Union Calendar No. 89

105TH CONGRESS
1ST SESSION

H. R. 2015

[Report No. 105–149]

A BILL

To provide 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

Reported from the Committee on the Budget; committed to the Committee of the Whole House on the State of the Union and ordered to be printed

105TH CONGRESS
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[Report No. 105–149]

To provide for reconciliation pursuant to subsections (b)(1) and (c) of section 105 of the concurrent resolution on the budget for fiscal year 1998.

IN THE HOUSE OF REPRESENTATIVES

JUNE 24, 1997

Mr. KASICH from the Committee on the Budget, reported the following bill; which was committed to the Committee of the Whole House on the State of the Union and ordered to be printed

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A BILL

To provide for reconciliation pursuant to subsections (b)(1) and (c) of section 105 of the concurrent resolution on the budget for fiscal year 1998.

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

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

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 em-

ployment 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:

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 licencees 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 Ad-

ministration 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 deter-

mines 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 Im-

pact 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))."

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 Commis-

sion 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 govern-

mental 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:

(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 per-

mits 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 per-

cent 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 provi-

sion 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 deter-

mined 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 por-

tion 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 pro-

gram 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 effective-

ness 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 Jan-

uary 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 pay-

ment 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 Om-

nibus 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 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 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 an 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 noncompliance 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 ini-

tially 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 orga-

nization 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. 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 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 par-

ticipate 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 PRE-EXISTING 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 for 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 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 prepregnancy 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.''.

(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(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 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:

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 serv-

ices, 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 num-

bers 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, coinsurance, 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 AVAIL-

ABLE 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 (begin-

ning 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 en-

rollment 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 (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 re-

sult 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 para-

graphs (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 determination (or determination on the reconsideration) as expeditiously as the en-

rollee'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 pro-

fessional'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 indi-

vidual 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 1/12 of the annual MedicarePlus capitation rate (as calculated under subsection (c)) with respect to that indi-

vidual 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 re-

quire 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, 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 sec-

tion 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 ad-

justed 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 pay-

ment 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 estab-

lished 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', 'consoli-

dated 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 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 orga-

nization 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 sec-

tion 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 ex-

perience (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 in-

dividual, 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 Sec-

retary) 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 ap-

plication. 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 grant-

ed 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 ne-

gotiated 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 pro-

vide 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 orga-

nization) 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) writ-

ten 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 organiza-

tion 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 re-

spect 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 estab-

lished 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 organiza-

tions 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 sec-

tion 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 then 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)''; and

(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 av-

erage 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 gyne-

cology 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 at-

tributable 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 simi-

lar 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.—he 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 sec-

tion 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 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. 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, includ-

ing 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 re-

view 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 Rep-

resentatives 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 person-

nel 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 respec-

tive 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 organiza-

tion 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 Se-

curity 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 regu-

latory 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), infor-

mation 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 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 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''; 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 Sec-

retary, 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 rel-

ative 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, in-

cluding glysolated 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 informa-

tion 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 an 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 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) 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 inserting ''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 inserting before the period at the end the following: ''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. 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 enti-

ties 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 Sec-

retary, 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 in-

serted 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 sub-

paragraph (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 in-

crease 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. 1395l(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. 1395l(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. 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 reha-

bilitation 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 fis-

cal 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:

''(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 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 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) 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 be-

ginning 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 appro-

priate 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 deter-

mined 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 amend-

ed 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 de-

fined 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 percentage/100)) -1; or

''(ii) less than 100 times the following amount: (0.93 + (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 physi-

cians' 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 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. 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;''.

(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. 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 lab-

oratory 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 inter-

ested 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 in-

travenous anti-emetics 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. 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 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 physi-

cian'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 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)''; 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 (im-

posed 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 cir-

cumstances 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, 1/7.

''(ii) For a month in 1999, 2/7.

''(iii) For a month in 2000, 3/7.

''(iv) For a month in 2001, 4/7.

''(v) For a month in 2002, 5/7.

''(vi) For a month in 2003, 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 Committees 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 appro-

priate 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 resi-

dents 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 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 subpara-

graph (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 para-

graph (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 rec-

ommendations 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 nonphysician health profes-

sions, 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. Contract-

ing 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 re-

quired 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 Is-

lands, 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 convinc-

ing 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 dam-

ages, 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 noneconomic 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 con-

tributed 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

subpargraph (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, ½ of the sum of—

''(aa) the percentage represented by the number of indi-

viduals 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 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 ac-

cordance 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.''.

(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 collec-

tive 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 rel-

evant 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 noncompliance.''.

(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 adjust-

ments 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 de-

faulted 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 col-

lects 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 ben-

efits 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 em-

ployer 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(e)(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 adminis-

tration, 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 mat-

ters 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 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 outstand-

ing 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 tem-

porary 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. 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 employ-

ees 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 Sec-

retary 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 employ-

ee'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 Sec-

retary'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 Janu-

ary 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.
	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.

	"Percentage of basic pay	Service period
	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 firefighter for firefighter service	2.50	August 1, 1920, to
	3.50	June 30, 1926.
		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.

	"Percentage of basic pay	Service period
	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.
	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.

	"Percentage of basic pay	Service period
	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 (re-

lating 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.
	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 action, 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 subsection (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:

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 de-

termines 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 Rep-

resentatives 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)''; and

(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:

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, 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, ⅓ 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 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 coordiate 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 subpara-

graph (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 ap-

plies, 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 griev-

ances 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 greivance 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 recieving 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 ASSIST-

ANCE.—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 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).''.

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 noncompliance.''.

(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 REDISCLOSURES 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 para-

graph (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)), para-

graph 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'.—';

(3) 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:

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 en-

rolled 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, coinsurance, 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 re-

quired 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 indi-

vidual'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 re-

gional 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 indi-

viduals 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 re-

ceipt 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 be-

tween 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, reg-

istered 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 re-

ducing 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 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 par-

ties) 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 pay-

ment 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 'pri-

mary 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 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 orga-

nization 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 sec-

tion 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 ex-

perience (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 in-

dividual, 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 Sec-

retary) 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 established under the pre-

ceding 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) writ-

ten 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 organiza-

tion 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 Sec-

retary 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 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. 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 then 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 cal-

endar 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 promul-

gated 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 re-

spect 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 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 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 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 dem-

onstration 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 sub-

section 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 informa-

tion 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 dem-

onstration 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 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 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 con-

ducted 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 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—

(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 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. 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 de-

scribed 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 per-

mitting 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 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 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''; 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 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''; 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''; 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 dia-

betic 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 indi-

viduals (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 glysolated 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 Sec-

retary 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 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 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 Se-

curity 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 DISPROPORTIONATELY 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 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. 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 an 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 per-

son 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 inserting ''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 inserting before the period at the end the following: ''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''.

(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 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 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 electrocardiagram equipment for electro-

cardiogram 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 preced-

ing 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 report-

ing 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 stand-

ardize 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 Sec-

retary 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 Sec-

retary 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, tech-

nology, 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) cov-

ering 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 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-de-

ductible 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. 1395l(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. 1395l(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. 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. 10421. 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 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(l);''.

(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:

''(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 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) 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 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 be-

ginning 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 appro-

priate 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 deter-

mined 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 amend-

ed 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 dis-

charges 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) 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 Septem-

ber 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 addi-

tional 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 prospec-

tive 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 × (((1+r) to the nth power) −1),

''(II) during fiscal year 1998, is equal to 1.62 × (((1+r) to the nth power) −1), and

''(III) during or after fiscal year 1999, is equal to 1.35 × (((1+r) to the nth 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 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''; 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 per-

centage 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 ⅔ 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 ⅔ 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 de-

scribed 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 para-

graph (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) ⅙ for 1998,

''(II) ⅔ for 1999,

"(III) 3/6 for 2000,

"(IV) 4/6 for 2001, and

"(V) 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.''.

(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 fa-

cility 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 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.''.

(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 sub-

section 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 physi-

cians' 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 percentage/100)) - 1; or

''(ii) less than 100 times the following amount: (0.93 + (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 do-

mestic 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 IN-

CREASE'' 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 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 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 lab-

oratory 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 inter-

ested 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 pay-

ment 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 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 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. 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)''; 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. 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 per-

formed 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 sec-

tion 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 cir-

cumstances 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 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. 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 pay-

able 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 re-

porting 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 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 (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 subpara-

graph (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 para-

graph (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 rec-

ommendations 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 train-

ing in the various nonphysician 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 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.''.

(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 pursu-

ant 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 nonpecuniary 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 resolu-

tion 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 noneconomic 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 con-

tributed 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.