying to extend the life of the Medicare Trust Fund, it makes no sense to start this special program that will be attractive only to those who can afford a high-deductible plan.

This program would be a terrible drain on Medicare. Currently, 20 percent of Medicare beneficiaries incur no program costs in any given year. Another ten percent incur almost no costs. They are very healthy people. Many of them will be tempted to try an MSA. When they do, Medicare will go from spending zero or next to zero on these beneficiaries to spending \$5000 to \$6000 a year on them. The money will not be spent on health care. It will be money spent to buy a private high-deductible insurance policy (as high as \$6,000), and the rest will be put into the individual's MSA account — resembling an Individual Retirement Account, which can be tapped for both medical and non-medical purposes.

As anyone can see from this example, this program will cost Medicare money. We don't need to demonstrate it. We don't need to test it. The result is obvious.

If Medicare were solvent for as far as the eye could see, if there were not better places to spend the next Medicare dollar in terms of drug coverage, respite care, help for the low income, etc., etc., we could try this "experiment." But we do face solvency problems. We do face unmet health needs. To spend money on MSAs is an incredible waste.

MSAs, more than any other item, made many of us reluctant to vote for this legislation. If this provision is deleted or drastically scaled back, our support for the package would be more enthusiastic.

Malpractice

It is the belief of most Democratic Members that current malpractice laws should not be weakened. In the world of managed care, physician practice has been completely reversed: physicians can make money by not ordering tests, not referring patients to specialists, and not doing surgery. Examples of the malpractice of under-treatment are numerous. Government agencies are unprepared to protect consumers in this new world of medicine and eroding malpractice laws will only lead to more instances of medical injury.

A recent Harvard Study estimated that of the 40 million hospital admissions per year, 400,000 patients, or one percent, suffer preventable injuries from substandard care. Fifty thousand of these people die from their treatment. The other 350,000 suffer non-fatal injuries resulting in 30 days of disability or longer. Yet only 2 percent of these incidents — 8,000 cases — make it to a malpractice trial. Other studies estimate the number of fatalities to be even higher — as many as 80,000 to 180,000 unnecessary deaths per year throughout the health care system.

Until we find better ways of making health care providers more quality conscious, the threat of a malpractice case can help deter careless and callous errors. The actual instances of malpractice — or wrongful treatment — are the true cost to our economy and society. In fact, weakening malpractice laws is likely to lead to more careless practice —

resulting in needless disabilities and deaths and raising costs by increasing the incidence of medical injuries. It is for these reasons the majority of Democrats do not support medical liability reform.

In addition, most Democratic Members of the Committee believe that malpractice reform should not be included in the Ways and Means reconciliation recommendation, because it is not in our jurisdiction. We should not be taking over the jurisdiction of the Judiciary Committee.

Beneficiaries and the Part B Premium

The legislation continues to charge the beneficiary 25 percent of Part B costs. It also increases Part B premiums by requiring enrollees to pay 25 percent of the cost of the transfer of post-100-visit home health care benefits from Part A to Part B. By 2007, this transfer will mean about an extra \$11 a month increase in the Part B premium. To avoid a sudden, sharp increase in Part B premiums next year, the transfer is phased in over 6 to 7 years.

We have two concerns about the home health transfer and the Part B premiums.

First, the May 2 negotiated Bipartisan Budget Agreement called for \$1.5 billion in assistance to low-income beneficiaries to help meet the higher Part B premium costs due to the home health transfer. The Commerce Committee was directed to use these funds to help beneficiaries, and we believe it is essential that that policy be carried out.

Twenty-five percent of seniors live below 150 percent of poverty; 10 percent — almost four million beneficiaries — live below the poverty line. Any increase in Part B premiums to these low-income citizens who are not receiving assistance will mean less food on the table, less heat in winter, and fewer basic necessities. We regret that the Committee rejected an amendment by Mr. Becerra to reduce the size of the MSA program in order to pay for help to these low-income Americans in meeting the extra costs of the home health transfer.

Second, the way in which the Majority makes the transfer needlessly fails to add several years of Part A Trust Fund solvency. The President's

plan actually extended the Part A Trust Fund's solvency to approximately 2009 or 2010. The Republican proposal in this Title would transfer small segments of the post-100-day visits to Part B over 6 years. However, each year it would immediately apply the full 25 percent cost of that year's transfer to beneficiaries. There is absolutely no difference in the Part B premium to seniors between the President's and the Republican's proposals. However, because less cost is transferred out of Part A in the initial years (and therefore the savings are less), the Trust Fund's solvency is only extended to about 2007.

A Democratic amendment to use the President's approach, and thus add several years to the life of Medicare, was defeated. We hope that the final product will extend solvency until 2010.

Anti-Fraud — Missed Opportunities

The Democratic Members of the Committee applaud the inclusion of several anti-fraud and abuse measures in the Medicare title. We are pleased to see the inclusion of legislation authored by Reps. Thurman and Stark and modeled on Florida's surety bond law, which has proven so successful in that State in reducing the number of questionable and fraudulent health care providers. However, several important anti-fraud and abuse provisions proposed by the Administration were not included in the Medicare proposal.

We should be doing everything we can to reduce health care fraud so that we don't have to cut payments to honest, hard-working providers. Each year fraud, waste, and abuse in the health care industry — private sector and public — account for an estimated 10 percent of our yearly health expenditures. The General Accounting Office and Department of Health and Human Services are just releasing a report that in the last year, Medicare lost \$23 billion through fraud, waste, and abuse. If we could root out all of this waste, we would save exactly the amount we are being asked to cut in this budget reconciliation bill.

A Democratic amendment, rejected by the Majority, would have included a comprehensive set of anti-fraud provisions originally proposed by the Administration and one proposed by Senator McCain (R., AZ).

These anti-fraud provisions would have saved at least \$500 million and deterred substantial fraud, waste, and abuse.

Consumer Protections

The Medicare title contains a number of important consumer protections for managed care plan enrollees, including physician anti-gag language cosponsored by a large majority of the House, and emergency room prudent layperson protections developed by Rep. Cardin.

The Cardin language will help solve the problem of managed care enrollees who go to trauma centers, burn centers, or emergency rooms (both in-plan and out-of-plan) and are then billed because it wasn't a "true" emergency. The amendment makes it clear that enrollees who are in severe pain or who have acute symptoms of sufficient severity that "a prudent layperson" would reasonably feel that an emergency is occurring and who go to an ER will be covered. The amendment also helps ensure post-stabilization care is covered. We urge the Secretary of HHS to issue regulations that ER's make a documented good faith effort to contact a managed care plan within thirty minutes of the point at which an enrolled individual is stabilized to request approval for recommended post-stabilization medical services, and that such plan respond within thirty minutes. The regulations should provide that if such plan denies coverage for a recommended service, it must arrange for a physician review of the denial and communication with the treating physician within thirty minutes of such request for review. The entire area of ER stabilization has been one of the most serious areas of contention between enrollees and their plans and between plans and out-of-plan ER rooms. This legislation and appropriate regulations should help put these constant disputes to rest.

Many Democratic Members remain concerned about other quality issues. We are concerned about the failure to include adequate language for expedited emergency appeals and about provisions that repeal the 50-50 rule before we have tested consumer protections already in place.¹

¹The 50-50 rule is the requirement that half of HMOs enrollees must be private pay or commercial members and no more than half can be Medicare beneficiaries.

Other Members are concerned whether Provider Sponsored Organizations (PSOs) can escape State quality standards. We urge readers to note the Majority report on section 1856 where it is clear that a State quality standard that does not interfere with the development and growth of MedicarePlus plans is permitted and is not overridden by this legislation. As the Majority Report states, it is the intent of the PSO standards section

(1) to encourage the development of a broad array of private health plan choices for beneficiaries; and (2) to ensure that beneficiaries choosing to enroll in such plans have protections available to ensure that they receive medically necessary and appropriate care in a timely manner.

Under the Medicare title, by 2002 beneficiaries will be increasingly “locked into” managed care plans once they sign up. Today, a beneficiary can enroll and dis-enroll on a monthly basis. After 2001, they can dis-enroll only in the first three months after signing up, then they are “locked in” till the next open enrollment period. There are exceptions, and one can dis-enroll for cause — and that cause includes denial of necessary medical treatment. But it is clear that we need to know much, much more about how to measure and report quality of care as more and more Americans move into managed care.

On the issue of quality, we also note that it is essential that Medicare explain these plans — and that plans explain themselves — in language people can easily understand. In many communities, that is a language other than English. The Democratic Members of the Committee thank the Majority for its cooperation and willingness to include report language protecting language minorities. The relevant legislative language, “The information disseminated under this paragraph shall be written and formatted using language that is easily understandable by Medicare beneficiaries,” certainly protects all Medicare beneficiaries, which includes “limited English” populations. As the Majority notes, according to the 1990 Census, there are 3.8 million people in the United States over age 65 who report that a language other than English is spoken in their home. Many of these elderly are limited in their English proficiency (LEP) and risk suffering negative health consequences if intelligible health care information is not made available to them. We appreciate the efforts of the Majority to

ensure that all Medicare beneficiaries will be given comparative information about the Medicare options in their area. We firmly believe this will empower all beneficiaries to make effective and informed health care choices.

Hospital Outpatient Department Overcharges

The Democratic Members are disappointed that a major Medicare consumer problem is not corrected more rapidly. Because of flaws in the law, today Medicare beneficiaries pay about 45 to 46 percent — and the percentage is rising steadily — of the total Medicare payment for hospital outpatient department (HOPD) services. In all other Part B services, they pay 20 percent and Medicare pays 80 percent.

The President's budget attempted to fix this problem over a 10-year period, first freezing the rise in the co-payment percentage and then gradually lowering it to 20 percent. The Republican bill fixes the problem over about 23 years. That is far too long.

Preventive Benefits

The Democratic Members of the Committee are pleased that the Majority added a variety of important, new preventive benefits. While we strongly support these new initiatives and worked closely with the Majority in helping to develop the package, we also wish that we could have eliminated co-payments for screening mammography. This would further assist in ensuring that women receive this vital preventive benefit.

On vaccinations for seniors, we are disappointed that the Administration and Chairman Thomas' effort to promote increased inoculation has ended with only an authorization for additional outreach and education. We hope the Appropriations Committee will provide the extra funds for this program — it is an excellent way to reduce the serious hospitalization costs of flu and pneumonia among seniors.

The Medicare title calls on the National Academy of Sciences to conduct a number of studies on preventive benefits. As the Academy studies nutrition therapy, we hope they will be able to examine the problem

of obesity and how to prevent or correct this serious problem which creates so many morbidities.

Teaching and Safety-Net Hospitals

The Democratic Members of the Committee are concerned about the survival of America's premier teaching and research hospitals. Our nation's academic teaching hospitals have long led the world in their creativity and genius – but that leadership is under serious challenge.

Carve-Out of GME/IME/DSH Payments to MedicarePlus Plans

Most Democratic Committee Members are concerned that this bill fails to "carve out" payments for graduate medical education (GME) and disproportionate share hospitals (DSH) from the payments made to MedicarePlus plans. Under the "carve out" proposal, these payments would go directly to those special hospitals when managed care plan enrollees actually use those hospitals. Failure to include this provision means that we will continue paying managed care plans for costs they are not incurring.

The Physician Payment Review Commission, the Prospective Payment Assessment Commission, and the American Academy of Actuaries all agree that carving out these payments from managed care rates and making sure they go directly to the service providers is the fairest way to proceed. Nonetheless, the Majority rejected a Democratic amendment that would have included the carve out.

GME Trust Fund and Children's Hospitals

We are also concerned that Medicare and Medicaid are the only source of teaching and safety-net hospital support. These hospitals serve all our citizens, and we must find a way for others to contribute to the cost of maintaining these institutions, including the training of pediatricians and others in children's hospitals. A Graduate Medical Education Trust Fund is essential, and we look forward to working with the majority to develop this legislation.

The Democratic Members are concerned that training programs in underserved areas could be adversely affected by decisions to place a cap on the overall number of residency positions. We believe that there exist many underserved rural as well as other underserved urban areas where residency training programs remain in their infancy. The ability to build on these training programs could be limited when training caps are applied. Likewise, we recognize that dental and podiatry residents in primary care are vital contributors to the delivery of necessary health care. We have concerns that the policy to cap residency training positions may have an adverse impact on non-M.D. training. We recognize that an insufficient number of residency positions in dentistry and podiatry exist at present. We must address the need for all primary care physicians in underserved areas in future legislation.

Our nation is growing older, and we need more geriatricians. Health manpower experts have predicted a critical shortage of geriatricians in the next century. It has been estimated that approximately 20,000 physicians trained in geriatric care will be required, yet today there are less than 7,000. Therefore, we remain committed to ensuring that a sufficient number of appropriate specialties have an opportunity to obtain necessary training.

There is little debate that our nation is experiencing a shortage of primary care physicians and an oversupply of some specialists. In order to help address this issue, in May 1996, the Health Care Financing Administration (HCFA) announced it would reduce graduate medical education reimbursement rates to hospitals for combined residency programs, as the majority of those programs produce physician specialists. Certain combined residency programs do, however, train primary care providers. The most obvious example is the Internal Medicine-Pediatrics dual residency program, which trains primary care physicians who can treat both adults and children. The Democratic Members of the Committee thank the Majority for including Section 10736 of the Title to restore full reimbursement for combined residency programs in which both of the programs in the combination are for training a primary care practitioner (as defined by current law) or where one in the combination is for primary care and the other is obstetrics and gynecology. We believe this provision retains the disincentive for producing specialists, while encouraging more residents to enter primary care.

Other Hospital Payment Issues

We note that \$100 million is being cut from Medicare disproportionate share hospitals over a two-year freeze, while a new DSH formula is developed. It is essential that this formula develop a new and more focused definition of what constitutes a safety-net hospital, and we look forward to working with the Administration in helping to develop this formula. We need a new DSH formula — and more help for the true safety-net hospitals.

When Puerto Rican hospitals were introduced into Medicare's Prospective Payment System in 1987, the base rate for reimbursement was determined to be 75 percent local Puerto Rican and 25 percent the national rate blend. In the 10 years since that time, Puerto Rican hospitals have not received a single update to this rate. At this point, we would like to underscore the comments of Puerto Rican Governor Pedro Rossello and Congressman Carlos Romero-Barcelo in their letter to the Committee leadership:

Puerto Rico residents contribute fully to the Medicare Trust Fund through payroll taxes, even though the Puerto Rico hospitals that provide Medicare services are reimbursed under an inequitable formula — and have been ever since 1987.

The Democratic Members of the Committee would like to thank the Majority for including in the Medicare title an adjustment to the Puerto Rican rate that would bring the Island's hospitals up to a 50/50 blend. While still inequitable, this update will enable Puerto Rican hospitals to continue giving care to the 500,000 Island residents currently enrolled in the program and will begin to address this funding imbalance.

DOD Subvention

The President proposed a Department of Defense (DOD) demonstration to expand health care coverage and options for our nation's military retirees by providing Medicare reimbursement to DOD facilities. The DOD demonstration program would test whether Medicare subvention is a cost-effective alternative for delivering accessible and quality care to

dual-eligible beneficiaries through the military health system without creating burdens for the Medicare budget.

There are approximately 1.2 million Medicare-eligible (dually eligible) military retirees. Currently, military retirees and their families are entitled to medical care only on a "space available" basis. While Rep. Tanner's amendment to include the demonstration project in this bill was rejected, we hope the Committee will address these issues in the 105th Congress in a manner that protects Medicare's revenues while improving service to our military retirees.

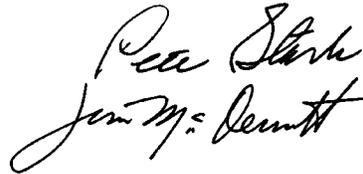
Medicare Demonstration for DI Beneficiaries

Finally, we believe that the legislation should have included a demonstration project providing extended Medicare benefits to Social Security Disability Insurance beneficiaries. Currently, only one-half of one percent of DI beneficiaries leave the disability rolls by returning to work. We can certainly improve on that record. Even a modest improvement will reduce expenditures from the Disability Insurance Trust Fund and offer people with disabilities a better life.

The single largest disincentive to work among disability beneficiaries is the fear of losing medical care coverage. The amendment offered by Rep. Kennelly would have established a demonstration project in which 4,500 individuals would have been provided continuing Medicare coverage — beyond that provided under current law — for the period of the demonstration (fiscal years 1999-2005). We need to move forward to help more individuals with disabilities fulfill their potential and increase their independence from disability benefits.

**Additional Views of Democratic Members
With Respect to Medicare**

<u>Sander N. Levin</u>	<u>Pea Stark</u>
<u>Joseph J. Kennelly</u>	<u>John Lewis</u>
<u>Charles Stenholm</u>	<u>William J. Ayne</u>
<u>Jerry Keeney</u>	<u>Benjamin L. Cardin</u>
<u>James E. Cooper</u>	<u>Tim W. Kaine</u>
<u>Karen L. Thurman</u>	<u>Blaine Luetkenhorst</u>
	<u>John Timmons</u>



ADDITIONAL VIEWS OF REP. PETE STARK AND REP JIM McDERMOTT,

"What might have been"... "the road not taken"... "the missed golden opportunity"- phrases that describe this Reconciliation package and its impact on the future of Medicare.

The Medicare Title of this Reconciliation bill extends the life of the Medicare Part A Hospital Insurance Trust Fund to 2007 or 2008. That is a major step forward. But it does not get the Trust Fund even to the start of the retirement of the Baby Boom generation. And that means that the nation's media will continue to report on the "impending crisis" in Medicare, politicians will continue to issue dire warnings, seniors will continue to worry, and younger people will continue to have more faith in flying saucers than the future of this fundamental insurance program. The relatively short-term extension of the life of the Trust Fund will feed Washington's cottage industry of think tankers who will urge the "restructuring" of Medicare [buzz words for shifting costs to seniors] and who will promote turning it into a defined contribution program [more buzz words for shifting costs to seniors]. The failure to extend Medicare for the long-term will fuel proposals to raise the retirement age of Medicare from 65 to 67, the very age which is most vulnerable to lay-offs, employer-health plan reductions, and impossibly expensive private insurance costs.

It didn't need to be this way.

If instead of the tax cuts in this bill, we had earmarked through the purchase of Medicare Trust Fund bonds the amount of tax cut money being needlessly pumped into this boom economy, we could extend the life of the Trust Fund past 2021.

By saving for the impact of the retirement of the Baby Boom generation, we could make Medicare solvent for nearly a generation--and well into the retirement of the Baby Boom generation. By not doing this tax cut, but saving the equivalent amount of money, we could avoid future quality-damaging cuts and future tax

increases.

Medicare can survive for future generations. It will take continued pressure on providers to restrain costs. It will take some increased payments by beneficiaries. And it will take some taxes. We don't need a Bipartisan Commission on the Effect of the Baby Boom Generation on the Medicare Program to figure this out--it is obvious. What we do need is the courage and political will to start making those changes, now.

The first step would have been not to give away \$250 billion in tax resources over the next ten years, but to earmark that money for saving Medicare.

This Reconciliation bill misses that opportunity--and makes saving Medicare in the next decade much, much more difficult.

DISSENTING VIEWS OF REPS. McDERMOTT, McNULTY and JEFFERSON

We voted against the Medicare title of this Reconciliation bill. While this year's bill has some good features, we believe the bad outweighed the good.

We believe that the best way to strengthen the Medicare program would be to work toward achieving universal coverage for all Americans rather than increase premiums on low-income Medicare beneficiaries and nudge them into Medicare managed care operations (HMOs).

Among the very worst features are Medical Savings Accounts.

The bill spends \$2.2 billion in four years on Medical Savings Accounts (MSA) for the healthiest and wealthiest in our society. Between now and 2007, it will spend \$5.7 billion on this give-away to a special few. The Congressional Budget Office estimates that the extra cost to Medicare of each person who signs up for a MSA will be \$1000 in 1999, rising to an extra \$1650 by 2007.

The Majority party insisted on this MSA provision and rejected a Democratic amendment to limit MSA expansion even if we used the savings to permit the nation's retired service personnel to receive medical care at nearby military hospitals (Medicare subvention).

The Majority party rejected Democratic attempts to reduce the MSA expansion even if we used the savings to pay for a small respite care benefit for Alzheimer's patients.

The Majority party rejected Democratic attempts to reduce the MSA expansion even if we used the savings to pay for an elimination of co-payments for mammography screening to detect cancer.

The Majority party rejected Democratic attempts to reduce the MSA expansion even if we used the savings to ensure children's hospitals have adequate funds to teach their medical residents how to give kids the best care possible.

The Majority party rejected Democratic attempts to reduce the MSA expansion even if we used the savings to treat patients in medically underserved areas in urban and rural America.

Worst of all, the Majority party rejected Democratic attempts to reduce the MSA expansion even if we used the savings to reduce the size of the Part B premium increase for lower-income seniors. The transfer of much of the cost of the home health benefit to Part B means that Part B premiums will increase substantially in the years to come. By 2007, seniors will be paying \$106.10 a month in Part B premiums, compared to \$43.80 a month this year. That may not sound like much to a Member of Congress, but for the 10.5% of seniors living below the poverty level, it is another blow, forcing

cutbacks in food and other basic necessities. Eighteen percent of seniors live below 125% of poverty, and health care spending consumes 30 to 31% of their family income. Congress should not casually impose higher Part B premiums, especially when it is uncertain whether the Majority party will comply with the Budget Agreement's commitment to help these low income seniors.

Some Republicans say that MSAs are not for the healthy and wealthy. We ask the reader -- would you give up your Medicare program to buy a \$6,000 deductible health insurance plan unless you felt pretty healthy?

The money in the MSA will accumulate tax-free, which is attractive if you are in the 28% or higher tax brackets. But, is it worth the gamble if you are among the 85% of seniors who are below the tax threshold or in the 15% bracket?

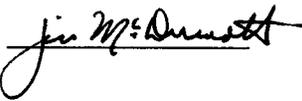
What is even more amazing is that 40% of the \$6,000 amount can be spent on non-health items -- including vacations or hobbies. That's a nice loophole, but not when the Medicare Trust Fund faces long-term solvency problems.

The MSA concept is the opposite of the concept of insurance. It is Social Darwinism at its worst. As the healthy wealthy take this approach, it leaves the sicker and the lower income in the Medicare insurance pool, which will in turn have higher and higher costs per-person. What is even stranger is that because one can decide to stop enrolling in MSAs each year and return to the Medicare program, it encourages people to game the program when they have planned medical expenses. For example, if you need a hip replacement operation, schedule it on January 2nd after the year you leave your MSA and return to regular Medicare. Same with a cataract operation. Same with many scheduled heart surgeries.

As written, the bill would allow a person to leave MSAs for a year, go into Medicare and undergo planned surgeries, and then once again join the MSA option without spending a penny from the MSA account -- legalizing a scheme which encourages non-medical use of MSA funds.

There are other reasons to oppose this bill. We join the additional views of our Democratic colleagues in pointing out that the bill does not do enough to stop fraud, waste, and abuse. Rather than cut honest providers and shift costs onto beneficiaries, we should do everything possible to stop the estimated 12% fraud, waste, and abuse that plagues not just Medicare, but the entire American health care system.

Michael C. M. Nulty


Jim M. Drumett


VIEWS OF BUDGET COMMITTEE MEMBERS

Clause (2)(1)(5) of rule XI requires each committee to afford a 2-day opportunity for members of the committee to file additional minority, or dissenting views and to include the view in its report. The views submitted are found at the end of this report.

John Spratt
6/23/97

Additional Views of Ranking Democrat John Spratt

Some Democrats supported and others opposed the budget resolution, but all agree that the reconciliation bills should comply with the Bipartisan Budget Agreement. This bill does not. It includes a number of provisions that directly violate the Budget Agreement or were never part of it and go well beyond its scope. We will keep working on the floor and in conference to see that the majority keeps its commitments and makes necessary changes to the bill. Those of us who voted for the bill in committee made clear that our votes on the floor will rest on the resolution of numerous outstanding issues, preferably by a self-executing rule.

Among the provisions that Democrats object to are:

- (a) **SLMB:** \$1.5 billion must be included for Medicaid to ease the impact of Medicare Part B premiums on low-income Medicare beneficiaries. These funds were provided both in the Bipartisan Budget Agreement and the budget resolution. The reconciliation bill provides only \$0.5 billion for this purpose. This money is important to protect low income Medicare beneficiaries who will be paying higher Part B premiums when the cost of home health care is shifted to the Part B. We understand that a satisfactory resolution to this issue will be included in the rule for consideration of the reconciliation bill.
- (b) **Children's Health:** The Children's Health Assistance Program is unacceptable in its present form because there is no safeguard that the \$14 billion the bill provides will reach the beneficiaries it is intended to help: uninsured children. CBO estimates that the committee bill would extend Medicaid and insurance coverage to 520,000 children each year who otherwise have been uninsured and to about 345,000 who have been insured even without the reconciliation bill. This is far short of the target of 5 million additional insured children set forth in the Budget Agreement. At a minimum, the bill should stipulate that the children's health care block grant be used solely to provide medical insurance to children under the age of 19 who would otherwise be uninsured.
- (c) **ELSA/Minimum Wage:** The sections affecting the Fair Labor Standards Act and related labor laws should be struck. When TANF (Temporary Assistance for Needy Families) beneficiaries take part in workfare in public sector and non-profit agency jobs, they should receive the minimum wage and the basic protections other American workers enjoy. The 1988 Family Support Act dealt with the status of workfare participants. Experience with its provisions has been uneventful and there is no reason not to carry forward its provisions. We have proposed, therefore, as an alternative to the bill the Family Support Act's definition of workfare, requiring that workfare serve a useful public purpose, connected with social services, health or environmental protection, urban or rural development, welfare, recreation, public facilities, public safety, and day care. All of the above was set forth in Section 482(f)(1A) of the Social Security Act until it was repealed by the welfare reform law. We have also

proposed that the hours of workfare be calculated by adding TANF cash assistance and Food Stamps and dividing that sum by the minimum wage. This was Section 482(f)(1)(B)(i) of the Social Security Act before it was repealed. It is not only unprecedented but unworkable to impute other benefits to income. We also propose that once the TANF recipient has satisfied all workfare hours, other activities (such as education, training, and job search) should count toward meeting the required hours of participation. We proposed borrowing two work standards from Sections 484(1) and (3) of the Social Security Act: (i) that each work assignment take into account the physical capacity, skills, experience, health and safety, and family responsibilities of the workfare participant, (ii) that participants not be discriminated against on the basis of race, sex, national origin, religion, age, or handicapping condition, and that they have rights available under applicable federal, state, and local laws prohibiting discrimination. This reasonable proposal is drawn from provisions of law that have been shown to be feasible. These provisions should be made part of the reconciliation bill by a self-executing rule, replacing provisions of the current text of the bill that are unfair and unworkable.

- (d) **Medicaid Eligibility for Disabled Children:** The bill should amend Supplemental Security Income (SSI) so that children who lose eligibility for SSI benefits as a result of the welfare reform law will still retain Medicaid benefits. The cost is nominal (\$100 million over 5 years), and it can be paid for by deducting it from funds allocated to the children's health block grant. The total for all children's health programs would remain \$16 billion, as called for in the Budget Agreement.
- (e) **SSI/State Maintenance of Effort:** The provision repealing current SSI state maintenance of effort requirements should be struck to protect individuals from losing their SSI and Medicaid benefits. Since federal SSI payments are not at issue, striking this provision will not reduce the savings in the bill. Yet under the bill, 2.7 million Americans could receive smaller state SSI supplemental payments. About 350,000 receive only state supplements because their Social Security check is virtually the same size as the federal SSI benefit. For them, losing the state supplement means losing their entire SSI benefit and thus Medicaid eligibility.
- (f) **Disabled Legal Immigrants:** Both the budget resolution and Budget Agreement explicitly provide that all legal immigrants who entered the United States before August 23, 1996, will be eligible for Medicaid and SSI if they later become disabled. President Clinton has sent Chairman Kasich a letter promising to veto the reconciliation bill unless its immigrant provisions conform to the Budget Agreement by extending SSI and Medicaid to such immigrants. We hope that Congress will heed the President's warning.
- (g) **Food Stamp Work Slots:** The budget resolution anticipated that up to 350,000 more workfare slots for people between age 18 and 50 would be created and allocated \$1

billion to this end. But the bill authorizes some of the funds to be used for purposes other than to create work slots. The bill should be clear that the extra \$1 billion can be used only to create workfare slots for these people and not to pay for state Food Stamp administration costs or any other purposes.

- (h) **Medicare Solvency:** The cost of home health care after 100 visits per year should be transferred from Medicare Part A to Part B in one step. This transfer is called for in the Budget Agreement as well as in the bill reported by Commerce, but Ways and Means proposes to transfer home health care costs in phases. Making the transfer immediate ensures solvency of the Part A Trust Fund for at least 10 years, adding at least 2 more years of assured solvency than a phased transfer.
- (i) **Medicaid for D.C. and the territories:** The Budget Agreement and budget resolution include an additional \$919 million to fund a higher Federal Medicaid match rate for the District of Columbia and \$250 million for an inflation adjustment for Medicaid programs in Puerto Rico and the territories. The reconciliation bill contained no funds for either purpose, and these funds should be added to meet commitments made.
- (j) **Multi-Employer Welfare Associations (MEWAs):** This proposal is controversial, was never included in the Budget Agreement or discussed in the budget negotiations, and should be deleted. It supplants state health insurance regulation and replaces it with inadequate solvency standards administered by a federal agency with little expertise in the field.
- (k) **Medical Savings Accounts:** MSAs are also controversial and were never part of the Budget Agreement. In addition, the 500,000 MSAs permitted by this bill will cost Medicare \$2 billion over the next five years, according to CBO. The Senate has heeded CBO's warning and limited MSAs to a demonstration level of 100,000. This is sufficient to test their merit as a Medicare alternative, and the bill should go no further than this limited level.
- (l) **Medical Malpractice:** The bill preempts state law and provides a two-year statute of limitations and a five-year statute of repose, a \$250,000 cap on non-economic damages, and limits on punitive damages. It also allows collateral benefits in evidence. The provisions apply to all medical malpractice actions, not just cases involving Medicare and Medicaid. These provisions were not considered by the Judiciary Committee, the committee with primary jurisdiction. They were not part of the Budget Agreement and should not be bolted onto this bill and considered in this manner.
- (m) **Food Stamp/Medicaid Eligibility Privatization:** The bill allows states to privatize Food Stamp and Medicaid eligibility determinations. Delegating an important government function like benefit eligibility to the private sector raises public policy issues that call for debate and careful consideration—something wholly lacking in this

omnibus bill.

- (n) **Administrative Cost Allocation:** The bill grants student loan guaranty agencies an "Administrative Cost Allowance" equal to 0.85 percent of new loan volume from the mandatory loan administrative funding account. The bill also allows guaranty agencies to keep a higher portion of recoveries on "consolidated" defaulted loans. In a time when mandatory spending keeps growing and discretionary spending keeps being squeezed, we should be wary of new direct spending devices. Neither of these proposals is necessary for the solvency of guaranty agencies. They do not help balance the budget, and if done at all, they should be done in another bill.

This is an illustrative list of our objections, issues that Democrats must have resolved before this bill can be called a "Bipartisan Budget Agreement."



John Spratt
6/28/97

Additional Views of Rep. John M. Spratt, Jr.

**Regarding House Commerce Committee Formula for Distribution of
Medicaid's Disproportionate Share Hospital (DSH) Payments**

The cost of Medicaid spiked upward in the late 1980s and early 1990s, and even though it tapered off last year, we all know that Medicaid has to contribute to our effort to get rid of the deficit. But Medicaid goes to people who have few other choices for medical care, and it goes to inner city and rural hospitals that would be in financial peril if Medicaid were cut too much.

The Administration made two major proposals for Medicaid cost containment. It proposed per capita state caps on Medicaid benefits; and it proposed a reduction in funds for Disproportionate Share Hospitals (DSH) along with a formula allocating DSH reductions from state to state.

The Budget Agreement rejected Medicaid caps, leaving almost all of the cost reduction in Medicaid to cutbacks in DSH. The Commerce Committee then dispensed with the Administration's allocation formula, and imposed a heavy burden on states that have been users of Medicaid's disproportionate share hospital (DSH) payments to operate their Medicaid program. In South Carolina, DSH payments account for over 20 percent of Medicaid spending. If the DSH cuts are applied as proposed in the Commerce Committee reconciliation bill, Medicaid in South Carolina will be severely disrupted.

Under the committee bill, those states whose DSH spending exceeds 12 percent of Medicaid spending (high DSH states) will have their DSH allocations cut by 40 percent in 2002. This reduction is twice as much as that applied to other states (whose DSH spending is under 12 percent of Medicaid spending). Only 12 states are designated high-DSH states in the bill. They are the only ones affected by the 40 percent cut. The other 38 states will see their DSH allocations reduced by 20 percent in 2002. Anyone can see that a DSH cut of 40 percent would be severe, unfair, and disruptive in a state like South Carolina.

When the Budget Committee considered the reconciliation package, we adopted an amendment stating that DSH cuts should not be excessive for those states whose DSH spending exceeds 12 percent of Medicaid spending. Chairman Kasich acknowledged that the formula was a serious problem for the high DSH states and agreed to work in conference to correct this disparity.

To avoid a formula fight, the simplest solution is the fairest: a return to the Administration's proposal. This, in essence, would allocate DSH reductions by equal percentage amounts in each state's DSH payments up to 12 percent of total Medicaid spending. This is the equitable way to wring the necessary savings out of Medicaid without damaging Medicaid severely in high DSH states.

COMMITTEE:
AGRICULTURE
BUDGET

Earl Pomeroy
Earl Pomeroy
Congress of the United States
North Dakota

U.S. Representative Earl Pomeroy (D-ND)
Minority Views - Budget Reconciliation Spending Act
June 23, 1997

WASHINGTON OFFICE:
 333 LONGWORTH BUILDING
 WASHINGTON, DC 20518
 (202) 225-2811
 EPOMEROY@HR.HOUSE.GOV

DISTRICT OFFICE:
 ROOM 376, FEDERAL BUILDING
 220 EAST ROSSMAN AVENUE
 BISMARCK, ND 58501
 (701) 224-6356
 ROOM 206, FEDERAL BUILDING
 607 SECOND AVENUE NORTH
 FARGO, ND 58102
 (701) 226-6760

I am pleased that this reconciliation spending bill represents progress toward implementation of the balanced budget agreement. Although we have several important areas of disagreement that must be resolved before the spending bill is sent to the President, Chairman Kasich worked diligently to address many of our concerns regarding the component reconciliation bills as they were reported out of committee. It is my sincere hope that the spirit of bipartisan cooperation that has governed the Committee's deliberations will continue until this spending bill is signed into law.

There are a few areas of the bill that remain of concern to me. I am most troubled by the inclusion in the bill of the Expansion of Portability and Health Insurance Coverage Act of 1997 (EPHIC). The EPHIC bill attempts to federalize a large portion of the health insurance marketplace by setting up federally certified Association Health Plans (AHPs) which are not subject to state regulation. As a former state insurance commissioner, I know the damaging effect this federal intrusion would have on the health insurance marketplace.

Today in the health care arena, states are playing their intended role as laboratories of innovation. States have enacted a wide variety of measures to increase access to health coverage and provide important consumer protections. Yet EPHIC places these state efforts in jeopardy and, as a result, has drawn the staunch opposition of state officials. Indeed, the National Governors Association, the National Conference of State Legislatures and the National Association of Insurance Commissioners all oppose the bill.

Why are state officials so concerned about this legislation? First, because EPHIC fragments the health insurance marketplace by removing healthy small employer groups from state regulation. Without the participation of these groups and their employees, state health reforms cannot succeed. Second, the bill reduces consumer protections for those who participate in AHPs. EPHIC exempts AHPs from over 1000 state consumer protection safeguards, which govern everything from marketing practices to covered services to quality standards. Applicable federal standards would be much weaker and inadequate. Third, EPHIC does not offer sufficient protection against the fraud frequently perpetrated by unscrupulous operators of multi-employer health plans. And fourth, EPHIC's solvency standards for AHPs are substantially weaker than most state standards, posing the risk of substantial losses for both plan participants and providers when plans go belly up.

Fortunately, EPHIC was not included in the Senate version of the reconciliation spending bill. I sincerely hope that in light of EPHIC's harmful effects on consumers and state health reform House and Senate conferees will exclude this legislation from the conference agreement. The states have produced many of our most successful health reforms and state officials are the ones with the real expertise in health insurance regulation. Now is not the time to risk untested federal intrusion into the health insurance marketplace.

**ADDITIONAL VIEWS TO THE HOUSE
BUDGET COMMITTEE ON ETHANOL**

Congressman David Minge

June 20, 1997

Mr. Chairman, the House Ways and Means tax legislation that passed the Committee last week was a serious blow to the ethanol community. During the past week, I have had the opportunity to analyze the ethanol provisions. I believe the detrimental effects of this bill, if enacted, must be underscored. The Rules Committee has a responsibility to delete this tragic departure from sound policy for several reasons.

Destruction of New Initiatives -- Not only does the legislation as currently drafted terminate the ethanol program in the year 2000, but it also effectively restricts production of ethanol at 1997 levels. This proposal seriously handicaps our efforts to develop a domestically-produced, clean and efficient renewable fuel. This legislation also has an adverse impact on the auto industry's recent initiatives to develop vehicles that run on ethanol, gutting the intentions of the Clean Air Act.

Smoke and Mirrors Accounting --The deviousness of the legislation cannot be overstated. Under the budget scoring rules, ethanol is considered a permanent program, even though it is scheduled to expire in 2000. The game of repealing a provisions that has already expired is a prime example of budget gimmickry. The additional "phony" savings was then used to finance other tax cuts. This is unconscionable in an era where all ought to be vigilant against "smoke and mirrors" in budgeting.

Reversal of Freedom to Farm --In 1996, Congress passed the Federal Agriculture Improvement and Reform Act (FAIR), directing farmers to diversify, establish new initiatives, and develop new markets for their products. Under this so-called "Freedom to Farm" law, farmers no longer depend on the federal government to dictate crop acreage and stabilize income. The Ways and Means ethanol provisions repudiate the congressional intent of Freedom to Farm. This proposal caps ethanol production at roughly 1997 levels and penalizes producers who exceed the caps. This ties the hands of producers and punishes farmers for seeking and developing new markets.

Not a Level Playing Field -- The fledgling ethanol industry needs a level playing field in order to compete with the mature petroleum industry. Federal tax benefits to the oil industry far outweigh the tax incentives currently in place for ethanol. For the past 20 years, we have invested time, effort, and dollars to diversify our nation's energy needs. In one week, the Ways and Means Committee has effectively attempted to eliminate ETBE, ensuring a virtual monopoly to the petroleum-based MTBE producers. The result is a stifling of national efforts to diversify into renewable fuels.

Mr. Chairman, I cannot underscore enough the detrimental effects of the Ways and Means Committee ethanol proposal. Although we have heard word that Speaker Gingrich intends to strike these provisions before the legislation is considered on the floor, I urge you to strike the Ways and Means provisions at the Rules Committee and ask for assurances that this proposal not be included in the Budget Reconciliation legislation. I look forward to working with you on this request.



**ADDITIONAL VIEWS TO THE HOUSE COMMITTEE ON THE BUDGET
REGARDING BUDGET ENFORCEMENT**

Congressman David Minge

June 20, 1997

Mr. Chairman, the budget package before this Committee represents a remarkable bipartisan commitment to deficit reduction, unparalleled by any budget agreement that has come before the House since my election to Congress. The agreement includes a promise we made to the American people to balance the budget by the year 2002, and puts us on our way to reducing the financial burden that has been placed on future generations because of burgeoning federal deficits.

Despite the best of intentions, long-term budget agreements have often resulted in higher spending and larger deficits than originally planned. Unfortunately, the proposal before us contains no guarantee that we can actually enforce the balanced budget agreement. We need to hold ourselves to high budgeting standards and continue to make the tough decisions necessary to reach our goal of a balanced budget. This requires the addition of budget enforcement mechanism provisions that will enable us to fulfill this commitment with regard to spending, entitlements and revenue.

The bipartisan budget enforcement provisions I propose provide a critical safeguard to ensure that the goals of the balanced budget agreement are met. Congress and the President would be held accountable if actual spending or revenues did not comply with the levels in the balanced budget resolution. The targets are adjusted to reflect changes in economic growth, inflation and the number of individuals eligible for entitlement programs.

If actual spending, revenues, and deficits deviate from the path set out in the budget agreement, an enforcement mechanism would be applied to the offending part of the budget. If spending is too high, the individual spending programs that caused the problems would be sequestered. If revenues fall short, the phase-in of new tax reductions would be delayed.

The expansive nature of the reconciliation bills we are considering underscores the need for tough enforcement. New programs are added, existing programs are enlarged. These appear to be well defined to avoid exploding the deficit. However, the tax cuts are different. The indexing of capital gains, delayed impact of IRA's, and phase-in of estate tax changes are budget time bombs. We must not let our desire to cut taxes destroy the deficit elimination prize. Similarly we must not forsake the important national goal of establishing solvency for the Social Security Trust Fund. We are using it to mask the size of our deficit. At a minimum, we have a duty to end that practice if our claim that we have balanced the budget is to be credible.

Mr. Chairman, I applaud your efforts on this balanced budget agreement. If we are serious about achieving real deficit reduction, this enforcement provision is the best vehicle available to take this agreement even further and ensure we reach our goal of a balanced budget by 2002.



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Michael R. McNulty

*Additional
Dissenting views of Rep. Michael R. McNulty
to the Medicare title of the reconciliation bill.*

I believe it is wrong to take \$115 Billion from Medicare while at the same time cutting taxes by \$135 Billion.

I have other objections to the bill. The Prospective Payment Systems (PPS) hospital payment freeze will seriously harm the hospitals in my district. The failure to carve out the GME, IME, and DSH payments to Medicare managed care plans and provide these payments directly to disproportionate share hospitals and to entities with recognized teaching hospitals is another defect in this bill.

KENNETH E. BENTSEN, JR.
25TH DISTRICT, TEXAS
128 CANNON HOUSE OFFICE BUILDING
WASHINGTON, DC 20515-4325
(202) 225-7908
(202) 225-2947 FAX
email: bentsen@rv.house.gov
http://www.house.gov/bentsen/welcome.html

COMMITTEES
BANKING AND FINANCIAL SERVICES
SUBCOMMITTEE ON
FINANCIAL INSTITUTIONS AND
CONSUMER CREDIT
SUBCOMMITTEE ON
DOMESTIC AND INTERNATIONAL
MONETARY POLICY
BUDGET

Congress of the United States
House of Representatives
Washington, DC 20515-4325

DISTRICT OFFICES:
6575 WEST LOOP SOUTH
SUITE 406
BELLARE, TX 77401
(713) 867-3554
(713) 867-4623 FAX
1001 E. SOUTHWARE
SUITE 810
PASADENA, TX 77502
(713) 475-4334
(713) 475-8887 FAX
1300 ROLLINGBROOK DRIVE
SUITE 517
BAYTOWN, TX 77521
(281) 495-5279

ADDITIONAL VIEWS OF HON. KENNETH E. BENTSEN, JR.
FIRST (SPENDING) RECONCILIATION BILL
June 20, 1997

I voted present on the spending reconciliation bill because, while I continue to support the bipartisan balanced budget agreement and the budget resolution implementing it, I believe this reconciliation bill in its current form falls short of the budget agreement and violates it in several significant ways. I am especially concerned about the devastating cuts this legislation would make in Medicaid funding for Disproportionate Share Hospitals (DSH) using a grossly unfair formula and its failure to implement the budget agreement in areas such as protection against premium increases for low-income Medicare beneficiaries, restoration of certain benefits for legal immigrants, and assurance that the children's health care provisions will actually expand insurance coverage for uninsured children. I am also concerned about provisions in the legislation that would eliminate basic worker protections for many Americans. I am heartened by Chairman Kasich's stated commitment to resolving many of these issues, and I look forward to working with him, Ranking Member Spratt, and my other colleagues in bringing legislation to the floor of the House that I can support.

This legislation does include two provisions in the Medicare reform section that I have advocated and that would greatly benefit our nation's health care system. These provisions, which are similar to legislation I have introduced, would help ensure that senior citizens have real choice under Medicare and our nation continues to invest properly in medical education at teaching hospitals. Both of these provisions were included in the Commerce Committee version of Medicare reform, and I strongly urge that they be included in the final legislation reported by the Conference Committee.

The first provision would give senior citizens who transfer into a managed care plan the right to buy supplemental insurance (Medigap), which pays for prescriptions and other vital services, if they return to traditional fee-for-service Medicare. Seniors currently lack this right, and this is a tremendous obstacle to real choice in Medicare.

The second provision would ensure that Medicare managed care plans help fund medical education in the same way as fee-for-service Medicare. The Commerce Committee proposal would carve out graduate medical education (GME), as well as disproportionate share hospital (DSH), amounts from the Average Adjusted Per Capita Cost (AAPCC) payment to Medicare managed care plans. This approach would ensure that this funding is used as intended to fund GME and DSH. This plan would not increase federal spending; rather, it would recapture funds

from the current Medicare managed care reimbursement formula so that all Medicare plans help pay for the cost of graduate medical education.

While these are positive aspects of this reconciliation bill, I remain very concerned about the approach this legislation takes in cutting funding for Disproportionate Share Hospitals under Medicaid. As currently written, this legislation is unfair and punitive toward states such as Texas that are most depend on the DSH program to meet the health care needs of a fast-growing, low-income population. There is bipartisan agreement in Congress that we need to reform the DSH program to contain costs and prevent abuse of the program. But these reforms must be fair and reasonable, not arbitrary and punitive as they are in this legislation.

Under this legislation, Texas and 12 other so-called "high-DSH states" would have their funding cut by twice the percentage of other states. In the year 2002, for example, funding for high-DSH states would be cut by 40 percent, while funding for other states would be cut by 20 percent or not at all. As a result, 13 states contribute 57 percent of the savings required, while some states bear no cuts at all. These states would face the closure of rural and urban public hospitals and substantial reductions in necessary health care for uninsured or indigent patients, particularly children. Additionally, the nation's children's hospitals would inherit an unsustainable financial burden as their caseload is often mainly Medicaid or indigent care.

During Budget Committee debate on this legislation, I offered a motion directing the Chairman to request that the rule for floor consideration of the spending reconciliation bill include an amendment to the bill that achieves savings in Medicaid DSH payments by taking an equal reduction from each state's 1995 DSH spending, up to a limit equal to 12 percent of its total Medicaid spending. I believe this is a fairer approach than the formula now in the legislation because all states would have their DSH funding cut by the same percentage. High-DSH states would continue to be cut by larger dollar amounts. This amendment would be revenue-neutral and fair.

In order to assure bipartisan support for my position, I withdrew my motion in favor of a substitute motion by Mr. Franks of New Jersey calling on the Chairman, when he appears before the Rules Committee, to request "that DSH payment reductions not be excessively burdensome to those states with DSH costs greater than 12 percent of total Medicaid spending." I am also pleased that the Chairman stated his commitment to changing the current formula for cutting DSH payments, and I urge that he advocate the approach outlined in my motion. If the DSH program is to be cut, it should be cut rationally, proportionally, and fairly.

The bipartisan budget agreement struck the right balance between fiscal responsibility and appropriate investment to meet the challenges facing our nation. The first reconciliation bill as drafted goes half the distance with important initiatives such as Medigap and GME reform, but these other matters must be corrected. I look forward to voting for final reconciliation legislation that remains true to this agreement.

DISSENTING VIEW BY CONGRESSMAN RON PAUL

Congress should reject the proposed budget reconciliation provision authorizing the expenditure of an additional \$3 billion in taxpayer dollars on “Welfare to Work” programs because it is part of the phony “budget deal” and because the federal government has no constitutional authority to spend taxpayer dollars on welfare-to-work programs.

I. PROBLEMS WITH THE BUDGET AGREEMENT

Congress is once again engaging in the tired ritual of the five-year balanced budget plan. Repeatedly over the past 25 years there have been lofty proclamations that the budget would be balanced in five years because of government forecasts of continued growth. Each five year plan was announced with great fanfare and happy feelings of bipartisanship, yet, each plan fails to balance the budget because the economic forecasting upon which they were based never reflect actual economic circumstances.

A. THE BUDGET DEAL IS BASED ON FAULTY ECONOMICS

The federal government cannot predict exactly how the economy, (the aggregate spending and saving habits of every individual in the nation) will behave over the course of the next five years. Because the economic situation in the future will be based upon the actions of individuals acting on their subjective preferences, these preferences are impossible to predict. The failure of every socialist government, whether totalitarian or democratic, to fulfill its leaders’ promises of unlimited economic prosperity demonstrates the futility of government planning based upon the economic forecasts of government officials.

It is, however, only a matter of time before the burden of taxes, spending, debt, and inflation catapult America’s economy into yet another recession. When the optimistic projections of growth prove to be based more in hope than reality, the budget figures will be “revised” and a future Congress will once again confront the questions of balancing the budget.

B. THE BUDGET DEAL CONTINUES UNCONSTITUTIONAL FEDERAL PROGRAMS

Even if the budget being considered by this Congress were guaranteed to balance the budget within five years, it should still be rejected because it fails to eliminate even one unconstitutional function of the federal government. Despite proclamations that “the era of Big Government is over,” this budget actually increases taxpayer spending for many unconstitutional programs. The main problem with government policy today is not that the government cannot

balance its books, but that the federal government is performing too many functions for which it lacks any constitutional authority.

II. SPECIFIC OBJECTIONS TO THE WELFARE-TO-WORK PROPOSAL

The reconciliation package, with its authorization of an additional three billion dollars for a welfare-to-work program, is a perfect example of how the budget proposal fails to address the basic question of how the welfare state exceeds the constitutional limitations on the power of the federal government. Under the tenth amendment to the United States Constitution, the federal government has no authority to take money from the people of Texas to spend on welfare programs for the people of New York. Welfare and job training programs are strictly the province of the individual states.

The reconciliation proposal not only unconstitutionally spends federal taxpayer funds on welfare programs, it dictates to the states how they must run their welfare-to-work programs. For example, states are required to spend one dollar of their own money for every three dollars of federal money they receive, and they must distribute the funds according to a pre-determined federal formula.

Short of defunding all welfare programs and transferring responsibility for those programs back to the states and the people, Congress should provide maximum flexibility to the states to manage these programs as state officials see fit. For example, the amendment offered and later withdrawn by Mr. Johnson to allow state governments to use nongovernmental personnel in the determination of eligibility under the Medicaid, Food Stamp, and special supplemental nutrition programs for Women, Infants, and Children, is a step toward restoring federalism in welfare policy. It is not for Washington to determine the strengths and weaknesses of such a plan, these decisions are solely the responsibility of the states.

In the name of transferring citizens from welfare to work, this bill provides millions of taxpayer dollars to move businesses onto the welfare rolls. Under this proposal, state governments may hand over taxpayer dollars to businesses for private sector job "creation," employment, wage subsidies, on-the-job training, contacts with job placement companies, and job vouchers. By providing payments to private businesses who place and hire welfare recipients, Congress is creating a dangerous and powerful new constituency for welfare programs and, in effect, making it more difficult for future Congresses to reduce welfare expenditures.

The welfare-to-work proposal also creates powerful disincentives for businesses to give welfare recipients a chance at a new life through an entry-level job. If this proposal becomes law, welfare recipients in entry-level jobs will be entitled to receive the minimum wage and be covered by certain health and safety regulations. Because mandating wages and benefits increases the costs to businesses of hiring new workers, any wage, safety, or health regulations discourage the hiring of new employees. This is especially true in the case of marginal employees who lack well-developed job skills. This bill restricts welfare recipients' ability to find gainful employment; the very population this bill is allegedly targeted to benefit!

It is time to return to the most effective job creation machine in history—the free market. Any alternative necessarily results in suboptimal employment. Government is institutionally incapable of creating bonafide jobs. Private citizens acting freely are more than capable of caring for the needs of the less fortunate if the federal government stops appropriating so many of their resources for wasteful, bureaucratic, federal programs.

III. CONCLUSION

The proposal to spend three billion in additional taxpayer dollars should be rejected by Congress for several reasons. First, it is part of a phony balanced budget plan whose projections rest on two dubious notions. 1. Government can predict the economic future of the country 2. The burden of taxes and spending placed on the economy by government will not cause America to experience an economic downturn.

Secondly, this proposal continues the federal government's unconstitutional micro-managing of state welfare programs. This bill extends corporate welfare in the form of subsidies to businesses which hire current welfare recipients thus creating a new client group for the welfare state.

The only way to permanently balance the budget and end welfare as we know it is to cease all federal expenditures for redistributionist programs not authorized under the United States Constitution. Therefore, all members of the House of Representatives sincerely committed to limited government must oppose this proposal and instead work to defund all unconstitutional programs and return the authority for welfare programs to those best able to manage them.

RON PAUL.

