

Union Calendar No. 89

105<sup>TH</sup> CONGRESS  
1<sup>ST</sup> Session

**H. R. 2015**

[Report No. 105-149]

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**A BILL**

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

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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  
1ST SESSION

# H. R. 2015

[Report No. 105-149]

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## 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.

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

3       **SECTION 1. SHORT TITLE.**

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

1 **SEC. 2. TABLE OF CONTENTS.**

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

2 **TITLE I—COMMITTEE ON**  
 3 **AGRICULTURE**

4 **SEC. 1001. EXEMPTION.**

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

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

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

11 (3) by inserting after paragraph (4) the follow-  
 12 ing new paragraph:

13 “(5) 15-PERCENT EXEMPTION.—

14 “(A) DEFINITIONS.—In this paragraph:

15 “(i) CASELOAD.—The term ‘caseload’  
 16 means the average monthly number of in-  
 17 dividuals receiving food stamps during the  
 18 12-month period ending the preceding  
 19 June 30.

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

6                   “(I) is not eligible for an excep-  
7                   tion under paragraph (3);

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

11                  “(III) is not complying with sub-  
12                  paragraph (A), (B), or (C) of para-  
13                  graph (2);

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

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

18           “(B) GENERAL RULE.—Subject to sub-  
19           paragraphs (C) through (F), a State agency  
20           may provide an exemption from the require-  
21           ments of paragraph (2) for covered individuals.

22           “(C) FISCAL YEAR 1998.—Subject to sub-  
23           paragraph (E), for fiscal year 1998, a State  
24           agency may provide a number of exemptions  
25           such that the average monthly number of the

1 exemptions in effect during the fiscal year does  
2 not exceed 15 percent of the number of covered  
3 individuals in the State in fiscal year 1998, as  
4 estimated by the Secretary, based on the survey  
5 conducted to carry out section 16(c) for fiscal  
6 year 1996 and such other factors as the Sec-  
7 retary considers appropriate due to the timing  
8 and limitations of the survey.

9 “(D) SUBSEQUENT FISCAL YEARS.—Sub-  
10 ject to subparagraphs (E) and (F), for fiscal  
11 year 1999 and each subsequent fiscal year, a  
12 State agency may provide a number of exemp-  
13 tions such that the average monthly number of  
14 the exemptions in effect during the fiscal year  
15 does not exceed 15 percent of the number of  
16 covered individuals in the State, as estimated  
17 by the Secretary under subparagraph (C), ad-  
18 justed by the Secretary to reflect changes in the  
19 State’s caseload and the Secretary’s estimate of  
20 changes in the proportion of food stamp recipi-  
21 ents covered by waivers granted under para-  
22 graph (4).

23 “(E) CASELOAD ADJUSTMENTS.—The Sec-  
24 retary shall adjust the number of individuals es-  
25 timated for a State under subparagraph (C) or

1 (D) during a fiscal year if the number of food  
2 stamp recipients in the State varies by a signifi-  
3 cant number from the caseload, as determined  
4 by the Secretary.

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

15 “(G) REPORTING REQUIREMENT.—A State  
16 agency shall submit such reports to the Sec-  
17 retary as the Secretary determines are nec-  
18 essary to ensure compliance with this para-  
19 graph.”.

20 **SEC. 1002. ADDITIONAL FUNDING FOR EMPLOYMENT AND**  
21 **TRAINING.**

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

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

1 “(1) IN GENERAL.—

2 “(A) AMOUNTS.—To carry out employ-  
3 ment and training programs, the Secretary  
4 shall reserve for allocation to State agencies, to  
5 remain available until expended, from funds  
6 made available for each fiscal year under sec-  
7 tion 18(a)(1) the amount of—

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

9 “(ii) for fiscal year 1997,  
10 \$79,000,000;

11 “(iii) for fiscal year 1998,  
12 \$221,000,000;

13 “(iv) for fiscal year 1999,  
14 \$224,000,000;

15 “(v) for fiscal year 2000,  
16 \$226,000,000;

17 “(vi) for fiscal year 2001,  
18 \$228,000,000; and

19 “(vii) for fiscal year 2002,  
20 \$210,000,000.

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

23 “(i) the funds provided in this sub-  
24 paragraph shall not be used for food stamp  
25 recipients who receive benefits under a

1 State program funded under part A of title  
2 IV of the Social Security Act (42 U.S.C.  
3 601 et seq.); and

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

9 “(C) ALLOCATION.—

10 “(i) ALLOCATION FORMULA.—The  
11 Secretary shall allocate the amounts re-  
12 served under subparagraph (A) among the  
13 State agencies using a reasonable formula,  
14 as determined and adjusted by the Sec-  
15 retary each fiscal year, to reflect changes  
16 in each State’s caseload (as defined in sec-  
17 tion 6(o)(5)(A)) that reflects the propor-  
18 tion of food stamp recipients who reside in  
19 each State—

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

22 “(II) who do not reside in an  
23 area subject to the waiver granted by  
24 the Secretary under section 6(o)(4), if  
25 the State agency does not provide em-



1                   employment and training services in the  
2                   area to food stamp recipients not ex-  
3                   cepted by section 6(o)(3).

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

9                   “(D) REALLOCATION.—

10                   “(i) NOTIFICATION.—A State agency  
11                   shall promptly notify the Secretary if the  
12                   State agency determines that it will not ex-  
13                   pend all of the funds allocated to it under  
14                   subparagraph (B).

15                   “(ii) REALLOCATION.—On notification  
16                   under clause (i), the Secretary shall reallo-  
17                   cate the funds that the State agency will  
18                   not expend as the Secretary considers ap-  
19                   propriate and equitable.

20                   “(E) MINIMUM ALLOCATION.—Notwith-  
21                   standing subparagraphs (A) through (C), the  
22                   Secretary shall ensure that each State agency  
23                   operating an employment and training program  
24                   shall receive not less than \$50,000 for each fis-  
25                   cal year.

1           “(F) MAINTENANCE OF EFFORT.—To re-  
2           ceive the additional funding under subpara-  
3           graph (A), as provided by the amendment made  
4           by section 1002 of the Balanced Budget Act of  
5           1997, a State agency shall maintain the ex-  
6           penditures of the State agency for employment  
7           and training programs and workfare programs  
8           for any fiscal year under paragraph (2), and  
9           administrative expenses under section 20(g)(1),  
10          at a level that is not less than the level of the  
11          expenditures by the State agency to carry out  
12          the programs for fiscal year 1996.”;

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

15          (3) by inserting after paragraph (1) the follow-  
16          ing new paragraph:

17          “(2) REPORT TO CONGRESS ON ADDITIONAL  
18          FUNDING.—Beginning one year after the date of the  
19          enactment of this paragraph, the Secretary shall  
20          submit an annual report to the Committee on Agri-  
21          culture of the House of Representatives and the  
22          Committee on Agriculture, Nutrition, and Forestry  
23          of the Senate regarding whether the additional fund-  
24          ing provided under paragraph (1)(A) has been uti-  
25          lized by State agencies to increase the number of

1 work slots in their employment and training pro-  
2 grams and workfare for recipients subject to section  
3 6(o) in the most efficient and effective manner.”;  
4 and

5 (4) in paragraph (3) (as so redesignated), by  
6 striking “paragraph (3)” and inserting “paragraph  
7 (4)”.

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

13 (2) Subsection (d)(1)(B)(ii) of section 22 of such Act  
14 (7 U.S.C. 2031) is amended by striking “(h)(2), and  
15 (h)(3) of section 16” and inserting “(h)(3), and (h)(4) of  
16 section 16”.

17 **SEC. 1003. AUTHORIZING USE OF NONGOVERNMENTAL**  
18 **PERSONNEL IN MAKING DETERMINATIONS**  
19 **OF ELIGIBILITY FOR BENEFITS UNDER THE**  
20 **FOOD STAMP PROGRAM.**

21 (a) IN GENERAL.—Notwithstanding any other provi-  
22 sion of law, no provision of law shall be construed as pre-  
23 venting any State (as defined in section 3(m) of the Food  
24 Stamp Act of 1977 (7 U.S.C. 2012(m))) from allowing  
25 eligibility determinations described in subsection (b) to be

1 made by an entity that is not a State or local government,  
2 or by an individual who is not an employee of a State or  
3 local government, which meets such qualifications as the  
4 State determines. For purposes of any Federal law, such  
5 determinations shall be considered to be made by the State  
6 and by a State agency.

7 (b) ELIGIBILITY DETERMINATIONS.—An eligibility  
8 determination described in this subsection is a determina-  
9 tion of eligibility of individuals or households to receive  
10 benefits under the food stamp program as defined in sec-  
11 tion 3(h) of the Food Stamp Act of 1977 (7 U.S.C.  
12 2012(h)).

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

15 (1) the conditions for eligibility for benefits (in-  
16 cluding any conditions relating to income or re-  
17 sources);

18 (2) the rights to challenge determinations re-  
19 garding eligibility or rights to benefits; and

20 (3) determinations regarding quality control or  
21 error rates.

1 **TITLE II—COMMITTEE ON BANK-**  
 2 **ING AND FINANCIAL SERV-**  
 3 **ICES**

4 **SEC. 2001. TABLE OF CONTENTS.**

5 The table of contents for this title is as follows:

TITLE II—COMMITTEE ON BANKING AND FINANCIAL SERVICES

Sec. 2001. Table of contents.

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

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

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

6 **SEC. 2002. EXTENSION OF FORECLOSURE AVOIDANCE AND**  
 7 **BORROWER ASSISTANCE PROVISIONS FOR**  
 8 **FHA SINGLE FAMILY HOUSING MORTGAGE**  
 9 **INSURANCE PROGRAM.**

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

12 (1) in subsection (c)—

13 (A) by striking “only”; and

14 (B) by inserting “, on, or after” after “be-  
 15 fore”; and

16 (2) by striking subsection (e).

1 **SEC. 2003. ADJUSTMENT OF MAXIMUM MONTHLY RENTS**  
2 **FOR CERTAIN DWELLING UNITS IN NEW CON-**  
3 **STRUCTION AND SUBSTANTIAL OR MOD-**  
4 **ERATE REHABILITATION PROJECTS AS-**  
5 **SISTED UNDER SECTION 8 RENTAL ASSIST-**  
6 **ANCE PROGRAM.**

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

11 **SEC. 2004. ADJUSTMENT OF MAXIMUM MONTHLY RENTS**  
12 **FOR NON-TURNOVER DWELLING UNITS AS-**  
13 **SISTED UNDER SECTION 8 RENTAL ASSIST-**  
14 **ANCE PROGRAM.**

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

19 **TITLE III—COMMITTEE ON**  
20 **COMMERCE-NONMEDICARE**  
21 **Subtitle A—Nuclear Regulatory**  
22 **Commission Annual Charges**

23 **SEC. 3001. NUCLEAR REGULATORY COMMISSION ANNUAL**  
24 **CHARGES.**

25 Section 6101(a)(3) of the Omnibus Budget Reconcili-  
26 ation Act of 1990 (42 U.S.C. 2214(a)(3)) is amended by

1 striking “September 30, 1998” and inserting “September  
2 30, 2002”.

3 **Subtitle B—Lease of Excess Strategic**  
4 **Petroleum Reserve Capacity**

5 **SEC. 3101. LEASE OF EXCESS STRATEGIC PETROLEUM RE-**  
6 **SERVE CAPACITY.**

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

10 “USE OF UNDERUTILIZED FACILITIES

11 “SEC. 168. (a) AUTHORITY.—Notwithstanding any  
12 other provision of this title, the Secretary, by lease or oth-  
13 erwise, for any term and under such other conditions as  
14 the Secretary considers necessary or appropriate, may  
15 store in underutilized Strategic Petroleum Reserve facili-  
16 ties petroleum product owned by a foreign government or  
17 its representative. Petroleum products stored under this  
18 section are not part of the Strategic Petroleum Reserve  
19 and may be exported without license from the United  
20 States.

21 “(b) PROTECTION OF FACILITIES.—All agreements  
22 entered into pursuant to subsection (a) shall contain provi-  
23 sions providing for fees to fully compensate the United  
24 States for all costs of storage and removals of petroleum  
25 products, including the cost of replacement facilities neces-  
26 sitated as a result of any withdrawals.

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

9       “(d) AVAILABILITY OF FUNDS.—Funds collected  
10 through the leasing of Strategic Petroleum Reserve facili-  
11 ties authorized by subsection (a) after September 30,  
12 2002, shall be used by the Secretary of Energy without  
13 further appropriation for the purchase of oil for, and oper-  
14 ation and maintenance costs of, the Strategic Petroleum  
15 Reserve.”.

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

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

## 20       **Subtitle C—Sale of DOE Assets**

### 21       **SEC. 3201. SALE OF DOE SURPLUS URANIUM ASSETS.**

22       (a) IN GENERAL.—The Secretary of Energy shall,  
23 during the period fiscal year 1999 through fiscal year  
24 2002, sell 3.2 million pounds per year of natural and low-  
25 enriched uranium that the President has determined is not



1 necessary for national security needs. Such sales shall  
2 be—

3 (1) made for delivery after January 1, 1999;

4 (2) subject to a determination, for the period  
5 fiscal year 1999 through fiscal year 2002, by the  
6 Secretary under section 3112(d)(2)(B) of the USEC  
7 Privatization Act (42 U.S.C. 2297h–10(d)(2)(B));  
8 and

9 (3) made at a price not less than the fair mar-  
10 ket value of the uranium and in a manner that  
11 maximizes proceeds to the Treasury.

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

16 (b) COSTS.—The costs of making the sales required  
17 by subsection (a) shall be covered by the unobligated bal-  
18 ances of appropriations of the Department of Energy.

## 19 **Subtitle D—Communications**

### 20 **SEC. 3301. SPECTRUM AUCTIONS.**

21 (a) EXTENSION AND EXPANSION OF AUCTION AU-  
22 THORITY.—

23 (1) AMENDMENTS.—Section 309(j) of the Com-  
24 munications Act of 1934 (47 U.S.C. 309(j)) is  
25 amended—

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

3 “(1) GENERAL AUTHORITY.—If, consistent with  
4 the obligations described in paragraph (6)(E), mutu-  
5 ally exclusive applications are accepted for any ini-  
6 tial license or construction permit which will involve  
7 an exclusive use of the electromagnetic spectrum,  
8 then the Commission shall grant such license or per-  
9 mit to a qualified applicant through a system of  
10 competitive bidding that meets the requirements of  
11 this subsection.

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

16 “(A) that, as the result of the Commission  
17 carrying out the obligations described in para-  
18 graph (6)(E), are not mutually exclusive;

19 “(B) for public safety radio services, in-  
20 cluding private internal radio services used by  
21 non-Government entities, that—

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

24 “(ii) are not made commercially avail-  
25 able to the public;

1           “(C) for initial licenses or construction  
2 permits assigned by the Commission to existing  
3 terrestrial broadcast licensees for new terres-  
4 trial digital television services; or

5           “(D) for public telecommunications serv-  
6 ices, as defined in section 397(14) of the Com-  
7 munications Act of 1934 (47 U.S.C. 397(14)),  
8 when the license application is for channels re-  
9 served for noncommercial use.”;

10           (B) in paragraph (3)—

11           (i) by inserting after the second sen-  
12 tence the following new sentence: “The  
13 Commission shall, directly or by contract,  
14 provide for the design and conduct (for  
15 purposes of testing) of competitive bidding  
16 using a contingent combinatorial bidding  
17 system that permits prospective bidders to  
18 bid on combinations or groups of licenses  
19 in a single bid and to enter multiple alter-  
20 native bids within a single bidding round.”;

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

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

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

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

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

9 “(ii) after issuance of bidding rules, to  
10 ensure that interested parties have a suffi-  
11 cient time to develop business plans, assess  
12 market conditions, and evaluate the avail-  
13 ability of equipment for the relevant serv-  
14 ices.”;

15 (C) in paragraph (8)—

16 (i) by striking subparagraph (B); and

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

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

21 (E) in paragraph (13)(F), by striking  
22 “September 30, 1998” and inserting “the date  
23 of enactment of the Balanced Budget Act of  
24 1997”.

1           (2) CONFORMING AMENDMENT.—Subsection (i)  
2 of section 309 of the Communications Act of 1934  
3 (47 U.S.C. 309(i)) is repealed.

4           (3) EFFECTIVE DATE.—The amendment made  
5 by paragraph (1)(A) shall not apply with respect to  
6 any license or permit for which the Federal Commu-  
7 nications Commission has accepted mutually exclu-  
8 sive applications on or before the date of enactment  
9 of this Act.

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

12           (1) IN GENERAL.—The Federal Communica-  
13 tions Commission shall complete all actions nec-  
14 essary to permit the assignment, by September 30,  
15 2002, by competitive bidding pursuant to section  
16 309(j) of the Communications Act of 1934 (47  
17 U.S.C. 309(j)) of licenses for the use of bands of  
18 frequencies that—

19                   (A) individually span not less than 25  
20 megahertz, unless a combination of smaller  
21 bands can, notwithstanding the provisions of  
22 paragraph (7) of such section, reasonably be ex-  
23 pected to produce greater receipts;

24                   (B) in the aggregate span not less than  
25 100 megahertz;

1 (C) are located below 3 gigahertz;

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

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

7 (ii) been identified by the Secretary of  
8 Commerce pursuant to section 113 of the  
9 National Telecommunications and Infor-  
10 mation Administration Organization Act;

11 (iii) been allocated for Federal Gov-  
12 ernment use pursuant to section 305 of the  
13 Communications Act of 1934 (47 U.S.C.  
14 305);

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

17 (v) been allocated for unlicensed use  
18 pursuant to part 15 of the Commission's  
19 regulations (47 C.F.R. Part 15), if the  
20 competitive bidding for licenses would  
21 interfere with operation of end-user prod-  
22 ucts permitted under such regulations; and

23 (E) notwithstanding section 115(b)(1)(B)  
24 of the National Telecommunications and Infor-  
25 mation Administration Organization Act (47

1 U.S.C. 925(b)(1)(B)) or any proposal pursuant  
2 to such section, include frequencies at 1,710–  
3 1,755 megahertz.

4 (2) CRITERIA FOR REASSIGNMENT.—In making  
5 available bands of frequencies for competitive bid-  
6 ding pursuant to paragraph (1), the Commission  
7 shall—

8 (A) seek to promote the most efficient use  
9 of the spectrum;

10 (B) take into account the cost to incum-  
11 bent licensees of relocating existing uses to  
12 other bands of frequencies or other means of  
13 communication; and

14 (C) comply with the requirements of inter-  
15 national agreements concerning spectrum allo-  
16 cations.

17 (3) NOTIFICATION TO NTIA.—The Commission  
18 shall notify the Secretary of Commerce if—

19 (A) the Commission is not able to provide  
20 for the effective relocation of incumbent licens-  
21 ees to bands of frequencies that are available to  
22 the Commission for assignment; and

23 (B) the Commission has identified bands  
24 of frequencies that are—

1 (i) suitable for the relocation of such  
2 licensees; and

3 (ii) allocated for Federal Government  
4 use, but that could be reallocated pursuant  
5 to part B of the National Telecommuni-  
6 cations and Information Administration  
7 Organization Act (as amended by this  
8 Act).

9 (4) PROTECTION OF SPACE RESEARCH USES.—

10 The licenses assigned pursuant to paragraph (1)  
11 shall require licensees to avoid interference with  
12 communications in space research and earth explo-  
13 ration-satellite services authorized under notes 750A  
14 and US90 to section 2.106 of the regulations of the  
15 Federal Communications Commission (47 C.F.R.  
16 2.106) as in effect on the date of enactment of this  
17 Act.

18 (c) IDENTIFICATION AND REALLOCATION OF FRE-  
19 QUENCIES.—The National Telecommunications and Infor-  
20 mation Administration Organization Act (47 U.S.C. 901  
21 et seq.) is amended—

22 (1) in section 113, by adding at the end the fol-  
23 lowing new subsection:

24 “(f) ADDITIONAL REALLOCATION REPORT.—If the  
25 Secretary receives a notice from the Commission pursuant



1 to section 3301(b)(3) of the Balanced Budget Act of 1997,  
2 the Secretary shall prepare and submit to the President,  
3 the Commission, and the Congress a report recommending  
4 for reallocation for use other than by Federal Government  
5 stations under section 305 of the 1934 Act (47 U.S.C.  
6 305), bands of frequencies that are suitable for the uses  
7 identified in the Commission’s notice. The Commission  
8 shall, not later than one year after receipt of such report,  
9 prepare, submit to the President and the Congress, and  
10 implement, a plan for the immediate allocation and assign-  
11 ment of such frequencies under the 1934 Act to incumbent  
12 licences described in section 3301(b)(3) of the Balanced  
13 Budget Act of 1997.”; and

14           (2) in section 114(a)(1), by striking “(a) or  
15           (d)(1)” and inserting “(a), (d)(1), or (f)”.

16           (d) IDENTIFICATION AND REALLOCATION OF  
17 AUCTIONABLE FREQUENCIES.—The National Tele-  
18 communications and Information Administration Organi-  
19 zation Act (47 U.S.C. 901 et seq.) is amended—

20           (1) in section 113(b)—

21                   (A) by striking the heading of paragraph  
22           (1) and inserting “INITIAL REALLOCATION RE-  
23           PORT”;

1 (B) by inserting “in the first report re-  
2 quired by subsection (a)” after “recommend for  
3 reallocation” in paragraph (1);

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

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

9 “(3) SECOND REALLOCATION REPORT.—In ac-  
10 cordance with the provisions of this section, the Sec-  
11 retary shall recommend for reallocation in the sec-  
12 ond report required by subsection (a), for use other  
13 than by Federal Government stations under section  
14 305 of the 1934 Act (47 U.S.C. 305), a band or  
15 bands of frequencies that—

16 “(A) in the aggregate span not less than  
17 20 megahertz;

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

22 “(C) are located below 3 gigahertz; and

23 “(D) meet the criteria specified in para-  
24 graphs (1) through (5) of subsection (a).”; and  
25 (2) in section 115—

1 (A) in subsection (b), by striking “the re-  
2 port required by section 113(a)” and inserting  
3 “the initial reallocation report required by sec-  
4 tion 113(a)”; and

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

7 “(c) ALLOCATION AND ASSIGNMENT OF FRE-  
8 QUENCIES IDENTIFIED IN THE SECOND REALLOCATION  
9 REPORT.—With respect to the frequencies made available  
10 for reallocation pursuant to section 113(b)(3), the Com-  
11 mission shall, not later than one year after receipt of the  
12 second reallocation report required by such section, pre-  
13 pare, submit to the President and the Congress, and im-  
14 plement, a plan for the immediate allocation and assign-  
15 ment under the 1934 Act of all such frequencies in accord-  
16 ance with section 309(j) of such Act.”.

17 (e) MINIMUM RECOVERY FOR PUBLIC REQUIRED.—

18 (1) METHODOLOGY TO SECURE MINIMUM  
19 AMOUNTS REQUIRED.—In establishing, pursuant to  
20 section 309(j)(3) of the Communications Act of  
21 1934 (47 U.S.C. 309(j)(3)), a competitive bidding  
22 methodology with respect to the frequencies required  
23 to be assigned by competitive bidding under sub-  
24 section (b) of this section and section 115(c) of the  
25 National Telecommunications and Information Ad-

1       ministration Organization Act (47 U.S.C. 925(c)),  
2       the Commission shall establish procedures that are  
3       designed to secure winning bids totaling not less  
4       than two-thirds of \$7,500,000,000.

5               (2) AUTHORITY.—In establishing such meth-  
6       odology, the Commission is authorized—

7                       (A) to partition the total required to be ob-  
8       tained under paragraph (1) among separate  
9       competitive bidding proceedings, or among sep-  
10      arate bands, regions, or markets;

11                      (B) to void any such separated competitive  
12      bidding proceeding that fails to obtain the par-  
13      titioned subtotal that pertains to that proceed-  
14      ing; and

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

18               (3) LICENSES WITHHELD.—Notwithstanding  
19      any other requirement of this section, or the amend-  
20      ments made by this section, the Commission shall  
21      refrain from conducting any competitive bidding  
22      pursuant to the methodology established pursuant to  
23      this subsection unless the Commission determines  
24      that such methodology will secure winning bids to-  
25      taling not less than two-thirds of \$7,500,000,000.

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

11 **SEC. 3302. AUCTION OF RECAPTURED BROADCAST TELE-**  
12 **VISION SPECTRUM.**

13       Section 309(j) of the Communications Act of 1934  
14 (47 U.S.C. 309(j)) is amended by adding at the end the  
15 following new paragraph:

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

18           “(A) LIMITATIONS ON TERMS OF TERRES-  
19       TRIAL TELEVISION BROADCAST LICENSES.—A  
20       television license that authorizes analog tele-  
21       vision services may not be renewed to authorize  
22       such service for a period that extends beyond  
23       December 31, 2006. The Commission shall  
24       grant by regulation an extension of such date to  
25       licensees in a market if the Commission deter-

1 mines that more than 5 percent of households  
2 in such market continue to rely exclusively on  
3 over-the-air terrestrial analog television signals.

4 “(B) SPECTRUM REVERSION AND RE-  
5 SALE.—

6 “(i) The Commission shall ensure  
7 that, when the authority to broadcast ana-  
8 log television services under a license ex-  
9 pires pursuant to subparagraph (A), each  
10 licensee shall return spectrum according to  
11 the Commission’s direction and the Com-  
12 mission shall reclaim such spectrum.

13 “(ii) Licensees for new services occu-  
14 pying spectrum reclaimed pursuant to  
15 clause (i) shall be selected in accordance  
16 with this subsection. The Commission shall  
17 start such selection process by July 1,  
18 2001, with payment pursuant to rules es-  
19 tablished by the Commission under this  
20 subsection.

21 “(C) MINIMUM RECOVERY FOR PUBLIC RE-  
22 QUIRED.—

23 “(i) METHODOLOGY TO SECURE MINI-  
24 MUM AMOUNTS REQUIRED.—In establish-  
25 ing, pursuant to section 309(j)(3) of the

1           Communications Act of 1934 (47 U.S.C.  
2           309(j)(3)), a competitive bidding methodol-  
3           ogy with respect to the frequencies re-  
4           quired to be assigned by competitive bid-  
5           ding under subparagraph (B) of this para-  
6           graph, the Commission shall establish pro-  
7           cedures that are designed to secure win-  
8           ning bids totaling not less than two-thirds  
9           of \$4,000,000,000.

10           “(ii) AUTHORITY.—In establishing  
11           such methodology, the Commission is au-  
12           thorized—

13                   “(I) to partition the total re-  
14                   quired to be obtained under clause (i)  
15                   among separate competitive bidding  
16                   proceedings, or among separate  
17                   bands, regions, or markets;

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

22                   “(III) to prescribe minimum bids  
23                   or other bidding requirements to ob-  
24                   tain such aggregate total.

1           “(iii) LICENSES WITHHELD.—Not-  
2           withstanding any other requirement of this  
3           paragraph, the Commission shall refrain  
4           from conducting any competitive bidding  
5           pursuant to the methodology established  
6           pursuant to this subparagraph unless the  
7           Commission determines that such meth-  
8           odology will secure winning bids totaling  
9           not less than two-thirds of  
10          \$4,000,000,000.

11          “(iv) AUTHORITY TO REBID AT A  
12          LATER TIME TO SECURE STATUTORY OB-  
13          JECTIVES.—Nothing in clause (ii) or (iii)  
14          shall preclude or limit the Commission  
15          from assigning the frequencies described in  
16          clause (i) by competitive bidding at such  
17          later date (than the date required by this  
18          paragraph) as the Commission determines,  
19          in its discretion, will better attain the ob-  
20          jectives of recovering for the public a fair  
21          portion of the value of the public spectrum  
22          resource and avoiding unjust enrichment.

23          “(D) CERTAIN LIMITATIONS ON QUALIFIED  
24          BIDDERS PROHIBITED.—In prescribing any reg-  
25          ulations relating to the qualification of bidders



1 for spectrum reclaimed pursuant to subpara-  
2 graph (B)(i), the Commission shall not—

3 “(i) preclude any party from being a  
4 qualified bidder for spectrum that is allo-  
5 cated for any use that includes digital tele-  
6 vision service on the basis of—

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

9 “(II) the Commission’s news-  
10 paper cross-ownership rule (47 C.F.R.  
11 73.3555(d)); or

12 “(ii) apply either such rule to preclude  
13 such a party that is a successful bidder in  
14 a competitive bidding for such spectrum  
15 from using such spectrum for digital tele-  
16 vision service.

17 “(E) DEFINITIONS.—As used in this para-  
18 graph:

19 “(i) The term ‘digital television serv-  
20 ice’ means television service provided using  
21 digital technology to enhance audio quality  
22 and video resolution, as further defined in  
23 the Memorandum Opinion, Report, and  
24 Order of the Commission entitled ‘Ad-  
25 vanced Television Systems and Their Im-

1 pact Upon the Existing Television Service’,  
2 MM Docket No. 87–268 and any subse-  
3 quent Commission proceedings dealing  
4 with digital television.

5 “(ii) The term ‘analog television serv-  
6 ice’ means service provided pursuant to the  
7 transmission standards prescribed by the  
8 Commission in section 73.682(a) of its reg-  
9 ulation (47 CFR 73.682(a)).”.

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

12 (a) IN GENERAL.—The Federal Communications  
13 Commission shall, not later than January 1, 1998, allocate  
14 on a national, regional, or market basis, from radio spec-  
15 trum between 746 megahertz and 806 megahertz—

16 (1) 24 megahertz of that spectrum for public  
17 safety services according to the terms and conditions  
18 established by the Commission, unless the Commis-  
19 sion determines that the needs for public safety serv-  
20 ices can be met in particular areas with allocations  
21 of less than 24 megahertz; and

22 (2) the remainder of that spectrum for commer-  
23 cial purposes to be assigned by competitive bidding  
24 in accordance with section 309(j).

25 (b) ASSIGNMENT.—The Commission shall—

1           (1) assign the licenses for public safety created  
2           pursuant to subsection (a) no later than March 31,  
3           1998; and

4           (2) commence competitive bidding for the com-  
5           mercial licenses created pursuant to subsection (a)  
6           no later than July 1, 2001.

7           (c) LICENSING OF UNUSED FREQUENCIES FOR PUB-  
8           LIC SAFETY RADIO SERVICES.—

9           (1) USE OF UNUSED CHANNELS FOR PUBLIC  
10          SAFETY.—It shall be the policy of the Commission,  
11          notwithstanding any other provision of this Act or  
12          any other law, to waive whatever licensee eligibility  
13          and other requirements (including bidding require-  
14          ments) are applicable in order to permit the use of  
15          unassigned frequencies for public safety purposes by  
16          a State or local governmental agency upon a show-  
17          ing that—

18                 (A) no other existing satisfactory public  
19                 safety channel is immediately available to sat-  
20                 isfy the requested use;

21                 (B) the proposed use is technically feasible  
22                 without causing harmful interference to existing  
23                 stations in the frequency band entitled to pro-  
24                 tection from such interference under the rules  
25                 of the Commission; and

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

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

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

14               (1) establish interference limits at the bound-  
15               aries of the spectrum block and service area;

16               (2) establish any additional technical restric-  
17               tions necessary to protect full-service analog tele-  
18               vision service and digital television service during a  
19               transition to digital television service; and

20               (3) permit public safety and commercial licens-  
21               ees—

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

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

1 (e) MINIMUM RECOVERY FOR PUBLIC REQUIRED.—

2 (1) METHODOLOGY TO SECURE MINIMUM  
3 AMOUNTS REQUIRED.—In establishing, pursuant to  
4 section 309(j)(3) of the Communications Act of  
5 1934 (47 U.S.C. 309(j)(3)), a competitive bidding  
6 methodology with respect to the frequencies required  
7 to be assigned by competitive bidding under this sec-  
8 tion, the Commission shall establish procedures that  
9 are designed to secure winning bids totaling not less  
10 than two-thirds of \$1,900,000,000.

11 (2) AUTHORITY.—In establishing such meth-  
12 odology, the Commission is authorized—

13 (A) to partition the total required to be ob-  
14 tained under paragraph (1) among separate  
15 competitive bidding proceedings, or among sep-  
16 arate bands, regions, or markets;

17 (B) to void any such separated competitive  
18 bidding proceeding that fails to obtain the par-  
19 tioned subtotal that pertains to that proceed-  
20 ing; and

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

24 (3) LICENSES WITHHELD.—Notwithstanding  
25 any other requirement of this section, the Commis-

1       sion shall refrain from conducting any competitive  
2       bidding pursuant to the methodology established  
3       pursuant to this subsection unless the Commission  
4       determines that such methodology will secure win-  
5       ning bids totaling not less than two-thirds of  
6       \$1,900,000,000.

7               (4) AUTHORITY TO REBID AT A LATER TIME TO  
8       SECURE STATUTORY OBJECTIVES.—Nothing in para-  
9       graph (2) or (3) shall preclude or limit the Commis-  
10      sion from assigning the frequencies described in  
11      paragraph (1) by competitive bidding at such later  
12      date (than the date required by this section) as the  
13      Commission determines, in its discretion, will better  
14      attain the objectives of recovering for the public a  
15      fair portion of the value of the public spectrum re-  
16      source and avoiding unjust enrichment.

17              (f) PROTECTION OF QUALIFYING LOW-POWER STA-  
18      TIONS.—Prior to making any allocation or assignment  
19      under this section the Commission shall assure that each  
20      qualifying low-power television station is assigned a fre-  
21      quency below 746 megahertz to permit the continued oper-  
22      ation of such station.

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

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

1           (2) DIGITAL TELEVISION SERVICE.—The term  
2           “digital television service” means television service  
3           provided using digital technology to enhance audio  
4           quality and video resolution, as further defined in  
5           the Memorandum Opinion, Report, and Order of the  
6           Commission entitled ‘Advanced Television Systems  
7           and Their Impact Upon the Existing Television  
8           Service’, MM Docket No. 87–268 and any subse-  
9           quent Commission proceedings dealing with digital  
10          television.

11          (3) ANALOG TELEVISION SERVICE.—The term  
12          “analog television service” means services provided  
13          pursuant to the transmission standards prescribed  
14          by the Commission in section 73.682(a) of its regu-  
15          lation (47 CFR 73.682(a)).

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

18                 (A) the sole or principal purpose of which  
19                 is to protect the safety of life, health, or prop-  
20                 erty;

21                 (B) that are provided—

22                         (i) by State or local government enti-  
23                         ties; or

24                         (ii) by nongovernmental, private orga-  
25                         nizations that are authorized by a govern-

1                   mental entity whose primary mission is the  
2                   provision of such services; and

3                   (C) that are not made commercially avail-  
4                   able to the public by the provider.

5                   (5) SERVICE AREA.—The term “service area”  
6                   means the geographic area over which a licensee  
7                   may provide service and is protected from inter-  
8                   ference.

9                   (6) SPECTRUM BLOCK.—The term “spectrum  
10                  block” means the range of frequencies over which  
11                  the apparatus licensed by the Commission is author-  
12                  ized to transmit signals.

13                  (7) QUALIFYING LOW-POWER TELEVISION STA-  
14                  TIONS.—A station is a qualifying low-power tele-  
15                  vision station if—

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

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

20                                 (ii) such station broadcast an average  
21                                 of at least 3 hours per week of program-  
22                                 ming that was produced within the com-  
23                                 munity of license of such station; and



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

4 (B) the Commission determines that the  
 5 public interest, convenience, and necessity  
 6 would be served by treating the station as a  
 7 qualifying low-power television station for pur-  
 8 poses of this section.

9 **SEC. 3304. INQUIRY REQUIRED.**

10 The Federal Communications Commission shall, not  
 11 later than July 1, 1997, initiate the inquiry required by  
 12 section 309(j)(12) of the Communications Act of 1934 (47  
 13 U.S.C. 309(j)(12)) for the purposes of collecting the infor-  
 14 mation required for its report under each of subpara-  
 15 graphs (A) through (E) of such section, and shall keep  
 16 the Congress fully and currently informed with respect to  
 17 the progress of such inquiry.

18 **Subtitle E—Medicaid**

19 **SEC. 3400. TABLE OF CONTENTS OF SUBTITLE; REF-**  
 20 **ERENCES.**

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

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

CHAPTER 1—STATE FLEXIBILITY

SUBCHAPTER A—USE OF MANAGED CARE

Sec. 3401. State options to provide benefits through managed care entities.

Sec. 3402. Elimination of 75:25 restriction on risk contracts.

- Sec. 3403. Primary care case management services as State option without need for waiver.
- Sec. 3404. Change in threshold amount for contracts requiring Secretary's prior approval.
- Sec. 3405. Determination of hospital stay.

## SUBCHAPTER B—PAYMENT METHODOLOGY

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

## SUBCHAPTER C—ELIGIBILITY

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

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

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

## SUBCHAPTER E—BENEFITS

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

## SUBCHAPTER F—ADMINISTRATION

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

## CHAPTER 2—QUALITY ASSURANCE

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

#### CHAPTER 3—FEDERAL PAYMENTS

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

1           (b) AMENDMENTS TO SOCIAL SECURITY ACT.—Ex-  
 2 cept as otherwise specifically provided, whenever in this  
 3 subtitle an amendment is expressed in terms of an amend-  
 4 ment to or repeal of a section or other provision, the ref-  
 5 erence is considered to be made to that section or other  
 6 provision of the Social Security Act.

### 7           **CHAPTER 1—STATE FLEXIBILITY**

#### 8           **Subchapter A—Use of Managed Care**

##### 9           **SEC. 3401. STATE OPTIONS TO PROVIDE BENEFITS** 10                                   **THROUGH MANAGED CARE ENTITIES.**

11           (a) IN GENERAL.—Section 1915(a) (42 U.S.C.  
 12 1396n(a)) is amended—

13                   (1) by striking “or” at the end of paragraph

14                   (1),

15                   (2) by striking the period at the end of para-  
 16                   graph (2) and inserting “; or”, and

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

1           “(3) requires individuals, other than special  
2 needs children (as defined in subsection (i)), eligible  
3 for medical assistance for items or services under  
4 the State plan to enroll with an entity that provides  
5 or arranges for services for enrollees under a con-  
6 tract pursuant to section 1903(m), or with a pri-  
7 mary care case manager (as defined in section  
8 1905(t)(2)) (or restricts the number of provider  
9 agreements with those entities under the State plan,  
10 consistent with quality of care), if—

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

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

21           “(ii) with respect to a rural area—

22           “(I) individuals who are required to  
23 enroll with a single entity are afforded the  
24 option to obtain covered services by an al-  
25 ternative provider; and

1           “(II) an individual who is offered no  
2           alternative to a single entity or manager is  
3           given a choice between at least two provid-  
4           ers within the entity or through the man-  
5           ager;

6           “(C) no individual who is an Indian (as de-  
7           fined in section 4 of the Indian Health Care  
8           Improvement Act of 1976) is required to enroll  
9           in any entity that is not one of the following  
10          (and only if such entity is participating under  
11          the plan): the Indian Health Service, an Indian  
12          health program operated by an Indian tribe or  
13          tribal organization pursuant to a contract,  
14          grant, cooperative agreement, or compact with  
15          the Indian Health Service pursuant to the In-  
16          dian Self-Determination Act (25 U.S.C. 450 et  
17          seq.), or an urban Indian health program oper-  
18          ated by an urban Indian organization pursuant  
19          to a grant or contract with the Indian Health  
20          Service pursuant to title V of the Indian Health  
21          Care Improvement Act (25 U.S.C. 1601 et  
22          seq.);

23          “(D) the State restricts those individuals  
24          from changing their enrollment without cause  
25          for periods no longer than six months (and per-

1 mits enrollees to change enrollment for cause at  
2 any time);

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

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

13 (b) SPECIAL NEEDS CHILDREN DEFINED.—Section  
14 1915 (42 U.S.C. 1396n) is amended by adding at the end  
15 the following:

16 “(i) For purposes of subsection (a)(3), the term ‘spe-  
17 cial needs child’ means an individual under 19 years of  
18 age who—

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

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

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

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

1 (c) CONFORMING AMENDMENT TO RISK-BASED AR-  
2 RANGEMENTS.—Section 1903(m)(2) (42 U.S.C.  
3 1396b(m)(2)) is amended—

4 (1) in paragraph (A)(vi)—

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

7 (B) by striking all that follows “to termi-  
8 nate such enrollment” and inserting “in accord-  
9 ance with the provisions of subparagraph (F);”;  
10 and

11 (2) in subparagraph (F)—

12 (A) by striking “In the case of—” and all  
13 that follows through “a State plan” and insert-  
14 ing “A State plan”, and

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

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

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

22 (a) 75 PERCENT LIMIT ON MEDICARE AND MEDIC-  
23 AID ENROLLMENT.—

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

4           (2) CONFORMING AMENDMENTS.—Section  
5 1903(m)(2) (42 U.S.C. 1396b(m)(2)) is amended—

6           (A) by striking subparagraphs (C), (D),  
7 and (E); and

8           (B) in subparagraph (G), by striking  
9 “clauses (i) and (ii)” and inserting “clause (i)”.

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

13 **SEC. 3403. PRIMARY CARE CASE MANAGEMENT SERVICES**  
14 **AS STATE OPTION WITHOUT NEED FOR WAIV-**  
15 **ER.**

16          (a) OPTIONAL COVERAGE AS PART OF MEDICAL AS-  
17 SISTANCE.—Section 1905(a) (42 U.S.C. 1396d(a)) is  
18 amended—

19           (1) by striking “and” at the end of paragraph  
20 (24);

21           (2) by redesignating paragraph (25) as para-  
22 graph (26) and by striking the period at the end of  
23 such paragraph and inserting a comma; and

24           (3) by inserting after paragraph (24) the fol-  
25 lowing new paragraph:



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

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

6           “(t)(1) The term ‘primary care case management  
7     services’ means case-management related services (includ-  
8     ing coordination and monitoring of health care services)  
9     provided by a primary care case manager under a primary  
10    care case management contract.

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

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

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

20                 “(ii) at State option—

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

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

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

3           “(3) The term ‘primary care case management con-  
4 tract’ means a contract with a State agency under which  
5 a primary care case manager undertakes to locate, coordi-  
6 nate and monitor covered primary care (and such other  
7 covered services as may be specified under the contract)  
8 to all individuals enrolled with the primary care case man-  
9 ager, and which provides for—

10                   “(A) reasonable and adequate hours of oper-  
11 ation, including 24-hour availability of information,  
12 referral, and treatment with respect to medical  
13 emergencies;

14                   “(B) restriction of enrollment to individuals re-  
15 siding sufficiently near a service delivery site of the  
16 entity to be able to reach that site within a reason-  
17 able time using available and affordable modes of  
18 transportation;

19                   “(C) employment of, or contracts or other ar-  
20 rangements with, sufficient numbers of physicians  
21 and other appropriate health care professionals to  
22 ensure that services under the contract can be fur-  
23 nished to enrollees promptly and without com-  
24 promise to quality of care;

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

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

11          “(4) For purposes of this subsection, the term ‘pri-  
12 mary care’ includes all health care services customarily  
13 provided in accordance with State licensure and certifi-  
14 cation laws and regulations, and all laboratory services  
15 customarily provided by or through, a general practitioner,  
16 family medicine physician, internal medicine physician, ob-  
17 stetrician/gynecologist, or pediatrician.”.

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

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

22           (2) in subsection (j), by striking “(25)” and in-  
23 serting “(26)”.

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

4 **SEC. 3404. CHANGE IN THRESHOLD AMOUNT FOR CON-**  
5 **TRACTS REQUIRING SECRETARY'S PRIOR AP-**  
6 **PROVAL.**

7 (a) IN GENERAL.—Section 1903(m)(2)(A)(iii) (42  
8 U.S.C. 1396b(m)(2)(A)(iii)) is amended by striking  
9 “\$100,000” and inserting “\$1,000,000 for 1998 and, for  
10 a subsequent year, the amount established under this  
11 clause for the previous year increased by the percentage  
12 increase in the consumer price index for all urban consum-  
13 ers over the previous year”.

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

17 **SEC. 3405. DETERMINATION OF HOSPITAL STAY.**

18 (a) IN GENERAL.—Title XIX, as amended by section  
19 3431(a), is amended—

20 (1) by redesignating section 1933 as section  
21 1934, and

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

24 “DETERMINATION OF HOSPITAL STAY

25 “SEC. 1933. (a) IN GENERAL.—A Medicaid health  
26 plan shall cover the length of an inpatient hospital stay

1 under this title as determined by the attending physician  
 2 (or other attending health care provider to the extent per-  
 3 mitted under State law) in consultation with the patient  
 4 to be medically appropriate.

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

7 “(1) as requiring the provision of inpatient cov-  
 8 erage if the attending physician (or other attending  
 9 health care provider to the extent permitted under  
 10 State law) and patient determine that a shorter pe-  
 11 riod of hospital stay is medically appropriate, or

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

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

## 18 **Subchapter B—Payment Methodology**

### 19 **SEC. 3411. FLEXIBILITY IN PAYMENT METHODS FOR HOS-** 20 **PITAL, NURSING FACILITY, AND ICF/MR SERV-** 21 **ICES; FLEXIBILITY FOR HOME HEALTH.**

22 (a) REPEAL OF BOREN REQUIREMENTS.—Section  
 23 1902(a)(13) (42 U.S.C. 1396a(a)) is amended—

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

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

6                   “(i) proposed rates are published, and  
7 providers, beneficiaries and their represent-  
8 atives, and other concerned State residents  
9 are given a reasonable opportunity for re-  
10 view and comment on the proposed rates;

11                   “(ii) final rates are published, to-  
12 gether with justifications, and

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

18           “(B) that the State shall provide assur-  
19 ances satisfactory to the Secretary that the av-  
20 erage level of payments under the plan for  
21 nursing facility services (as determined on an  
22 aggregate per resident-day basis) and the level  
23 of payments under the plan for inpatient hos-  
24 pital services (as determined on an aggregate  
25 hospital payment basis) furnished during the

1 18-month period beginning October 1, 1997, is  
2 not less than the average level of payments that  
3 would be made under the plan during such 18-  
4 month period for such respective services (de-  
5 termined on such basis) based on rates or pay-  
6 ment basis in effect as of May 1, 1997;” and  
7 (2) by striking subparagraph (C).

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

10 (1) by adding “and” at the end of subpara-  
11 graph (D),

12 (2) by striking “and” at the end of subpara-  
13 graph (E), and

14 (3) by striking subparagraph (F).

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

19 **SEC. 3412. PAYMENT FOR CENTER AND CLINIC SERVICES.**

20 (a) PHASE-OUT OF PAYMENT BASED ON REASON-  
21 ABLE COSTS.—Section 1902(a)(13)(E) (42 U.S.C.  
22 1396a(a)(13)(E)) is amended by inserting “(or 95 percent  
23 for services furnished during fiscal year 2000, 90 percent  
24 for service furnished during fiscal year 2001, and 85 per-

1 cent for services furnished during fiscal year 2002)” after  
2 “100 percent”.

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

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

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

9 (B) by inserting before the semicolon at  
10 the end the following: “and (ii) in carrying out  
11 clause (i) in the case of services furnished by a  
12 federally qualified health center or a rural  
13 health clinic pursuant to a contract between the  
14 center and a health maintenance organization  
15 under section 1903(m), for payment by the  
16 State of a supplemental payment equal to the  
17 amount (if any) by which the amount deter-  
18 mined under clause (i) exceeds the amount of  
19 the payments provided under such contract”.

20 (2) CONFORMING AMENDMENT TO MANAGED  
21 CARE CONTRACT REQUIREMENT.—Clause (ix) of sec-  
22 tion 1903(m)(2)(A) (42 U.S.C. 1396b(m)(2)(A)) is  
23 amended to read as follows:

24 “(ix) such contract provides, in the case of an  
25 entity that has entered into a contract for the provi-



1 sion of services with a federally qualified health cen-  
2 ter or a rural health clinic, that the entity shall pro-  
3 vide payment that is not less than the level and  
4 amount of payment which the entity would make for  
5 the services if the services were furnished by a pro-  
6 vider which is not a federally qualified health center  
7 or a rural health clinic;”.

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

11 (c) END OF TRANSITIONAL PAYMENT RULES.—Ef-  
12 fective for services furnished on or after October 1,  
13 2002—

14 (1) subparagraph (E) of section 1902(a)(13)  
15 (42 U.S.C. 1396a(a)(13)) is repealed, and

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

18 (d) FLEXIBILITY IN COVERAGE OF NON-FREE-  
19 STANDING LOOK-ALIKES.—

20 (1) IN GENERAL.—Section 1905(l)(2)(B)(iii)  
21 (42 U.S.C. 1396d(l)(2)(B)(iii)) is amended by in-  
22 sserting “and is not other than an entity that is  
23 owned, controlled, or operated by another provider”  
24 after “such a grant”.

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

4           (e) GAO REPORT.—By not later than February 1,  
5 2001, the Comptroller General shall submit to Congress  
6 a report on the impact of the amendments made by this  
7 section on access to health care for medicaid beneficiaries  
8 and the uninsured served at health centers and rural  
9 health clinics and the ability of health centers and rural  
10 health clinics to become integrated in a managed care sys-  
11 tem.

12 **SEC. 3413. TREATMENT OF STATE TAXES IMPOSED ON CER-**  
13 **TAIN HOSPITALS THAT PROVIDE FREE CARE.**

14           (a) EXCEPTION FROM TAX DOES NOT DISQUALIFY  
15 AS BROAD-BASED TAX.—Section 1903(w)(3) (42 U.S.C.  
16 1396b(w)(3)) is amended—

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

19           (2) by adding at the end the following:

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

1 (b) REDUCTION IN FEDERAL FINANCIAL PARTICIPA-  
 2 TION IN CASE OF IMPOSITION OF TAX.—Section 1903(b)  
 3 (42 U.S.C. 1396b(b)) is amended by adding at the end  
 4 the following:

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

11 (c) EFFECTIVE DATE.—The amendments made by  
 12 subsection (a) shall apply to taxes imposed before, on, or  
 13 after the date of the enactment of this Act and the amend-  
 14 ment made by subsection (b) shall apply to taxes imposed  
 15 on or after such date.

## 16 **Subchapter C—Eligibility**

### 17 **SEC. 3421. STATE OPTION OF CONTINUOUS ELIGIBILITY** 18 **FOR 12 MONTHS; CLARIFICATION OF STATE** 19 **OPTION TO COVER CHILDREN.**

20 (a) CONTINUOUS ELIGIBILITY OPTION.—Section  
 21 1902(e) (42 U.S.C. 1396a(e)) is amended by adding at  
 22 the end the following new paragraph:

23 “(12) At the option of the State, the plan may pro-  
 24 vide that an individual who is under an age specified by  
 25 the State (not to exceed 19 years of age) and who is deter-

1 mined to be eligible for benefits under a State plan ap-  
 2 proved under this title under subsection (a)(10)(A) shall  
 3 remain eligible for those benefits until the earlier of—

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

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

8           (b) CLARIFICATION OF STATE OPTION TO COVER  
 9 ALL CHILDREN UNDER 19 YEARS OF AGE.—Section  
 10 1902(l)(1)(D) (42 U.S.C. 1396a(l)(1)(D)) is amended by  
 11 inserting “(or, at the option of a State, after any earlier  
 12 date)” after “children born after September 30, 1983”.

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

16 **SEC. 3422. PAYMENT OF HOME-HEALTH-RELATED MEDI-**  
 17 **CARE PART B PREMIUM AMOUNT FOR CER-**  
 18 **TAIN LOW-INCOME INDIVIDUALS.**

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

21           (1) by striking “and” at the end of clause (ii),  
 22 and

23           (2) by inserting after clause (iii) the following:

24           “(iv) subject to section 1905(p)(4), for  
 25 making medical assistance available for the por-

1           tion of medicare cost sharing described in sec-  
2           tion 1905(p)(3)(A)(ii), that is attributable to  
3           the application under section 1839(a)(5) of sec-  
4           tion 1833(d)(2) for individuals who would be  
5           described in clause (iii) but for the fact that  
6           their income exceeds 120 percent, but is less  
7           than 175 percent, of the official poverty line  
8           (referred to in section 1905(p)(2)) for a family  
9           of the size involved;”.

10          (b) 100 PERCENT FEDERAL PAYMENT.—The third  
11         sentence of section 1905(b) (42 U.S.C. 1396d(b)) is  
12         amended by inserting “and with respect to amounts ex-  
13         pended for medical assistance described in section  
14         1902(a)(10)(E)(iv) for individuals described in such sec-  
15         tion” before the period at the end..

16         **SEC. 3423. PENALTY FOR FRAUDULENT ELIGIBILITY.**

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

20                 (1) by amending paragraph (6) to read as fol-  
21         lows:

22                 “(6) for a fee knowingly and willfully counsels  
23         or assists an individual to dispose of assets (includ-  
24         ing by any transfer in trust) in order for the individ-  
25         ual to become eligible for medical assistance under

1 a State plan under title XIX, if disposing of the as-  
2 sets results in the imposition of a period of ineligibil-  
3 ity for such assistance under section 1917(c),”;

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

9 **SEC. 3424. TREATMENT OF CERTAIN SETTLEMENT PAY-**  
10 **MENTS.**

11 Notwithstanding any other provision of law, the pay-  
12 ments made from any fund established pursuant to the  
13 settlement in the case of In re Factor VIII or IX Con-  
14 centrate Blood Products Litigation, MDL-986, no. 93-  
15 C7452 (N.D. Ill.) shall not be considered income or re-  
16 sources in determining eligibility for, or the amount of  
17 benefits under, a State plan of medical assistance ap-  
18 proved under title XIX of the Social Security Act.

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

21 **SEC. 3431. ESTABLISHMENT OF PACE PROGRAM AS MEDIC-**  
22 **AID STATE OPTION.**

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

24 (1) in section 1905(a) (42 U.S.C. 1396d(a)), as  
25 amended by section 3403(a)—

1 (A) by striking “and” at the end of para-  
2 graph (25);

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

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

7 “(26) services furnished under a PACE pro-  
8 gram under section 1932 to PACE program eligible  
9 individuals enrolled under the program under such  
10 section; and”;

11 (2) by redesignating section 1932 as section  
12 1933; and

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

15 “PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY

16 (PACE)

17 “SEC. 1932. (a) OPTION.—

18 “(1) IN GENERAL.—A State may elect to pro-  
19 vide medical assistance under this section with re-  
20 spect to PACE program services to PACE program  
21 eligible individuals who are eligible for medical as-  
22 sistance under the State plan and who are enrolled  
23 in a PACE program under a PACE program agree-  
24 ment. Such individuals need not be eligible for bene-  
25 fits under part A, or enrolled under part B, of title  
26 XVIII to be eligible to enroll under this section. In

1 the case of an individual enrolled with a PACE pro-  
2 gram pursuant to such an election—

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

6 “(B) the PACE provider shall receive pay-  
7 ment in accordance with the PACE program  
8 agreement for provision of such benefits.

9 A State may limit through its PACE program agree-  
10 ment the number of individuals who may be enrolled  
11 in a PACE program under the State plan.

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

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

19 “(B) COMPREHENSIVE BENEFITS.—The  
20 program provides comprehensive health care  
21 services to PACE program eligible individuals  
22 in accordance with the PACE program agree-  
23 ment and regulations under this section.

24 “(C) TRANSITION.—In the case of an indi-  
25 vidual who is enrolled under the program under



1 this section and whose enrollment ceases for  
2 any reason (including the individual no longer  
3 qualifies as a PACE program eligible individual,  
4 the termination of a PACE program agreement,  
5 or otherwise), the program provides assistance  
6 to the individual in obtaining necessary transi-  
7 tional care through appropriate referrals and  
8 making the individual’s medical records avail-  
9 able to new providers.

10 “(3) PACE PROVIDER DEFINED.—

11 “(A) IN GENERAL.—For purposes of this  
12 section, the term ‘PACE provider’ means an en-  
13 tity that—

14 “(i) subject to subparagraph (B), is  
15 (or is a distinct part of) a public entity or  
16 a private, nonprofit entity organized for  
17 charitable purposes under section  
18 501(c)(3) of the Internal Revenue Code of  
19 1986, and

20 “(ii) has entered into a PACE pro-  
21 gram agreement with respect to its oper-  
22 ation of a PACE program.

23 “(B) TREATMENT OF PRIVATE, FOR-PROF-  
24 IT PROVIDERS.—Clause (i) of subparagraph (A)  
25 shall not apply—

1                   “(i) to entities subject to a dem-  
2                   onstration project waiver under subsection  
3                   (h); and

4                   “(ii) after the date the report under  
5                   section 4014(b) of the Balanced Budget  
6                   Act of 1997 is submitted, unless the Sec-  
7                   retary determines that any of the findings  
8                   described in subparagraph (A), (B), (C) or  
9                   (D) of paragraph (2) of such section are  
10                  true.

11                 “(4) PACE PROGRAM AGREEMENT DEFINED.—  
12                 For purposes of this section, the term ‘PACE pro-  
13                 gram agreement’ means, with respect to a PACE  
14                 provider, an agreement, consistent with this section,  
15                 section 1894 (if applicable), and regulations promul-  
16                 gated to carry out such sections, between the PACE  
17                 provider, the Secretary, and a State administering  
18                 agency for the operation of a PACE program by the  
19                 provider under such sections.

20                 “(5) PACE PROGRAM ELIGIBLE INDIVIDUAL  
21                 DEFINED.—For purposes of this section, the term  
22                 ‘PACE program eligible individual’ means, with re-  
23                 spect to a PACE program, an individual who—

24                   “(A) is 55 years of age or older;

1           “(B) subject to subsection (c)(4), is deter-  
2           mined under subsection (e) to require the level  
3           of care required under the State medicaid plan  
4           for coverage of nursing facility services;

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

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

11          “(6) PACE PROTOCOL.—For purposes of this  
12          section, the term ‘PACE protocol’ means the Proto-  
13          col for the Program of All-inclusive Care for the El-  
14          derly (PACE), as published by On Lok, Inc., as of  
15          April 14, 1995.

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

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

1           “(B) Section 9412(b) of the Omnibus  
2           Budget Reconciliation Act of 1986 (Public Law  
3           99–509).

4           “(8) STATE ADMINISTERING AGENCY DE-  
5           FINED.—For purposes of this section, the term  
6           ‘State administering agency’ means, with respect to  
7           the operation of a PACE program in a State, the  
8           agency of that State (which may be the single agen-  
9           cy responsible for administration of the State plan  
10          under this title in the State) responsible for admin-  
11          istering PACE program agreements under this sec-  
12          tion and section 1894 in the State.

13          “(9) TRIAL PERIOD DEFINED.—

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

20                 “(B) TREATMENT OF ENTITIES PRE-  
21                 VIOUSLY OPERATING PACE DEMONSTRATION  
22                 WAIVER PROGRAMS.—Each contract year (in-  
23                 cluding a year occurring before the effective  
24                 date of this section) during which an entity has  
25                 operated a PACE demonstration waiver pro-

1           gram shall be counted under subparagraph (A)  
2           as a contract year during which the entity oper-  
3           ated a PACE program as a PACE provider  
4           under a PACE program agreement.

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

9           “(b) SCOPE OF BENEFITS; BENEFICIARY SAFE-  
10          GUARDS.—

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

13           “(A) provide to PACE program eligible in-  
14          dividuals, regardless of source of payment and  
15          directly or under contracts with other entities,  
16          at a minimum—

17           “(i) all items and services covered  
18          under title XVIII (for individuals enrolled  
19          under section 1894) and all items and  
20          services covered under this title, but with-  
21          out any limitation or condition as to  
22          amount, duration, or scope and without  
23          application of deductibles, copayments, co-  
24          insurance, or other cost-sharing that would

1 otherwise apply under such title or this  
2 title, respectively; and

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

6 “(B) provide such enrollees access to nec-  
7 essary covered items and services 24 hours per  
8 day, every day of the year;

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

14 “(D) specify the covered items and services  
15 that will not be provided directly by the entity,  
16 and to arrange for delivery of those items and  
17 services through contracts meeting the require-  
18 ments of regulations.

19 “(2) QUALITY ASSURANCE; PATIENT SAFE-  
20 GUARDS.—The PACE program agreement shall re-  
21 quire the PACE provider to have in effect at a mini-  
22 mum—

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

1           “(B) written safeguards of the rights of  
2 enrolled participants (including a patient bill of  
3 rights and procedures for grievances and ap-  
4 peals) in accordance with regulations and with  
5 other requirements of this title and Federal and  
6 State law designed for the protection of pa-  
7 tients.

8           “(c) ELIGIBILITY DETERMINATIONS.—

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

12           “(A) shall be made under and in accord-  
13 ance with the PACE program agreement, and

14           “(B) who is entitled to medical assistance  
15 under this title, shall be made (or who is not  
16 so entitled, may be made) by the State admin-  
17 istering agency.

18           “(2) CONDITION.—An individual is not a PACE  
19 program eligible individual (with respect to payment  
20 under this section) unless the individual’s health sta-  
21 tus has been determined, in accordance with regula-  
22 tions, to be comparable to the health status of indi-  
23 viduals who have participated in the PACE dem-  
24 onstration waiver programs. Such determination  
25 shall be based upon information on health status

1 and related indicators (such as medical diagnoses  
2 and measures of activities of daily living, instrumen-  
3 tal activities of daily living, and cognitive impair-  
4 ment) that are part of a uniform minimum data set  
5 collected by PACE providers on potential eligible in-  
6 dividuals.

7 “(3) ANNUAL ELIGIBILITY RECERTIFI-  
8 CATIONS.—

9 “(A) IN GENERAL.—Subject to subpara-  
10 graph (B), the determination described in sub-  
11 section (a)(5)(B) for an individual shall be re-  
12 evaluated at least once a year.

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

24 “(4) CONTINUATION OF ELIGIBILITY.—An indi-  
25 vidual who is a PACE program eligible individual



1        may be deemed to continue to be such an individual  
2        notwithstanding a determination that the individual  
3        no longer meets the requirement of subsection  
4        (a)(5)(B) if, in accordance with regulations, in the  
5        absence of continued coverage under a PACE pro-  
6        gram the individual reasonably would be expected to  
7        meet such requirement within the succeeding 6-  
8        month period.

9            “(5) ENROLLMENT; DISENROLLMENT.—The en-  
10        rollment and disenrollment of PACE program eligi-  
11        ble individuals in a PACE program shall be pursu-  
12        ant to regulations and the PACE program agree-  
13        ment and shall permit enrollees to voluntarily  
14        disenroll without cause at any time.

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

17            “(1) IN GENERAL.—In the case of a PACE pro-  
18        vider with a PACE program agreement under this  
19        section, except as provided in this subsection or by  
20        regulations, the State shall make prospective month-  
21        ly payments of a capitation amount for each PACE  
22        program eligible individual enrolled under the agree-  
23        ment under this section.

24            “(2) CAPITATION AMOUNT.—The capitation  
25        amount to be applied under this subsection for a

1 provider for a contract year shall be an amount  
2 specified in the PACE program agreement for the  
3 year. Such amount shall be an amount, specified  
4 under the PACE agreement, which is less than the  
5 amount that would otherwise have been made under  
6 the State plan if the individuals were not so enrolled  
7 and shall be adjusted to take into account the com-  
8 parative frailty of PACE enrollees and such other  
9 factors as the Secretary determines to be appro-  
10 priate. The payment under this section shall be in  
11 addition to any payment made under section 1894  
12 for individuals who are enrolled in a PACE program  
13 under such section.

14 “(e) PACE PROGRAM AGREEMENT.—

15 “(1) REQUIREMENT.—

16 “(A) IN GENERAL.—The Secretary, in  
17 close cooperation with the State administering  
18 agency, shall establish procedures for entering  
19 into, extending, and terminating PACE pro-  
20 gram agreements for the operation of PACE  
21 programs by entities that meet the require-  
22 ments for a PACE provider under this section,  
23 section 1894, and regulations.

24 “(B) NUMERICAL LIMITATION.—

1           “(i) IN GENERAL.—The Secretary  
2 shall not permit the number of PACE pro-  
3 viders with which agreements are in effect  
4 under this section or under section 9412(b)  
5 of the Omnibus Budget Reconciliation Act  
6 of 1986 to exceed—

7                   “(I) 40 as of the date of the en-  
8 actment of this section, or

9                   “(II) as of each succeeding anni-  
10 versary of such date, the numerical  
11 limitation under this subparagraph for  
12 the preceding year plus 20.

13 Subclause (II) shall apply without regard  
14 to the actual number of agreements in ef-  
15 fect as of a previous anniversary date.

16           “(ii) TREATMENT OF CERTAIN PRI-  
17 VATE, FOR-PROFIT PROVIDERS.—The nu-  
18 merical limitation in clause (i) shall not  
19 apply to a PACE provider that—

20                   “(I) is operating under a dem-  
21 onstration project waiver under sub-  
22 section (h), or

23                   “(II) was operating under such a  
24 waiver and subsequently qualifies for

1 PACE provider status pursuant to  
2 subsection (a)(3)(B)(ii).

3 “(2) SERVICE AREA AND ELIGIBILITY.—

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

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

8 “(ii) may provide additional require-  
9 ments for individuals to qualify as PACE  
10 program eligible individuals with respect to  
11 the program;

12 “(iii) shall be effective for a contract  
13 year, but may be extended for additional  
14 contract years in the absence of a notice by  
15 a party to terminate and is subject to ter-  
16 mination by the Secretary and the State  
17 administering agency at any time for cause  
18 (as provided under the agreement);

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

22 “(v) shall have such additional terms  
23 and conditions as the parties may agree to  
24 consistent with this section and regula-  
25 tions.

1           “(B) SERVICE AREA OVERLAP.—In des-  
2           ignating a service area under a PACE program  
3           agreement under subparagraph (A)(i), the Sec-  
4           retary (in consultation with the State admin-  
5           istering agency) may exclude from designation  
6           an area that is already covered under another  
7           PACE program agreement, in order to avoid  
8           unnecessary duplication of services and avoid  
9           impairing the financial and service viability of  
10          an existing program.

11          “(3) DATA COLLECTION.—

12           “(A) IN GENERAL.—Under a PACE pro-  
13          gram agreement, the PACE provider shall—

14                   “(i) collect data,

15                   “(ii) maintain, and afford the Sec-  
16                   retary and the State administering agency  
17                   access to, the records relating to the pro-  
18                   gram, including pertinent financial, medi-  
19                   cal, and personnel records, and

20                   “(iii) make to the Secretary and the  
21                   State administering agency reports that  
22                   the Secretary finds (in consultation with  
23                   State administering agencies) necessary to  
24                   monitor the operation, cost, and effective-

1           ness of the PACE program under this title  
2           and title XVIII.

3           “(B) REQUIREMENTS DURING TRIAL PE-  
4           RIOD.—During the first three years of oper-  
5           ation of a PACE program (either under this  
6           section or under a PACE demonstration waiver  
7           program), the PACE provider shall provide  
8           such additional data as the Secretary specifies  
9           in regulations in order to perform the oversight  
10          required under paragraph (4)(A).

11          “(4) OVERSIGHT.—

12                 “(A) ANNUAL, CLOSE OVERSIGHT DURING  
13                 TRIAL PERIOD.—During the trial period (as de-  
14                 fined in subsection (a)(9)) with respect to a  
15                 PACE program operated by a PACE provider,  
16                 the Secretary (in cooperation with the State ad-  
17                 ministering agency) shall conduct a comprehen-  
18                 sive annual review of the operation of the  
19                 PACE program by the provider in order to as-  
20                 sure compliance with the requirements of this  
21                 section and regulations. Such a review shall in-  
22                 clude—

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

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

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

6           “(iv) detailed analysis of the entity’s  
7           substantial compliance with all significant  
8           requirements of this section and regula-  
9           tions; and

10           “(v) any other elements the Secretary  
11           or State agency considers necessary or ap-  
12           propriate.

13           “(B) CONTINUING OVERSIGHT.—After the  
14           trial period, the Secretary (in cooperation with  
15           the State administering agency) shall continue  
16           to conduct such review of the operation of  
17           PACE providers and PACE programs as may  
18           be appropriate, taking into account the per-  
19           formance level of a provider and compliance of  
20           a provider with all significant requirements of  
21           this section and regulations.

22           “(C) DISCLOSURE.—The results of reviews  
23           under this paragraph shall be reported prompt-  
24           ly to the PACE provider, along with any rec-  
25           ommendations for changes to the provider’s

1 program, and shall be made available to the  
2 public upon request.

3 “(5) TERMINATION OF PACE PROVIDER AGREE-  
4 MENTS.—

5 “(A) IN GENERAL.—Under regulations—

6 “(i) the Secretary or a State admin-  
7 istering agency may terminate a PACE  
8 program agreement for cause, and

9 “(ii) a PACE provider may terminate  
10 such an agreement after appropriate notice  
11 to the Secretary, the State agency, and en-  
12 rollees.

13 “(B) CAUSES FOR TERMINATION.—In ac-  
14 cordance with regulations establishing proce-  
15 dures for termination of PACE program agree-  
16 ments, the Secretary or a State administering  
17 agency may terminate a PACE program agree-  
18 ment with a PACE provider for, among other  
19 reasons, the fact that—

20 “(i) the Secretary or State admin-  
21 istering agency determines that—

22 “(I) there are significant defi-  
23 ciencies in the quality of care provided  
24 to enrolled participants; or



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

5                   “(ii) the entity has failed to develop  
6                   and successfully initiate, within 30 days of  
7                   the date of the receipt of written notice of  
8                   such a determination, and continue imple-  
9                   mentation of a plan to correct the defi-  
10                  ciencies.

11                  “(C) TERMINATION AND TRANSITION PRO-  
12                  CEDURES.—An entity whose PACE provider  
13                  agreement is terminated under this paragraph  
14                  shall implement the transition procedures re-  
15                  quired under subsection (a)(2)(C).

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

18                  “(A) IN GENERAL.—Under regulations, if  
19                  the Secretary determines (after consultation  
20                  with the State administering agency) that a  
21                  PACE provider is failing substantially to com-  
22                  ply with the requirements of this section and  
23                  regulations, the Secretary (and the State ad-  
24                  ministering agency) may take any or all of the  
25                  following actions:

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

4           “(ii) Withhold some or all further  
5           payments under the PACE program agree-  
6           ment under this section or section 1894  
7           with respect to PACE program services  
8           furnished by such provider until the defi-  
9           ciencies have been corrected.

10          “(iii) Terminate such agreement.

11          “(B) APPLICATION OF INTERMEDIATE  
12          SANCTIONS.—Under regulations, the Secretary  
13          may provide for the application against a  
14          PACE provider of remedies described in section  
15          1857(f)(2) (or, for periods before January 1,  
16          1999, section 1876(i)(6)(B)) or 1903(m)(6)(B)  
17          in the case of violations by the provider of the  
18          type described in section 1857(f)(1) (or  
19          1876(i)(6)(A) for such periods) or  
20          1903(m)(6)(A), respectively (in relation to  
21          agreements, enrollees, and requirements under  
22          section 1894 or this section, respectively).

23          “(7) PROCEDURES FOR TERMINATION OR IMPO-  
24          SITION OF SANCTIONS.—Under regulations, the pro-  
25          visions of section 1857(g) (or for periods before Jan-

1 uary 1, 1999, section 1876(i)(9)) shall apply to ter-  
2 mination and sanctions respecting a PACE program  
3 agreement and PACE provider under this subsection  
4 in the same manner as they apply to a termination  
5 and sanctions with respect to a contract and a  
6 MedicarePlus organization under part C (or for such  
7 periods an eligible organization under section 1876).

8 “(8) TIMELY CONSIDERATION OF APPLICATIONS  
9 FOR PACE PROGRAM PROVIDER STATUS.—In consid-  
10 ering an application for PACE provider program  
11 status, the application shall be deemed approved un-  
12 less the Secretary, within 90 days after the date of  
13 the submission of the application to the Secretary,  
14 either denies such request in writing or informs the  
15 applicant in writing with respect to any additional  
16 information that is needed in order to make a final  
17 determination with respect to the application. After  
18 the date the Secretary receives such additional infor-  
19 mation, the application shall be deemed approved  
20 unless the Secretary, within 90 days of such date,  
21 denies such request.

22 “(f) REGULATIONS.—

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

1           “(2) USE OF PACE PROTOCOL.—

2                   “(A) IN GENERAL.—In issuing such regu-  
3 lations, the Secretary shall, to the extent con-  
4 sistent with the provisions of this section, incor-  
5 porate the requirements applied to PACE dem-  
6 onstration waiver programs under the PACE  
7 protocol.

8                   “(B) FLEXIBILITY.—The Secretary (in  
9 close consultation with State administering  
10 agencies) may modify or waive such provisions  
11 of the PACE protocol in order to provide for  
12 reasonable flexibility in adapting the PACE  
13 service delivery model to the needs of particular  
14 organizations (such as those in rural areas or  
15 those that may determine it appropriate to use  
16 non-staff physicians accordingly to State licens-  
17 ing law requirements) under this section and  
18 section 1932 where such flexibility is not incon-  
19 sistent with and would not impair the essential  
20 elements, objectives, and requirements of the  
21 this section, including—

22                           “(i) the focus on frail elderly qualify-  
23 ing individuals who require the level of  
24 care provided in a nursing facility;

1                   “(ii) the delivery of comprehensive, in-  
2                   tegrated acute and long-term care services;

3                   “(iii) the interdisciplinary team ap-  
4                   proach to care management and service de-  
5                   livery;

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

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

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

14                   “(A) IN GENERAL.—In issuing such regu-  
15                   lations and subject to subparagraph (B), the  
16                   Secretary may apply with respect to PACE pro-  
17                   grams, providers, and agreements such require-  
18                   ments of part C of title XVIII (or, for periods  
19                   before January 1, 1999, section 1876) and sec-  
20                   tion 1903(m) relating to protection of bene-  
21                   ficiaries and program integrity as would apply  
22                   to MedicarePlus organizations under such part  
23                   C (or for such periods eligible organizations  
24                   under risk-sharing contracts under section  
25                   1876) and to health maintenance organizations

1 under prepaid capitation agreements under sec-  
2 tion 1903(m).

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

5 “(i) take into account the differences  
6 between populations served and benefits  
7 provided under this section and under part  
8 C of title XVIII (or, for periods before  
9 January 1, 1999, section 1876) and sec-  
10 tion 1903(m);

11 “(ii) not include any requirement that  
12 conflicts with carrying out PACE pro-  
13 grams under this section; and

14 “(iii) not include any requirement re-  
15 stricting the proportion of enrollees who  
16 are eligible for benefits under this title or  
17 title XVIII.

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

22 “(1) Section 1902(a)(1), relating to any re-  
23 quirement that PACE programs or PACE program  
24 services be provided in all areas of a State.

1           “(2) Section 1902(a)(10), insofar as such sec-  
2           tion relates to comparability of services among dif-  
3           ferent population groups.

4           “(3) Sections 1902(a)(23) and 1915(b)(4), re-  
5           lating to freedom of choice of providers under a  
6           PACE program.

7           “(4) Section 1903(m)(2)(A), insofar as it re-  
8           stricts a PACE provider from receiving prepaid capi-  
9           tation payments.

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

12           “(1) IN GENERAL.—In order to demonstrate  
13           the operation of a PACE program by a private, for-  
14           profit entity, the Secretary (in close consultation  
15           with State administering agencies) shall grant waiv-  
16           ers from the requirement under subsection (a)(3)  
17           that a PACE provider may not be a for-profit, pri-  
18           vate entity.

19           “(2) SIMILAR TERMS AND CONDITIONS.—

20           “(A) IN GENERAL.—Except as provided  
21           under subparagraph (B), and paragraph (1),  
22           the terms and conditions for operation of a  
23           PACE program by a provider under this sub-  
24           section shall be the same as those for PACE

1 providers that are nonprofit, private organiza-  
2 tions.

3 “(B) NUMERICAL LIMITATION.—The num-  
4 ber of programs for which waivers are granted  
5 under this subsection shall not exceed 10. Pro-  
6 grams with waivers granted under this sub-  
7 section shall not be counted against the numeri-  
8 cal limitation specified in subsection (e)(1)(B).

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

15 “(j) MISCELLANEOUS PROVISIONS.—

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

24 (b) CONFORMING AMENDMENTS.—



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

3                   (A) in subsection (a)(10)(C)(iv), by strik-  
4                   ing “(25)” and inserting “(26)”, and

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

7           (2) Section 1924(a)(5) (42 U.S.C. 1396r-  
8           5(a)(5)) is amended—

9                   (A) in the heading, by striking “FROM OR-  
10                   GANIZATIONS RECEIVING CERTAIN WAIVERS”  
11                   and inserting “UNDER PACE PROGRAMS”, and

12                   (B) by striking “from any organization”  
13                   and all that follows and inserting “under a  
14                   PACE demonstration waiver program (as de-  
15                   fined in subsection (a)(7) of section 1932) or  
16                   under a PACE program under section 1894.”.

17           (3) Section 1903(f)(4)(C) (42 U.S.C.  
18           1396b(f)(4)(C)) is amended by inserting “or who is  
19           a PACE program eligible individual enrolled in a  
20           PACE program under section 1932,” after “section  
21           1902(a)(10)(A),”.

22   **SEC. 3432. COVERAGE OF PACE UNDER THE MEDICARE**  
23                   **PROGRAM.**

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

1 “PAYMENTS TO, AND COVERAGE OF BENEFITS UNDER,  
2 PROGRAMS OF ALL-INCLUSIVE CARE FOR THE EL-  
3 DERLY (PACE)

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

7 “(1) BENEFITS THROUGH ENROLLMENT IN A  
8 PACE PROGRAM.—In accordance with this section, in  
9 the case of an individual who is entitled to benefits  
10 under part A or enrolled under part B and who is  
11 a PACE program eligible individual with respect to  
12 a PACE program offered by a PACE provider under  
13 a PACE program agreement—

14 “(A) the individual may enroll in the pro-  
15 gram under this section; and

16 “(B) so long as the individual is so en-  
17 rolled and in accordance with regulations—

18 “(i) the individual shall receive bene-  
19 fits under this title solely through such  
20 program, and

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

1           “(2) APPLICATION OF DEFINITIONS.—The defi-  
2           nitions of terms under section 1932(a) shall apply  
3           under this section in the same manner as they apply  
4           under section 1932.

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

11          “(c) PAYMENT.—

12           “(1) ADJUSTMENT IN PAYMENT AMOUNTS.—In  
13           the case of individuals enrolled in a PACE program  
14           under this section, the amount of payment under  
15           this section shall not be the amount calculated under  
16           section 1932(d)(2), but shall be an amount, specified  
17           under the PACE agreement, based upon payment  
18           rates established for purposes of payment under sec-  
19           tion 1854 (or, for periods before January 1, 1999,  
20           for purposes of risk-sharing contracts under section  
21           1876) and shall be adjusted to take into account the  
22           comparative frailty of PACE enrollees and such  
23           other factors as the Secretary determines to be ap-  
24           propriate. Such amount under such an agreement  
25           shall be computed in a manner so that the total pay-

1       ment level for all PACE program eligible individuals  
2       enrolled under a program is less than the projected  
3       payment under this title for a comparable population  
4       not enrolled under a PACE program.

5           “(2) FORM.—The Secretary shall make pro-  
6       spective monthly payments of a capitation amount  
7       for each PACE program eligible individual enrolled  
8       under this section in the same manner and from the  
9       same sources as payments are made to a  
10      MedicarePlus organization under section 1854 (or,  
11      for periods beginning before January 1, 1999, to an  
12      eligible organization under a risk-sharing contract  
13      under section 1876). Such payments shall be subject  
14      to adjustment in the manner described in section  
15      1854(a)(2) or section 1876(a)(1)(E), as the case  
16      may be.

17          “(d) WAIVERS OF REQUIREMENTS.—With respect to  
18      carrying out a PACE program under this section, the fol-  
19      lowing requirements of this title (and regulations relating  
20      to such requirements) are waived and shall not apply:

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

23           “(2) Sections 1813, 1814, 1833, and 1886, in-  
24      sofar as such sections relate to rules for payment for  
25      benefits.

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

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

7           “(5) Sections 1862(a)(1) and 1862(a)(9), inso-  
8           far as they may prevent payment for PACE program  
9           services to individuals enrolled under PACE pro-  
10          grams.”.

11 **SEC. 3433. EFFECTIVE DATE; TRANSITION.**

12          (a) **TIMELY ISSUANCE OF REGULATIONS; EFFECTIVE**  
13 **DATE.**—The Secretary of Health and Human Services  
14 shall promulgate regulations to carry out this subchapter  
15 in a timely manner. Such regulations shall be designed  
16 so that entities may establish and operate PACE pro-  
17 grams under sections 1894 and 1932 for periods begin-  
18 ning not later than 1 year after the date of the enactment  
19 of this Act.

20          (b) **EXPANSION AND TRANSITION FOR PACE DEM-**  
21 **ONSTRATION PROJECT WAIVERS.**—

22               (1) **EXPANSION IN CURRENT NUMBER AND EX-**  
23 **TENSION OF DEMONSTRATION PROJECTS.**—Section  
24 9412(b) of the Omnibus Budget Reconciliation Act  
25 of 1986, as amended by section 4118(g) of the Om-

1 nibus Budget Reconciliation Act of 1987, is amend-  
2 ed—

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

9 (B) in paragraph (2)—

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

15 (ii) in subparagraph (C), by adding at  
16 the end the following: “In granting further  
17 extensions, an organization shall not be re-  
18 quired to provide for reporting of informa-  
19 tion which is only required because of the  
20 demonstration nature of the project.”.

21 (2) ELIMINATION OF REPLICATION REQUIRE-  
22 MENT.—Subparagraph (B) of paragraph (2) of such  
23 section shall not apply to waivers granted under  
24 such section after the date of the enactment of this  
25 Act.

1           (3) TIMELY CONSIDERATION OF APPLICA-  
2           TIONS.—In considering an application for waivers  
3           under such section before the effective date of re-  
4           peals under subsection (c), subject to the numerical  
5           limitation under the amendment made by paragraph  
6           (1), the application shall be deemed approved unless  
7           the Secretary of Health and Human Services, within  
8           90 days after the date of its submission to the Sec-  
9           retary, either denies such request in writing or in-  
10          forms the applicant in writing with respect to any  
11          additional information which is needed in order to  
12          make a final determination with respect to the appli-  
13          cation. After the date the Secretary receives such  
14          additional information, the application shall be  
15          deemed approved unless the Secretary, within 90  
16          days of such date, denies such request.

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

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

1 (A) first, to entities that are operating a  
2 PACE demonstration waiver program (as de-  
3 fined in section 1932(a)(7) of such Act), and

4 (B) then entities that have applied to oper-  
5 ate such a program as of May 1, 1997.

6 (2) NEW WAIVERS.—The Secretary shall give  
7 priority, in the awarding of additional waivers under  
8 section 9412(b) of the Omnibus Budget Reconcili-  
9 ation Act of 1986—

10 (A) to any entities that have applied for  
11 such waivers under such section as of May 1,  
12 1997; and

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

18 (3) SPECIAL CONSIDERATION.—The Secretary  
19 shall give special consideration, in the processing of  
20 applications described in paragraph (1) and the  
21 awarding of waivers described in paragraph (2), to  
22 an entity which as of May 1, 1997 through formal  
23 activities (such as entering into contracts for fea-  
24 sibility studies) has indicated a specific intent to be-  
25 come a PACE provider.



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

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

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

7 (B) Section 9220 of the Consolidated Om-  
8 nibus Budget Reconciliation Act of 1985 (Pub-  
9 lic Law 99–272).

10 (C) Section 9412(b) of the Omnibus Budg-  
11 et Reconciliation Act of 1986 (Public Law 99–  
12 509).

13 (2) DELAY IN APPLICATION.—

14 (A) IN GENERAL.—Subject to subpara-  
15 graph (B), the repeals made by paragraph (1)  
16 shall not apply to waivers granted before the  
17 initial effective date of regulations described in  
18 subsection (a).

19 (B) APPLICATION TO APPROVED WAIV-  
20 ERS.—Such repeals shall apply to waivers  
21 granted before such date only after allowing  
22 such organizations a transition period (of up to  
23 24 months) in order to permit sufficient time  
24 for an orderly transition from demonstration  
25 project authority to general authority provided

1 under the amendments made by this sub-  
2 chapter.

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

9 **SEC. 3434. STUDY AND REPORTS.**

10 (a) STUDY.—

11 (1) IN GENERAL.—The Secretary of Health and  
12 Human Services (in close consultation with State  
13 administering agencies, as defined in section  
14 1932(a)(8) of the Social Security Act) shall conduct  
15 a study of the quality and cost of providing PACE  
16 program services under the medicare and medicaid  
17 programs under the amendments made by this sub-  
18 chapter.

19 (2) STUDY OF PRIVATE, FOR-PROFIT PROVID-  
20 ERS.—Such study shall specifically compare the  
21 costs, quality, and access to services by entities that  
22 are private, for-profit entities operating under dem-  
23 onstration projects waivers granted under section  
24 1932(h) of the Social Security Act with the costs,

1 quality, and access to services of other PACE pro-  
2 viders.

3 (b) REPORT.—

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

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

14 (A) The number of covered lives enrolled  
15 with entities operating under demonstration  
16 project waivers under section 1932(h) of the  
17 Social Security Act is fewer than 800 (or such  
18 lesser number as the Secretary may find statis-  
19 tically sufficient to make determinations re-  
20 specting findings described in the succeeding  
21 subparagraphs).

22 (B) The population enrolled with such en-  
23 tities is less frail than the population enrolled  
24 with other PACE providers.

1 (C) Access to or quality of care for individ-  
2 uals enrolled with such entities is lower than  
3 such access or quality for individuals enrolled  
4 with other PACE providers.

5 (D) The application of such section has re-  
6 sulted in an increase in expenditures under the  
7 medicare or medicaid programs above the ex-  
8 penditures that would have been made if such  
9 section did not apply.

10 (c) INFORMATION INCLUDED IN ANNUAL REC-  
11 OMMENDATIONS.—The Medicare Payment Advisory Com-  
12 mission shall include in its annual report under section  
13 1805(b)(1)(B) of the Social Security Act recommenda-  
14 tions on the methodology and level of payments made to  
15 PACE providers under section 1894(d) of such Act and  
16 on the treatment of private, for-profit entities as PACE  
17 providers.

18 **Subchapter E—Benefits**  
19 **SEC. 3441. ELIMINATION OF REQUIREMENT TO PAY FOR**  
20 **PRIVATE INSURANCE.**

21 (a) REPEAL OF STATE PLAN PROVISION.—Section  
22 1902(a)(25) (42 U.S.C. 1396a(a)(25)) is amended—  
23 (1) by striking subparagraph (G); and  
24 (2) by redesignating subparagraphs (H) and (I)  
25 as subparagraphs (G) and (H), respectively.

1 (b) MAKING PROVISION OPTIONAL.—Section 1906  
2 (42 U.S.C. 1396e) is amended—

3 (1) in subsection (a)—

4 (A) by striking “For purposes of section  
5 1902(a)(25)(G) and subject to subsection (d),  
6 each” and inserting “Each”,

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

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

11 (2) by striking subsection (d).

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

15 **SEC. 3442. PERMITTING SAME COPAYMENTS IN HEALTH**  
16 **MAINTENANCE ORGANIZATIONS AS IN FEE-**  
17 **FOR-SERVICE.**

18 (a) IN GENERAL.—Section 1916(a)(2)(D) (42 U.S.C.  
19 1396o(a)(2)(D)) is amended by inserting “(at the option  
20 of the State)” after “section 1905(a)(4)(C), or”.

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

1 **SEC. 3443. PHYSICIAN QUALIFICATION REQUIREMENTS.**

2 (a) IN GENERAL.—Section 1903(i) (42 U.S.C.  
3 1396b(i)) is amended by striking paragraph (12)

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

7 **SEC. 3444. ELIMINATION OF REQUIREMENT OF PRIOR IN-**  
8 **STITUTIONALIZATION WITH RESPECT TO HA-**  
9 **BILITATION SERVICES FURNISHED UNDER A**  
10 **WAIVER FOR HOME OR COMMUNITY-BASED**  
11 **SERVICES.**

12 (a) IN GENERAL.—Section 1915(c)(5) (42 U.S.C.  
13 1396n(c)(5)) is amended, in the matter preceding sub-  
14 paragraph (A), by striking “, with respect to individuals  
15 who receive such services after discharge from a nursing  
16 facility or intermediate care facility for the mentally re-  
17 tarded”.

18 (b) EFFECTIVE DATE.—The amendment made by  
19 subsection (a) apply to services furnished on or after Octo-  
20 ber 1, 1997.

21 **SEC. 3445. BENEFITS FOR SERVICES OF PHYSICIAN ASSIST-**  
22 **ANTS.**

23 (a) IN GENERAL.—Section 1905(a) (42 U.S.C.  
24 1396d(a)), as amended by sections 3403(a) and 3431(a),  
25 is amended—

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

3 (2) by inserting after paragraph (21) the fol-  
4 lowing new paragraph:

5 “(22) services furnished by an physician assist-  
6 ant (as defined in section 1861(aa)(5)) which the as-  
7 sistant is legally authorized to perform under State  
8 law and with the supervision of a physician;”.

9 (b) CONFORMING AMENDMENTS.—Section 1902 (42  
10 U.S.C. 1396a), as amended by sections 3403(c) and  
11 3431(b)(1), is amended—

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

14 (2) in subsection (j), by striking “(27)” and in-  
15 serting “(28)”.

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

18 (a) STUDY.—The Secretary of Health and Human  
19 Services shall provide for a study on the actuarial value  
20 of the provision of early and periodic screening, diagnostic,  
21 and treatment services (as defined in section 1905(r) of  
22 the Social Security Act (42 U.S.C. 1396d(r))) under the  
23 medicaid program under title XIX of such Act. Such study  
24 shall include an examination of the portion of such value

1 that is attributable to paragraph (5) of such section and  
2 to the second sentence of such section.

3 (b) REPORT.—By not later than 18 months after the  
4 date of the enactment of this Act, the Secretary shall sub-  
5 mit a report to Congress on the results of the study under  
6 subsection (a).

## 7 **Subchapter F—Administration**

### 8 **SEC. 3451. ELIMINATION OF DUPLICATIVE INSPECTION OF** 9 **CARE REQUIREMENTS FOR ICFS/MR AND** 10 **MENTAL HOSPITALS.**

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

13 (1) by striking “provide—

14 “(A) with respect to each patient” and in-  
15 serting “provide, with respect to each patient”;

16 and

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

18 (b) ICFS/MR.—Section 1902(a)(31) (42 U.S.C.  
19 1396a(a)(31)) is amended—

20 (1) by striking “provide—

21 “(A) with respect to each patient” and in-  
22 serting “provide, with respect to each patient”;

23 and

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



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

4 **SEC. 3452. ALTERNATIVE SANCTIONS FOR NONCOMPLIANT**  
5 **ICFS/MR.**

6 (a) IN GENERAL.—Section 1902(i)(1)(B) (42 U.S.C.  
7 1396a(i)(1)(B)) is amended by striking “provide” and in-  
8 serting “establish alternative remedies if the State dem-  
9 onstrates to the Secretary’s satisfaction that the alter-  
10 native remedies are effective in deterring noncompliance  
11 and correcting deficiencies, and may provide”.

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

15 **SEC. 3453. MODIFICATION OF MMIS REQUIREMENTS.**

16 (a) IN GENERAL.—Section 1903(r) (42 U.S.C.  
17 1396b(r)) is amended—

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

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

1           “(A) is adequate to provide efficient, economi-  
2 cal, and effective administration of such State plan;

3           “(B) is compatible with the claims processing  
4 and information retrieval systems used in the admin-  
5 istration of title XVIII, and for this purpose—

6                   “(i) has a uniform identification cod-  
7 ing system for providers, other payees, and  
8 beneficiaries under this title or title XVIII;

9                   “(ii) provides liaison between States  
10 and carriers and intermediaries with agree-  
11 ments under title XVIII to facilitate timely  
12 exchange of appropriate data; and

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

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

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

21           “(E) is designed to receive provider claims in  
22 standard formats to the extent specified by the Sec-  
23 retary; and

24           “(F) effective for claims filed on or after Janu-  
25 ary 1, 1999, provides for electronic transmission of

1 claims data in the format specified by the Secretary  
2 and consistent with the Medicaid Statistical Infor-  
3 mation System (MSIS) (including detailed individual  
4 enrollee encounter data and other information that  
5 the Secretary may find necessary).”.

6 (2) in paragraph (5)—

7 (A) by striking subparagraph (B);

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

10 “(2) In order to meet the requirements of this para-  
11 graph, mechanized claims processing and information re-  
12 trieval systems must meet the following requirements:”;

13 (C) in clause (iii), by striking “under para-  
14 graph (6)”; and

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

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

18 (b) CONFORMING AMENDMENTS.—Section  
19 1902(a)(25)(A)(ii) (42 U.S.C. 1396a(a)(25)(A)(ii)) is  
20 amended by striking all that follows “shall” and inserting  
21 the following: “be integrated with, and be monitored as  
22 a part of the Secretary’s review of, the State’s mechanized  
23 claims processing and information retrieval system under  
24 section 1903(r);”.

1 (c) EFFECTIVE DATE.—Except as otherwise specifi-  
2 cally provided, the amendments made by this section shall  
3 take effect on January 1, 1998.

4 **SEC. 3454. FACILITATING IMPOSITION OF STATE ALTER-**  
5 **NATIVE REMEDIES ON NONCOMPLIANT**  
6 **NURSING FACILITIES.**

7 (a) IN GENERAL.—Section 1919(h)(3)(D) (42 U.S.C.  
8 1396r(h)(3)(D)) is amended—

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

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

16 **SEC. 3455. MEDICALLY ACCEPTED INDICATION.**

17 Section 1927(g)(1)(B)(i) (42 U.S.C. 1396r-  
18 8(g)(1)(B)(i)) is amended—

- 19 (1) by striking “and” at the end of subclause  
20 (II),  
21 (2) by redesignating subclause (III) as sub-  
22 clause (IV), and  
23 (3) by inserting after subclause (II) the follow-  
24 ing:

1                                   “(III) the DRUGDEX Informa-  
2                                   tion System; and”.

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

5           (a) IN GENERAL.—Section 1115 (42 U.S.C. 1315)  
6 is amended by adding at the end the following new sub-  
7 section:

8           “(e)(1) The provisions of this subsection shall apply  
9 to the extension of State-wide comprehensive demonstra-  
10 tion project (in this subsection referred to as ‘waiver  
11 project’) for which a waiver of compliance with require-  
12 ments of title XIX is granted under subsection (a).

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

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

22           “(4) If such a request is granted, the deadline for  
23 submittal of a final report under the waiver project is  
24 deemed to have been extended until the date that is 1 year

1 after the date the waivers under subsection (a) with re-  
2 spect to the project would otherwise have expired.

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

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

13 “(7) If an original condition of approval of a waiver  
14 project was that Federal expenditures under the project  
15 not exceed the Federal expenditures that would otherwise  
16 have been made, the Secretary shall take such steps as  
17 may be necessary to assure that, in the extension of the  
18 project under this subsection, such condition continues to  
19 be met. In applying the previous sentence, the Secretary  
20 shall take into account the Secretary’s best estimate of  
21 rates of change in expenditures at the time of the exten-  
22 sion.”.

23 (b) EFFECTIVE DATE.—The amendment made by  
24 subsection (a) shall apply to demonstration projects ini-

1 tially approved before, on, or after the date of the enact-  
2 ment of this Act.

3 **SEC. 3457. AUTHORIZING ADMINISTRATIVE STREAMLINING**  
4 **AND PRIVATIZING MODIFICATIONS UNDER**  
5 **THE MEDICAID PROGRAM.**

6 Section 1902 (42 U.S.C. 1396a) is amended by add-  
7 ing at the end the following:

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

18 “(2) Nothing in this subsection shall be construed as  
19 affecting—

20 “(A) the conditions for eligibility for benefits  
21 (including any conditions relating to income or re-  
22 sources); and

23 “(B) the rights to challenge determinations re-  
24 garding eligibility or rights to benefits; and

1           “(C) determinations regarding quality control  
2           or error rates.”.

3 **SEC. 3458. EXTENSION OF MORATORIUM.**

4           Section 6408(a)(3) of the Omnibus Budget Reconcili-  
5           ation Act of 1989, as amended by section 13642 of the  
6           Omnibus Budget Reconciliation Act of 1993, is amended  
7           by striking “December 31, 1995” and inserting “Decem-  
8           ber 31, 2002”.

9           **CHAPTER 2—QUALITY ASSURANCE**

10 **SEC. 3461. REQUIREMENTS TO ENSURE QUALITY OF AND**  
11           **ACCESS TO CARE UNDER MANAGED CARE**  
12           **PLANS.**

13           (a) STATE PLAN REQUIREMENT.—Section 1902(a)  
14           (42 U.S.C. 1396a(a)) is amended—

15           (1) in paragraph (62), by striking “; and” at  
16           the end and inserting a semicolon;

17           (2) by striking the period at the end of para-  
18           graph (63) and inserting “; and”; and

19           (3) by inserting after paragraph (63) the fol-  
20           lowing new paragraph:

21           “(64) provide, with respect to all contracts de-  
22           scribed in section 1903(m)(2)(A) with an organiza-  
23           tion or provider, that—

24           “(A) the State agency develops and imple-  
25           ments a quality assessment and improvement



1 strategy, consistent with standards that the  
2 Secretary shall establish, in consultation with  
3 the States, and monitor and that do not pre-  
4 empt the application of stricter State standards,  
5 which includes—

6 “(i) standards for access to care so  
7 that covered services are available within  
8 reasonable timeframes and in a manner  
9 that ensures continuity of care and ade-  
10 quate primary care and, where applicable,  
11 specialized services capacity, including pe-  
12 diatric specialized services for special needs  
13 children (as defined in section 1915(i));  
14 and

15 “(ii) procedures for monitoring and  
16 evaluating the quality and appropriateness  
17 of care and services to beneficiaries that  
18 reflect the full spectrum of populations en-  
19 rolled under the contract and that in-  
20 clude—

21 “(I) requirements for provision of  
22 quality assurance data to the State  
23 using the data and information set  
24 that the Secretary shall specify with  
25 respect to entities contracting under

1 section 1876 or alternative data re-  
2 quirements approved by the Secretary;

3 “(II) regular and periodic exam-  
4 ination of the scope and content of  
5 the quality improvement strategy; and

6 “(III) other aspects of care and  
7 service directly related to the improve-  
8 ment of quality of care (including  
9 grievance procedures and marketing  
10 and information standards); and

11 “(B) that adequate provision is made, con-  
12 sistent with standards that the Secretary shall  
13 specify and monitor, with respect to financial  
14 reporting under the contracts.”.

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

18 “(7) DEEMED COMPLIANCE.—

19 “(A) MEDICARE ORGANIZATIONS.—At the op-  
20 tion of a State, the requirements of the previous  
21 provisions of this subsection shall not apply with re-  
22 spect to a health maintenance organization if the or-  
23 ganization is an eligible organization with a contract  
24 in effect under section 1876 or a MedicarePlus orga-

1 nization with a contract in effect under C of title  
2 XVIII.

3 “(B) PRIVATE ACCREDITATION.—

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

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

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

17 “(ii) STANDARDS AND PROCESS.—Not  
18 later than 180 days after the date of the enact-  
19 ment of this paragraph, the Secretary shall  
20 specify requirements for the standards and  
21 process under which a health maintenance orga-  
22 nization is accredited by an organization meet-  
23 ing the requirements of subparagraph (C).

1           “(C) ACCREDITING ORGANIZATION.—An ac-  
2           crediting organization meets the requirements of this  
3           subparagraph if the organization—

4                   “(i) is a private, nonprofit organization;

5                   “(ii) exists for the primary purpose of ac-  
6           crediting managed care organizations or health  
7           care providers; and

8                   “(iii) is independent of health care provid-  
9           ers or associations of health care providers.”.

10          (c) APPLICATION TO MANAGED CARE ENTITIES.—

11          Section 1903(m)(2)(A) (42 U.S.C. 1396b(m)(2)(A)) is  
12          amended—

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

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

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

18                   “(xii) such contract provides for—

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

22                   “(II) maintenance of an internal quality  
23           assurance program consistent with section  
24           1902(a)(64)(A), and meeting standards that  
25           the Secretary shall establish in regulations; and

1           “(III) providing effective procedures for  
2           hearing and resolving grievances between the  
3           entity and members enrolled with the organiza-  
4           tion under this subsection.”.

5           (d) APPLICATION TO PRIMARY CARE CASE MANAGE-  
6           MENT CONTRACTS.—Section 1905(t)(3), as added by sec-  
7           tion 3403(b), is amended—

8           (1) by striking “and” at the end of subpara-  
9           graph (D),

10          (2) by striking the period at the end of sub-  
11          paragraph (E) and inserting “; and”, and

12          (3) by adding at the end the following new sub-  
13          paragraph:

14           “(F) if payment is made to the organization on  
15           a prepaid capitated or other risk basis, compliance  
16           with the requirements of section 1903(m)(2)(A)(xii)  
17           in the same manner such requirements apply to a  
18           health maintenance organization under section  
19           1903(m)(2)(A).”.

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

1 **SEC. 3462. SOLVENCY STANDARDS FOR CERTAIN HEALTH**  
2 **MAINTENANCE ORGANIZATIONS.**

3 (a) IN GENERAL.—Section 1903(m)(1) (42 U.S.C.  
4 1396b(m)(1)) is amended—

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

9 (2) by adding at the end the following:

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

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

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

21 “(II) the organization is a public entity;

22 “(III) the solvency of the organization is guar-  
23 anteed by the State; or

24 “(IV) the organization is (or is controlled by)  
25 one or more federally-qualified health centers and

1 meets solvency standards established by the State  
2 for such an organization.

3 For purposes of subclause (IV), the term ‘control’ means  
4 the possession, whether direct or indirect, of the power to  
5 direct or cause the direction of the management and poli-  
6 cies of the organization through membership, board rep-  
7 resentation, or an ownership interest equal to or greater  
8 than 50.1 percent.”

9 (b) EFFECTIVE DATE.—The amendments made by  
10 subsection (a) shall apply to contracts entered into or re-  
11 newed on or after October 1, 1998.

12 (c) TRANSITION.—In the case of a health mainte-  
13 nance organization that as of the date of the enactment  
14 of this Act has entered into a contract with a State for  
15 the provision of medical assistance under title XIX under  
16 which the organization assumes full financial risk and is  
17 receiving capitation payments, the amendment made by  
18 subsection (a) shall not apply to such organization until  
19 3 years after the date of the enactment of this Act.

20 **SEC. 3463. APPLICATION OF PRUDENT LAYPERSON STAND-**  
21 **ARD FOR EMERGENCY MEDICAL CONDITION**  
22 **AND PROHIBITION OF GAG RULE RESTRIC-**  
23 **TIONS.**

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

1       “(8)(A)(i) Each contract with a health maintenance  
2 organization under this subsection shall require the orga-  
3 nization—

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

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

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

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

19           “(ii) are needed to evaluate or stabilize an  
20 emergency medical condition (as defined in subpara-  
21 graph (C)).

22       “(C) In subparagraph (B)(ii), the term ‘emergency  
23 medical condition’ means a medical condition manifesting  
24 itself by acute symptoms of sufficient severity such that  
25 a prudent layperson, who possesses an average knowledge



1 of health and medicine, could reasonably expect the ab-  
2 sence of immediate medical attention to result in—

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

6 “(ii) serious impairment to bodily functions, or

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

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

20 “(B) Subparagraph (A) shall not be construed as re-  
21 quiring a health maintenance organization to provide, re-  
22 imburse for, or provide coverage of a counseling or referral  
23 service if the organization—

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

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

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

12          “(D) For purposes of this paragraph, the term  
13          ‘health care professional’ means a physician (as defined  
14          in section 1861(r)) or other health care professional if cov-  
15          erage for the professional’s services is provided under the  
16          contract under this subsection for the services of the pro-  
17          fessional. Such term includes a podiatrist, optometrist,  
18          chiropractor, psychologist, dentist, physician assistant,  
19          physical or occupational therapist and therapy assistant,  
20          speech-language pathologist, audiologist, registered or li-  
21          censed practical nurse (including nurse practitioner, clini-  
22          cal nurse specialist, certified registered nurse anesthetist,  
23          and certified nurse-midwife), licensed certified social work-  
24          er, registered respiratory therapist, and certified res-  
25          piratory therapy technician.”.

1 **SEC. 3464. ADDITIONAL FRAUD AND ABUSE PROTECTIONS**  
2 **IN MANAGED CARE.**

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

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

9 (2) by adding at the end the following:

10 “(10)(A)(i) A health maintenance organization with  
11 respect to activities under this subsection may not distrib-  
12 ute directly or through any agent or independent contrac-  
13 tor marketing materials within any State—

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

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

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

21 “(iii) The State may not enter into or renew a con-  
22 tract with a health maintenance organization for the provi-  
23 sion of services to individuals enrolled under the State  
24 plan under this title if the State determines that the entity  
25 distributed directly or through any agent or independent

1 contractor marketing materials in violation of clause  
2 (i)(II).

3 “(B) A health maintenance organization shall distrib-  
4 ute marketing materials to the entire service area of such  
5 organization.

6 “(C) A health maintenance organization, or any  
7 agency of such organization, may not seek to influence an  
8 individual’s enrollment with the organization in conjunc-  
9 tion with the sale of any other insurance.

10 “(D) Each health maintenance organization shall  
11 comply with such procedures and conditions as the Sec-  
12 retary prescribes in order to ensure that, before an individ-  
13 ual is enrolled with the organization under this title, the  
14 individual is provided accurate oral and written and suffi-  
15 cient information to make an informed decision whether  
16 or not to enroll.

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

20 (b) PROHIBITING AFFILIATIONS WITH INDIVIDUALS  
21 DEBARRED BY FEDERAL AGENCIES.—Section 1903(m)  
22 (42 U.S.C. 1396b(m)), as amended by section 3463 and  
23 subsection (a), is further amended by adding at the end  
24 the following:

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

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

7 “(ii) have an employment, consulting, or other  
8 agreement with a person described in such subpara-  
9 graph for the provision of items and services that  
10 are significant and material to the organization’s ob-  
11 ligations under its contract with the State.

12 “(B) If a State finds that a health maintenance orga-  
13 nization is not in compliance with clause (i) or (ii) of sub-  
14 paragraph (A), the State—

15 “(i) shall notify the Secretary of such non-  
16 compliance;

17 “(ii) may continue an existing agreement with  
18 the organization unless the Secretary (in consulta-  
19 tion with the Inspector General of the Department  
20 of Health and Human Services) directs otherwise;  
21 and

22 “(iii) may not renew or otherwise extend the  
23 duration of an existing agreement with the organiza-  
24 tion unless the Secretary (in consultation with the  
25 Inspector General of the Department of Health and

1 Human Services) provides to the State and to the  
2 Congress a written statement describing compelling  
3 reasons that exist for renewing or extending the  
4 agreement.

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

7 “(i) is debarred, suspended, or otherwise ex-  
8 cluded from participating in procurement activities  
9 under the Federal acquisition regulation or from  
10 participating in nonprocurement activities under reg-  
11 ulations issued pursuant to Executive Order 12549;  
12 or

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

16 (c) APPLICATION OF STATE CONFLICT-OF-INTEREST  
17 SAFEGUARDS.—Section 1903(m)(2)(A) (42 U.S.C.  
18 1396b(m)(2)(A)), as amended by section 3461(c), is  
19 amended—

20 (1) by striking “and” at the end of clause (xi),  
21 (2) by striking the period at the end of clause  
22 (xii) and inserting “; and”, and

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

24 “(xiii) the State has in effect conflict-of-interest  
25 safeguards with respect to officers and employees of

1 the State with responsibilities relating to contracts  
2 with such organizations and to any default enroll-  
3 ment process that are at least as effective as the  
4 Federal safeguards provided under section 27 of the  
5 Office of Federal Procurement Policy Act (41 U.S.C.  
6 423), against conflicts of interest that apply with re-  
7 spect to Federal procurement officials with com-  
8 parable responsibilities with respect to such con-  
9 tracts.”.

10 (d) LIMITATION ON AVAILABILITY OF FFP FOR USE  
11 OF ENROLLMENT BROKERS.—Section 1903(b) (42 U.S.C.  
12 1396b(b)), as amended by section 3413(b), is amended by  
13 adding at the end the following:

14 “(5) Amounts expended by a State for the use an  
15 enrollment broker in marketing health maintenance orga-  
16 nizations and other managed care entities to eligible indi-  
17 viduals under this title shall be considered, for purposes  
18 of subsection (a)(7), to be necessary for the proper and  
19 efficient administration of the State plan but only if the  
20 following conditions are met with respect to the broker:

21 “(A) The broker is independent of any such en-  
22 tity and of any health care providers (whether or not  
23 any such provider participates in the State plan  
24 under this title) that provide coverage of services in

1 the same State in which the broker is conducting en-  
2 rollment activities.

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

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

13 **SEC. 3465. GRIEVANCES UNDER MANAGED CARE PLANS.**

14 Section 1903(m) (42 U.S.C. 1396b(m)) is amend-  
15 ed—

16 (1) in paragraph (2)(A), as amended by sec-  
17 tions 3461(c) and 3464(c),—

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

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

22 (C) by inserting after clause (xiii) the fol-  
23 lowing new clause:



1           “(xiv) such contract provides for compliance of  
2           the organization with the grievance and appeals re-  
3           quirements described in paragraph (3).”; and

4           (2) by inserting after paragraph (2) the follow-  
5           ing new paragraph:

6           “(3)(A) An eligible organization must provide a  
7           meaningful and expedited procedure, which includes notice  
8           and hearing requirements, for resolving grievances be-  
9           tween the organization (including any entity or individual  
10          through which the organization provides health care serv-  
11          ices) and members enrolled with the organization under  
12          this subsection. Under the procedure any member enrolled  
13          with the organization may at any time file orally or in  
14          writing a complaint to resolve grievances between the  
15          member and the organization before a board of appeals  
16          established under subparagraph (C).

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

21          “(ii) Such notice shall include the following:

22                  “(I) A clear statement of the reason for the de-  
23          nial.

1           “(II) An explanation of the complaint process  
2           under subparagraph (C) which is available to the en-  
3           rollee upon request.

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

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

11          “(C)(i) Each eligible organization shall establish a  
12          board of appeals to hear and make determinations on com-  
13          plaints by enrollees under this subsection concerning deni-  
14          als of coverage or payment for services (whether in-net-  
15          work or out-of-network) and the medical necessity and ap-  
16          propriateness of covered items and services.

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

19                 “(I) representatives of the organization, includ-  
20                 ing physicians, nonphysicians, administrators, and  
21                 enrollees;

22                 “(II) consumers who are not enrollees; and

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

1       “(iii) A board of appeals shall hear and resolve com-  
2       plaints within 30 days after the date the complaint is filed  
3       with the board.

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

8       **SEC. 3466. STANDARDS RELATING TO ACCESS TO OBSTET-**  
9                               **ICAL AND GYNECOLOGICAL SERVICES**  
10                              **UNDER MANAGED CARE PLANS.**

11       (a) IN GENERAL.—Section 1903(m)(2)(A) (42  
12       U.S.C. 1396b(m)(2)(A)), as amended by sections 3461(e),  
13       3464(c), and 3465(1), is amended—

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

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

17               (3) by inserting after clause (xiv) the following:

18               “(xv) the organization complies with the re-  
19       quirements of paragraph (12).”.

20       (b) REQUIREMENTS.—Section 1903(m) (42 U.S.C.  
21       1396b(m)), as amended by sections 3463, 3464(a), and  
22       3464(b), is amended by adding at the end the following  
23       new paragraph:

24               “(12)(A) If a health maintenance organization, under  
25       a contract under this subsection, requires or provides for

1 an enrollee to designate a participating primary care pro-  
2 vider—

3 “(i) the organization shall permit a female en-  
4 rollee to designate an obstetrician-gynecologist who  
5 has agreed to be designated as such, as the enroll-  
6 ee’s primary care provider; and

7 “(ii) if such an enrollee has not designated such  
8 a provider as a primary care provider, the organiza-  
9 tion—

10 “(I) may not require prior authorization by  
11 the enrollee’s primary care provider or other-  
12 wise for coverage of obstetric and gynecologic  
13 care provided by a participating obstetrician-  
14 gynecologist, or a participating health care pro-  
15 fessional practicing in collaboration with the ob-  
16 stetrician-gynecologist and in accordance with  
17 State law, to the extent such care is otherwise  
18 covered, and

19 “(II) shall treat the ordering of other  
20 gynecologic care by such a participating physi-  
21 cian as the prior authorization of the primary  
22 care provider with respect to such care under  
23 the contract.

24 “(B) Nothing in subparagraph (A)(ii)(II) shall waive  
25 any requirements of coverage relating to medical necessity

1 or appropriateness with respect to coverage of gynecologic  
2 care so ordered.”.

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

## 6 **CHAPTER 3—FEDERAL PAYMENTS**

### 7 **SEC. 3471. REFORMING DISPROPORTIONATE SHARE PAY-** 8 **MENTS UNDER STATE MEDICAID PROGRAMS.**

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

11 (1) by striking “and” at the end of subpara-  
12 graph (A),

13 (2) by striking the period at the end of sub-  
14 paragraph (B) and inserting “, and”, and

15 (3) by adding at the end the following new sub-  
16 paragraph:

17 “(C) provides that payment adjustments  
18 under the plan under this section for services  
19 furnished by a hospital on or after October 1,  
20 1997, for individuals entitled to benefits under  
21 the plan, and enrolled with an entity described  
22 in section 1903(m), under a primary care case  
23 management system (described in section  
24 1905(t)), or other managed care plan—

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

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

7           (b) ADJUSTMENT TO STATE DSH ALLOCATIONS.—

8                   (1) IN GENERAL.—Subsection (f) of such sec-  
9                   tion is amended—

10                   (A) in paragraph (2)(A), by inserting “and  
11                   paragraph (5)” after “subparagraph (B)”, and

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

14                   “(5) ADJUSTMENTS IN DSH ALLOTMENTS.—

15                   “(A) ALLOTMENT FROZEN FOR STATES  
16                   WITH VERY LOW DSH EXPENDITURES.—In the  
17                   case of a State for which its State 1995 DSH  
18                   spending did not exceed 1 percent of the total  
19                   amount expenditures made under the State  
20                   plan under this title for medical assistance dur-  
21                   ing fiscal year 1995 (as reported by the State  
22                   no later than January 1, 1997, on HCFA Form  
23                   64), the DSH allotment for each of fiscal years  
24                   1998 through 2002 is equal to its State 1995  
25                   DSH spending.

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

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

16           “(D) FULL REDUCTION PERCENTAGE.—  
17 For purposes of this paragraph, the ‘full reduc-  
18 tion percentage’ for—

19                   “(i) fiscal year 1998 is 2 percent,  
20                   “(ii) fiscal year 1999 is 5 percent,  
21                   “(iii) fiscal year 2000 is 20 percent,  
22                   “(iv) fiscal year 2001 is 30 percent,  
23                   and  
24                   “(v) fiscal year 2002 is 40 percent.

25           “(E) DEFINITIONS.— In this paragraph:

1           “(i) STATE.—The term ‘State’ means  
2           the 50 States and the District of Colum-  
3           bia.

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

12          (2) EFFECTIVE DATE.—The amendments made  
13          by paragraph (1) shall apply to fiscal years begin-  
14          ning with fiscal year 1998.

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

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

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



1 **SEC. 3472. ADDITIONAL FUNDING FOR STATE EMERGENCY**  
2 **HEALTH SERVICES FURNISHED TO UNDOCU-**  
3 **MENTED ALIENS.**

4 (a) **TOTAL AMOUNT AVAILABLE FOR ALLOTMENT.—**  
5 There are available for allotments under this section for  
6 each of the 5 fiscal years (beginning with fiscal year 1998)  
7 \$20,000,000 for payments to certain States under this  
8 section.

9 (b) **STATE ALLOTMENT AMOUNT.—**

10 (1) **IN GENERAL.—**The Secretary of Health and  
11 Human Services shall compute an allotment for each  
12 fiscal year beginning with fiscal year 1998 and end-  
13 ing with fiscal year 2002 for each of the 12 States  
14 with the highest number of undocumented aliens.  
15 The amount of such allotment for each such State  
16 for a fiscal year shall bear the same ratio to the  
17 total amount available for allotments under sub-  
18 section (a) for the fiscal year as the ratio of the  
19 number of undocumented aliens in the State in the  
20 fiscal year bears to the total of such numbers for all  
21 such States for such fiscal year. The amount of al-  
22 lotment to a State provided under this paragraph for  
23 a fiscal year that is not paid out under subsection  
24 (c) shall be available for payment during the subse-  
25 quent fiscal year.

1           (2) DETERMINATION.—For purposes of para-  
2           graph (1), the number of undocumented aliens in a  
3           State under this section shall be determined based  
4           on estimates of the resident illegal alien population  
5           residing in each State prepared by the Statistics Di-  
6           vision of the Immigration and Naturalization Service  
7           as of October 1992 (or as of such later date if such  
8           date is at least 1 year before the beginning of the  
9           fiscal year involved),

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

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

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

1                   **Subtitle F—Child Health**  
 2                   **Assistance Program (CHAP)**

3 **SEC. 3501. SHORT TITLE OF SUBTITLE; TABLE OF CON-**  
 4                   **TENTS OF SUBTITLE.**

5           (a) **SHORT TITLE OF SUBTITLE.**—This subtitle may  
 6 be cited as the “Child Health Assistance Program Act of  
 7 1997”.

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

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

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

“TITLE XXI—CHILD HEALTH ASSISTANCE PROGRAM

“Sec. 2101. Purpose; State child health plans.

“Sec. 2102. Contents of State child health plan.

“Sec. 2103. Allotments.

“Sec. 2104. Payments to States.

“Sec. 2105. Process for submission, approval, and amendment of State  
 child health plans.

“Sec. 2106. Strategic objectives and performance goals; plan administra-  
 tion.

“Sec. 2107. Annual reports; evaluations.

“Sec. 2108. Definitions.

Sec. 3503. Optional use of State child health assistance funds for enhanced  
 medicaid match for expanded medicaid eligibility.

Sec. 3504. Medicaid presumptive eligibility for low-income children.

10 **SEC. 3502. ESTABLISHMENT OF CHILD HEALTH ASSIST-**  
 11                   **ANCE PROGRAM (CHAP).**

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



1 health assistance to needy children consistent with  
2 the provisions of this title, and

3 “(2) is approved under section 2105.

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

9 “(d) EFFECTIVE DATE.—No State is eligible for pay-  
10 ments under section 2104 for any calendar quarter begin-  
11 ning before October 1, 1997.

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

13 “(a) GENERAL BACKGROUND AND DESCRIPTION.—  
14 A State child health plan shall include a description, con-  
15 sistent with the requirements of this title, of—

16 “(1) the extent to which, and manner in which,  
17 children in the State, including targeted low-income  
18 children and other classes of children classified by  
19 income and other relevant factors, currently have  
20 creditable health coverage (as defined in section  
21 2108(c)(2));

22 “(2) current State efforts to provide or obtain  
23 creditable health coverage for uncovered children, in-  
24 cluding the steps the State is taking to identify and  
25 enroll all uncovered children who are eligible to par-

1        participate in public health insurance programs and  
2        health insurance programs that involve public-pri-  
3        vate partnerships;

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

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

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

11                “(1) ELIGIBILITY STANDARDS.—

12                        “(A) IN GENERAL.—The plan shall include  
13        a description of the standards used to deter-  
14        mine the eligibility of targeted low-income chil-  
15        dren for child health assistance under the plan.  
16        Such standards may include (to the extent con-  
17        sistent with this title) those relating to the geo-  
18        graphic areas to be served by the plan, age, in-  
19        come and resources (including any standards  
20        relating to spenddowns and disposition of re-  
21        sources), residency, disability status, immigra-  
22        tion status, access to or coverage under other  
23        health coverage, and duration of eligibility.  
24        Such standards may not discriminate on the  
25        basis of diagnosis.

1           “(B) LIMITATIONS ON ELIGIBILITY STAND-  
2 ARDS.—Such eligibility standards—

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

8           “(ii) may not deny eligibility based on  
9 a child having a preexisting medical condi-  
10 tion.

11           “(2) METHODOLOGY.—The plan shall include a  
12 description of methods of establishing and continu-  
13 ing eligibility and enrollment, including a methodol-  
14 ogy for computing family income that is consistent  
15 with the methodology used under section  
16 1902(l)(3)(E).

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

21           “(A) through both intake and followup  
22 screening, that only targeted low-income chil-  
23 dren are furnished child health assistance under  
24 the State child health plan;

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

6           “(C) that the insurance provided under the  
7           State child health plan does not substitute for  
8           coverage under group health plans; and

9           “(D) coordination with other public and  
10          private programs providing creditable coverage  
11          for low-income children.

12          “(4) NONENTITLEMENT.—Nothing in this title  
13          shall be construed as providing an individual with an  
14          entitlement to child health assistance under a State  
15          child health plan.

16          “(c) DESCRIPTION OF ASSISTANCE.—

17                 “(1) IN GENERAL.—A State child health plan  
18                 shall include a description of the child health assist-  
19                 ance provided under the plan for targeted low-in-  
20                 come children. The child health assistance provided  
21                 to a targeted low-income child under the plan in the  
22                 form described in paragraph (2) of section 2101(a)  
23                 shall include benefits (in an amount, duration, and  
24                 scope specified under the plan) for at least the fol-  
25                 lowing categories of services:



1           “(A) Inpatient and outpatient hospital  
2 services.

3           “(B) Physicians’ surgical and medical serv-  
4 ices.

5           “(C) Laboratory and x-ray services.

6           “(D) Well-baby and well-child care, includ-  
7 ing age-appropriate immunizations.

8           The previous sentence shall not apply to coverage  
9 under a group health plan if the benefits under such  
10 coverage for individuals under this title are no less  
11 than the benefits for other individuals similarly cov-  
12 ered under the plan.

13           “(2) ITEMS.—The description shall include the  
14 following:

15           “(A) COST SHARING.—Subject to para-  
16 graph (3), the amount (if any) of premiums,  
17 deductibles, coinsurance, and other cost sharing  
18 imposed.

19           “(B) DELIVERY METHOD.—The State’s  
20 approach to delivery of child health assistance,  
21 including a general description of—

22           “(i) the use (or intended use) of dif-  
23 ferent delivery methods, which may include  
24 the delivery methods used under the medic-  
25 aid plan under title XIX, fee-for-service,

1 managed care arrangements (such as  
2 capitated health care plans, case manage-  
3 ment, and case coordination), direct provi-  
4 sion of health care services (such as  
5 through community health centers and dis-  
6 proportionate share hospitals), vouchers,  
7 and other delivery methods; and

8 “(ii) utilization control systems.

9 “(3) LIMITATIONS ON COST SHARING.—

10 “(A) NO COST SHARING ON PREVENTIVE  
11 BENEFITS.—The plan may not impose  
12 deductibles, coinsurance, or similar cost sharing  
13 with respect to benefits for preventive services.

14 “(B) SLIDING SCALE.—To the extent prac-  
15 ticable, any premiums imposed under the plan  
16 shall be imposed on a sliding scale related to in-  
17 come and the plan may only vary premiums,  
18 deductibles, coinsurance, and other cost sharing  
19 based on the family income of targeted low-in-  
20 come children only in a manner that does not  
21 favor children from families with higher income  
22 over children from families with lower income.

23 “(4) RESTRICTION ON APPLICATION OF PRE-  
24 EXISTING CONDITION EXCLUSIONS.—

1           “(A) IN GENERAL.—Subject to subpara-  
2 graph (B), the State child health plan shall not  
3 permit the imposition of any preexisting condi-  
4 tion exclusion for covered benefits under the  
5 plan.

6           “(B) GROUP HEALTH PLANS AND GROUP  
7 HEALTH INSURANCE COVERAGE.—If the State  
8 child health plan provides for benefits through  
9 payment for, or a contract with, a group health  
10 plan or group health insurance coverage, the  
11 plan may permit the imposition of a preexisting  
12 condition exclusion but only insofar as it is per-  
13 mitted under the applicable provisions of part 7  
14 of subtitle B of title I of the Employee Retire-  
15 ment Income Security Act of 1974 and title  
16 XXVII of the Public Health Service Act.

17           “(5) SPECIAL PROTECTION FOR CHILDREN  
18 WITH CHRONIC HEALTH CONDITIONS AND SPECIAL  
19 HEALTH CARE NEEDS.—In the case of a child who  
20 has a chronic condition, life-threatening condition, or  
21 combination of conditions that warrants medical spe-  
22 cialty care and who is eligible for benefits under the  
23 plan with respect to such care, the State child health  
24 plan shall assure access to such care, including the

1 use of a medical specialist as a primary care pro-  
2 vider.

3 “(6) SECONDARY PAYMENT.—Nothing in this  
4 section shall be construed as preventing a State  
5 from denying benefits to an individual to the extent  
6 such benefits are available to the individual under  
7 another public or private health care insurance pro-  
8 gram.

9 “(7) TREATMENT OF CASH PAYMENTS.—Pay-  
10 ments in the form of cash or vouchers provided as  
11 child health or other assistance under the State child  
12 health plan to parents, guardians or other caretakers  
13 of a targeted low-income child are not considered in-  
14 come for purpose of eligibility for, or benefits pro-  
15 vided under, any means-tested Federal or Federally-  
16 assisted program.

17 “(d) OUTREACH AND COORDINATION.—A State child  
18 health plan shall include a description of the procedures  
19 to be used by the State to accomplish the following:

20 “(1) OUTREACH.—Outreach to families of chil-  
21 dren likely to be eligible for child health assistance  
22 under the plan or under other public or private  
23 health coverage programs to inform these families of  
24 the availability of, and to assist them in enrolling  
25 their children in, such a program.

1           “(2) COORDINATION WITH OTHER HEALTH IN-  
2           SURANCE PROGRAMS.—Coordination of the adminis-  
3           tration of the State program under this subtitle with  
4           other public and private health insurance programs.

5   **“SEC. 2103. ALLOTMENTS.**

6           “(a) TOTAL ALLOTMENT.—The total allotment that  
7           is available under this title for each fiscal year, beginning  
8           with fiscal year 1998, is \$2,880,000,000.

9           “(b) ALLOTMENTS TO 50 STATES AND DISTRICT OF  
10          COLUMBIA.—

11           “(1) IN GENERAL.—Subject to paragraphs (4)  
12           and (5), of the total allotment available under sub-  
13           section (a) for a fiscal year, reduced by the amount  
14           of allotments made under subsection (c) for the fis-  
15           cal year, the Secretary shall allot to each State  
16           (other than a State described in such subsection)  
17           with a State child health plan approved under this  
18           title the same proportion as the ratio of—

19                   “(A) the product of (i) the number of un-  
20                   covered low-income children for the fiscal year  
21                   in the State (as determined under paragraph  
22                   (2)) and (ii) the State cost factor for that State  
23                   (established under paragraph (3)); to

24                   “(B) the sum of the products computed  
25                   under subparagraph (A).

1           “(2) NUMBER OF UNCOVERED LOW-INCOME  
2 CHILDREN.—For the purposes of paragraph  
3 (1)(A)(i), the number of uncovered low-income chil-  
4 dren for a fiscal year in a State is equal to the arith-  
5 metic average of the number of low-income children  
6 (as defined in section 2108(c)(4)) with no health in-  
7 surance coverage, as reported and defined in the 3  
8 most recent March supplements to the Current Pop-  
9 ulation Survey of the Bureau of the Census before  
10 the beginning of the fiscal year.

11           “(3) ADJUSTMENT FOR GEOGRAPHIC VARI-  
12 ATIONS IN HEALTH COSTS.—

13           “(A) IN GENERAL.—For purposes of para-  
14 graph (1)(A)(ii), the ‘State cost factor’ for a  
15 State for a fiscal year equal to the sum of—

16                   “(i) 0.15, and

17                   “(ii) 0.85 multiplied by the ratio of—

18                           “(I) the annual average wages  
19 per employee for the State for such  
20 year (as determined under subpara-  
21 graph (B)), to

22                           “(II) the annual average wages  
23 per employee for the 50 States and  
24 the District of Columbia.

1           “(B) ANNUAL AVERAGE WAGES PER EM-  
2           PLOYEE.—For purposes of subparagraph (A),  
3           the ‘annual average wages per employee’ for a  
4           State, or for all the States. for a fiscal year is  
5           equal to the average of the annual wages per  
6           employee for the State or for the 50 States and  
7           the District of Columbia for employees in the  
8           health services industry (SIC code 8000), as re-  
9           ported by the Bureau of Labor Statistics of the  
10          Department of Labor for each of the for the  
11          most recent 3 years before the beginning of the  
12          fiscal year involved.

13          “(4) FLOOR FOR STATES.—Subject to para-  
14          graph (5), in no case shall the amount of the allot-  
15          ment under this subsection for one of the 50 States  
16          or the District of Columbia for a year be less than  
17          \$2,000,000. To the extent that the application of the  
18          previous sentence results in an increase in the allot-  
19          ment to a State above the amount otherwise pro-  
20          vided, the allotments for the other States and the  
21          District of Columbia under this subsection shall be  
22          decreased in a pro rata manner (but not below  
23          \$2,000,000) so that the total of such allotments in  
24          a fiscal year does not exceed the amount otherwise

1 provided for allotment under paragraph (1) for that  
2 fiscal year.

3 “(5) OFFSET FOR EXPENDITURES UNDER MED-  
4 ICAID PRESUMPTIVE ELIGIBILITY.—The amount of  
5 the allotment otherwise provided to a State under  
6 this subsection for a fiscal year shall be reduced by  
7 the amount of the payments made to the State  
8 under section 1903(a) for calendar quarters during  
9 such fiscal year that are attributable to provision of  
10 medical assistance to a child during a presumptive  
11 eligibility period under section 1920A.

12 “(c) ALLOTMENTS TO TERRITORIES.—

13 “(1) IN GENERAL.—Subject to paragraph (3),  
14 of the total allotment under subsection (a) for a fis-  
15 cal year, the Secretary shall allot 0.5 percent among  
16 each of the commonwealths and territories described  
17 in paragraph (4) in the same proportion as the per-  
18 centage specified in paragraph (2) for such common-  
19 wealth or territory bears to the sum of such percent-  
20 ages for all such commonwealths or territories so de-  
21 scribed.

22 “(2) PERCENTAGE.—The percentage specified  
23 in this paragraph for—

24 “(A) Puerto Rico is 91.6 percent,

25 “(B) Guam is 3.5 percent,



1           “(C) Virgin Islands is 2.6 percent,

2           “(D) American Samoa is 1.2 percent, and

3           “(E) the Northern Mariana Islands is 1.1

4           percent.

5           “(3) FLOOR.—In no case shall the amount of  
6           the allotment to a commonwealth or territory under  
7           paragraph (1) for a fiscal year be less than  
8           \$100,000. To the extent that the application of the  
9           previous sentence results in an increase in the allot-  
10          ment to a commonwealth or territory above the  
11          amount otherwise provided, the allotments for the  
12          other commonwealths and territories under this sub-  
13          section for the fiscal year shall be decreased (but not  
14          below \$100,000) in a pro rata manner so that the  
15          total of such allotments does not exceed the total  
16          amount otherwise provided for allotment under para-  
17          graph (1).

18          “(4) COMMONWEALTHS AND TERRITORIES.—A  
19          commonwealth or territory described in this para-  
20          graph is any of the following if it has a State child  
21          health plan approved under this title:

22                 “(A) Puerto Rico.

23                 “(B) Guam.

24                 “(C) the Virgin Islands.

25                 “(D) American Samoa.

1                   “(E) the Northern Mariana Islands.

2           “(d) ADJUSTMENT FOR STATES USING ENHANCED  
3 MEDICAID MATCH.—In the case of a State that elects the  
4 increased medicaid matching option under section 1905(t),  
5 the amount of the State’s allotment under this section  
6 shall be reduced by the amount of additional payment  
7 made under section 1903 that is attributable to the in-  
8 crease in the Federal medical assistance percentage ef-  
9 fected under such option.

10          “(e) 3-YEAR AVAILABILITY OF AMOUNTS ALLOT-  
11 TED.—Amounts allotted to a State pursuant to this sec-  
12 tion for a fiscal year shall remain available for expenditure  
13 by the State through the end of the second succeeding fis-  
14 cal year.

15   **“SEC. 2104. PAYMENTS TO STATES.**

16          “(a) IN GENERAL.—Subject to the succeeding provi-  
17 sions of this section, the Secretary shall pay to each State  
18 with a program approved under this title, from its allot-  
19 ment under section 2103 (as may be adjusted under sec-  
20 tion 2103(d)), an amount for each quarter up to 80 per-  
21 cent of expenditures under that program in the quarter  
22 for—

23                   “(1) child health assistance for targeted low-in-  
24           come children;

1           “(2) health services initiatives for improving the  
2 health of children (including targeted low-income  
3 children and other low-income children);

4           “(3) expenditures for outreach activities as pro-  
5 vided in section 2102(d)(1); and

6           “(4) other reasonable costs incurred by the  
7 State to administer the plan.

8           “(b) LIMITATION ON CERTAIN PAYMENTS FOR CER-  
9 TAIN EXPENDITURES.—

10           “(1) IN GENERAL.—Funds provided to a State  
11 under this title shall only be used to carry out the  
12 purposes of this title.

13           “(2) LIMITATION ON EXPENDITURES NOT USED  
14 FOR ASSISTANCE.—Payment shall not be made  
15 under subsection (a) for expenditures for items de-  
16 scribed in paragraphs (2), (3), or (4) of subsection  
17 to the extent the total of such expenditures exceeds  
18 15 percent of total expenditures under the plan for  
19 the period involved (including any in such total addi-  
20 tional Federal medical assistance payments under  
21 section 1903(a)(1) that are attributable to an en-  
22 hanced State medicaid match under section  
23 1905(t)).

24           “(3) PURCHASE OF FAMILY COVERAGE.—The  
25 Secretary shall establish rules regarding the extent

1 to which payment may be made under subsection  
2 (a)(1) for the purchase of family coverage under a  
3 group health plan or health insurance coverage that  
4 includes coverage of targeted low-income children.  
5 Under such rules such payment may be permitted,  
6 notwithstanding that a portion may be considered  
7 attributable to purchase of coverage for other family  
8 members, if the State demonstrates that purchase of  
9 such coverage is cost effective relative to the  
10 amounts that the State would have paid to obtain  
11 comparable coverage only of the targeted low-income  
12 children involved. In making such determination,  
13 there shall be taken into account the costs of provid-  
14 ing coverage for medical assistance for children with  
15 similar actuarial characteristics under section  
16 1902(l).

17 “(4) DENIAL OF PAYMENT FOR REDUCTION OF  
18 MEDICAID ELIGIBILITY STANDARDS.—No payment  
19 may be made under subsection (a) with respect to  
20 child health assistance provided under a State child  
21 health plan to a targeted low-income child if the  
22 child would be eligible for medical assistance under  
23 the State plan under title XIX (as such plan was in  
24 effect as of June 1, 1997) but for a change in the

1 income or assets standards or methodology under  
2 such plan effected after such date.

3 “(5) DISALLOWANCES FOR EXCLUDED PROVID-  
4 ERS.—

5 “(A) IN GENERAL.—Payment shall not be  
6 made to a State under subsection (a) for ex-  
7 penditures for items and services furnished—

8 “(i) by a provider who was excluded  
9 from participation under title V, XVIII, or  
10 XX or under this title pursuant to section  
11 1128, 1128A, 1156, or 1842(j)(2), or

12 “(ii) under the medical direction or on  
13 the prescription of a physician who was so  
14 excluded, if the provider of the services  
15 knew or had reason to know of the exclu-  
16 sion.

17 “(B) EXCEPTION FOR EMERGENCY SERV-  
18 ICES.—Subparagraph (A) shall not apply to  
19 emergency items or services, not including hos-  
20 pital emergency room services.

21 “(6) USE OF NON-FEDERAL FUNDS FOR STATE  
22 MATCHING REQUIREMENT.—Amounts provided by  
23 the Federal Government, or services assisted or sub-  
24 sidized to any significant extent by the Federal Gov-  
25 ernment, may not be included in determining the

1 amount of non-Federal contributions required under  
2 subsection (a).

3 “(7) TREATMENT OF THIRD PARTY LIABIL-  
4 ITY.—No payment shall be made to a State under  
5 this section for expenditures for child health assist-  
6 ance provided for a targeted low-income child under  
7 its plan to the extent that a private insurer (as de-  
8 fined by the Secretary by regulation and including a  
9 group health plan (as defined in section 607(1) of  
10 the Employee Retirement Income Security Act of  
11 1974), a service benefit plan, and a health mainte-  
12 nance organization) would have been obligated to  
13 provide such assistance but for a provision of its in-  
14 surance contract which has the effect of limiting or  
15 excluding such obligation because the individual is  
16 eligible for or is provided child health assistance  
17 under the plan.

18 “(8) SECONDARY PAYER PROVISIONS.—Except  
19 as otherwise provided by law, no payment shall be  
20 made to a State under this section for expenditures  
21 for child health assistance provided for a targeted  
22 low-income child under its plan to the extent that  
23 payment has been made or can reasonably be ex-  
24 pected to be made promptly (as determined in ac-  
25 cordance with regulations) under any other federally

1 operated or financed health care insurance program,  
2 other than an insurance program operated or fi-  
3 nanced by the Indian Health Service, as identified  
4 by the Secretary. For purposes of this paragraph,  
5 rules similar to the rules for overpayments under  
6 section 1903(d)(2) shall apply.

7 “(9) LIMITATION ON PAYMENT FOR ABOR-  
8 TIONS.—

9 “(A) IN GENERAL.—Payment shall not be  
10 made to a State under this section for any  
11 amount expended under the State plan to pay  
12 for any abortion or to assist in the purchase, in  
13 whole or in part, of health benefit coverage that  
14 includes coverage of abortion.

15 “(B) EXCEPTION.—Subparagraph (A)  
16 shall not apply to an abortion—

17 “(i) if the pregnancy is the result of  
18 an act of rape or incest, or

19 “(ii) in the case where a woman suf-  
20 fers from a physical disorder, illness, or in-  
21 jury that would, as certified by a physi-  
22 cian, place the woman in danger of death  
23 unless an abortion is performed.

24 “(c) ADVANCE PAYMENT; RETROSPECTIVE ADJUST-  
25 MENT.—The Secretary may make payments under this

1 section for each quarter on the basis of advance estimates  
2 of expenditures submitted by the State and other inves-  
3 tigation the Secretary may find necessary, and may reduce  
4 or increase the payments as necessary to adjust for any  
5 overpayment or underpayment for prior quarters.

6 **“SEC. 2105. PROCESS FOR SUBMISSION, APPROVAL, AND**  
7 **AMENDMENT OF STATE CHILD HEALTH**  
8 **PLANS.**

9 “(a) INITIAL PLAN.—

10 “(1) IN GENERAL.—As a condition of receiving  
11 funding under section 2104, a State shall submit to  
12 the Secretary a State child health plan that meets  
13 the applicable requirements of this title.

14 “(2) APPROVAL.—Except as the Secretary may  
15 provide under subsection (e), a State plan submitted  
16 under paragraph (1)—

17 “(A) shall be approved for purposes of this  
18 title, and

19 “(B) shall be effective beginning with a  
20 calendar quarter that is specified in the plan,  
21 but in no case earlier than the first calendar  
22 quarter that begins at least 60 days after the  
23 date the plan is submitted.

24 “(b) PLAN AMENDMENTS.—



1           “(1) IN GENERAL.—A State may amend, in  
2 whole or in part, its State child health plan at any  
3 time through transmittal of a plan amendment.

4           “(2) APPROVAL.—except as the secretary may  
5 provide under subsection (e), an amendment to a  
6 state plan submitted under paragraph (1)—

7                   “(A) shall be approved for purposes of this  
8 title, and

9                   “(B) shall be effective as provided in para-  
10 graph (3).

11           “(3) EFFECTIVE DATES FOR AMENDMENTS.—

12                   “(A) IN GENERAL.—Subject to the suc-  
13 ceeding provisions of this paragraph, an amend-  
14 ment to a State plan shall take effect on one or  
15 more effective dates specified in the amend-  
16 ment.

17                   “(B) AMENDMENTS RELATING TO ELIGI-  
18 BILITY OR BENEFITS.—

19                           “(i) NOTICE REQUIREMENT.—Any  
20 plan amendment that eliminates or re-  
21 stricts eligibility or benefits under the plan  
22 may not take effect unless the State cer-  
23 tifies that it has provided prior or contem-  
24 poraneous public notice of the change, in a

1 form and manner provided under applica-  
2 ble State law.

3 “(ii) **TIMELY TRANSMITTAL.**—Any  
4 plan amendment that eliminates or re-  
5 stricts eligibility or benefits under the plan  
6 shall not be effective for longer than a 60-  
7 day period unless the amendment has been  
8 transmitted to the Secretary before the end  
9 of such period.

10 “(C) **OTHER AMENDMENTS.**—Any plan  
11 amendment that is not described in subpara-  
12 graph (C) becomes effective in a State fiscal  
13 year may not remain in effect after the end of  
14 such fiscal year (or, if later, the end of the 90-  
15 day period on which it becomes effective) unless  
16 the amendment has been transmitted to the  
17 Secretary.

18 “(c) **DISAPPROVAL OF PLANS AND PLAN AMEND-**  
19 **MENTS.**—

20 “(1) **PROMPT REVIEW OF PLAN SUBMITTALS.**—  
21 The Secretary shall promptly review State plans and  
22 plan amendments submitted under this section to  
23 determine if they substantially comply with the re-  
24 quirements of this title.

1           “(2) 90-DAY APPROVAL DEADLINES.—A State  
2           plan or plan amendment is considered approved un-  
3           less the Secretary notifies the State in writing, with-  
4           in 90 days after receipt of the plan or amendment,  
5           that the plan or amendment is disapproved (and the  
6           reasons for disapproval) or that specified additional  
7           information is needed.

8           “(3) CORRECTION.—In the case of a dis-  
9           approval of a plan or plan amendment, the Secretary  
10          shall provide a State with a reasonable opportunity  
11          for correction before taking financial sanctions  
12          against the State on the basis of such disapproval.

13          “(d) PROGRAM OPERATION.—

14                 “(1) IN GENERAL.—The State shall conduct the  
15                 program in accordance with the plan (and any  
16                 amendments) approved under subsection (c) and  
17                 with the requirements of this title.

18                 “(2) VIOLATIONS.—The Secretary shall estab-  
19                 lish a process for enforcing requirements under this  
20                 title. Such process shall provide for the withholding  
21                 of funds in the case of substantial noncompliance  
22                 with such requirements. In the case of an enforce-  
23                 ment action against a State under this paragraph,  
24                 the Secretary shall provide a State with a reasonable  
25                 opportunity for correction before taking financial

1 sanctions against the State on the basis of such an  
2 action.

3 “(e) CONTINUED APPROVAL.—An approved State  
4 child health plan shall continue in effect unless and until  
5 the State amends the plan under subsection (b) or the Sec-  
6 retary finds substantial noncompliance of the plan with  
7 the requirements of this title under section subsection  
8 (d)(2).

9 **“SEC. 2106. STRATEGIC OBJECTIVES AND PERFORMANCE**  
10 **GOALS; PLAN ADMINISTRATION.**

11 “(a) STRATEGIC OBJECTIVES AND PERFORMANCE  
12 GOALS.—

13 “(1) DESCRIPTION.—A State child health plan  
14 shall include a description of—

15 “(A) the strategic objectives,

16 “(B) the performance goals, and

17 “(C) the performance measures,

18 the State has established for providing child health  
19 assistance to targeted low-income children under the  
20 plan and otherwise for maximizing health coverage  
21 for other low-income children and children generally  
22 in the State.

23 “(2) STRATEGIC OBJECTIVES.—Such plan shall  
24 identify specific strategic objectives relating to in-  
25 creasing the extent of creditable health coverage

1 among targeted low-income children and other low-  
2 income children.

3 “(3) PERFORMANCE GOALS.—Such plan shall  
4 specify one or more performance goals for each such  
5 strategic objective so identified.

6 “(4) PERFORMANCE MEASURES.—Such plan  
7 shall describe how performance under the plan will  
8 be—

9 “(A) measured through objective, inde-  
10 pendently verifiable means, and

11 “(B) compared against performance goals,  
12 in order to determine the State’s performance  
13 under this title.

14 “(b) RECORDS, REPORTS, AUDITS, AND EVALUA-  
15 TION.—

16 “(1) DATA COLLECTION, RECORDS, AND RE-  
17 PORTS.—A State child health plan shall include an  
18 assurance that the State will collect the data, main-  
19 tain the records, and furnish the reports to the Sec-  
20 retary, at the times and in the standardized format  
21 the Secretary may require in order to enable the  
22 Secretary to monitor State program administration  
23 and compliance and to evaluate and compare the ef-  
24 fectiveness of State plans under this title.

1           “(2) STATE ASSESSMENT AND STUDY.—A State  
2           child health plan shall include a description of the  
3           State’s plan for the annual assessments and reports  
4           under section 2107(a) and the evaluation required  
5           by section 2107(b).

6           “(3) AUDITS.—A State child health plan shall  
7           include an assurance that the State will afford the  
8           Secretary access to any records or information relat-  
9           ing to the plan for the purposes of review or audit.

10          “(c) PROGRAM DEVELOPMENT PROCESS.—A State  
11          child health plan shall include a description of the process  
12          used to involve the public in the design and implementa-  
13          tion of the plan and the method for ensuring ongoing pub-  
14          lic involvement.

15          “(d) PROGRAM BUDGET.—A State child health plan  
16          shall include a description of the budget for the plan. The  
17          description shall be updated periodically as necessary and  
18          shall include details on the planned use of funds and the  
19          sources of the non-Federal share of plan expenditures, in-  
20          cluding any requirements for cost sharing by beneficiaries.

21          “(e) APPLICATION OF CERTAIN GENERAL PROVI-  
22          SIONS.—The following sections in part A of title XI shall  
23          apply to States under this title in the same manner as  
24          they applied to a State under title XIX:

1           “(1) Section 1101(a)(1) (relating to definition  
2 of State).

3           “(2) Section 1116 (relating to administrative  
4 and judicial review), but only insofar as consistent  
5 with the provisions of part B.

6           “(3) Section 1124 (relating to disclosure of  
7 ownership and related information).

8           “(4) Section 1126 (relating to disclosure of in-  
9 formation about certain convicted individuals).

10           “(5) Section 1128B(d) (relating to criminal  
11 penalties for certain additional charges).

12           “(6) Section 1132 (relating to periods within  
13 which claims must be filed).

14 **“SEC. 2107. ANNUAL REPORTS; EVALUATIONS.**

15           “(a) ANNUAL REPORT.—The State shall—

16           “(1) assess the operation of the State plan  
17 under this title in each fiscal year, including the  
18 progress made in reducing the number of uncovered  
19 low-income children; and

20           “(2) report to the Secretary, by January 1 fol-  
21 lowing the end of the fiscal year, on the result of the  
22 assessment.

23           “(b) STATE EVALUATIONS.—

24           “(1) IN GENERAL.—By March 31, 2000, each  
25 State that has a State child health plan shall submit

1 to the Secretary an evaluation that includes each of  
2 the following:

3 “(A) An assessment of the effectiveness of  
4 the State plan in increasing the number of chil-  
5 dren with creditable health coverage.;

6 “(B) A description and analysis of the ef-  
7 fectiveness of elements of the State plan, in-  
8 cluding—

9 “(i) the characteristics of the children  
10 and families assisted under the State plan  
11 including age of the children, family in-  
12 come, and the assisted child’s access to or  
13 coverage by other health insurance prior to  
14 the State plan and after eligibility for the  
15 State plan ends,

16 “(ii) the quality of health coverage  
17 provided including the types of benefits  
18 provided,

19 “(iii) the amount and level (payment  
20 of part or all of the premium) of assistance  
21 provided by the State,

22 “(iv) the service area of the State  
23 plan,

24 “(v) the time limits for coverage of a  
25 child under the State plan,



1           “(vi) the State’s choice of health in-  
2           surance plans and other methods used for  
3           providing child health assistance , and

4           “(vii) the sources of non-Federal  
5           funding used in the State plan;

6           “(C) an assessment of the effectiveness of  
7           other public and private programs in the State  
8           in increasing the availability of affordable qual-  
9           ity individual and family health insurance for  
10          children;

11          “(D) a review and assessment of State ac-  
12          tivities to coordinate the plan under this title  
13          with other public and private programs provid-  
14          ing health care and health care financing, in-  
15          cluding Medicaid and maternal and child health  
16          services;

17          “(E) an analysis of changes and trends in  
18          the State that affect the provision of accessible,  
19          affordable, quality health insurance and health  
20          care to children;

21          “(F) a description of any plans the State  
22          has for improving the availability of health in-  
23          surance and health care for children;

24          “(G) recommendations for improving the  
25          program under this title; and

1           “(H) any other matters the State and the  
2           Secretary consider appropriate.

3           “(2) REPORT OF THE SECRETARY.—The Sec-  
4           retary shall submit to the Congress and make avail-  
5           able to the public by December 31, 2000, a report  
6           based on the evaluations submitted by States under  
7           paragraph (1), containing any conclusions and rec-  
8           ommendations the Secretary considers appropriate.

9   **“SEC. 2108. DEFINITIONS.**

10          “(a) CHILD HEALTH ASSISTANCE.—For purposes of  
11 this title, the term ‘child health assistance’ means pay-  
12 ment of part or all of the cost of any of the following,  
13 or assistance in the purchase, in whole or in part, of health  
14 benefit coverage that includes any of the following, for tar-  
15 geted low-income children (as defined in subsection (b))  
16 as specified under the State plan:

17           “(1) Inpatient hospital services.

18           “(2) Outpatient hospital services.

19           “(3) Physician services.

20           “(4) Surgical services.

21           “(5) Clinic services (including health center  
22 services) and other ambulatory health care services.

23           “(6) Prescription drugs and biologicals and the  
24 administration of such drugs and biologicals, only if  
25 such drugs and biologicals are not furnished for the

1 purpose of causing, or assisting in causing, the  
2 death, suicide, euthanasia, or mercy killing of a per-  
3 son.

4 “(7) Over-the-counter medications.

5 “(8) Laboratory and radiological services.

6 “(9) Prenatal care and prepregnancy family  
7 planning services and supplies.

8 “(10) Inpatient mental health services, includ-  
9 ing services furnished in a State-operated mental  
10 hospital and including residential or other 24-hour  
11 therapeutically planned structured services.

12 “(11) Outpatient mental health services, includ-  
13 ing services furnished in a State-operated mental  
14 hospital and including community-based services.

15 “(12) Durable medical equipment and other  
16 medically-related or remedial devices (such as pros-  
17 thetic devices, implants, eyeglasses, hearing aids,  
18 dental devices, and adaptive devices).

19 “(13) Disposable medical supplies.

20 “(14) Home and community-based health care  
21 services and related supportive services (such as  
22 home health nursing services, home health aide serv-  
23 ices, personal care, assistance with activities of daily  
24 living, chore services, day care services, respite care

1 services, training for family members, and minor  
2 modifications to the home).

3 “(15) Nursing care services (such as nurse  
4 practitioner services, nurse midwife services, ad-  
5 vanced practice nurse services, private duty nursing  
6 care, pediatric nurse services, and respiratory care  
7 services) in a home, school, or other setting.

8 “(16) Abortion only if necessary to save the life  
9 of the mother or if the pregnancy is the result of an  
10 act of rape or incest.

11 “(17) Dental services.

12 “(18) Inpatient substance abuse treatment  
13 services and residential substance abuse treatment  
14 services.

15 “(19) Outpatient substance abuse treatment  
16 services.

17 “(20) Case management services.

18 “(21) Care coordination services.

19 “(22) Physical therapy, occupational therapy,  
20 and services for individuals with speech, hearing,  
21 and language disorders.

22 “(23) Hospice care.

23 “(24) Any other medical, diagnostic, screening,  
24 preventive, restorative, remedial, therapeutic, or re-  
25 habilitative services (whether in a facility, home,

1 school, or other setting) if recognized by State law  
2 and only if the service is—

3 “(A) prescribed by or furnished by a physi-  
4 cian or other licensed or registered practitioner  
5 within the scope of practice as defined by State  
6 law,

7 “(B) performed under the general super-  
8 vision or at the direction of a physician, or

9 “(C) furnished by a health care facility  
10 that is operated by a State or local government  
11 or is licensed under State law and operating  
12 within the scope of the license.

13 “(25) Premiums for private health care insur-  
14 ance coverage.

15 “(26) Medical transportation.

16 “(27) Enabling services (such as transpor-  
17 tation, translation, and outreach services) only if de-  
18 signed to increase the accessibility of primary and  
19 preventive health care services for eligible low-in-  
20 come individuals.

21 “(28) Any other health care services or items  
22 specified by the Secretary and not excluded under  
23 this section.

24 “(b) TARGETED LOW-INCOME CHILD DEFINED.—

25 For purposes of this title—

1           “(1) IN GENERAL.—The term ‘targeted low-in-  
2           come child’ means a child—

3                   “(A) who has been determined eligible by  
4                   the State for child health assistance under the  
5                   State plan;

6                   “(B) whose family income (as determined  
7                   under the State child health plan)—

8                           “(i) exceeds the medicaid applicable  
9                           income level (as defined in paragraph (2)  
10                           and expressed as a percentage of the pov-  
11                           erty line), but

12                           “(ii) but does not exceed an income  
13                           level that is 75 percentage points higher  
14                           (as so expressed) than the medicaid appli-  
15                           cable income level, or, if higher, 133 per-  
16                           cent of the poverty line for a family of the  
17                           size involved; and

18                   “(C) who is not found to be eligible for  
19                   medical assistance under title XIX or covered  
20                   under a group health plan or under health in-  
21                   surance coverage (as such terms are defined in  
22                   section 2791 of the Public Health Service Act).

23           Such term does not include a child who is an inmate  
24           of a public institution.

1           “(2) MEDICAID APPLICABLE INCOME LEVEL.—

2           The term ‘medicaid applicable income level’ means,  
3           with respect to a child, the effective income level (ex-  
4           pressed as a percent of the poverty line) that has  
5           been specified under the State plan under title XIX  
6           (including under a waiver authorized by the Sec-  
7           retary or under section 1902(r)(2)), as of June 1,  
8           1997, for the child to be eligible for medical assist-  
9           ance under section 1902(l)(2) for the age of such  
10          child. In applying the previous sentence in the case  
11          of a child described in section 1902(l)(2)(D), such  
12          level shall be applied taking into account the ex-  
13          panded coverage effected among such children under  
14          such section with the passage of time.

15          “(c) ADDITIONAL DEFINITIONS.—For purposes of  
16 this title:

17           “(1) CHILD.—The term ‘child’ means an indi-  
18           vidual under 19 years of age.

19           “(2) CREDITABLE HEALTH COVERAGE.—The  
20           term ‘creditable health coverage’ has the meaning  
21           given the term ‘creditable coverage’ under section  
22           2701(e) of the Public Health Service Act (42 U.S.C.  
23           300gg(e)) and includes coverage (including the di-  
24           rect provision of services) provided to a targeted low-  
25           income child under this title.

1           “(3) GROUP HEALTH PLAN; HEALTH INSUR-  
2           ANCE COVERAGE; ETC.—The terms ‘group health  
3           plan’, ‘group health insurance coverage’, and ‘health  
4           insurance coverage’ have the meanings given such  
5           terms in section 2191 of the Public Health Service  
6           Act.

7           “(4) LOW-INCOME.—The term ‘low-income  
8           child’ means a child whose family income is below  
9           200 percent of the poverty line for a family of the  
10          size involved.

11          “(5) POVERTY LINE DEFINED.—The term ‘pov-  
12          erty line’ has the meaning given such term in section  
13          673(2) of the Community Services Block Grant Act  
14          (42 U.S.C. 9902(2)), including any revision required  
15          by such section.

16          “(6) PREEXISTING CONDITION EXCLUSION.—  
17          The term ‘preexisting condition exclusion’ has the  
18          meaning given such term in section 2701(b)(1)(A) of  
19          the Public Health Service Act (42 U.S.C.  
20          300gg(b)(1)(A)).

21          “(7) STATE CHILD HEALTH PLAN; PLAN.—Un-  
22          less the context otherwise requires, the terms ‘State  
23          child health plan’ and ‘plan’ mean a State child  
24          health plan approved under section 2105.



1           “(8) UNCOVERED CHILD.—The term ‘uncovered  
2 child’ means a child that does not have creditable  
3 health coverage.”.

4           (b) CONFORMING AMENDMENTS.—

5           (1) DEFINITION OF STATE.—Section  
6 1101(a)(1) is amended—

7           (A) by striking “and XIX” and inserting  
8 “XIX, and XXI”, and

9           (B) by striking “title XIX” and inserting  
10 “titles XIX and XXI”.

11 **SEC. 3503. OPTIONAL USE OF STATE CHILD HEALTH AS-**  
12 **SISTANCE FUNDS FOR ENHANCED MEDICAID**  
13 **MATCH FOR EXPANDED MEDICAID ELIGI-**  
14 **BILITY.**

15           (a) INCREASED FMAP FOR MEDICAL ASSISTANCE  
16 FOR EXPANDED COVERAGE OF TARGETED LOW-INCOME  
17 CHILDREN.—Section 1905 of the Social Security Act (42  
18 U.S.C. 1396d) is amended—

19           (1) in subsection (b), by adding at the end the  
20 following new sentence: “Notwithstanding the first  
21 sentence of this subsection, in the case of a State  
22 plan that meets the condition described in subsection  
23 (t)(1), with respect to expenditures for medical as-  
24 sistance for optional targeted low-income children  
25 described in subsection (t)(2), the Federal medical

1 assistance percentage is equal to the enhanced medi-  
2 cal assistance percentage described in subsection  
3 (t)(3).”; and

4 (2) by adding at the end the following new sub-  
5 section:

6 “(t)(1) The conditions described in this paragraph for  
7 a State plan are as follows:

8 “(A) The plan is not applying income and re-  
9 source standards and methodologies for the purpose  
10 of determining eligibility of individuals under section  
11 1902(l) that are more restrictive than those applied  
12 as of June 1, 1997, for the purpose of determining  
13 eligibility of individuals under such section.

14 “(B) The plan provides for such reporting of in-  
15 formation about expenditures and payments attrib-  
16 utable to the operation of this subsection as the Sec-  
17 retary deems necessary in order to carry out sections  
18 2103(d) and 2104(b)(2).

19 “(C) The amount of the increased payments  
20 under section 1903(a) resulting from the application  
21 of this subsection does not exceed the total amount  
22 of any allotment not otherwise expended by the  
23 State under section 2103 for the period involved.

24 “(2) For purposes of subsection (b), the term ‘op-  
25 tional targeted low-income child’ means a targeted low-

1 income child described in section 2108(b)(1) who would  
2 not qualify for medical assistance under the State plan  
3 under this title based on such plan as in effect on June  
4 1, 1997 (taking into account the process of individuals  
5 aging into eligibility under section 1902(l)(2)(D)).

6 “(3) The enhanced medical assistance percentage de-  
7 scribed in this paragraph for a State is equal to the Fed-  
8 eral medical assistance percentage (as defined in the first  
9 sentence of subsection (b)) for the State increased by a  
10 number of percentage points equal to 30 percent of the  
11 number of percentage points by which (A) such Federal  
12 medical assistance percentage for the State, is less than  
13 (B) 100 percent.

14 “(4) Notwithstanding any other provision of this title,  
15 a State plan under this title may impose a limit on the  
16 number of optional targeted low-income children described  
17 in paragraph (2).”.

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

21

1 **SEC. 3504. MEDICAID PRESUMPTIVE ELIGIBILITY FOR LOW-**  
2 **INCOME CHILDREN.**

3 (a) IN GENERAL.—Title XIX of the Social Security  
4 Act is amended by inserting after section 1920 the follow-  
5 ing new section:

6 “PRESUMPTIVE ELIGIBILITY FOR CHILDREN

7 “SEC. 1920A. (a) A State plan approved under sec-  
8 tion 1902 may provide for making medical assistance with  
9 respect to health care items and services covered under  
10 the State plan available to a child during a presumptive  
11 eligibility period.

12 “(b) For purposes of this section:

13 “(1) The term ‘child’ means an individual  
14 under 19 years of age.

15 “(2) The term ‘presumptive eligibility period’  
16 means, with respect to a child, the period that—

17 “(A) begins with the date on which a  
18 qualified entity determines, on the basis of pre-  
19 liminary information, that the family income of  
20 the child does not exceed the applicable income  
21 level of eligibility under the State plan, and

22 “(B) ends with (and includes) the earlier  
23 of—

24 “(i) the day on which a determination  
25 is made with respect to the eligibility of

1 the child for medical assistance under the  
2 State plan, or

3 “(ii) in the case of a child on whose  
4 behalf an application is not filed by the  
5 last day of the month following the month  
6 during which the entity makes the deter-  
7 mination referred to in subparagraph (A),  
8 such last day.

9 “(3)(A) Subject to subparagraph (B), the term  
10 ‘qualified entity’ means any entity that—

11 “(i)(I) is eligible for payments under a  
12 State plan approved under this title and pro-  
13 vides items and services described in subsection  
14 (a) or (II) is authorized to determine eligibility  
15 of a child to participate in a Head Start pro-  
16 gram under the Head Start Act (42 U.S.C.  
17 9821 et seq.), eligibility of a child to receive  
18 child care services for which financial assistance  
19 is provided under the Child Care and Develop-  
20 ment Block Grant Act of 1990 (42 U.S.C. 9858  
21 et seq.), eligibility of an infant or child to re-  
22 ceive assistance under the special supplemental  
23 nutrition program for women, infants, and chil-  
24 dren (WIC) under section 17 of the Child Nu-  
25 trition Act of 1966 (42 U.S.C. 1786); and

1           “(ii) is determined by the State agency to  
2           be capable of making determinations of the type  
3           described in paragraph (1)(A).

4           “(B) The Secretary may issue regulations fur-  
5           ther limiting those entities that may become quali-  
6           fied entities in order to prevent fraud and abuse and  
7           for other reasons.

8           “(C) Nothing in this section shall be construed  
9           as preventing a State from limiting the classes of en-  
10          tities that may become qualified entities, consistent  
11          with any limitations imposed under subparagraph  
12          (B).

13          “(c)(1) The State agency shall provide qualified enti-  
14          ties with—

15                 “(A) such forms as are necessary for an appli-  
16                 cation to be made on behalf of a child for medical  
17                 assistance under the State plan, and

18                 “(B) information on how to assist parents,  
19                 guardians, and other persons in completing and fil-  
20                 ing such forms.

21          “(2) A qualified entity that determines under sub-  
22          section (b)(1)(A) that a child is presumptively eligible for  
23          medical assistance under a State plan shall—

1           “(A) notify the State agency of the determina-  
2           tion within 5 working days after the date on which  
3           determination is made, and

4           “(B) inform the parent or custodian of the  
5           child at the time the determination is made that an  
6           application for medical assistance under the State  
7           plan is required to be made by not later than the  
8           last day of the month following the month during  
9           which the determination is made.

10          “(3) In the case of a child who is determined by a  
11         qualified entity to be presumptively eligible for medical as-  
12         sistance under a State plan, the parent, guardian, or other  
13         person shall make application on behalf of the child for  
14         medical assistance under such plan by not later than the  
15         last day of the month following the month during which  
16         the determination is made, which application may be the  
17         application used for the receipt of medical assistance by  
18         individuals described in section 1902(l)(1).

19          “(d) Notwithstanding any other provision of this title,  
20         medical assistance for items and services described in sub-  
21         section (a) that—

22                 “(1) are furnished to a child—

23                         “(A) during a presumptive eligibility pe-  
24                         riod,

1                   “(B) by a entity that is eligible for pay-  
2                   ments under the State plan; and

3                   “(2) are included in the care and services cov-  
4                   ered by a State plan;  
5 shall be treated as medical assistance provided by such  
6 plan for purposes of section 1903.”.

7           (b) CONFORMING AMENDMENTS.—(1) Section  
8 1902(a)(47) of such Act (42 U.S.C. 1396a(a)(47)) is  
9 amended by inserting before the semicolon at the end the  
10 following: “and provide for making medical assistance for  
11 items and services described in subsection (a) of section  
12 1920A available to children during a presumptive eligi-  
13 bility period in accordance with such section”.

14           (2) Section 1903(u)(1)(D)(v) of such Act (42 U.S.C.  
15 1396b(u)(1)(D)(v)) of such Act is amended by inserting  
16 before the period at the end the following: “or for items  
17 and services described in subsection (a) of section 1920A  
18 provided to a child during a presumptive eligibility period  
19 under such section”.

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



1           **TITLE IV—COMMITTEE ON**  
2           **COMMERCE—MEDICARE**

3   **SEC. 4000. AMENDMENTS TO SOCIAL SECURITY ACT AND**  
4           **REFERENCES TO OBRA; TABLE OF CONTENTS**  
5           **OF TITLE.**

6           (a) AMENDMENTS TO SOCIAL SECURITY ACT.—Ex-  
7   cept as otherwise specifically provided, whenever in this  
8   title an amendment is expressed in terms of an amend-  
9   ment to or repeal of a section or other provision, the ref-  
10   erence shall be considered to be made to that section or  
11   other provision of the Social Security Act.

12          (b) REFERENCES TO OBRA.—In this title, the terms  
13   “OBRA–1986”, “OBRA–1987”, “OBRA–1989”,  
14   “OBRA–1990”, and “OBRA–1993” refer to the Omnibus  
15   Budget Reconciliation Act of 1986 (Public Law 99–509),  
16   the Omnibus Budget Reconciliation Act of 1987 (Public  
17   Law 100–203), the Omnibus Budget Reconciliation Act  
18   of 1989 (Public Law 101–239), the Omnibus Budget Rec-  
19   onciliation Act of 1990 (Public Law 101–508), and the  
20   Omnibus Budget Reconciliation Act of 1993 (Public Law  
21   103–66), respectively.

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

Sec. 4000. Amendments to Social Security Act and references to OBRA; table  
of contents of title.

Subtitle A—MedicarePlus Program

## CHAPTER 1—MEDICAREPLUS PROGRAM

## SUBCHAPTER A—MEDICAREPLUS PROGRAM

Sec. 4001. Establishment of MedicarePlus program.

## “PART C—MEDICAREPLUS PROGRAM

“Sec. 1851. Eligibility, election, and enrollment.

“Sec. 1852. Benefits and beneficiary protections.

“Sec. 1853. Payments to MedicarePlus organizations.

“Sec. 1854. Premiums.

“Sec. 1855. Organizational and financial requirements for MedicarePlus organizations; provider-sponsored organizations.

“Sec. 1856. Establishment of standards.

“Sec. 1857. Contracts with MedicarePlus organizations.

“Sec. 1859. Definitions; miscellaneous provisions.

Sec. 4002. Transitional rules for current medicare HMO program.

Sec. 4003. Conforming changes in medigap program.

SUBCHAPTER B—SPECIAL RULES FOR MEDICAREPLUS MEDICAL SAVINGS  
ACCOUNTS

Sec. 4006. MedicarePlus MSA.

SUBCHAPTER C—GME, IME, AND DSH PAYMENTS FOR MANAGED CARE  
ENROLLEES

Sec. 4008. Graduate medical education and indirect medical education payments for managed care enrollees.

Sec. 4009. Disproportionate share hospital payments for managed care enrollees.

## 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.

Sec. 4012. Reference to establishment of PACE program as medicaid State option.

## SUBCHAPTER B—SOCIAL HEALTH MAINTENANCE ORGANIZATIONS (SHMOS)

Sec. 4015. Social health maintenance organizations (SHMOs).

## SUBCHAPTER C—OTHER PROGRAMS

Sec. 4018. Orderly transition of municipal health service demonstration projects.

Sec. 4019. Extension of certain medicare community nursing organization demonstration projects.

## CHAPTER 3—MEDICARE PAYMENT ADVISORY COMMISSION

Sec. 4021. Medicare Payment Advisory Commission.

## CHAPTER 4—MEDIGAP PROTECTIONS

Sec. 4031. Medigap protections.

Sec. 4032. Medicare prepaid competitive pricing demonstration project.

Subtitle B—Prevention Initiatives

- Sec. 4101. Screening mammography.
- Sec. 4102. Screening pap smear and pelvic exams.
- Sec. 4103. Prostate cancer screening tests.
- Sec. 4104. Coverage of colorectal screening.
- Sec. 4105. Diabetes screening tests.
- Sec. 4106. Standardization of medicare coverage of bone mass measurements.
- Sec. 4107. Vaccines outreach expansion.
- Sec. 4108. Study on preventive benefits.

Subtitle C—Rural Initiatives

- Sec. 4206. Informatics, telemedicine, and education demonstration project.

Subtitle D—Anti-Fraud and Abuse Provisions

- Sec. 4301. Permanent exclusion for those convicted of 3 health care related crimes.
- Sec. 4302. Authority to refuse to enter into medicare agreements with individuals or entities convicted of felonies.
- Sec. 4303. Inclusion of toll-free number to report medicare waste, fraud, and abuse in explanation of benefits forms.
- Sec. 4304. Liability of medicare carriers and fiscal intermediaries for claims submitted by excluded providers.
- Sec. 4305. Exclusion of entity controlled by family member of a sanctioned individual.
- Sec. 4306. Imposition of civil money penalties.
- Sec. 4307. Disclosure of information and surety bonds.
- Sec. 4308. Provision of certain identification numbers.
- Sec. 4309. Advisory opinions regarding certain physician self-referral provisions.
- Sec. 4310. Nondiscrimination in post-hospital referral to home health agencies.
- Sec. 4311. Other fraud and abuse related provisions.

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.
- Sec. 4412. Extension of reductions in payments for costs of hospital outpatient services.
- Sec. 4413. Prospective payment system for hospital outpatient department services.

SUBCHAPTER B—REHABILITATION SERVICES

- Sec. 4421. Rehabilitation agencies and services.
- Sec. 4422. Comprehensive outpatient rehabilitation facilities (conf).

SUBCHAPTER C—AMBULANCE SERVICES

- Sec. 4431. Payments for ambulance services.
- Sec. 4432. Demonstration of coverage of ambulance services under medicare through contracts with units of local government.

## CHAPTER 3—PAYMENT UNDER PARTS A AND B

Sec. 4441. Prospective payment for home health services.

## Subtitle G—Provisions Relating to Part B Only

## CHAPTER 1—PHYSICIANS’ SERVICES

- Sec. 4601. Establishment of single conversion factor for 1998.  
 Sec. 4602. Establishing update to conversion factor to match spending under sustainable growth rate.  
 Sec. 4603. Replacement of volume performance standard with sustainable growth rate.  
 Sec. 4604. Payment rules for anesthesia services.  
 Sec. 4605. Implementation of resource-based physician practice expense.  
 Sec. 4606. Dissemination of information on high per admission relative values for in-hospital physicians’ services.  
 Sec. 4607. No X-ray required for chiropractic services.  
 Sec. 4608. Temporary coverage restoration for portable electrocardiogram transportation.

## CHAPTER 2—OTHER PAYMENT PROVISIONS

- Sec. 4611. Payments for durable medical equipment.  
 Sec. 4612. Oxygen and oxygen equipment.  
 Sec. 4613. Reduction in updates to payment amounts for clinical diagnostic laboratory tests.  
 Sec. 4614. Simplification in administration of laboratory services benefit.  
 Sec. 4615. Updates for ambulatory surgical services.  
 Sec. 4616. Reimbursement for drugs and biologicals.  
 Sec. 4617. Coverage of oral anti-nausea drugs under chemotherapeutic regimen.  
 Sec. 4618. Rural health clinic services.  
 Sec. 4619. Increased medicare reimbursement for nurse practitioners and clinical nurse specialists.  
 Sec. 4620. Increased medicare reimbursement for physician assistants.  
 Sec. 4621. Renal dialysis-related services.  
 Sec. 4622. Payment for cochlear implants as customized durable medical equipment.

## CHAPTER 3—PART B PREMIUM

Sec. 4631. Part B premium.

## 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.  
 Sec. 4702. Clarification of time and filing limitations.  
 Sec. 4703. Permitting recovery against third party administrators.

## CHAPTER 2—HOME HEALTH SERVICES

- Sec. 4711. Recapturing savings resulting from temporary freeze on payment increases for home health services.  
 Sec. 4712. Interim payments for home health services.  
 Sec. 4713. Clarification of part-time or intermittent nursing care.

- Sec. 4714. Study of definition of homebound.
- Sec. 4715. Payment based on location where home health service is furnished.
- Sec. 4716. Normative standards for home health claims denials,
- Sec. 4717. No home health benefits based solely on drawing blood.
- Sec. 4718. Making part B primary payor for certain home health services.

#### CHAPTER 3—BABY BOOM GENERATION MEDICARE COMMISSION

- Sec. 4721. Bipartisan Commission on the Effect of the Baby Boom Generation on the Medicare Program.

#### 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.
- Sec. 4732. Phased-in limitation on hospital overhead and supervisory physician component of direct medical education costs.
- Sec. 4733. Permitting payment to non-hospital providers.
- Sec. 4734. Incentive payments under plans for voluntary reduction in number of residents.
- Sec. 4735. Demonstration project on use of consortia.
- Sec. 4736. Recommendations on long-term payment policies regarding financing teaching hospitals and graduate medical education.
- Sec. 4737. Medicare special reimbursement rule for certain combined residency programs.

#### CHAPTER 5—OTHER PROVISIONS

- Sec. 4741. Centers of excellence.
- 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.
- Sec. 4743. Competitive bidding for certain items and services.

#### Subtitle I—Medical Liability Reform

##### CHAPTER 1—GENERAL PROVISIONS

- Sec. 4801. Federal reform of health care liability actions.
- Sec. 4802. Definitions.
- Sec. 4803. Effective date.

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

- Sec. 4811. Statute of limitations.
- Sec. 4812. Calculation and payment of damages.
- Sec. 4813. Alternative dispute resolution.

1 **Subtitle A—MedicarePlus Program**

2 **CHAPTER 1—MEDICAREPLUS PROGRAM**

3 **Subchapter A—MedicarePlus Program**

4 **SEC. 4001. ESTABLISHMENT OF MEDICAREPLUS PROGRAM.**

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

8 “PART C—MEDICAREPLUS PROGRAM

9 “ELIGIBILITY, ELECTION, AND ENROLLMENT

10 “SEC. 1851. (a) CHOICE OF MEDICARE BENEFITS  
11 THROUGH MEDICAREPLUS PLANS.—

12 “(1) IN GENERAL.—Subject to the provisions of  
13 this section, each MedicarePlus eligible individual  
14 (as defined in paragraph (3)) is entitled to elect to  
15 receive benefits under this title—

16 “(A) through the medicare fee-for-service  
17 program under parts A and B, or

18 “(B) through enrollment in a MedicarePlus  
19 plan under this part.

20 “(2) TYPES OF MEDICAREPLUS PLANS THAT  
21 MAY BE AVAILABLE.—A MedicarePlus plan may be  
22 any of the following types of plans of health insur-  
23 ance:

24 “(A) COORDINATED CARE PLANS.—Coordi-  
25 nated care plans which provide health care serv-

1 ices, including health maintenance organization  
2 plans and preferred provider organization plans.

3 “(B) PLANS OFFERED BY PROVIDER-SPON-  
4 SORED ORGANIZATION.—A MedicarePlus plan  
5 offered by a provider-sponsored organization, as  
6 defined in section 1855(e).

7 “(C) COMBINATION OF MSA PLAN AND  
8 CONTRIBUTIONS TO MEDICAREPLUS MSA.—An  
9 MSA plan, as defined in section 1859(b)(2),  
10 and a contribution into a MedicarePlus medical  
11 savings account (MSA).

12 “(3) MEDICAREPLUS ELIGIBLE INDIVIDUAL.—

13 “(A) IN GENERAL.—In this title, subject to  
14 subparagraph (B), the term ‘MedicarePlus eligi-  
15 ble individual’ means an individual who is enti-  
16 tled to benefits under part A and enrolled under  
17 part B.

18 “(B) SPECIAL RULE FOR END-STAGE  
19 RENAL DISEASE.—Such term shall not include  
20 an individual medically determined to have end-  
21 stage renal disease, except that an individual  
22 who develops end-stage renal disease while en-  
23 rolled in a MedicarePlus plan may continue to  
24 be enrolled in that plan.

25 “(b) SPECIAL RULES.—

1 “(1) RESIDENCE REQUIREMENT.—

2 “(A) IN GENERAL.—Except as the Sec-  
3 retary may otherwise provide, an individual is  
4 eligible to elect a MedicarePlus plan offered by  
5 a MedicarePlus organization only if the organi-  
6 zation serves the geographic area in which the  
7 individual resides.

8 “(B) CONTINUATION OF ENROLLMENT  
9 PERMITTED.—Pursuant to rules specified by  
10 the Secretary, the Secretary shall provide that  
11 an individual may continue enrollment in a  
12 plan, notwithstanding that the individual no  
13 longer resides in the service area of the plan, so  
14 long as the plan provides benefits for enrollees  
15 located in the area in which the individual re-  
16 sides.

17 “(2) SPECIAL RULE FOR CERTAIN INDIVIDUALS  
18 COVERED UNDER FEHBP OR ELIGIBLE FOR VETER-  
19 ANS OR MILITARY HEALTH BENEFITS, VETERANS .—

20 “(A) FEHBP.—An individual who is en-  
21 rolled in a health benefit plan under chapter 89  
22 of title 5, United States Code, is not eligible to  
23 enroll in an MSA plan until such time as the  
24 Director of the Office of Management and  
25 Budget certifies to the Secretary that the Office



1 of Personnel Management has adopted policies  
2 which will ensure that the enrollment of such  
3 individuals in such plans will not result in in-  
4 creased expenditures for the Federal Govern-  
5 ment for health benefit plans under such chap-  
6 ter.

7 “(B) VA AND DOD.—The Secretary may  
8 apply rules similar to the rules described in  
9 subparagraph (A) in the case of individuals who  
10 are eligible for health care benefits under chap-  
11 ter 55 of title 10, United States Code, or under  
12 chapter 17 of title 38 of such Code.

13 “(3) LIMITATION ON ELIGIBILITY OF QUALI-  
14 FIED MEDICARE BENEFICIARIES AND OTHER MEDIC-  
15 AID BENEFICIARIES TO ENROLL IN AN MSA  
16 PLAN.—An individual who is a qualified medicare  
17 beneficiary (as defined in section 1905(p)(1)), a  
18 qualified disabled and working individual (described  
19 in section 1905(s)), an individual described in sec-  
20 tion 1902(a)(10)(E)(iii), or otherwise entitled to  
21 medicare cost-sharing under a State plan under title  
22 XIX is not eligible to enroll in an MSA plan.

23 “(4) COVERAGE UNDER MSA PLANS ON A DEM-  
24 ONSTRATION BASIS.—

1           “(A) IN GENERAL.—An individual is not  
2 eligible to enroll in an MSA plan under this  
3 part—

4           “(i) on or after January 1, 2003, un-  
5 less the enrollment is the continuation of  
6 such an enrollment in effect as of such  
7 date; or

8           “(ii) as of any date if the number of  
9 such individuals so enrolled as of such date  
10 has reached 500,000.

11 Under rules established by the Secretary, an in-  
12 dividual is not eligible to enroll (or continue en-  
13 rollment) in an MSA plan for a year unless the  
14 individual provides assurances satisfactory to  
15 the Secretary that the individual will reside in  
16 the United States for at least 183 days during  
17 the year.

18           “(B) EVALUATION.—The Secretary shall  
19 regularly evaluate the impact of permitting en-  
20 rollment in MSA plans under this part on selec-  
21 tion (including adverse selection), use of preven-  
22 tive care, access to care, and the financial sta-  
23 tus of the Trust Funds under this title.

24           “(C) REPORTS.—The Secretary shall sub-  
25 mit to Congress periodic reports on the num-

1           bers of individuals enrolled in such plans and  
2           on the evaluation being conducted under sub-  
3           paragraph (B). The Secretary shall submit such  
4           a report, by not later than March 1, 2002, on  
5           whether the time limitation under subparagraph  
6           (A)(i) should be extended or removed and  
7           whether to change the numerical limitation  
8           under subparagraph (A)(ii).

9           “(c) PROCESS FOR EXERCISING CHOICE.—

10           “(1) IN GENERAL.—The Secretary shall estab-  
11           lish a process through which elections described in  
12           subsection (a) are made and changed, including the  
13           form and manner in which such elections are made  
14           and changed. Such elections shall be made or  
15           changed only during coverage election periods speci-  
16           fied under subsection (e) and shall become effective  
17           as provided in subsection (f).

18           “(2) COORDINATION THROUGH MEDICAREPLUS  
19           ORGANIZATIONS.—

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

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

8           “(3) DEFAULT.—

9           “(A) INITIAL ELECTION.—

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

16           “(ii) SEAMLESS CONTINUATION OF  
17 COVERAGE.—The Secretary may establish  
18 procedures under which an individual who  
19 is enrolled in a health plan (other than  
20 MedicarePlus plan) offered by a  
21 MedicarePlus organization at the time of  
22 the initial election period and who fails to  
23 elect to receive coverage other than  
24 through the organization is deemed to have  
25 elected the MedicarePlus plan offered by

1 the organization (or, if the organization of-  
2 fers more than one such plan, such plan or  
3 plans as the Secretary identifies under  
4 such procedures).

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

10 “(i) the individual changes the elec-  
11 tion under this section, or

12 “(ii) a MedicarePlus plan is discon-  
13 tinued, if the individual had elected such  
14 plan at the time of the discontinuation.

15 “(d) PROVIDING INFORMATION TO PROMOTE IN-  
16 FORMED CHOICE.—

17 “(1) IN GENERAL.—The Secretary shall provide  
18 for activities under this subsection to broadly dis-  
19 seminate information to medicare beneficiaries (and  
20 prospective medicare beneficiaries) on the coverage  
21 options provided under this section in order to pro-  
22 mote an active, informed selection among such op-  
23 tions.

24 “(2) PROVISION OF NOTICE.—

1           “(A) OPEN SEASON NOTIFICATION.—At  
2           least 30 days before the beginning of each an-  
3           nual, coordinated election period (as defined in  
4           subsection (e)(3)(B)), the Secretary shall mail  
5           to each MedicarePlus eligible individual residing  
6           in an area the following:

7                   “(i) GENERAL INFORMATION.—The  
8                   general information described in paragraph  
9                   (3).

10                   “(ii) LIST OF PLANS AND COMPARI-  
11                   SON OF PLAN OPTIONS.—A list identifying  
12                   the MedicarePlus plans that are (or will  
13                   be) available to residents of the area and  
14                   information described in paragraph (4)  
15                   concerning such plans. Such information  
16                   shall be presented in a comparative form.

17                   “(iii) MEDICAREPLUS MONTHLY CAPI-  
18                   TATION RATE.—The amount of the month-  
19                   ly MedicarePlus capitation rate for the  
20                   area.

21                   “(iv) ADDITIONAL INFORMATION.—  
22                   Any other information that the Secretary  
23                   determines will assist the individual in  
24                   making the election under this section.

1           The mailing of such information shall be coordi-  
2           nated with the mailing of any annual notice  
3           under section 1804.

4           “(B) NOTIFICATION TO NEWLY  
5           MEDICAREPLUS ELIGIBLE INDIVIDUALS.—To  
6           the extent practicable, the Secretary shall, not  
7           later than 2 months before the beginning of the  
8           initial MedicarePlus enrollment period for an  
9           individual described in subsection (e)(1), mail  
10          to the individual the information described in  
11          subparagraph (A).

12          “(C) FORM.—The information dissemi-  
13          nated under this paragraph shall be written and  
14          formatted using language that is easily under-  
15          standable by medicare beneficiaries.

16          “(D) PERIODIC UPDATING.—The informa-  
17          tion described in subparagraph (A) shall be up-  
18          dated on at least an annual basis to reflect  
19          changes in the availability of MedicarePlus  
20          plans and the benefits and monthly premiums  
21          (and net monthly premiums) for such plans.

22          “(3) GENERAL INFORMATION.—General infor-  
23          mation under this paragraph, with respect to cov-  
24          erage under this part during a year, shall include  
25          the following:

1           “(A) BENEFITS UNDER FEE-FOR-SERVICE  
2 PROGRAM OPTION.—A general description of  
3 the benefits covered (and not covered) under  
4 the medicare fee-for-service program under  
5 parts A and B, including—

6                   “(i) covered items and services,

7                   “(ii) beneficiary cost sharing, such as  
8 deductibles, coinsurance, and copayment  
9 amounts, and

10                   “(iii) any beneficiary liability for bal-  
11 ance billing.

12           “(B) PART B PREMIUM.—The part B pre-  
13 mium rates that will be charged for part B cov-  
14 erage.

15           “(C) ELECTION PROCEDURES.—Informa-  
16 tion and instructions on how to exercise election  
17 options under this section.

18           “(D) RIGHTS.—The general description of  
19 procedural rights (including grievance and ap-  
20 peals procedures) of beneficiaries under the  
21 medicare fee-for-service program and the  
22 MedicarePlus program and right to be pro-  
23 tected against discrimination based on health  
24 status-related factors under section 1852(b).



1           “(E) INFORMATION ON MEDIGAP AND  
2           MEDICARE SELECT.—A general description of  
3           the benefits, enrollment rights, and other re-  
4           quirements applicable to medicare supplemental  
5           policies under section 1882 and provisions relat-  
6           ing to medicare select policies described in sec-  
7           tion 1882(t).

8           “(F) POTENTIAL FOR CONTRACT TERMI-  
9           NATION.—The fact that a MedicarePlus organi-  
10          zation may terminate or refuse to renew its  
11          contract under this part and the effect the ter-  
12          mination or nonrenewal of its contract may  
13          have on individuals enrolled with the  
14          MedicarePlus plan under this part.

15          “(4) INFORMATION COMPARING PLAN OP-  
16          TIONS.—Information under this paragraph, with re-  
17          spect to a MedicarePlus plan for a year, shall in-  
18          clude the following:

19                 “(A) BENEFITS.—The benefits covered  
20                 (and not covered) under the plan, including—

21                         “(i) covered items and services beyond  
22                         those provided under the medicare fee-for-  
23                         service program,

24                                 “(ii) any beneficiary cost sharing,

1           “(iii) any maximum limitations on  
2 out-of-pocket expenses,

3           “(iv) in the case of an MSA plan, dif-  
4 ferences in cost sharing under such a plan  
5 compared to under other MedicarePlus  
6 plans,

7           “(v) the use of provider networks and  
8 the restriction on payments for services  
9 furnished other than by other through the  
10 organization,

11           “(vi) the organization’s coverage of  
12 emergency and urgently needed care,

13           “(vii) the appeal and grievance rights  
14 of enrollees,

15           “(viii) number of grievances and ap-  
16 peals, and information on their disposition  
17 in the aggregate,

18           “(ix) procedures used by the organiza-  
19 tion to control utilization of services and  
20 expenditures, and

21           “(x) any exclusions in the types of  
22 providers participating in the plan’s net-  
23 work.

1           “(B) PREMIUMS.—The monthly premium  
2           (and net monthly premium), if any, for the  
3           plan.

4           “(C) SERVICE AREA.—The service area of  
5           the plan.

6           “(D) QUALITY AND PERFORMANCE.—To  
7           the extent available, plan quality and perform-  
8           ance indicators for the benefits under the plan  
9           (and how they compare to such indicators  
10          under the medicare fee-for-service program  
11          under parts A and B in the area involved), in-  
12          cluding—

13               “(i) disenrollment rates for medicare  
14               enrollees electing to receive benefits  
15               through the plan for the previous 2 years  
16               (excluding disenrollment due to death or  
17               moving outside the plan’s service area),

18               “(ii) information on medicare enrollee  
19               satisfaction,

20               “(iii) information on health outcomes,  
21               and

22               “(iv) the recent record regarding com-  
23               pliance of the plan with requirements of  
24               this part (as determined by the Secretary).

1           “(E) SUPPLEMENTAL BENEFITS OP-  
2           TIONS.—Whether the organization offering the  
3           plan offers optional supplemental benefits and  
4           the terms and conditions (including premiums)  
5           for such coverage.

6           “(5) MAINTAINING A TOLL-FREE NUMBER AND  
7           INTERNET SITE.—The Secretary shall maintain a  
8           toll-free number for inquiries regarding  
9           MedicarePlus options and the operation of this part  
10          in all areas in which MedicarePlus plans are offered  
11          and an Internet site through which individuals may  
12          electronically obtain information on such options and  
13          MedicarePlus plans.

14          “(6) USE OF NONFEDERAL ENTITIES.—The  
15          Secretary may enter into contracts with non-Federal  
16          entities to carry out activities under this subsection.

17          “(7) PROVISION OF INFORMATION.—A  
18          MedicarePlus organization shall provide the Sec-  
19          retary with such information on the organization  
20          and each MedicarePlus plan it offers as may be re-  
21          quired for the preparation of the information re-  
22          ferred to in paragraph (2)(A).

23          “(e) COVERAGE ELECTION PERIODS.—

24                 “(1) INITIAL CHOICE UPON ELIGIBILITY TO  
25                 MAKE ELECTION IF MEDICAREPLUS PLANS AVAIL-

1 ABLE TO INDIVIDUAL.—If, at the time an individual  
2 first becomes entitled to benefits under part A and  
3 enrolled under part B, there is one or more  
4 MedicarePlus plans offered in the area in which the  
5 individual resides, the individual shall make the elec-  
6 tion under this section during a period (of a dura-  
7 tion and beginning at a time specified by the Sec-  
8 retary) at such time. Such period shall be specified  
9 in a manner so that, in the case of an individual who  
10 elects a MedicarePlus plan during the period, cov-  
11 erage under the plan becomes effective as of the first  
12 date on which the individual may receive such cov-  
13 erage.

14 “(2) OPEN ENROLLMENT AND DISENROLLMENT  
15 OPPORTUNITIES.—Subject to paragraph (5)—

16 “(A) CONTINUOUS OPEN ENROLLMENT  
17 AND DISENROLLMENT THROUGH 2000.—At any  
18 time during 1998, 1999, and 2000, a  
19 MedicarePlus eligible individual may change the  
20 election under subsection (a)(1).

21 “(B) CONTINUOUS OPEN ENROLLMENT  
22 AND DISENROLLMENT FOR FIRST 6 MONTHS  
23 DURING 2001.—

24 “(i) IN GENERAL.—Subject to clause  
25 (ii), at any time during the first 6 months

1 of 2001, or, if the individual first becomes  
2 a MedicarePlus eligible individual during  
3 2001, during the first 6 months during  
4 2001 in which the individual is a  
5 MedicarePlus eligible individual, a  
6 MedicarePlus eligible individual may  
7 change the election under subsection  
8 (a)(1).

9 “(ii) LIMITATION OF ONE CHANGE  
10 PER YEAR.—An individual may exercise  
11 the right under clause (i) only once during  
12 2001. The limitation under this clause  
13 shall not apply to changes in elections ef-  
14 fected during an annual, coordinated elec-  
15 tion period under paragraph (3) or during  
16 a special enrollment period under para-  
17 graph (4).

18 “(C) CONTINUOUS OPEN ENROLLMENT  
19 AND DISENROLLMENT FOR FIRST 3 MONTHS IN  
20 SUBSEQUENT YEARS.—

21 “(i) IN GENERAL.—Subject to clause  
22 (ii), at any time during the first 3 months  
23 of a year after 2001, or, if the individual  
24 first becomes a MedicarePlus eligible indi-  
25 vidual during a year after 2001, during the

1 first 3 months of such year in which the  
2 individual is a MedicarePlus eligible indi-  
3 vidual, a MedicarePlus eligible individual  
4 may change the election under subsection  
5 (a)(1).

6 “(ii) LIMITATION OF ONE CHANGE  
7 PER YEAR.—An individual may exercise  
8 the right under clause (i) only once a year.  
9 The limitation under this clause shall not  
10 apply to changes in elections effected dur-  
11 ing an annual, coordinated election period  
12 under paragraph (3) or during a special  
13 enrollment period under paragraph (4).

14 “(3) ANNUAL, COORDINATED ELECTION PE-  
15 RIOD.—

16 “(A) IN GENERAL.—Subject to paragraph  
17 (5), each individual who is eligible to make an  
18 election under this section may change such  
19 election during an annual, coordinated election  
20 period.

21 “(B) ANNUAL, COORDINATED ELECTION  
22 PERIOD.—For purposes of this section, the  
23 term ‘annual, coordinated election period’  
24 means, with respect to a calendar year (begin-

1           ning with 2001), the month of October before  
2           such year.

3           “(C) **MEDICAREPLUS HEALTH FAIRS.**—In  
4           the month of October of each year (beginning  
5           with 1998), the Secretary shall provide for a  
6           nationally coordinated educational and publicity  
7           campaign to inform MedicarePlus eligible indi-  
8           viduals about MedicarePlus plans and the elec-  
9           tion process provided under this section.

10          “(4) **SPECIAL ELECTION PERIODS.**—Effective  
11          as of January 1, 2001, an individual may dis-  
12          continue an election of a MedicarePlus plan offered  
13          by a MedicarePlus organization other than during  
14          an annual, coordinated election period and make a  
15          new election under this section if—

16                 “(A) the organization’s or plan’s certifi-  
17                 cation under this part has been terminated or  
18                 the organization has terminated or otherwise  
19                 discontinued providing the plan;

20                 “(B) the individual is no longer eligible to  
21                 elect the plan because of a change in the indi-  
22                 vidual’s place of residence or other change in  
23                 circumstances (specified by the Secretary, but  
24                 not including termination of the individual’s en-



1 rollment on the basis described in clause (i) or  
2 (ii) of subsection (g)(3)(B));

3 “(C) the individual demonstrates (in ac-  
4 cordance with guidelines established by the Sec-  
5 retary) that—

6 “(i) the organization offering the plan  
7 substantially violated a material provision  
8 of the organization’s contract under this  
9 part in relation to the individual (including  
10 the failure to provide an enrollee on a  
11 timely basis medically necessary care for  
12 which benefits are available under the plan  
13 or the failure to provide such covered care  
14 in accordance with applicable quality  
15 standards); or

16 “(ii) the organization (or an agent or  
17 other entity acting on the organization’s  
18 behalf) materially misrepresented the  
19 plan’s provisions in marketing the plan to  
20 the individual; or

21 “(D) the individual meets such other ex-  
22 ceptional conditions as the Secretary may pro-  
23 vide.

1           “(5) SPECIAL RULES FOR MSA PLANS.—Not-  
2     withstanding the preceding provisions of this sub-  
3     section, an individual—

4           “(A) may elect an MSA plan only during—

5           “(i) an initial open enrollment period  
6     described in paragraph (1),

7           “(ii) an annual, coordinated election  
8     period described in paragraph (3)(B), or

9           “(iii) the months of October 1998 and  
10    October 1999; and

11          “(B) may not discontinue an election of an  
12    MSA plan except during the periods described  
13    in clause (ii) or (iii) of subparagraph (A) and  
14    under paragraph (4).

15          “(f) EFFECTIVENESS OF ELECTIONS AND CHANGES  
16    OF ELECTIONS.—

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

1           “(2) DURING CONTINUOUS OPEN ENROLLMENT  
2 PERIODS.—An election or change of coverage made  
3 under subsection (e)(2) shall take effect with the  
4 first day of the first calendar month following the  
5 date on which the election is made.

6           “(3) ANNUAL, COORDINATED ELECTION PE-  
7 RIOD.—An election or change of coverage made dur-  
8 ing an annual, coordinated election period (as de-  
9 fined in subsection (e)(3)(B)) in a year shall take ef-  
10 fect as of the first day of the following year.

11           “(4) OTHER PERIODS.—An election or change  
12 of coverage made during any other period under  
13 subsection (e)(4) shall take effect in such manner as  
14 the Secretary provides in a manner consistent (to  
15 the extent practicable) with protecting continuity of  
16 health benefit coverage.

17           “(g) GUARANTEED ISSUE AND RENEWAL.—

18           “(1) IN GENERAL.—Except as provided in this  
19 subsection, a MedicarePlus organization shall pro-  
20 vide that at any time during which elections are ac-  
21 cepted under this section with respect to a  
22 MedicarePlus plan offered by the organization, the  
23 organization will accept without restrictions individ-  
24 uals who are eligible to make such election.

1           “(2) PRIORITY.—If the Secretary determines  
2           that a MedicarePlus organization, in relation to a  
3           MedicarePlus plan it offers, has a capacity limit and  
4           the number of MedicarePlus eligible individuals who  
5           elect the plan under this section exceeds the capacity  
6           limit, the organization may limit the election of indi-  
7           viduals of the plan under this section but only if pri-  
8           ority in election is provided—

9                   “(A) first to such individuals as have elect-  
10                  ed the plan at the time of the determination,  
11                  and

12                  “(B) then to other such individuals in such  
13                  a manner that does not discriminate, on a basis  
14                  described in section 1852(b), among the individ-  
15                  uals (who seek to elect the plan).

16           The preceding sentence shall not apply if it would  
17           result in the enrollment of enrollees substantially  
18           nonrepresentative, as determined in accordance with  
19           regulations of the Secretary, of the medicare popu-  
20           lation in the service area of the plan.

21           “(3) LIMITATION ON TERMINATION OF ELEC-  
22           TION.—

23                   “(A) IN GENERAL.—Subject to subpara-  
24                  graph (B), a MedicarePlus organization may  
25                  not for any reason terminate the election of any

1 individual under this section for a MedicarePlus  
2 plan it offers.

3 “(B) BASIS FOR TERMINATION OF ELEC-  
4 TION.—A MedicarePlus organization may ter-  
5 minate an individual’s election under this sec-  
6 tion with respect to a MedicarePlus plan it of-  
7 fers if—

8 “(i) any net monthly premiums re-  
9 quired with respect to such plan are not  
10 paid on a timely basis (consistent with  
11 standards under section 1856 that provide  
12 for a grace period for late payment of net  
13 monthly premiums),

14 “(ii) the individual has engaged in  
15 disruptive behavior (as specified in such  
16 standards), or

17 “(iii) the plan is terminated with re-  
18 spect to all individuals under this part in  
19 the area in which the individual resides.

20 “(C) CONSEQUENCE OF TERMINATION.—

21 “(i) TERMINATIONS FOR CAUSE.—  
22 Any individual whose election is terminated  
23 under clause (i) or (ii) of subparagraph  
24 (B) is deemed to have elected the medicare

1 fee-for-service program option described in  
2 subsection (a)(1)(A).

3 “(ii) TERMINATION BASED ON PLAN  
4 TERMINATION OR SERVICE AREA REDUC-  
5 TION.—Any individual whose election is  
6 terminated under subparagraph (B)(iii)  
7 shall have a special election period under  
8 subsection (e)(4)(A) in which to change  
9 coverage to coverage under another  
10 MedicarePlus plan. Such an individual who  
11 fails to make an election during such pe-  
12 riod is deemed to have chosen to change  
13 coverage to the medicare fee-for-service  
14 program option described in subsection  
15 (a)(1)(A).

16 “(D) ORGANIZATION OBLIGATION WITH  
17 RESPECT TO ELECTION FORMS.—Pursuant to a  
18 contract under section 1857, each MedicarePlus  
19 organization receiving an election form under  
20 subsection (c)(2) shall transmit to the Secretary  
21 (at such time and in such manner as the Sec-  
22 retary may specify) a copy of such form or such  
23 other information respecting the election as the  
24 Secretary may specify.

1       “(h) APPROVAL OF MARKETING MATERIAL AND AP-  
2 PPLICATION FORMS.—

3           “(1) SUBMISSION.—No marketing material or  
4 application form may be distributed by a  
5 MedicarePlus organization to (or for the use of)  
6 MedicarePlus eligible individuals unless—

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

11           “(B) the Secretary has not disapproved the  
12 distribution of such material or form.

13           “(2) REVIEW.—The standards established  
14 under section 1856 shall include guidelines for the  
15 review of all such material or form submitted and  
16 under such guidelines the Secretary shall disapprove  
17 (or later require the correction of) such material or  
18 form if the material or form is materially inaccurate  
19 or misleading or otherwise makes a material mis-  
20 representation.

21           “(3) DEEMED APPROVAL (1-STOP SHOPPING).—  
22 In the case of material or form that is submitted  
23 under paragraph (1)(A) to the Secretary or a re-  
24 gional office of the Department of Health and  
25 Human Services and the Secretary or the office has

1 not disapproved the distribution of marketing mate-  
2 rial or form under paragraph (1)(B) with respect to  
3 a MedicarePlus plan in an area, the Secretary is  
4 deemed not to have disapproved such distribution in  
5 all other areas covered by the plan and organization  
6 except to the extent that such material or form is  
7 specific only to an area involved.

8 “(4) PROHIBITION OF CERTAIN MARKETING  
9 PRACTICES.—Each MedicarePlus organization shall  
10 conform to fair marketing standards, in relation to  
11 MedicarePlus plans offered under this part, included  
12 in the standards established under section 1856.  
13 Such standards shall include a prohibition against a  
14 MedicarePlus organization (or agent of such an or-  
15 ganization) completing any portion of any election  
16 form used to carry out elections under this section  
17 on behalf of any individual.

18 “(i) EFFECT OF ELECTION OF MEDICAREPLUS PLAN  
19 OPTION.—Subject to sections 1852(a)(5), 1857(f)(2), and  
20 1857(g)—

21 “(1) payments under a contract with a  
22 MedicarePlus organization under section 1853(a)  
23 with respect to an individual electing a MedicarePlus  
24 plan offered by the organization shall be instead of  
25 the amounts which (in the absence of the contract)



1 would otherwise be payable under parts A and B for  
2 items and services furnished to the individual, and

3 “(2) subject to subsections (e) and (f) of section  
4 1853, only the MedicarePlus organization shall be  
5 entitled to receive payments from the Secretary  
6 under this title for services furnished to the individ-  
7 ual.

8 “BENEFITS AND BENEFICIARY PROTECTIONS

9 “SEC. 1852. (a) BASIC BENEFITS.—

10 “(1) IN GENERAL.—Except as provided in sec-  
11 tion 1859(b)(2) for MSA plans, each MedicarePlus  
12 plan shall provide to members enrolled under this  
13 part, through providers and other persons that meet  
14 the applicable requirements of this title and part A  
15 of title XI—

16 “(A) those items and services for which  
17 benefits are available under parts A and B to  
18 individuals residing in the area served by the  
19 plan, and

20 “(B) additional benefits required under  
21 section 1854(f)(1)(A).

22 “(2) SATISFACTION OF REQUIREMENT.—A  
23 MedicarePlus plan (other than an MSA plan) offered  
24 by a MedicarePlus organization satisfies paragraph  
25 (1)(A), with respect to benefits for items and serv-  
26 ices furnished other than through a provider that

1 has a contract with the organization offering the  
2 plan, if the plan provides (in addition to any cost  
3 sharing provided for under the plan) for at least the  
4 total dollar amount of payment for such items and  
5 services as would otherwise be authorized under  
6 parts A and B (including any balance billing per-  
7 mitted under such parts).

8 “(3) SUPPLEMENTAL BENEFITS.—

9 “(A) BENEFITS INCLUDED SUBJECT TO  
10 SECRETARY’S APPROVAL.—Each MedicarePlus  
11 organization may provide to individuals enrolled  
12 under this part (without affording those individ-  
13 uals an option to decline the coverage) supple-  
14 mental health care benefits that the Secretary  
15 may approve. The Secretary shall approve any  
16 such supplemental benefits unless the Secretary  
17 determines that including such supplemental  
18 benefits would substantially discourage enroll-  
19 ment by MedicarePlus eligible individuals with  
20 the organization.

21 “(B) AT ENROLLEES’ OPTION.—A

22 MedicarePlus organization may provide to indi-  
23 viduals enrolled under this part (other than  
24 under an MSA plan) supplemental health care

1           benefits that the individuals may elect, at their  
2           option, to have covered.

3           “(4) ORGANIZATION AS SECONDARY PAYER.—

4           Notwithstanding any other provision of law, a  
5           MedicarePlus organization may (in the case of the  
6           provision of items and services to an individual  
7           under a MedicarePlus plan under circumstances in  
8           which payment under this title is made secondary  
9           pursuant to section 1862(b)(2)) charge or authorize  
10          the provider of such services to charge, in accord-  
11          ance with the charges allowed under such a law,  
12          plan, or policy—

13                 “(A) the insurance carrier, employer, or  
14                 other entity which under such law, plan, or pol-  
15                 icy is to pay for the provision of such services,  
16                 or

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

20          “(5) NATIONAL COVERAGE DETERMINATIONS.—

21          If there is a national coverage determination made  
22          in the period beginning on the date of an announce-  
23          ment under section 1853(b) and ending on the date  
24          of the next announcement under such section and  
25          the Secretary projects that the determination will re-

1 sult in a significant change in the costs to a  
2 MedicarePlus organization of providing the benefits  
3 that are the subject of such national coverage deter-  
4 mination and that such change in costs was not in-  
5 corporated in the determination of the annual  
6 MedicarePlus capitation rate under section 1853 in-  
7 cluded in the announcement made at the beginning  
8 of such period—

9 “(A) such determination shall not apply to  
10 contracts under this part until the first contract  
11 year that begins after the end of such period,  
12 and

13 “(B) if such coverage determination pro-  
14 vides for coverage of additional benefits or cov-  
15 erage under additional circumstances, section  
16 1851(i) shall not apply to payment for such ad-  
17 ditional benefits or benefits provided under such  
18 additional circumstances until the first contract  
19 year that begins after the end of such period,  
20 unless otherwise required by law.

21 “(b) ANTIDISCRIMINATION.—

22 “(1) IN GENERAL.—A MedicarePlus organiza-  
23 tion may not deny, limit, or condition the coverage  
24 or provision of benefits under this part, for individ-  
25 uals permitted to be enrolled with the organization

1 under this part, based on any health status-related  
2 factor described in section 2702(a)(1) of the Public  
3 Health Service Act.

4 “(2) CONSTRUCTION.—Paragraph (1) shall not  
5 be construed as requiring a MedicarePlus organiza-  
6 tion to enroll individuals who are determined to have  
7 end-stage renal disease, except as provided under  
8 section 1851(a)(3)(B).

9 “(c) DETAILED DESCRIPTION OF PLAN PROVI-  
10 SIONS.—A MedicarePlus organization shall disclose, in  
11 clear, accurate, and standardized form to each enrollee  
12 with a MedicarePlus plan offered by the organization  
13 under this part at the time of enrollment and at least an-  
14 nually thereafter, the following information regarding such  
15 plan:

16 “(1) SERVICE AREA.—The plan’s service area.

17 “(2) BENEFITS.—Benefits offered (and not of-  
18 fered) under the plan offered, including information  
19 described in section 1851(d)(3)(A) and exclusions  
20 from coverage and, if it is an MSA plan, a compari-  
21 son of benefits under such a plan with benefits  
22 under other MedicarePlus plans.

23 “(3) ACCESS.—The number, mix, and distribu-  
24 tion of plan providers and any point-of-service option

1 (including the supplemental premium for such op-  
2 tion).

3 “(4) OUT-OF-AREA COVERAGE.—Out-of-area  
4 coverage provided by the plan.

5 “(5) EMERGENCY COVERAGE.—Coverage of  
6 emergency services and urgently needed care, includ-  
7 ing—

8 “(A) the appropriate use of emergency  
9 services, including use of the 911 telephone sys-  
10 tem or its local equivalent in emergency situa-  
11 tions and an explanation of what constitutes an  
12 emergency situation;

13 “(B) the process and procedures of the  
14 plan for obtaining emergency services; and

15 “(C) the locations of (i) emergency depart-  
16 ments, and (ii) other settings, in which plan  
17 physicians and hospitals provide emergency  
18 services and post-stabilization care..

19 “(6) SUPPLEMENTAL BENEFITS.—Supple-  
20 mental benefits available from the organization of-  
21 fering the plan, including—

22 “(A) whether the supplemental benefits are  
23 optional,

24 “(B) the supplemental benefits covered,  
25 and

1           “(C) the premium price for the supple-  
2           mental benefits.

3           “(7) PRIOR AUTHORIZATION RULES.—Rules re-  
4           garding prior authorization or other review require-  
5           ments that could result in nonpayment.

6           “(8) PLAN GRIEVANCE AND APPEALS PROCE-  
7           DURES.—Any appeal or grievance rights and proce-  
8           dures.

9           “(9) QUALITY ASSURANCE PROGRAM.—A de-  
10          scription of the organization’s quality assurance pro-  
11          gram under subsection (e).

12          “(d) ACCESS TO SERVICES.—

13          “(1) IN GENERAL.—A MedicarePlus organiza-  
14          tion offering a MedicarePlus plan may select the  
15          providers from whom the benefits under the plan are  
16          provided so long as—

17                 “(A) the organization makes such benefits  
18                 available and accessible to each individual elect-  
19                 ing the plan within the plan service area with  
20                 reasonable promptness and in a manner which  
21                 assures continuity in the provision of benefits;

22                 “(B) when medically necessary in the opin-  
23                 ion of the treating health care provider the or-  
24                 ganization makes such benefits available and  
25                 accessible 24 hours a day and 7 days a week;

1           “(C) the plan provides for reimbursement  
2 with respect to services which are covered under  
3 subparagraphs (A) and (B) and which are pro-  
4 vided to such an individual other than through  
5 the organization, if—

6           “(i) the services were medically nec-  
7 essary in the opinion of the treating health  
8 care provider and immediately required be-  
9 cause of an unforeseen illness, injury, or  
10 condition, and it was not reasonable given  
11 the circumstances to obtain the services  
12 through the organization,

13           “(ii) the services were renal dialysis  
14 services and were provided other than  
15 through the organization because the indi-  
16 vidual was temporarily out of the plan’s  
17 service area, or

18           “(iii) the services are maintenance  
19 care or post-stabilization care covered  
20 under the guidelines established under  
21 paragraph (2);

22           “(D) the organization provides access to  
23 appropriate providers, including credentialed  
24 specialists, for treatment and services when  
25 such treatment and services are determined to



1 be medically necessary in the professional opin-  
2 ion of the treating health care provider, in con-  
3 sultation with the individual; and

4 “(E) coverage is provided for emergency  
5 services (as defined in paragraph (3)) without  
6 regard to prior authorization or the emergency  
7 care provider’s contractual relationship with the  
8 organization.

9 “(2) GUIDELINES RESPECTING COORDINATION  
10 OF POST-STABILIZATION CARE.—A MedicarePlus  
11 plan shall comply with such guidelines as the Sec-  
12 retary may prescribe relating to promoting efficient  
13 and timely coordination of appropriate maintenance  
14 and post-stabilization care of an enrollee after the  
15 enrollee has been determined to be stable under sec-  
16 tion 1867.

17 “(3) DEFINITION OF EMERGENCY SERVICES.—  
18 In this subsection—

19 “(A) IN GENERAL.—The term ‘emergency  
20 services’ means, with respect to an individual  
21 enrolled with an organization, covered inpatient  
22 and outpatient services that—

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

1                   “(ii) are needed to evaluate or sta-  
2                   bilize an emergency medical condition (as  
3                   defined in subparagraph (B)).

4                   “(B) EMERGENCY MEDICAL CONDITION  
5                   BASED ON PRUDENT LAYPERSON.—The term  
6                   ‘emergency medical condition’ means a medical  
7                   condition manifesting itself by acute symptoms  
8                   of sufficient severity such that a prudent  
9                   layperson, who possesses an average knowledge  
10                  of health and medicine, could reasonably expect  
11                  the absence of immediate medical attention to  
12                  result in—

13                   “(i) placing the health of the individ-  
14                   ual (or, with respect to a pregnant woman,  
15                   the health of the woman or her unborn  
16                   child) in serious jeopardy,

17                   “(ii) serious impairment to bodily  
18                   functions, or

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

21                  “(4) DETERMINATION OF HOSPITAL LENGTH  
22                  OF STAY.—

23                   “(A) IN GENERAL.—A MedicarePlus orga-  
24                   nization shall cover the length of an inpatient  
25                   hospital stay under this part as determined by

1 the attending physician (or other attending  
2 health care provider to the extent permitted  
3 under State law) in consultation with the pa-  
4 tient to be medically appropriate.

5 “(B) CONSTRUCTION.—Nothing in this  
6 paragraph shall be construed—

7 “(i) as requiring the provision of inpa-  
8 tient coverage if the attending physician  
9 (or other attending health care provider to  
10 the extent permitted under State law) and  
11 patient determine that a shorter period of  
12 hospital stay is medically appropriate, or

13 “(ii) as affecting the application of  
14 deductibles and coinsurance.

15 “(e) QUALITY ASSURANCE PROGRAM.—

16 “(1) IN GENERAL.—Each MedicarePlus organi-  
17 zation must have arrangements, consistent with any  
18 regulation, for an ongoing quality assurance pro-  
19 gram for health care services it provides to individ-  
20 uals enrolled with MedicarePlus plans of the organi-  
21 zation.

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

24 “(A) stress health outcomes and provide  
25 for the collection, analysis, and reporting of

1 data (in accordance with a quality measurement  
2 system that the Secretary recognizes) that will  
3 permit measurement of outcomes and other in-  
4 dices of the quality of MedicarePlus plans and  
5 organizations;

6 “(B) provide for the establishment of writ-  
7 ten protocols for utilization review, based on  
8 current standards of medical practice;

9 “(C) provide review by physicians and  
10 other health care professionals of the process  
11 followed in the provision of such health care  
12 services;

13 “(D) monitor and evaluate high volume  
14 and high risk services and the care of acute and  
15 chronic conditions;

16 “(E) evaluate the continuity and coordina-  
17 tion of care that enrollees receive;

18 “(F) have mechanisms to detect both un-  
19 derutilization and overutilization of services;

20 “(G) after identifying areas for improve-  
21 ment, establish or alter practice parameters;

22 “(H) take action to improve quality and  
23 assesses the effectiveness of such action  
24 through systematic followup;

1           “(I) make available information on quality  
2           and outcomes measures to facilitate beneficiary  
3           comparison and choice of health coverage op-  
4           tions (in such form and on such quality and  
5           outcomes measures as the Secretary determines  
6           to be appropriate);

7           “(J) be evaluated on an ongoing basis as  
8           to its effectiveness;

9           “(K) include measures of consumer satis-  
10          faction; and

11          “(L) provide the Secretary with such ac-  
12          cess to information collected as may be appro-  
13          priate to monitor and ensure the quality of care  
14          provided under this part.

15          “(3) EXTERNAL REVIEW.—Each MedicarePlus  
16          organization shall, for each MedicarePlus plan it op-  
17          erates, have an agreement with an independent qual-  
18          ity review and improvement organization approved  
19          by the Secretary to perform functions of the type de-  
20          scribed in sections 1154(a)(4)(B) and 1154(a)(14)  
21          with respect to services furnished by MedicarePlus  
22          plans for which payment is made under this title.

23          “(4) TREATMENT OF ACCREDITATION.—The  
24          Secretary shall provide that a MedicarePlus organi-  
25          zation is deemed to meet requirements of para-

1 graphs (1) through (3) of this subsection and sub-  
2 section (h) (relating to confidentiality and accuracy  
3 of enrollee records) if the organization is accredited  
4 (and periodically reaccredited) by a private organiza-  
5 tion under a process that the Secretary has deter-  
6 mined assures that the organization, as a condition  
7 of accreditation, applies and enforces standards with  
8 respect to the requirements involved that are no less  
9 stringent than the standards established under sec-  
10 tion 1856 to carry out the respective requirements.

11 “(f) COVERAGE DETERMINATIONS.—

12 “(1) DECISIONS ON NONEMERGENCY CARE.—A  
13 MedicarePlus organization shall make determina-  
14 tions regarding authorization requests for non-  
15 emergency care on a timely basis, depending on the  
16 urgency of the situation. The organization shall pro-  
17 vide notice of any coverage denial, which notice shall  
18 include a statement of the reasons for the denial and  
19 a description of the grievance and appeals processes  
20 available.

21 “(2) RECONSIDERATIONS.—

22 “(A) IN GENERAL.—Subject to subsection  
23 (g)(4), a reconsideration of a determination of  
24 an organization denying coverage shall be made  
25 within 30 days of the date of receipt of medical

1 information, but not later than 60 days after  
2 the date of the determination.

3 “(B) PHYSICIAN DECISION ON CERTAIN  
4 RECONSIDERATIONS.—A reconsideration relat-  
5 ing to a determination to deny coverage based  
6 on a lack of medical necessity shall be made  
7 only by a physician with appropriate expertise  
8 in the field of medicine which necessitates treat-  
9 ment who is other than a physician involved in  
10 the initial determination.

11 “(g) GRIEVANCES AND APPEALS.—

12 “(1) GRIEVANCE MECHANISM.—Each  
13 MedicarePlus organization must provide meaningful  
14 procedures for hearing and resolving grievances be-  
15 tween the organization (including any entity or indi-  
16 vidual through which the organization provides  
17 health care services) and enrollees with  
18 MedicarePlus plans of the organization under this  
19 part.

20 “(2) APPEALS.—An enrollee with a  
21 MedicarePlus plan of a MedicarePlus organization  
22 under this part who is dissatisfied by reason of the  
23 enrollee’s failure to receive any health service to  
24 which the enrollee believes the enrollee is entitled  
25 and at no greater charge than the enrollee believes

1 the enrollee is required to pay is entitled, if the  
2 amount in controversy is \$100 or more, to a hearing  
3 before the Secretary to the same extent as is pro-  
4 vided in section 205(b), and in any such hearing the  
5 Secretary shall make the organization a party. If the  
6 amount in controversy is \$1,000 or more, the indi-  
7 vidual or organization shall, upon notifying the other  
8 party, be entitled to judicial review of the Sec-  
9 retary's final decision as provided in section 205(g),  
10 and both the individual and the organization shall be  
11 entitled to be parties to that judicial review. In ap-  
12 plying sections 205(b) and 205(g) as provided in  
13 this paragraph, and in applying section 205(l) there-  
14 to, any reference therein to the Commissioner of So-  
15 cial Security or the Social Security Administration  
16 shall be considered a reference to the Secretary or  
17 the Department of Health and Human Services, re-  
18 spectively.

19 “(3) INDEPENDENT REVIEW OF COVERAGE DE-  
20 NIALS.—The Secretary shall contract with an inde-  
21 pendent, outside entity to review and resolve in a  
22 timely manner reconsiderations that affirm denial of  
23 coverage.

24 “(4) EXPEDITED DETERMINATIONS AND RE-  
25 CONSIDERATIONS.—



1           “(A) RECEIPT OF REQUESTS.—An enrollee  
2           in a MedicarePlus plan may request, either in  
3           writing or orally, an expedited determination or  
4           reconsideration by the MedicarePlus organiza-  
5           tion regarding a matter described in paragraph  
6           (2). The organization shall also permit the ac-  
7           ceptance of such requests by physicians.

8           “(B) ORGANIZATION PROCEDURES.—

9           “(i) IN GENERAL.—The MedicarePlus  
10          organization shall maintain procedures for  
11          expediting organization determinations and  
12          reconsiderations when, upon request of an  
13          enrollee, the organization determines that  
14          the application of normal time frames for  
15          making a determination (or a reconsider-  
16          ation involving a determination) could seri-  
17          ously jeopardize the life or health of the  
18          enrollee or the enrollee’s ability to regain  
19          maximum function.

20          “(ii) TIMELY RESPONSE.—In an ur-  
21          gent case described in clause (i), the orga-  
22          nization shall notify the enrollee (and the  
23          physician involved, as appropriate) of the  
24          determination (or determination on the re-  
25          consideration) as expeditiously as the en-

1           rollee’s health condition requires, but not  
2           later than 72 hours (or 24 hours in the  
3           case of a reconsideration) of the time of re-  
4           ceipt of the request for the determination  
5           or reconsideration (or receipt of the infor-  
6           mation necessary to make the determina-  
7           tion or reconsideration), or such longer pe-  
8           riod as the Secretary may permit in speci-  
9           fied cases.

10           “(iii) SECRETARIAL REPORT.—The  
11           Secretary shall annually report publicly on  
12           the number and disposition of denials and  
13           appeals within each MedicarePlus organi-  
14           zation, and those reviewed and resolved by  
15           the independent entities under this sub-  
16           section.

17           “(h) CONFIDENTIALITY AND ACCURACY OF EN-  
18           ROLLEE RECORDS.—Each MedicarePlus organization  
19           shall establish procedures—

20           “(1) to safeguard the privacy of individually  
21           identifiable enrollee information,

22           “(2) to maintain accurate and timely medical  
23           records and other health information for enrollees,  
24           and

1           “(3) to assure timely access of enrollees to their  
2           medical information.

3           “(i) INFORMATION ON ADVANCE DIRECTIVES.—Each  
4 MedicarePlus organization shall meet the requirement of  
5 section 1866(f) (relating to maintaining written policies  
6 and procedures respecting advance directives).

7           “(j) RULES REGARDING PHYSICIAN PARTICIPA-  
8 TION.—

9           “(1) PROCEDURES.—Each MedicarePlus orga-  
10 nization shall establish reasonable procedures relat-  
11 ing to the participation (under an agreement be-  
12 tween a physician and the organization) of physi-  
13 cians under MedicarePlus plans offered by the orga-  
14 nization under this part. Such procedures shall in-  
15 clude—

16                   “(A) providing notice of the rules regard-  
17 ing participation,

18                   “(B) providing written notice of participa-  
19 tion decisions that are adverse to physicians,  
20 and

21                   “(C) providing a process within the organi-  
22 zation for appealing such adverse decisions, in-  
23 cluding the presentation of information and  
24 views of the physician regarding such decision.

1           “(2) CONSULTATION IN MEDICAL POLICIES.—A  
2 MedicarePlus organization shall consult with physi-  
3 cians who have entered into participation agree-  
4 ments with the organization regarding the organiza-  
5 tion’s medical policy, quality, and medical manage-  
6 ment procedures.

7           “(3) PROHIBITING INTERFERENCE WITH PRO-  
8 VIDER ADVICE TO ENROLLEES.—

9           “(A) IN GENERAL.—Subject to subpara-  
10 graphs (B) and (C), a MedicarePlus organiza-  
11 tion (in relation to an individual enrolled under  
12 a MedicarePlus plan offered by the organization  
13 under this part) shall not prohibit or otherwise  
14 restrict a covered health care professional (as  
15 defined in subparagraph (D)) from advising  
16 such an individual who is a patient of the pro-  
17 fessional about the health status of the individ-  
18 ual or medical care or treatment for the individ-  
19 ual’s condition or disease, regardless of whether  
20 benefits for such care or treatment are provided  
21 under the plan, if the professional is acting  
22 within the lawful scope of practice.

23           “(B) CONSCIENCE PROTECTION.—Sub-  
24 paragraph (A) shall not be construed as requir-  
25 ing a MedicarePlus plan to provide, reimburse

1 for, or provide coverage of a counseling or re-  
2 ferral service if the MedicarePlus organization  
3 offering the plan—

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

6 “(ii) in the manner and through the  
7 written instrumentalities such  
8 MedicarePlus organization deems appro-  
9 priate, makes available information on its  
10 policies regarding such service to prospec-  
11 tive enrollees before or during enrollment  
12 and to enrollees within 90 days after the  
13 date that the organization or plan adopts  
14 a change in policy regarding such a coun-  
15 seling or referral service.

16 “(C) CONSTRUCTION.—Nothing in sub-  
17 paragraph (B) shall be construed to affect dis-  
18 closure requirements under State law or under  
19 the Employee Retirement Income Security Act  
20 of 1974.

21 “(D) HEALTH CARE PROFESSIONAL DE-  
22 FINED.—For purposes of this paragraph, the  
23 term ‘health care professional’ means a physi-  
24 cian (as defined in section 1861(r)) or other  
25 health care professional if coverage for the pro-

1 professional's services is provided under the  
2 MedicarePlus plan for the services of the pro-  
3 fessional. Such term includes a podiatrist, op-  
4 tometrist, chiropractor, psychologist, dentist,  
5 physician assistant, physical or occupational  
6 therapist and therapy assistant, speech-lan-  
7 guage pathologist, audiologist, registered or li-  
8 censed practical nurse (including nurse practi-  
9 tioner, clinical nurse specialist, certified reg-  
10 istered nurse anesthetist, and certified nurse-  
11 midwife), licensed certified social worker, reg-  
12 istered respiratory therapist, and certified res-  
13 piratory therapy technician.

14 “(4) LIMITATIONS ON HEALTH CARE PROVIDER  
15 INCENTIVE PLANS.—

16 “(A) IN GENERAL.—No MedicarePlus or-  
17 ganization may operate any health care provider  
18 incentive plan (as defined in subparagraph (B))  
19 unless the following requirements are met:

20 “(i) No specific payment is made di-  
21 rectly or indirectly under the plan to a  
22 health care provider or health care pro-  
23 vider group as an inducement to reduce or  
24 limit medically necessary services provided

1 with respect to a specific individual en-  
2 rolled with the organization.

3 “(ii) If the plan places a health care  
4 provider or health care provider group at  
5 substantial financial risk (as determined by  
6 the Secretary) for services not provided by  
7 the health care provider or health care pro-  
8 vider group, the organization—

9 “(I) provides stop-loss protection  
10 for the health care provider or group  
11 that is adequate and appropriate,  
12 based on standards developed by the  
13 Secretary that take into account the  
14 number of health care providers  
15 placed at such substantial financial  
16 risk in the group or under the plan  
17 and the number of individuals enrolled  
18 with the organization who receive  
19 services from the health care provider  
20 or group, and

21 “(II) conducts periodic surveys of  
22 both individuals enrolled and individ-  
23 uals previously enrolled with the orga-  
24 nization to determine the degree of  
25 access of such individuals to services

1 provided by the organization and sat-  
2 isfaction with the quality of such serv-  
3 ices.

4 “(iii) The organization provides the  
5 Secretary with descriptive information re-  
6 garding the plan, sufficient to permit the  
7 Secretary to determine whether the plan is  
8 in compliance with the requirements of this  
9 subparagraph.

10 “(B) HEALTH CARE PROVIDER INCENTIVE  
11 PLAN DEFINED.—In this paragraph, the term  
12 ‘health care provider incentive plan’ means any  
13 compensation arrangement between a  
14 MedicarePlus organization and a health care  
15 provider or health care provider group that may  
16 directly or indirectly have the effect of reducing  
17 or limiting services provided with respect to in-  
18 dividuals enrolled with the organization under  
19 this part.

20 “(C) HEALTH CARE PROVIDER DE-  
21 FINED.—For the purposes of this paragraph,  
22 the term ‘health care provider’ has the meaning  
23 given the term ‘health care professional’ in  
24 paragraph (3)(D).



1           “(5) LIMITATION ON PROVIDER INDEMNIFICA-  
2           TION.—A MedicarePlus organization may not pro-  
3           vide (directly or indirectly) for a provider (or group  
4           of providers) to indemnify the organization against  
5           any liability resulting from a civil action brought for  
6           any damage caused to an enrollee with a  
7           MedicarePlus plan of the organization under this  
8           part by the organization’s denial of medically nec-  
9           essary care.

10           “(6) LIMITATION ON NON-COMPETE CLAUSE.—  
11           A MedicarePlus organization may not (directly or in-  
12           directly) seek to enforce any contractual provision  
13           which prevents a provider whose contractual obliga-  
14           tions to the organization for the provision of services  
15           through the organization have ended from joining or  
16           forming any competing MedicarePlus organization  
17           that is a provider-sponsored organization in the  
18           same area.

19           “(k) TREATMENT OF SERVICES FURNISHED BY CER-  
20           TAIN PROVIDERS.—A physician or other entity (other  
21           than a provider of services) that does not have a contract  
22           establishing payment amounts for services furnished to an  
23           individual enrolled under this part with a MedicarePlus  
24           organization shall accept as payment in full for covered  
25           services under this title that are furnished to such an indi-

1 individual the amounts that the physician or other entity could  
2 collect if the individual were not so enrolled. Any penalty  
3 or other provision of law that applies to such a payment  
4 with respect to an individual entitled to benefits under this  
5 title (but not enrolled with a MedicarePlus organization  
6 under this part) also applies with respect to an individual  
7 so enrolled.

8       “(1) DISCLOSURE OF USE OF DSH AND TEACHING  
9 HOSPITALS.—Each MedicarePlus organization shall pro-  
10 vide the Secretary with information on—

11           “(1) the extent to which the organization pro-  
12 vides inpatient and outpatient hospital benefits  
13 under this part—

14           “(A) through the use of hospitals that are  
15 eligible for additional payments under section  
16 1886(d)(5)(F)(i) (relating to so-called DSH  
17 hospitals), or

18           “(B) through the use of teaching hospitals  
19 that receive payments under section 1886(h);  
20 and

21           “(2) the extent to which differences between  
22 payment rates to different hospitals reflect the dis-  
23 proportionate share percentage of low-income pa-  
24 tients and the presence of medical residency training  
25 programs in those hospitals.

1       “(m) OUT-OF-NETWORK ACCESS.—If an organiza-  
2 tion offers to members enrolled under this section one plan  
3 which provides for coverage of services covered under  
4 parts A and B primarily through providers and other per-  
5 sons who are members of a network of providers and other  
6 persons who have entered into a contract with the organi-  
7 zation to provide such services, nothing in this section  
8 shall be construed as preventing the organization from of-  
9 fering such members (at the time of enrollment) another  
10 plan which provides for coverage of such items which are  
11 not furnished through such network providers.

12       “(n) NON-PREEMPTION OF STATE LAW.—A State  
13 may establish or enforce requirements with respect to ben-  
14 efiary protections in this section, but only if such re-  
15 quirements are more stringent than the requirements es-  
16 tablished under this section.

17       “(o) NONDISCRIMINATION IN SELECTION OF NET-  
18 WORK HEALTH PROFESSIONALS.—

19               “(1) IN GENERAL.—A MedicarePlus organiza-  
20 tion offering a MedicarePlus plan offering network  
21 coverage shall not discriminate in selecting the mem-  
22 bers of its health professional network (or in estab-  
23 lishing the terms and conditions for membership in  
24 such network) on the basis of the race, national ori-  
25 gin, gender, age, or disability (other than a disability

1 that impairs the ability of an individual to provide  
2 health care services or that may threaten the health  
3 of enrollees) of the health professional.

4 “(2) APPROPRIATE RANGE OF SERVICES.—A  
5 MedicarePlus organization shall not deny any health  
6 care professionals, based solely on the license or cer-  
7 tification as applicable under State law, the ability  
8 to participate in providing covered health care serv-  
9 ices, or be reimbursed or indemnified by a network  
10 plan for providing such services under this part.

11 “(2) DEFINITIONS.—For purposes of this sub-  
12 section:

13 “(A) NETWORK.—The term ‘network’  
14 means, with respect to a MedicarePlus organi-  
15 zation offering a MedicarePlus plan, the partici-  
16 pating health professionals and providers  
17 through whom the organization provides health  
18 care items and services to enrollees.

19 “(B) NETWORK COVERAGE.—The term  
20 ‘network coverage’ means a MedicarePlus plan  
21 offered by a MedicarePlus organization that  
22 provides or arranges for the provision of health  
23 care items and services to enrollees through  
24 participating health professionals and providers.

1           “(C) PARTICIPATING.—The term ‘partici-  
2           pating’ means, with respect to a health profes-  
3           sional or provider, a health professional or pro-  
4           vider that provides health care items and serv-  
5           ices to enrollees under network coverage under  
6           an agreement with the MedicarePlus organiza-  
7           tion offering the coverage.

8           “(p) SPECIAL RULE FOR UNRESTRICTED FEE-FOR-  
9           SERVICE MSA PLANS.—Subsections (j)(1) and (k) shall  
10          not apply to a MedicarePlus organization with respect to  
11          an MSA plan it offers if the plan does not limit the provid-  
12          ers through whom benefits may be obtained under the  
13          plan.

14          “PAYMENTS TO MEDICAREPLUS ORGANIZATIONS

15          “SEC. 1853. (a) PAYMENTS TO ORGANIZATIONS.—

16                  “(1) MONTHLY PAYMENTS.—

17                          “(A) IN GENERAL.—Under a contract  
18                          under section 1857 and subject to subsections  
19                          (e) and (f), the Secretary shall make monthly  
20                          payments under this section in advance to each  
21                          MedicarePlus organization, with respect to cov-  
22                          erage of an individual under this part in a  
23                          MedicarePlus payment area for a month, in an  
24                          amount equal to  $\frac{1}{12}$  of the annual  
25                          MedicarePlus capitation rate (as calculated  
26                          under subsection (c)) with respect to that indi-

1           vidual for that area, adjusted for such risk fac-  
2           tors as age, disability status, gender, institu-  
3           tional status, and such other factors as the Sec-  
4           retary determines to be appropriate, so as to  
5           ensure actuarial equivalence. The Secretary  
6           may add to, modify, or substitute for such fac-  
7           tors, if such changes will improve the deter-  
8           mination of actuarial equivalence.

9           “(B) SPECIAL RULE FOR END-STAGE  
10          RENAL DISEASE.—The Secretary shall establish  
11          separate rates of payment to a MedicarePlus  
12          organization with respect to classes of individ-  
13          uals determined to have end-stage renal disease  
14          and enrolled in a MedicarePlus plan of the or-  
15          ganization. Such rates of payment shall be ac-  
16          tuarily equivalent to rates paid to other en-  
17          rollees in the MedicarePlus payment area (or  
18          such other area as specified by the Secretary).  
19          In accordance with regulations, the Secretary  
20          shall provide for the application of the seventh  
21          sentence of section 1881(b)(7) to payments  
22          under this section covering the provision of  
23          renal dialysis treatment in the same manner as  
24          such sentence applies to composite rate pay-  
25          ments described in such sentence.

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

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

11           “(B) SPECIAL RULE FOR CERTAIN EN-  
12 ROLLEES.—

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

1           that for purposes of making such retro-  
2           active adjustments under this subpara-  
3           graph, such period may not exceed 90  
4           days.

5           “(ii) EXCEPTION.—No adjustment  
6           may be made under clause (i) with respect  
7           to any individual who does not certify that  
8           the organization provided the individual  
9           with the information required to be dis-  
10          closed under section 1852(c) at the time  
11          the individual enrolled with the organiza-  
12          tion.

13          “(3) ESTABLISHMENT OF RISK ADJUSTMENT  
14          FACTORS.—

15               “(A) REPORT.—The Secretary shall de-  
16               velop, and submit to Congress by not later than  
17               October 1, 1999, a report on a method of risk  
18               adjustment of payment rates under this section  
19               that accounts for variations in per capita costs  
20               based on health status. Such report shall in-  
21               clude an evaluation of such method by an out-  
22               side, independent actuary of the actuarial  
23               soundness of the proposal.

24               “(B) DATA COLLECTION.—In order to  
25               carry out this paragraph, the Secretary shall re-



1           quire MedicarePlus organizations (and eligible  
2           organizations with risk-sharing contracts under  
3           section 1876) to submit, for periods beginning  
4           on or after January 1, 1998, data regarding in-  
5           patient hospital services and other services and  
6           other information the Secretary deems nec-  
7           essary.

8           “(C) INITIAL IMPLEMENTATION.—The  
9           Secretary shall first provide for implementation  
10          of a risk adjustment methodology that accounts  
11          for variations in per capita costs based on  
12          health status and other demographic factors for  
13          payments by no later than January 1, 2000.

14          “(b) ANNUAL ANNOUNCEMENT OF PAYMENT  
15          RATES.—

16               “(1) ANNUAL ANNOUNCEMENT.—The Secretary  
17               shall annually determine, and shall announce (in a  
18               manner intended to provide notice to interested par-  
19               ties) not later than August 1 before the calendar  
20               year concerned—

21                       “(A) the annual MedicarePlus capitation  
22                       rate for each MedicarePlus payment area for  
23                       the year, and

1           “(B) the risk and other factors to be used  
2           in adjusting such rates under subsection  
3           (a)(1)(A) for payments for months in that year.

4           “(2) ADVANCE NOTICE OF METHODOLOGICAL  
5           CHANGES.—At least 45 days before making the an-  
6           nouncement under paragraph (1) for a year, the  
7           Secretary shall provide for notice to MedicarePlus  
8           organizations of proposed changes to be made in the  
9           methodology from the methodology and assumptions  
10          used in the previous announcement and shall provide  
11          such organizations an opportunity to comment on  
12          such proposed changes.

13          “(3) EXPLANATION OF ASSUMPTIONS.—In each  
14          announcement made under paragraph (1), the Sec-  
15          retary shall include an explanation of the assump-  
16          tions and changes in methodology used in the an-  
17          nouncement in sufficient detail so that MedicarePlus  
18          organizations can compute monthly adjusted  
19          MedicarePlus capitation rates for individuals in each  
20          MedicarePlus payment area which is in whole or in  
21          part within the service area of such an organization.

22          “(c) CALCULATION OF ANNUAL MEDICAREPLUS  
23          CAPITATION RATES.—

24                 “(1) IN GENERAL.—For purposes of this part,  
25                 each annual MedicarePlus capitation rate, for a

1 MedicarePlus payment area for a contract year con-  
2 sisting of a calendar year, is equal to the largest of  
3 the amounts specified in the following subpara-  
4 graphs (A), (B), or (C):

5 “(A) BLENDED CAPITATION RATE.—The  
6 sum of—

7 “(i) area-specific percentage for the  
8 year (as specified under paragraph (2) for  
9 the year) of the annual area-specific  
10 MedicarePlus capitation rate for the year  
11 for the MedicarePlus payment area, as de-  
12 termined under paragraph (3), and

13 “(ii) national percentage (as specified  
14 under paragraph (2) for the year) of the  
15 input-price-adjusted annual national  
16 MedicarePlus capitation rate for the year,  
17 as determined under paragraph (4),

18 multiplied by the payment adjustment factors  
19 described in subparagraphs (A) and (B) of  
20 paragraph (5).

21 “(B) MINIMUM AMOUNT.—12 multiplied  
22 by the following amount:

23 “(i) For 1998, \$350 (but not to ex-  
24 ceed, in the case of an area outside the 50  
25 States and the District of Columbia, 150

1 percent of the annual per capita rate of  
2 payment for 1997 determined under sec-  
3 tion 1876(a)(1)(C) for the area).

4 “(ii) For a succeeding year, the mini-  
5 mum amount specified in this clause (or  
6 clause (i)) for the preceding year increased  
7 by the national per capita MedicarePlus  
8 growth percentage, specified under para-  
9 graph (6) for that succeeding year.

10 “(C) MINIMUM PERCENTAGE INCREASE.—

11 “(i) For 1998, the annual per capita  
12 rate of payment for 1997 determined  
13 under section 1876(a)(1)(C) for the  
14 MedicarePlus payment area.

15 “(ii) For 1999 and 2000, 101 percent  
16 of the annual MedicarePlus capitation rate  
17 under this paragraph for the area for the  
18 previous year.

19 “(iii) For a subsequent year, 102 per-  
20 cent of the annual MedicarePlus capitation  
21 rate under this paragraph for the area for  
22 the previous year.

23 “(2) AREA-SPECIFIC AND NATIONAL PERCENT-  
24 AGES.—For purposes of paragraph (1)(A)—

1           “(A) for 1998, the ‘area-specific percent-  
2           age’ is 90 percent and the ‘national percentage’  
3           is 10 percent,

4           “(B) for 1999, the ‘area-specific percent-  
5           age’ is 85 percent and the ‘national percentage’  
6           is 15 percent,

7           “(C) for 2000, the ‘area-specific percent-  
8           age’ is 80 percent and the ‘national percentage’  
9           is 20 percent,

10           “(D) for 2001, the ‘area-specific percent-  
11           age’ is 75 percent and the ‘national percentage’  
12           is 25 percent, and

13           “(E) for a year after 2001, the ‘area-spe-  
14           cific percentage’ is 70 percent and the ‘national  
15           percentage’ is 30 percent.

16           “(3) ANNUAL AREA-SPECIFIC MEDICAREPLUS  
17           CAPITATION RATE.—

18           “(A) IN GENERAL.—For purposes of para-  
19           graph (1)(A), subject to subparagraph (B), the  
20           annual area-specific MedicarePlus capitation  
21           rate for a MedicarePlus payment area—

22           “(i) for 1998 is the annual per capita  
23           rate of payment for 1997 determined  
24           under section 1876(a)(1)(C) for the area,  
25           increased by the national per capita

1 MedicarePlus growth percentage for 1998  
2 (as defined in paragraph (6)); or

3 “(ii) for a subsequent year is the an-  
4 nual area-specific MedicarePlus capitation  
5 rate for the previous year determined  
6 under this paragraph for the area, in-  
7 creased by the national per capita  
8 MedicarePlus growth percentage for such  
9 subsequent year.

10 “(B) REMOVAL OF MEDICAL EDUCATION  
11 AND DISPROPORTIONATE SHARE HOSPITAL PAY-  
12 MENTS FROM CALCULATION OF ADJUSTED AV-  
13 ERAGE PER CAPITA COST.—

14 “(i) IN GENERAL.—In determining  
15 the area-specific MedicarePlus capitation  
16 rate under subparagraph (A), for a year  
17 (beginning with 1998), the annual per cap-  
18 ita rate of payment for 1997 determined  
19 under section 1876(a)(1)(C) shall be ad-  
20 justed to exclude from the rate the applica-  
21 ble percent (specified in clause (ii)) of the  
22 payment adjustments described in subpara-  
23 graph (C).

1                   “(ii) APPLICABLE PERCENT.—For  
2 purposes of clause (i), the applicable per-  
3 cent for—

4                   “(I) 1998 is 20 percent,

5                   “(II) 1999 is 40 percent,

6                   “(III) 2000 is 60 percent,

7                   “(IV) 2001 is 80 percent, and

8                   “(V) a succeeding year is 100  
9 percent.

10                  “(C) PAYMENT ADJUSTMENT.—The pay-  
11 ment adjustments described in this subpara-  
12 graph are payment adjustments which the Sec-  
13 retary estimates were payable during 1997—

14                  “(i) under section 1886(d)(5)(F) for  
15 hospitals serving a disproportionate share  
16 of low-income patients,

17                  “(ii) for the indirect costs of medical  
18 education under section 1886(d)(5)(B),  
19 and

20                  “(iii) for direct graduate medical edu-  
21 cation costs under section 1886(h),

22 multiplied by a ratio (estimated by the Sec-  
23 retary) of total payments under subsection (h)  
24 and section 1858 in 1998 to payments under  
25 such subsection and payments under such sec-

1           tion in such year for hospitals not reimbursed  
2           under section 1814(b)(3).

3           “(4) INPUT-PRICE-ADJUSTED ANNUAL NA-  
4           TIONAL MEDICAREPLUS CAPITATION RATE.—

5                   “(A) IN GENERAL.—For purposes of para-  
6           graph (1)(A), the input-price-adjusted annual  
7           national MedicarePlus capitation rate for a  
8           MedicarePlus payment area for a year is equal  
9           to the sum, for all the types of medicare serv-  
10          ices (as classified by the Secretary), of the  
11          product (for each such type of service) of—

12                   “(i) the national standardized annual  
13          MedicarePlus capitation rate (determined  
14          under subparagraph (B)) for the year,

15                   “(ii) the proportion of such rate for  
16          the year which is attributable to such type  
17          of services, and

18                   “(iii) an index that reflects (for that  
19          year and that type of services) the relative  
20          input price of such services in the area  
21          compared to the national average input  
22          price of such services.

23          In applying clause (iii), the Secretary shall, sub-  
24          ject to subparagraph (C), apply those indices  
25          under this title that are used in applying (or



1 updating) national payment rates for specific  
2 areas and localities.

3 “(B) NATIONAL STANDARDIZED ANNUAL  
4 MEDICAREPLUS CAPITATION RATE.—In sub-  
5 paragraph (A)(i), the ‘national standardized an-  
6 nual MedicarePlus capitation rate’ for a year is  
7 equal to—

8 “(i) the sum (for all MedicarePlus  
9 payment areas) of the product of—

10 “(I) the annual area-specific  
11 MedicarePlus capitation rate for that  
12 year for the area under paragraph  
13 (3), and

14 “(II) the average number of med-  
15 icare beneficiaries residing in that  
16 area in the year, multiplied by the av-  
17 erage of the risk factor weights used  
18 to adjust payments under subsection  
19 (a)(1)(A) for such beneficiaries in  
20 such area; divided by

21 “(ii) the sum of the products de-  
22 scribed in clause (i)(II) for all areas for  
23 that year.

24 “(C) SPECIAL RULES FOR 1998.—In apply-  
25 ing this paragraph for 1998—

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

4           “(ii) the proportions described in sub-  
5           paragraph (A)(ii)—

6                       “(I) for part A services shall be  
7                       the ratio (expressed as a percentage)  
8                       of the national average annual per  
9                       capita rate of payment for part A for  
10                      1997 to the total national average an-  
11                      nual per capita rate of payment for  
12                      parts A and B for 1997, and

13                     “(II) for part B services shall be  
14                     100 percent minus the ratio described  
15                     in subclause (I);

16                     “(iii) for part A services, 70 percent  
17                     of payments attributable to such services  
18                     shall be adjusted by the index used under  
19                     section 1886(d)(3)(E) to adjust payment  
20                     rates for relative hospital wage levels for  
21                     hospitals located in the payment area in-  
22                     volved;

23                     “(iv) for part B services—

24                               “(I) 66 percent of payments at-  
25                               tributable to such services shall be ad-

1           justed by the index of the geographic  
2           area factors under section 1848(e)  
3           used to adjust payment rates for phy-  
4           sicians' services furnished in the pay-  
5           ment area, and

6                       “(II) of the remaining 34 percent  
7                       of the amount of such payments, 40  
8                       percent shall be adjusted by the index  
9                       described in clause (iii); and

10                      “(v) the index values shall be com-  
11                      puted based only on the beneficiary popu-  
12                      lation who are 65 years of age or older and  
13                      who are not determined to have end stage  
14                      renal disease.

15           The Secretary may continue to apply the rules  
16           described in this subparagraph (or similar  
17           rules) for 1999.

18                      “(5) PAYMENT ADJUSTMENT BUDGET NEU-  
19                      TRALITY FACTORS.—For purposes of paragraph  
20                      (1)(A)—

21                              “(A) BLENDED RATE PAYMENT ADJUST-  
22                              MENT FACTOR.—For each year, the Secretary  
23                              shall compute a blended rate payment adjust-  
24                              ment factor such that, not taking into account  
25                              subparagraphs (B) and (C) of paragraph (1)

1 and the application of the payment adjustment  
2 factor described in subparagraph (B) but tak-  
3 ing into account paragraph (7), the aggregate  
4 of the payments that would be made under this  
5 part is equal to the aggregate payments that  
6 would have been made under this part (not tak-  
7 ing into account such subparagraphs and such  
8 other adjustment factor) if the area-specific  
9 percentage under paragraph (1) for the year  
10 had been 100 percent and the national percent-  
11 age had been 0 percent.

12 “(B) FLOOR-AND-MINIMUM-UPDATE PAY-  
13 MENT ADJUSTMENT FACTOR.—For each year,  
14 the Secretary shall compute a floor-and-mini-  
15 mum-update payment adjustment factor so  
16 that, taking into account the application of the  
17 blended rate payment adjustment factor under  
18 subparagraph (A) and subparagraphs (B) and  
19 (C) of paragraph (1) and the application of the  
20 adjustment factor under this subparagraph, the  
21 aggregate of the payments under this part shall  
22 not exceed the aggregate payments that would  
23 have been made under this part if subpara-  
24 graphs (B) and (C) of paragraph (1) did not  
25 apply and if the floor-and-minimum-update pay-

1           ment adjustment factor under this subpara-  
2           graph was 1.

3           “(6) NATIONAL PER CAPITA MEDICAREPLUS  
4           GROWTH PERCENTAGE DEFINED.—

5                   “(A) IN GENERAL.—In this part, the ‘na-  
6           tional per capita MedicarePlus growth percent-  
7           age’ for a year is the percentage determined by  
8           the Secretary, by April 30th before the begin-  
9           ning of the year involved, to reflect the Sec-  
10          retary’s estimate of the projected per capita  
11          rate of growth in expenditures under this title  
12          for an individual entitled to benefits under part  
13          A and enrolled under part B, reduced by the  
14          number of percentage points specified in sub-  
15          paragraph (B) for the year. Separate deter-  
16          minations may be made for aged enrollees, dis-  
17          abled enrollees, and enrollees with end-stage  
18          renal disease. Such percentage shall include an  
19          adjustment for over or under projection in the  
20          growth percentage for previous years.

21                   “(B) ADJUSTMENT.—The number of per-  
22          centage points specified in this subparagraph  
23          is—

24                           “(i) for 1998, 0.5 percentage points,

25                           “(ii) for 1999, 0.5 percentage points,

1                   “(iii) for 2000, 0.5 percentage points,  
2                   “(iv) for 2001, 0.5 percentage points,  
3                   “(v) for 2002, 0.5 percentage points,  
4                   and  
5                   “(vi) for a year after 2002, 0 percent-  
6                   age points.

7                   “(7) TREATMENT OF AREAS WITH HIGHLY  
8                   VARIABLE PAYMENT RATES.—In the case of a  
9                   MedicarePlus payment area for which the annual  
10                  per capita rate of payment determined under section  
11                  1876(a)(1)(C) for 1997 varies by more than 20 per-  
12                  cent from such rate for 1996, for purposes of this  
13                  subsection the Secretary may substitute for such  
14                  rate for 1997 a rate that is more representative of  
15                  the costs of the enrollees in the area.

16                  “(d) MEDICAREPLUS PAYMENT AREA DEFINED.—

17                  “(1) IN GENERAL.—In this part, except as pro-  
18                  vided in paragraph (3), the term ‘MedicarePlus pay-  
19                  ment area’ means a county, or equivalent area speci-  
20                  fied by the Secretary.

21                  “(2) RULE FOR ESRD BENEFICIARIES.—In the  
22                  case of individuals who are determined to have end  
23                  stage renal disease, the MedicarePlus payment area  
24                  shall be a State or such other payment area as the  
25                  Secretary specifies.

1 “(3) GEOGRAPHIC ADJUSTMENT.—

2 “(A) IN GENERAL.—Upon written request  
3 of the chief executive officer of a State for a  
4 contract year (beginning after 1998) made at  
5 least 7 months before the beginning of the year,  
6 the Secretary shall make a geographic adjust-  
7 ment to a MedicarePlus payment area in the  
8 State otherwise determined under paragraph  
9 (1)—

10 “(i) to a single statewide  
11 MedicarePlus payment area,

12 “(ii) to the metropolitan based system  
13 described in subparagraph (C), or

14 “(iii) to consolidating into a single  
15 MedicarePlus payment area noncontiguous  
16 counties (or equivalent areas described in  
17 paragraph (1)) within a State.

18 Such adjustment shall be effective for payments  
19 for months beginning with January of the year  
20 following the year in which the request is re-  
21 ceived.

22 “(B) BUDGET NEUTRALITY ADJUST-  
23 MENT.—In the case of a State requesting an  
24 adjustment under this paragraph, the Secretary  
25 shall adjust the payment rates otherwise estab-

1           lished under this section for MedicarePlus pay-  
2           ment areas in the State in a manner so that the  
3           aggregate of the payments under this section in  
4           the State shall not exceed the aggregate pay-  
5           ments that would have been made under this  
6           section for MedicarePlus payment areas in the  
7           State in the absence of the adjustment under  
8           this paragraph.

9           “(C) METROPOLITAN BASED SYSTEM.—

10          The metropolitan based system described in this  
11          subparagraph is one in which—

12                 “(i) all the portions of each metropoli-  
13                 tan statistical area in the State or in the  
14                 case of a consolidated metropolitan statis-  
15                 tical area, all of the portions of each pri-  
16                 mary metropolitan statistical area within  
17                 the consolidated area within the State, are  
18                 treated as a single MedicarePlus payment  
19                 area, and

20                 “(ii) all areas in the State that do not  
21                 fall within a metropolitan statistical area  
22                 are treated as a single MedicarePlus pay-  
23                 ment area.

24           “(D) AREAS.—In subparagraph (C), the  
25          terms ‘metropolitan statistical area’, ‘consoli-



1           dated metropolitan statistical area’, and ‘pri-  
2           mary metropolitan statistical area’ mean any  
3           area designated as such by the Secretary of  
4           Commerce.

5           “(e) SPECIAL RULES FOR INDIVIDUALS ELECTING  
6 MSA PLANS.—

7           “(1) IN GENERAL.—If the amount of the  
8           monthly premium for an MSA plan for a  
9           MedicarePlus payment area for a year is less than  
10           $\frac{1}{12}$  of the annual MedicarePlus capitation rate ap-  
11          plied under this section for the area and year in-  
12          volved, the Secretary shall deposit an amount equal  
13          to 100 percent of such difference in a MedicarePlus  
14          MSA established (and, if applicable, designated) by  
15          the individual under paragraph (2).

16          “(2) ESTABLISHMENT AND DESIGNATION OF  
17          MEDICAREPLUS MEDICAL SAVINGS ACCOUNT AS RE-  
18          QUIREMENT FOR PAYMENT OF CONTRIBUTION.—In  
19          the case of an individual who has elected coverage  
20          under an MSA plan, no payment shall be made  
21          under paragraph (1) on behalf of an individual for  
22          a month unless the individual—

23                  “(A) has established before the beginning  
24                  of the month (or by such other deadline as the  
25                  Secretary may specify) a MedicarePlus MSA

1 (as defined in section 138(b)(2) of the Internal  
2 Revenue Code of 1986), and

3 “(B) if the individual has established more  
4 than one such MedicarePlus MSA, has des-  
5 ignated one of such accounts as the individual’s  
6 MedicarePlus MSA for purposes of this part.

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

10 “(3) LUMP SUM DEPOSIT OF MEDICAL SAVINGS  
11 ACCOUNT CONTRIBUTION.—In the case of an indi-  
12 vidual electing an MSA plan effective beginning with  
13 a month in a year, the amount of the contribution  
14 to the MedicarePlus MSA on behalf of the individual  
15 for that month and all successive months in the year  
16 shall be deposited during that first month. In the  
17 case of a termination of such an election as of a  
18 month before the end of a year, the Secretary shall  
19 provide for a procedure for the recovery of deposits  
20 attributable to the remaining months in the year.

21 “(f) PAYMENTS FROM TRUST FUND.—The payment  
22 to a MedicarePlus organization under this section for indi-  
23 viduals enrolled under this part with the organization and  
24 payments to a MedicarePlus MSA under subsection (e)(1)  
25 shall be made from the Federal Hospital Insurance Trust

1 Fund and the Federal Supplementary Medical Insurance  
2 Trust Fund in such proportion as the Secretary deter-  
3 mines reflects the relative weight that benefits under part  
4 A and under part B represents of the actuarial value of  
5 the total benefits under this title. Monthly payments oth-  
6 erwise payable under this section for October 2001 shall  
7 be paid on the last business day of September 2001.

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

13               “(1) election under this part of a MedicarePlus  
14 plan offered by a MedicarePlus organization—

15                       “(A) payment for such services until the  
16 date of the individual’s discharge shall be made  
17 under this title through the MedicarePlus plan  
18 or the medicare fee-for-service program option  
19 described in section 1851(a)(1)(A) (as the case  
20 may be) elected before the election with such  
21 organization,

22                       “(B) the elected organization shall not be  
23 financially responsible for payment for such  
24 services until the date after the date of the indi-  
25 vidual’s discharge, and

1           “(C) the organization shall nonetheless be  
2           paid the full amount otherwise payable to the  
3           organization under this part; or

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

6           “(A) the organization shall be financially  
7           responsible for payment for such services after  
8           such date and until the date of the individual’s  
9           discharge,

10           “(B) payment for such services during the  
11           stay shall not be made under section 1886(d) or  
12           by any succeeding MedicarePlus organization,  
13           and

14           “(C) the terminated organization shall not  
15           receive any payment with respect to the individ-  
16           ual under this part during the period the indi-  
17           vidual is not enrolled.

18                                   “PREMIUMS

19           “SEC. 1854. (a) SUBMISSION AND CHARGING OF  
20           PREMIUMS.—

21           “(1) IN GENERAL.—Subject to paragraph (3),  
22           each MedicarePlus organization shall file with the  
23           Secretary each year, in a form and manner and at  
24           a time specified by the Secretary—

25           “(A) the amount of the monthly premium  
26           for coverage for services under section 1852(a)

1 under each MedicarePlus plan it offers under  
2 this part in each MedicarePlus payment area  
3 (as defined in section 1853(d)) in which the  
4 plan is being offered; and

5 “(B) the enrollment capacity in relation to  
6 the plan in each such area.

7 “(2) TERMINOLOGY.—In this part—

8 “(A) the term ‘monthly premium’ means,  
9 with respect to a MedicarePlus plan offered by  
10 a MedicarePlus organization, the monthly pre-  
11 mium filed under paragraph (1), not taking  
12 into account the amount of any payment made  
13 toward the premium under section 1853; and

14 “(B) the term ‘net monthly premium’  
15 means, with respect to such a plan and an indi-  
16 vidual enrolled with the plan, the premium (as  
17 defined in subparagraph (A)) for the plan re-  
18 duced by the amount of payment made toward  
19 such premium under section 1853.

20 “(b) MONTHLY PREMIUM CHARGED.—The monthly  
21 amount of the premium charged by a MedicarePlus orga-  
22 nization for a MedicarePlus plan offered in a  
23 MedicarePlus payment area to an individual under this  
24 part shall be equal to the net monthly premium plus any

1 monthly premium charged in accordance with subsection  
2 (e)(2) for supplemental benefits.

3 “(c) UNIFORM PREMIUM.—The monthly premium  
4 and monthly amount charged under subsection (b) of a  
5 MedicarePlus organization under this part may not vary  
6 among individuals who reside in the same MedicarePlus  
7 payment area.

8 “(d) TERMS AND CONDITIONS OF IMPOSING PRE-  
9 MIUMS.—Each MedicarePlus organization shall permit the  
10 payment of net monthly premiums on a monthly basis and  
11 may terminate election of individuals for a MedicarePlus  
12 plan for failure to make premium payments only in ac-  
13 cordance with section 1851(g)(3)(B)(i). A MedicarePlus  
14 organization is not authorized to provide for cash or other  
15 monetary rebates as an inducement for enrollment or oth-  
16 erwise.

17 “(e) LIMITATION ON ENROLLEE COST-SHARING.—

18 “(1) FOR BASIC AND ADDITIONAL BENEFITS.—  
19 Except as provided in paragraph (2), in no event  
20 may—

21 “(A) the net monthly premium (multiplied  
22 by 12) and the actuarial value of the  
23 deductibles, coinsurance, and copayments appli-  
24 cable on average to individuals enrolled under  
25 this part with a MedicarePlus plan of an orga-

1           nization with respect to required benefits de-  
2           scribed in section 1852(a)(1) and additional  
3           benefits (if any) required under subsection  
4           (f)(1) for a year, exceed

5           “(B) the actuarial value of the deductibles,  
6           coinsurance, and copayments that would be ap-  
7           plicable on average to individuals entitled to  
8           benefits under part A and enrolled under part  
9           B if they were not members of a MedicarePlus  
10          organization for the year.

11          “(2) FOR SUPPLEMENTAL BENEFITS.—If the  
12          MedicarePlus organization provides to its members  
13          enrolled under this part supplemental benefits de-  
14          scribed in section 1852(a)(3), the sum of the month-  
15          ly premium rate (multiplied by 12) charged for such  
16          supplemental benefits and the actuarial value of its  
17          deductibles, coinsurance, and copayments charged  
18          with respect to such benefits may not exceed the ad-  
19          justed community rate for such benefits (as defined  
20          in subsection (f)(4)).

21          “(3) EXCEPTION FOR MSA PLANS.—Paragraphs  
22          (1) and (2) do not apply to an MSA plan.

23          “(4) DETERMINATION ON OTHER BASIS.—If the  
24          Secretary determines that adequate data are not  
25          available to determine the actuarial value under

1 paragraph (1)(A) or (2), the Secretary may deter-  
2 mine such amount with respect to all individuals in  
3 the MedicarePlus payment area, the State, or in the  
4 United States, eligible to enroll in the MedicarePlus  
5 plan involved under this part or on the basis of other  
6 appropriate data.

7 “(f) REQUIREMENT FOR ADDITIONAL BENEFITS.—

8 “(1) REQUIREMENT.—

9 “(A) IN GENERAL.—Each MedicarePlus  
10 organization (in relation to a MedicarePlus plan  
11 it offers) shall provide that if there is an excess  
12 amount (as defined in subparagraph (B)) for  
13 the plan for a contract year, subject to the suc-  
14 ceeding provisions of this subsection, the orga-  
15 nization shall provide to individuals such addi-  
16 tional benefits (as the organization may specify)  
17 in a value which is at least equal to the ad-  
18 justed excess amount (as defined in subpara-  
19 graph (C)).

20 “(B) EXCESS AMOUNT.—For purposes of  
21 this paragraph, the ‘excess amount’, for an or-  
22 ganization for a plan, is the amount (if any) by  
23 which—

24 “(i) the average of the capitation pay-  
25 ments made to the organization under sec-



1           tion 1853 for the plan at the beginning of  
2           contract year, exceeds

3           “(ii) the actuarial value of the re-  
4           quired benefits described in section  
5           1852(a)(1) under the plan for individuals  
6           under this part, as determined based upon  
7           an adjusted community rate described in  
8           paragraph (4) (as reduced for the actuarial  
9           value of the coinsurance and deductibles  
10          under parts A and B).

11          “(C) ADJUSTED EXCESS AMOUNT.—For  
12          purposes of this paragraph, the ‘adjusted excess  
13          amount’, for an organization for a plan, is the  
14          excess amount reduced to reflect any amount  
15          withheld and reserved for the organization for  
16          the year under paragraph (2).

17          “(D) NO APPLICATION TO MSA PLANS.—  
18          Subparagraph (A) shall not apply to an MSA  
19          plan.

20          “(E) UNIFORM APPLICATION.—This para-  
21          graph shall be applied uniformly for all enroll-  
22          ees for a plan in a MedicarePlus payment area.

23          “(F) CONSTRUCTION.—Nothing in this  
24          subsection shall be construed as preventing a  
25          MedicarePlus organization from providing

1 health care benefits that are in addition to the  
2 benefits otherwise required to be provided under  
3 this paragraph and from imposing a premium  
4 for such additional benefits.

5 “(2) STABILIZATION FUND.—A MedicarePlus  
6 organization may provide that a part of the value of  
7 an excess amount described in paragraph (1) be  
8 withheld and reserved in the Federal Hospital Insur-  
9 ance Trust Fund and in the Federal Supplementary  
10 Medical Insurance Trust Fund (in such proportions  
11 as the Secretary determines to be appropriate) by  
12 the Secretary for subsequent annual contract peri-  
13 ods, to the extent required to stabilize and prevent  
14 undue fluctuations in the additional benefits offered  
15 in those subsequent periods by the organization in  
16 accordance with such paragraph. Any of such value  
17 of the amount reserved which is not provided as ad-  
18 ditional benefits described in paragraph (1)(A) to in-  
19 dividuals electing the MedicarePlus plan of the orga-  
20 nization in accordance with such paragraph prior to  
21 the end of such periods, shall revert for the use of  
22 such trust funds.

23 “(3) DETERMINATION BASED ON INSUFFICIENT  
24 DATA.—For purposes of this subsection, if the Sec-  
25 retary finds that there is insufficient enrollment ex-

1 perience (including no enrollment experience in the  
2 case of a provider-sponsored organization) to deter-  
3 mine an average of the capitation payments to be  
4 made under this part at the beginning of a contract  
5 period, the Secretary may determine such an aver-  
6 age based on the enrollment experience of other con-  
7 tracts entered into under this part.

8 “(4) ADJUSTED COMMUNITY RATE.—

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

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

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

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

19               “(B) SPECIAL RULE FOR PROVIDER-SPON-  
20               SORED ORGANIZATIONS.—In the case of a  
21               MedicarePlus organization that is a provider-  
22               sponsored organization, the adjusted community  
23               rate under subparagraph (A) for a  
24               MedicarePlus plan of the organization may be  
25               computed (in a manner specified by the Sec-

1           retary) using data in the general commercial  
2           marketplace or (during a transition period)  
3           based on the costs incurred by the organization  
4           in providing such a plan.

5           “(g) PERIODIC AUDITING.—The Secretary shall pro-  
6           vide for the annual auditing of the financial records (in-  
7           cluding data relating to medicare utilization, costs, and  
8           computation of the adjusted community rate) of at least  
9           one-third of the MedicarePlus organizations offering  
10          MedicarePlus plans under this part. The Comptroller Gen-  
11          eral shall monitoring auditing activities conducted under  
12          this subsection.

13          “(h) PROHIBITION OF STATE IMPOSITION OF PRE-  
14          MIUM TAXES.—No State may impose a premium tax or  
15          similar tax with respect to premiums on MedicarePlus  
16          plans or the offering of such plans.

17          “ORGANIZATIONAL AND FINANCIAL REQUIREMENTS FOR  
18          MEDICAREPLUS ORGANIZATIONS; PROVIDER-SPON-  
19          SORED ORGANIZATIONS

20          “SEC. 1855. (a) ORGANIZED AND LICENSED UNDER  
21          STATE LAW.—

22                  “(1) IN GENERAL.—Subject to paragraphs (2)  
23                  and (3), a MedicarePlus organization shall be orga-  
24                  nized and licensed under State law as a risk-bearing  
25                  entity eligible to offer health insurance or health

1 benefits coverage in each State in which it offers a  
2 MedicarePlus plan.

3 “(2) SPECIAL EXCEPTION FOR PROVIDER-SPON-  
4 SORED ORGANIZATIONS.—

5 “(A) IN GENERAL.—In the case of a pro-  
6 vider-sponsored organization that seeks to offer  
7 a MedicarePlus plan in a State, the Secretary  
8 shall waive the requirement of paragraph (1)  
9 that the organization be licensed in that State  
10 if—

11 “(i) the organization files an applica-  
12 tion for such waiver with the Secretary,  
13 and

14 “(ii) the Secretary determines, based  
15 on the application and other evidence pre-  
16 sented to the Secretary, that any of the  
17 grounds for approval of the application de-  
18 scribed in subparagraph (B), (C), or (D)  
19 has been met.

20 “(B) FAILURE TO ACT ON LICENSURE AP-  
21 PPLICATION ON A TIMELY BASIS.—A ground for  
22 approval of such a waiver application is that the  
23 State has failed to complete action on a licens-  
24 ing application of the organization within 90  
25 days of the date of the State’s receipt of the ap-

1           plication. No period before the date of the en-  
2           actment of this section shall be included in de-  
3           termining such 90-day period.

4           “(C) DENIAL OF APPLICATION BASED ON  
5           DISCRIMINATORY TREATMENT.—A ground for  
6           approval of such a waiver application is that the  
7           State has denied such a licensing application  
8           and—

9                   “(i) the State has imposed docu-  
10                   mentation or information requirements not  
11                   related to solvency requirements that are  
12                   not generally applicable to other entities  
13                   engaged in substantially similar business,  
14                   or

15                   “(ii) the standards or review process  
16                   imposed by the State as a condition of ap-  
17                   proval of the license imposes any material  
18                   requirements, procedures, or standards  
19                   (other than requirements and standards  
20                   relating to solvency) to such organizations  
21                   that are not generally applicable to other  
22                   entities engaged in substantially similar  
23                   business.

24           “(D) DENIAL OF APPLICATION BASED ON  
25           APPLICATION OF SOLVENCY REQUIREMENTS.—

1 A ground for approval of such a waiver applica-  
2 tion is that the State has denied such a licens-  
3 ing application based (in whole or in part) on  
4 the organization’s failure to meet applicable sol-  
5 vency requirements and—

6 “(i) such requirements are not the  
7 same as the solvency standards established  
8 under section 1856(a); or

9 “(ii) the State has imposed as a con-  
10 dition of approval of the license any docu-  
11 mentation or information requirements re-  
12 lating to solvency or other material re-  
13 quirements, procedures, or standards relat-  
14 ing to solvency that are different from the  
15 requirements, procedures, and standards  
16 applied by the Secretary under subsection  
17 (d)(2).

18 For purposes of this subparagraph, the term  
19 ‘solvency requirements’ means requirements re-  
20 lating to solvency and other matters covered  
21 under the standards established under section  
22 1856(a).

23 “(E) TREATMENT OF WAIVER.—Subject to  
24 section 1852(m), in the case of a waiver grant-



1 ed under this paragraph for a provider-spon-  
2 sored organization—

3 “(i) the waiver shall be effective for a  
4 36-month period, except it may be renewed  
5 based on a subsequent application filed  
6 during the last 6 months of such period,

7 “(ii) the waiver is conditioned upon  
8 the pendency of the licensure application  
9 during the period the waiver is in effect,  
10 and

11 “(iii) any provisions of State law  
12 which relate to the licensing of the organi-  
13 zation and which prohibit the organization  
14 from providing coverage pursuant to a con-  
15 tract under this part shall be superseded.

16 Nothing in this subparagraph shall be con-  
17 strued as limiting the number of times such a  
18 waiver may be renewed. Nothing in clause (iii)  
19 shall be construed as waiving any provision of  
20 State law which relates to quality of care or  
21 consumer protection (and does not relate to sol-  
22 vency standards) and which is imposed on a  
23 uniform basis and is generally applicable to  
24 other entities engaged in substantially similar  
25 business.

1           “(F) PROMPT ACTION ON APPLICATION.—

2           The Secretary shall grant or deny such a waiver  
3           application within 60 days after the date the  
4           Secretary determines that a substantially com-  
5           plete application has been filed. Nothing in this  
6           section shall be construed as preventing an or-  
7           ganization which has had such a waiver applica-  
8           tion denied from submitting a subsequent wai-  
9           ver application.

10           “(3) EXCEPTION IF REQUIRED TO OFFER MORE  
11           THAN MEDICAREPLUS PLANS.—Paragraph (1) shall  
12           not apply to a MedicarePlus organization in a State  
13           if the State requires the organization, as a condition  
14           of licensure, to offer any product or plan other than  
15           a MedicarePlus plan.

16           “(4) LICENSURE DOES NOT SUBSTITUTE FOR  
17           OR CONSTITUTE CERTIFICATION.—The fact that an  
18           organization is licensed in accordance with para-  
19           graph (1) does not deem the organization to meet  
20           other requirements imposed under this part.

21           “(b) PREPAID PAYMENT.—A MedicarePlus organiza-  
22           tion shall be compensated (except for premiums,  
23           deductibles, coinsurance, and copayments) for the provi-  
24           sion of health care services to enrolled members under the  
25           contract under this part by a payment which is paid on

1 a periodic basis without regard to the date the health care  
2 services are provided and which is fixed without regard  
3 to the frequency, extent, or kind of health care service ac-  
4 tually provided to a member.

5 “(c) ASSUMPTION OF FULL FINANCIAL RISK.—The  
6 MedicarePlus organization shall assume full financial risk  
7 on a prospective basis for the provision of the health care  
8 services (except, at the election of the organization, hos-  
9 pice care) for which benefits are required to be provided  
10 under section 1852(a)(1), except that the organization—

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

15 “(2) may obtain insurance or make other ar-  
16 rangements for the cost of such services provided to  
17 its enrolled members other than through the organi-  
18 zation because medical necessity required their pro-  
19 vision before they could be secured through the orga-  
20 nization,

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

1           “(4) may make arrangements with physicians  
2           or other health professionals, health care institu-  
3           tions, or any combination of such individuals or in-  
4           stitutions to assume all or part of the financial risk  
5           on a prospective basis for the provision of basic  
6           health services by the physicians or other health pro-  
7           fessionals or through the institutions.

8           “(d) CERTIFICATION OF PROVISION AGAINST RISK  
9           OF INSOLVENCY FOR UNLICENSED PSOS.—

10           “(1) IN GENERAL.—Each MedicarePlus organi-  
11           zation that is a provider-sponsored organization,  
12           that is not licensed by a State under subsection (a),  
13           and for which a waiver application has been ap-  
14           proved under subsection (a)(2), shall meet standards  
15           established under section 1856(a) relating to the fi-  
16           nancial solvency and capital adequacy of the organi-  
17           zation.

18           “(2) CERTIFICATION PROCESS FOR SOLVENCY  
19           STANDARDS FOR PSOS.—The Secretary shall estab-  
20           lish a process for the receipt and approval of appli-  
21           cations of a provider-sponsored organization de-  
22           scribed in paragraph (1) for certification (and peri-  
23           odic recertification) of the organization as meeting  
24           such solvency standards. Under such process, the  
25           Secretary shall act upon such an application not

1 later than 60 days after the date the application has  
2 been received.

3 “(e) PROVIDER-SPONSORED ORGANIZATION DE-  
4 FINED.—

5 “(1) IN GENERAL.—In this part, the term ‘pro-  
6 vider-sponsored organization’ means a public or pri-  
7 vate entity—

8 “(A) that is established or organized by a  
9 health care provider, or group of affiliated  
10 health care providers,

11 “(B) that provides a substantial proportion  
12 (as defined by the Secretary in accordance with  
13 paragraph (2)) of the health care items and  
14 services under the contract under this part di-  
15 rectly through the provider or affiliated group  
16 of providers, and

17 “(C) with respect to which those affiliated  
18 providers that share, directly or indirectly, sub-  
19 stantial financial risk with respect to the provi-  
20 sion of such items and services have at least a  
21 majority financial interest in the entity.

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

1           “(A) shall take into account (i) the need  
2           for such an organization to assume responsibil-  
3           ity for a substantial proportion of services in  
4           order to assure financial stability and (ii) the  
5           practical difficulties in such an organization in-  
6           tegrating a very wide range of service providers;  
7           and

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

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

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

17               “(B) both providers are part of a con-  
18               trolled group of corporations under section  
19               1563 of the Internal Revenue Code of 1986, or

20               “(C) both providers are part of an affili-  
21               ated service group under section 414 of such  
22               Code.

23          “(4) CONTROL.—For purposes of paragraph  
24          (3), control is presumed to exist if one party, di-  
25          rectly or indirectly, owns, controls, or holds the

1 power to vote, or proxies for, not less than 51 per-  
2 cent of the voting rights or governance rights of an-  
3 other.

4 “(5) HEALTH CARE PROVIDER DEFINED.—In  
5 this subsection, the term ‘health care provider’  
6 means—

7 “(A) any individual who is engaged in the  
8 delivery of health care services in a State and  
9 who is required by State law or regulation to be  
10 licensed or certified by the State to engage in  
11 the delivery of such services in the State, and

12 “(B) any entity that is engaged in the de-  
13 livery of health care services in a State and  
14 that, if it is required by State law or regulation  
15 to be licensed or certified by the State to en-  
16 gage in the delivery of such services in the  
17 State, is so licensed.

18 “(6) REGULATIONS.—The Secretary shall issue  
19 regulations to carry out this subsection.

20 “ESTABLISHMENT OF STANDARDS

21 “SEC. 1856. (a) ESTABLISHMENT OF SOLVENCY  
22 STANDARDS FOR PROVIDER-SPONSORED ORGANIZA-  
23 TIONS.—

24 “(1) ESTABLISHMENT.—

25 “(A) IN GENERAL.—The Secretary shall  
26 establish, on an expedited basis and using a ne-

1           gotiated rulemaking process under subchapter  
2           III of chapter 5 of title 5, United States Code,  
3           standards described in section 1855(d)(1) (re-  
4           lating to the financial solvency and capital ade-  
5           quacy of the organization) that entities must  
6           meet to qualify as provider-sponsored organiza-  
7           tions under this part.

8           “(B) FACTORS TO CONSIDER FOR SOL-  
9           VENCY STANDARDS.—In establishing solvency  
10          standards under subparagraph (A) for provider-  
11          sponsored organizations, the Secretary shall  
12          consult with interested parties and shall take  
13          into account—

14               “(i) the delivery system assets of such  
15               an organization and ability of such an or-  
16               ganization to provide services directly to  
17               enrollees through affiliated providers, and

18               “(ii) alternative means of protecting  
19               against insolvency, including reinsurance,  
20               unrestricted surplus, letters of credit, guar-  
21               antees, organizational insurance coverage,  
22               partnerships with other licensed entities,  
23               and valuation attributable to the ability of  
24               such an organization to meet its service  
25               obligations through direct delivery of care.



1           “(C) ENROLLEE PROTECTION AGAINST IN-  
2           SOLVENCY.—Such standards shall include pro-  
3           visions to prevent enrollees from being held lia-  
4           ble to any person or entity for the MedicarePlus  
5           organization’s debts in the event of the organi-  
6           zation’s insolvency.

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

17          “(3) TARGET DATE FOR PUBLICATION OF  
18          RULE.—As part of the notice under paragraph (2),  
19          and for purposes of this subsection, the ‘target date  
20          for publication’ (referred to in section 564(a)(5) of  
21          such title) shall be April 1, 1998.

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

1           “(5) APPOINTMENT OF NEGOTIATED RULE-  
2           MAKING COMMITTEE AND FACILITATOR.—The Sec-  
3           retary shall provide for—

4                   “(A) the appointment of a negotiated rule-  
5           making committee under section 565(a) of such  
6           title by not later than 30 days after the end of  
7           the comment period provided for under section  
8           564(c) of such title (as shortened under para-  
9           graph (4)), and

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

14           “(6) PRELIMINARY COMMITTEE REPORT.—The  
15           negotiated rulemaking committee appointed under  
16           paragraph (5) shall report to the Secretary, by not  
17           later than January 1, 1998, regarding the commit-  
18           tee’s progress on achieving a consensus with regard  
19           to the rulemaking proceeding and whether such con-  
20           sensus is likely to occur before one month before the  
21           target date for publication of the rule. If the com-  
22           mittee reports that the committee has failed to make  
23           significant progress towards such consensus or is  
24           unlikely to reach such consensus by the target date,  
25           the Secretary may terminate such process and pro-

1       vide for the publication of a rule under this sub-  
2       section through such other methods as the Secretary  
3       may provide.

4               “(7) FINAL COMMITTEE REPORT.—If the com-  
5       mittee is not terminated under paragraph (6), the  
6       rulemaking committee shall submit a report contain-  
7       ing a proposed rule by not later than one month be-  
8       fore the target date of publication.

9               “(8) INTERIM, FINAL EFFECT.—The Secretary  
10      shall publish a rule under this subsection in the Fed-  
11      eral Register by not later than the target date of  
12      publication. Such rule shall be effective and final im-  
13      mediately on an interim basis, but is subject to  
14      change and revision after public notice and oppor-  
15      tunity for a period (of not less than 60 days) for  
16      public comment. In connection with such rule, the  
17      Secretary shall specify the process for the timely re-  
18      view and approval of applications of entities to be  
19      certified as provider-sponsored organizations pursu-  
20      ant to such rules and consistent with this subsection.

21              “(9) PUBLICATION OF RULE AFTER PUBLIC  
22      COMMENT.—The Secretary shall provide for consid-  
23      eration of such comments and republication of such  
24      rule by not later than 1 year after the target date  
25      of publication.

1 “(b) ESTABLISHMENT OF OTHER STANDARDS.—

2 “(1) IN GENERAL.—The Secretary shall estab-  
3 lish by regulation other standards (not described in  
4 subsection (a)) for MedicarePlus organizations and  
5 plans consistent with, and to carry out, this part.

6 “(2) USE OF CURRENT STANDARDS.—Consist-  
7 ent with the requirements of this part, standards es-  
8 tablished under this subsection shall be based on  
9 standards established under section 1876 to carry  
10 out analogous provisions of such section. The Sec-  
11 retary shall also consider State model and other  
12 standards relating to consumer protection and assur-  
13 ing quality of care.

14 “(3) USE OF INTERIM STANDARDS.—For the  
15 period in which this part is in effect and standards  
16 are being developed and established under the pre-  
17 ceding provisions of this subsection, the Secretary  
18 shall provide by not later than June 1, 1998, for the  
19 application of such interim standards (without re-  
20 gard to any requirements for notice and public com-  
21 ment) as may be appropriate to provide for the expe-  
22 dited implementation of this part. Such interim  
23 standards shall not apply after the date standards  
24 are established under the preceding provisions of  
25 this subsection.

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

11          “(5) RELATION TO STATE LAWS.—Subject to  
12          section 1852(m), the standards established under  
13          this subsection shall supersede any State law or reg-  
14          ulation with respect to MedicarePlus plans which are  
15          offered by MedicarePlus organizations under this  
16          part to the extent such law or regulation is incon-  
17          sistent with such standards. The previous sentence  
18          shall not be construed as superseding a State law or  
19          regulation that is not related to solvency, that is ap-  
20          plied on a uniform basis and is generally applicable  
21          to other entities engaged in substantially similar  
22          business, and that provides consumer protections in  
23          addition to, or more stringent than, those provided  
24          under the standards under this subsection.

1 “CONTRACTS WITH MEDICAREPLUS ORGANIZATIONS

2 “SEC. 1857. (a) IN GENERAL.—The Secretary shall  
3 not permit the election under section 1851 of a  
4 MedicarePlus plan offered by a MedicarePlus organization  
5 under this part, and no payment shall be made under sec-  
6 tion 1853 to an organization, unless the Secretary has en-  
7 tered into a contract under this section with the organiza-  
8 tion with respect to the offering of such plan. Such a con-  
9 tract with an organization may cover more than one  
10 MedicarePlus plan. Such contract shall provide that the  
11 organization agrees to comply with the applicable require-  
12 ments and standards of this part and the terms and condi-  
13 tions of payment as provided for in this part.

14 “(b) MINIMUM ENROLLMENT REQUIREMENTS.—

15 “(1) IN GENERAL.—Subject to paragraphs (2)  
16 and (3), the Secretary may not enter into a contract  
17 under this section with a MedicarePlus organization  
18 unless the organization has at least 5,000 individ-  
19 uals (or 1,500 individuals in the case of an organiza-  
20 tion that is a provider-sponsored organization) who  
21 are receiving health benefits through the organiza-  
22 tion, except that the standards under section 1856  
23 may permit the organization to have a lesser number  
24 of beneficiaries (but not less than 500 in the case  
25 of an organization that is a provider-sponsored orga-

1 nization) if the organization primarily serves individ-  
2 uals residing outside of urbanized areas.

3 “(2) EXCEPTION FOR MSA PLAN.—Paragraph  
4 (1) shall not apply with respect to a contract that  
5 relates only to an MSA plan.

6 “(3) ALLOWING TRANSITION.—The Secretary  
7 may waive the requirement of paragraph (1) during  
8 the first 3 contract years with respect to an organi-  
9 zation.

10 “(c) CONTRACT PERIOD AND EFFECTIVENESS.—

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

17 “(2) TERMINATION AUTHORITY.—In accord-  
18 ance with procedures established under subsection  
19 (h), the Secretary may at any time terminate any  
20 such contract or may impose the intermediate sanc-  
21 tions described in an applicable paragraph of sub-  
22 section (g)(3) on the MedicarePlus organization if  
23 the Secretary determines that the organization—

24 “(A) has failed substantially to carry out  
25 the contract;

1           “(B) is carrying out the contract in a man-  
2           ner inconsistent with the efficient and effective  
3           administration of this part; or

4           “(C) no longer substantially meets the ap-  
5           plicable conditions of this part.

6           “(3) EFFECTIVE DATE OF CONTRACTS.—The  
7           effective date of any contract executed pursuant to  
8           this section shall be specified in the contract, except  
9           that in no case shall a contract under this section  
10          which provides for coverage under an MSA plan be  
11          effective before January 1998 with respect to such  
12          coverage.

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

21          “(5) CONTRACTING AUTHORITY.—The author-  
22          ity vested in the Secretary by this part may be per-  
23          formed without regard to such provisions of law or  
24          regulations relating to the making, performance,  
25          amendment, or modification of contracts of the



1 United States as the Secretary may determine to be  
2 inconsistent with the furtherance of the purpose of  
3 this title.

4 “(d) PROTECTIONS AGAINST FRAUD AND BENE-  
5 FICIARY PROTECTIONS.—

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

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

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

23 “(2) ENROLLEE NOTICE AT TIME OF TERMI-  
24 NATION.—Each contract under this section shall re-  
25 quire the organization to provide (and pay for) writ-

1 ten notice in advance of the contract's termination,  
2 as well as a description of alternatives for obtaining  
3 benefits under this title, to each individual enrolled  
4 with the organization under this part.

5 “(3) DISCLOSURE.—

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

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

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

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

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

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

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

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

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

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

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

17                  “(I) is an officer or director;

18                  “(II) is a partner (if such entity  
19                  is organized as a partnership);

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

23                  “(IV) has a mortgage, deed of  
24                  trust, note, or other interest valuing

1 more than 5 percent of the assets of  
2 such entity;

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

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

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

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

18 “(e) ADDITIONAL CONTRACT TERMS.—

19 “(1) IN GENERAL.—The contract shall contain  
20 such other terms and conditions not inconsistent  
21 with this part (including requiring the organization  
22 to provide the Secretary with such information) as  
23 the Secretary may find necessary and appropriate.

24 “(2) COST-SHARING IN ENROLLMENT-RELATED  
25 COSTS.—The contract with a MedicarePlus organiza-

1       tion shall require the payment to the Secretary for  
2       the organization's pro rata share (as determined by  
3       the Secretary) of the estimated costs to be incurred  
4       by the Secretary in carrying out section 1851 (relat-  
5       ing to enrollment and dissemination of information)  
6       and section 4360 of the Omnibus Budget Reconcili-  
7       ation Act of 1990 (relating to the health insurance  
8       counseling and assistance program). Such payments  
9       are appropriated to defray the costs described in the  
10      preceding sentence, to remain available until ex-  
11      pended.

12           “(3) NOTICE TO ENROLLEES IN CASE OF DE-  
13      CERTIFICATION.—If a contract with a MedicarePlus  
14      organization is terminated under this section, the or-  
15      ganization shall notify each enrollee with the organi-  
16      zation under this part of such termination.

17           “(f) PROMPT PAYMENT BY MEDICAREPLUS ORGANI-  
18      ZATION.—

19           “(1) REQUIREMENT.—A contract under this  
20      part shall require a MedicarePlus organization to  
21      provide prompt payment (consistent with the provi-  
22      sions of sections 1816(c)(2) and 1842(c)(2)) of  
23      claims submitted for services and supplies furnished  
24      to individuals pursuant to the contract, if the serv-  
25      ices or supplies are not furnished under a contract

1 between the organization and the provider or sup-  
2 plier.

3 “(2) SECRETARY’S OPTION TO BYPASS NON-  
4 COMPLYING ORGANIZATION.—In the case of a  
5 MedicarePlus eligible organization which the Sec-  
6 retary determines, after notice and opportunity for  
7 a hearing, has failed to make payments of amounts  
8 in compliance with paragraph (1), the Secretary may  
9 provide for direct payment of the amounts owed to  
10 providers and suppliers for covered services and sup-  
11 plies furnished to individuals enrolled under this  
12 part under the contract. If the Secretary provides  
13 for the direct payments, the Secretary shall provide  
14 for an appropriate reduction in the amount of pay-  
15 ments otherwise made to the organization under this  
16 part to reflect the amount of the Secretary’s pay-  
17 ments (and the Secretary’s costs in making the pay-  
18 ments).

19 “(g) INTERMEDIATE SANCTIONS.—

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

23 “(A) fails substantially to provide medi-  
24 cally necessary items and services that are re-  
25 quired (under law or under the contract) to be

1 provided to an individual covered under the con-  
2 tract, if the failure has adversely affected (or  
3 has substantial likelihood of adversely affecting)  
4 the individual;

5 “(B) imposes net monthly premiums on in-  
6 dividuals enrolled under this part in excess of  
7 the net monthly premiums permitted;

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

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

18 “(E) misrepresents or falsifies information  
19 that is furnished—

20 “(i) to the Secretary under this part,

21 or

22 “(ii) to an individual or to any other  
23 entity under this part;

24 “(F) fails to comply with the requirements  
25 of section 1852(j)(3); or



1           “(G) employs or contracts with any indi-  
2           vidual or entity that is excluded from participa-  
3           tion under this title under section 1128 or  
4           1128A for the provision of health care, utiliza-  
5           tion review, medical social work, or administra-  
6           tive services or employs or contracts with any  
7           entity for the provision (directly or indirectly)  
8           through such an excluded individual or entity of  
9           such services;

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

13           “(2) REMEDIES.—The remedies described in  
14          this paragraph are—

15           “(A) civil money penalties of not more  
16          than \$25,000 for each determination under  
17          paragraph (1) or, with respect to a determina-  
18          tion under subparagraph (D) or (E)(i) of such  
19          paragraph, of not more than \$100,000 for each  
20          such determination, plus, with respect to a de-  
21          termination under paragraph (1)(B), double the  
22          excess amount charged in violation of such  
23          paragraph (and the excess amount charged  
24          shall be deducted from the penalty and returned  
25          to the individual concerned), and plus, with re-

1           spect to a determination under paragraph  
2           (1)(D), \$15,000 for each individual not enrolled  
3           as a result of the practice involved,

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

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

18          “(3) OTHER INTERMEDIATE SANCTIONS.—In  
19          the case of a MedicarePlus organization for which  
20          the Secretary makes a determination under sub-  
21          section (c)(2) the basis of which is not described in  
22          paragraph (1), the Secretary may apply the follow-  
23          ing intermediate sanctions:

24                 “(A) Civil money penalties of not more  
25                 than \$25,000 for each determination under

1 subsection (e)(2) if the deficiency that is the  
2 basis of the determination has directly adversely  
3 affected (or has the substantial likelihood of ad-  
4 versely affecting) an individual covered under  
5 the organization's contract

6 “(B) Civil money penalties of not more  
7 than \$10,000 for each week beginning after the  
8 initiation of procedures by the Secretary under  
9 subsection (g) during which the deficiency that  
10 is the basis of a determination under subsection  
11 (e)(2) exists.

12 “(C) Suspension of enrollment of individ-  
13 uals under this part after the date the Sec-  
14 retary notifies the organization of a determina-  
15 tion under subsection (e)(2) and until the Sec-  
16 retary is satisfied that the deficiency that is the  
17 basis for the determination has been corrected  
18 and is not likely to recur.

19 “(h) PROCEDURES FOR TERMINATION.—

20 “(1) IN GENERAL.—The Secretary may termi-  
21 nate a contract with a MedicarePlus organization  
22 under this section in accordance with formal inves-  
23 tigation and compliance procedures established by  
24 the Secretary under which—

1           “(A) the Secretary provides the organiza-  
2           tion with the reasonable opportunity to develop  
3           and implement a corrective action plan to cor-  
4           rect the deficiencies that were the basis of the  
5           Secretary’s determination under subsection  
6           (c)(2);

7           “(B) the Secretary shall impose more se-  
8           vere sanctions on an organization that has a  
9           history of deficiencies or that has not taken  
10          steps to correct deficiencies the Secretary has  
11          brought to the organization’s attention;

12          “(C) there are no unreasonable or unneces-  
13          sary delays between the finding of a deficiency  
14          and the imposition of sanctions; and

15          “(D) the Secretary provides the organiza-  
16          tion with reasonable notice and opportunity for  
17          hearing (including the right to appeal an initial  
18          decision) before terminating the contract.

19          “(2) CIVIL MONEY PENALTIES.—The provisions  
20          of section 1128A (other than subsections (a) and  
21          (b)) shall apply to a civil money penalty under sub-  
22          section (f) or under paragraph (2) or (3) of sub-  
23          section (g) in the same manner as they apply to a  
24          civil money penalty or proceeding under section  
25          1128A(a).

1           “(3) EXCEPTION FOR IMMINENT AND SERIOUS  
2 RISK TO HEALTH.—Paragraph (1) shall not apply if  
3 the Secretary determines that a delay in termi-  
4 nation, resulting from compliance with the proce-  
5 dures specified in such paragraph prior to termi-  
6 nation, would pose an imminent and serious risk to  
7 the health of individuals enrolled under this part  
8 with the organization.

9           “DEFINITIONS; MISCELLANEOUS PROVISIONS

10          “SEC. 1859. (a) DEFINITIONS RELATING TO  
11 MEDICAREPLUS ORGANIZATIONS.—In this part—

12           “(1) MEDICAREPLUS ORGANIZATION.—The  
13 term ‘MedicarePlus organization’ means a public or  
14 private entity that is certified under section 1856 as  
15 meeting the requirements and standards of this part  
16 for such an organization.

17           “(2) PROVIDER-SPONSORED ORGANIZATION.—  
18 The term ‘provider-sponsored organization’ is de-  
19 fined in section 1855(e)(1).

20          “(b) DEFINITIONS RELATING TO MEDICAREPLUS  
21 PLANS.—

22           “(1) MEDICAREPLUS PLAN.—The term  
23 ‘MedicarePlus plan’ means health benefits coverage  
24 offered under a policy, contract, or plan by a  
25 MedicarePlus organization pursuant to and in ac-  
26 cordance with a contract under section 1857.

1 “(2) MSA PLAN.—

2 “(A) IN GENERAL.—The term ‘MSA plan’  
3 means a MedicarePlus plan that—

4 “(i) provides reimbursement for at  
5 least the items and services described in  
6 section 1852(a)(1) in a year but only after  
7 the enrollee incurs countable expenses (as  
8 specified under the plan) equal to the  
9 amount of an annual deductible (described  
10 in subparagraph (B));

11 “(ii) counts as such expenses (for pur-  
12 poses of such deductible) at least all  
13 amounts that would have been payable  
14 under parts A and B, and that would have  
15 been payable by the enrollee as deductibles,  
16 coinsurance, or copayments, if the enrollee  
17 had elected to receive benefits through the  
18 provisions of such parts; and

19 “(iii) provides, after such deductible is  
20 met for a year and for all subsequent ex-  
21 penses for items and services referred to in  
22 clause (i) in the year, for a level of reim-  
23 bursement that is not less than—

24 “(I) 100 percent of such ex-  
25 penses, or

1                   “(II) 100 percent of the amounts  
2                   that would have been paid (without  
3                   regard to any deductibles or coinsur-  
4                   ance) under parts A and B with re-  
5                   spect to such expenses,  
6                   whichever is less.

7                   “(B) DEDUCTIBLE.—The amount of an-  
8                   nual deductible under an MSA plan—

9                   “(i) for contract year 1999 shall be  
10                  not more than \$6,000; and

11                  “(ii) for a subsequent contract year  
12                  shall be not more than the maximum  
13                  amount of such deductible for the previous  
14                  contract year under this subparagraph in-  
15                  creased by the national per capita  
16                  MedicarePlus growth percentage under  
17                  section 1853(c)(6) for the year.

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

21                  “(c) OTHER REFERENCES TO OTHER TERMS.—

22                  “(1) MEDICAREPLUS ELIGIBLE INDIVIDUAL.—  
23                  The term ‘MedicarePlus eligible individual’ is de-  
24                  fined in section 1851(a)(3).

1           “(2) MEDICAREPLUS PAYMENT AREA.—The  
2 term ‘MedicarePlus payment area’ is defined in sec-  
3 tion 1853(d).

4           “(3) NATIONAL PER CAPITA MEDICAREPLUS  
5 GROWTH PERCENTAGE.—The ‘national per capita  
6 MedicarePlus growth percentage’ is defined in sec-  
7 tion 1853(c)(6).

8           “(4) MONTHLY PREMIUM; NET MONTHLY PRE-  
9 MIUM.—The terms ‘monthly premium’ and ‘net  
10 monthly premium’ are defined in section 1854(a)(2).

11          “(d) COORDINATED ACUTE AND LONG-TERM CARE  
12 BENEFITS UNDER A MEDICAREPLUS PLAN.—Nothing in  
13 this part shall be construed as preventing a State from  
14 coordinating benefits under a medicaid plan under title  
15 XIX with those provided under a MedicarePlus plan in  
16 a manner that assures continuity of a full-range of acute  
17 care and long-term care services to poor elderly or disabled  
18 individuals eligible for benefits under this title and under  
19 such plan.

20          “(e) RESTRICTION ON ENROLLMENT FOR CERTAIN  
21 MEDICAREPLUS PLANS.—

22           “(1) IN GENERAL.—In the case of a  
23 MedicarePlus religious fraternal benefit society plan  
24 described in paragraph (2), notwithstanding any  
25 other provision of this part to the contrary and in



1 accordance with regulations of the Secretary, the so-  
2 ciety offering the plan may restrict the enrollment of  
3 individuals under this part to individuals who are  
4 members of the church, convention, or group de-  
5 scribed in paragraph (3)(B) with which the society  
6 is affiliated.

7 “(2) MEDICAREPLUS RELIGIOUS FRATERNAL  
8 BENEFIT SOCIETY PLAN DESCRIBED.—For purposes  
9 of this subsection, a MedicarePlus religious fraternal  
10 benefit society plan described in this paragraph is a  
11 MedicarePlus plan described in section  
12 1851(a)(2)(A) that—

13 “(A) is offered by a religious fraternal ben-  
14 efit society described in paragraph (3) only to  
15 members of the church, convention, or group  
16 described in paragraph (3)(B); and

17 “(B) permits all such members to enroll  
18 under the plan without regard to health status-  
19 related factors.

20 Nothing in this subsection shall be construed as  
21 waiving any plan requirements relating to financial  
22 solvency. In developing solvency standards under  
23 section 1856, the Secretary shall take into account  
24 open contract and assessment features characteristic  
25 of fraternal insurance certificates.

1           “(3) RELIGIOUS FRATERNAL BENEFIT SOCIETY  
2           DEFINED.—For purposes of paragraph (2)(A), a ‘re-  
3           ligious fraternal benefit society’ described in this  
4           section is an organization that—

5                   “(A) is exempt from Federal income tax-  
6                   ation under section 501(c)(8) of the Internal  
7                   Revenue Code of 1986;

8                   “(B) is affiliated with, carries out the te-  
9                   nets of, and shares a religious bond with, a  
10                  church or convention or association of churches  
11                  or an affiliated group of churches;

12                  “(C) offers, in addition to a MedicarePlus  
13                  religious fraternal benefit society plan, health  
14                  coverage to individuals not entitled to benefits  
15                  under this title who are members of such  
16                  church, convention, or group; and

17                  “(D) does not impose any limitation on  
18                  membership in the society based on any health  
19                  status-related factor.

20           “(4) PAYMENT ADJUSTMENT.—Under regula-  
21           tions of the Secretary, in the case of individuals en-  
22           rolled under this part under a MedicarePlus reli-  
23           gious fraternal benefit society plan described in  
24           paragraph (2), the Secretary shall provide for such  
25           adjustment to the payment amounts otherwise estab-

1 lished under section 1854 as may be appropriate to  
2 assure an appropriate payment level, taking into ac-  
3 count the actuarial characteristics and experience of  
4 such individuals.”.

5 (b) REPORT ON COVERAGE OF BENEFICIARIES WITH  
6 END-STAGE RENAL DISEASE.—The Secretary of Health  
7 and Human Services shall provide for a study on the fea-  
8 sibility and impact of removing the limitation under sec-  
9 tion 1851(b)(3)(B) of the Social Security Act (as inserted  
10 by subsection (a)) on eligibility of most individuals medi-  
11 cally determined to have end-stage renal disease to enroll  
12 in MedicarePlus plans. By not later than October 1, 1998,  
13 the Secretary shall submit to Congress a report on such  
14 study and shall include in the report such recommenda-  
15 tions regarding removing or restricting the limitation as  
16 may be appropriate.

17 (c) REPORT ON MEDICAREPLUS TEACHING PRO-  
18 GRAMS AND USE OF DSH AND TEACHING HOSPITALS.—  
19 Based on the information provided to the Secretary of  
20 Health and Human Services under section 1852(k) of the  
21 Social Security Act and such information as the Secretary  
22 may obtain, by not later than October 1, 1999, the Sec-  
23 retary shall submit to Congress a report on graduate med-  
24 ical education programs operated by MedicarePlus organi-  
25 zations and the extent to which MedicarePlus organiza-

1 tions are providing for payments to hospitals described in  
2 such section.

3 **SEC. 4002. TRANSITIONAL RULES FOR CURRENT MEDICARE**  
4 **HMO PROGRAM.**

5 (a) **AUTHORIZING TRANSITIONAL WAIVER OF 50:50**  
6 **RULE.**—Section 1876(f) (42 U.S.C. 1395mm(f)) is  
7 amended—

8 (1) in paragraph (2), by striking “The Sec-  
9 retary” and inserting “Subject to paragraph (4), the  
10 Secretary”, and

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

13 “(4) Effective for contract periods beginning after  
14 December 31, 1996, the Secretary may waive or modify  
15 the requirement imposed by paragraph (1) to the extent  
16 the Secretary finds that it is in the public interest.”.

17 (b) **TRANSITION.**—Section 1876 (42 U.S.C.  
18 1395mm) is amended by adding at the end the following  
19 new subsection:

20 “(k)(1) Except as provided in paragraph (3), the Sec-  
21 retary shall not enter into, renew, or continue any risk-  
22 sharing contract under this section with an eligible organi-  
23 zation for any contract year beginning on or after—

24 “(A) the date standards for MedicarePlus orga-  
25 nizations and plans are first established under sec-

1       tion 1856 with respect to MedicarePlus organiza-  
2       tions that are insurers or health maintenance orga-  
3       nizations, or

4               “(B) in the case of such an organization with  
5       such a contract in effect as of the date such stand-  
6       ards were first established, 1 year after such date.

7       “(2) The Secretary shall not enter into, renew, or  
8       continue any risk-sharing contract under this section with  
9       an eligible organization for any contract year beginning  
10      on or after January 1, 2000.

11      “(3) An individual who is enrolled in part B only and  
12      is enrolled in an eligible organization with a risk-sharing  
13      contract under this section on December 31, 1998, may  
14      continue enrollment in such organization in accordance  
15      with regulations issued by not later than July 1, 1998.

16      “(4) Notwithstanding subsection (a), the Secretary  
17      shall provide that payment amounts under risk-sharing  
18      contracts under this section for months in a year (begin-  
19      ning with January 1998) shall be computed—

20               “(A) with respect to individuals entitled to ben-  
21      efits under both parts A and B, by substituting pay-  
22      ment rates under section 1853(a) for the payment  
23      rates otherwise established under subsection  
24      1876(a), and

1           “(B) with respect to individuals only entitled to  
2           benefits under part B, by substituting an appro-  
3           priate proportion of such rates (reflecting the rel-  
4           ative proportion of payments under this title attrib-  
5           utable to such part) for the payment rates otherwise  
6           established under subsection (a).

7 For purposes of carrying out this paragraph for payments  
8 for months in 1998, the Secretary shall compute, an-  
9 nounce, and apply the payment rates under section  
10 1853(a) (notwithstanding any deadlines specified in such  
11 section) in as timely a manner as possible and may (to  
12 the extent necessary) provide for retroactive adjustment  
13 in payments made under this section not in accordance  
14 with such rates.”.

15           (c) ENROLLMENT TRANSITION RULE.—An individual  
16 who is enrolled on December 31, 1998, with an eligible  
17 organization under section 1876 of the Social Security Act  
18 (42 U.S.C. 1395mm) shall be considered to be enrolled  
19 with that organization on January 1, 1999, under part  
20 C of title XVIII of such Act if that organization has a  
21 contract under that part for providing services on January  
22 1, 1999 (unless the individual has disenrolled effective on  
23 that date).

24           (d) ADVANCE DIRECTIVES.—Section 1866(f) (42  
25 U.S.C. 1395c(f)) is amended—

1 (1) in paragraph (1)—

2 (A) by inserting “1855(i),” after  
3 “1833(s),”, and

4 (B) by inserting “, MedicarePlus organiza-  
5 tion,” after “provider of services”; and

6 (2) in paragraph (2)(E), by inserting “or a  
7 MedicarePlus organization” after “section  
8 1833(a)(1)(A)”.

9 (e) EXTENSION OF PROVIDER REQUIREMENT.—Sec-  
10 tion 1866(a)(1)(O) (42 U.S.C. 1395cc(a)(1)(O)) is  
11 amended—

12 (1) by striking “in the case of hospitals and  
13 skilled nursing facilities,”;

14 (2) by striking “inpatient hospital and extended  
15 care”;

16 (3) by inserting “with a MedicarePlus organiza-  
17 tion under part C or” after “any individual en-  
18 rolled”;

19 (4) by striking “(in the case of hospitals) or  
20 limits (in the case of skilled nursing facilities)”;

21 (5) by inserting “(less any payments under sec-  
22 tion 1858)” after “under this title”.

23 (f) ADDITIONAL CONFORMING CHANGES.—

24 (1) CONFORMING REFERENCES TO PREVIOUS  
25 PART C.—Any reference in law (in effect before the

1 date of the enactment of this Act) to part C of title  
2 XVIII of the Social Security Act is deemed a ref-  
3 erence to part D of such title (as in effect after such  
4 date).

5 (2) SECRETARIAL SUBMISSION OF LEGISLATIVE  
6 PROPOSAL.—Not later than 90 days after the date  
7 of the enactment of this Act, the Secretary of  
8 Health and Human Services shall submit to the ap-  
9 propriate committees of Congress a legislative pro-  
10 posal providing for such technical and conforming  
11 amendments in the law as are required by the provi-  
12 sions of this chapter.

13 (g) IMMEDIATE EFFECTIVE DATE FOR CERTAIN RE-  
14 QUIREMENTS FOR DEMONSTRATIONS.—Section  
15 1857(e)(2) of the Social Security Act (requiring contribu-  
16 tion to certain costs related to the enrollment process com-  
17 parative materials) applies to demonstrations with respect  
18 to which enrollment is effected or coordinated under sec-  
19 tion 1851 of such Act.

20 (h) USE OF INTERIM, FINAL REGULATIONS.—In  
21 order to carry out the amendments made by this chapter  
22 in a timely manner, the Secretary of Health and Human  
23 Services may promulgate regulations that take effect on  
24 an interim basis, after notice and pending opportunity for  
25 public comment.



1           (i) **TRANSITION RULE FOR PSO ENROLLMENT.**—In  
2 applying subsection (g)(1) of section 1876 of the Social  
3 Security Act (42 U.S.C. 1395mm) to a risk-sharing con-  
4 tract entered into with an eligible organization that is a  
5 provider-sponsored organization (as defined in section  
6 1855(e)(1) of such Act, as inserted by section 4001) for  
7 a contract year beginning on or after January 1, 1998,  
8 there shall be substituted for the minimum number of en-  
9 rollees provided under such section the minimum number  
10 of enrollees permitted under section 1857(b)(1) of such  
11 Act (as so inserted).

12 **SEC. 4003. CONFORMING CHANGES IN MEDIGAP PROGRAM.**

13           (a) **CONFORMING AMENDMENTS TO MEDICAREPLUS**  
14 **CHANGES.**—

15                   (1) **IN GENERAL.**—Section 1882(d)(3)(A)(i) (42  
16 U.S.C. 1395ss(d)(3)(A)(i)) is amended—

17                           (A) in the matter before subclause (I), by  
18 inserting “(including an individual electing a  
19 MedicarePlus plan under section 1851)” after  
20 “of this title”; and

21                           (B) in subclause (II)—

22                                   (i) by inserting “in the case of an in-  
23 dividual not electing a MedicarePlus plan”  
24 after “(II)”, and

1 (ii) by inserting before the comma at  
2 the end the following: “or in the case of an  
3 individual electing a MedicarePlus plan, a  
4 medicare supplemental policy with knowl-  
5 edge that the policy duplicates health bene-  
6 fits to which the individual is otherwise en-  
7 titled under the MedicarePlus plan or  
8 under another medicare supplemental pol-  
9 icy”.

10 (2) CONFORMING AMENDMENTS.—Section  
11 1882(d)(3)(B)(i)(I) (42 U.S.C.  
12 1395ss(d)(3)(B)(i)(I)) is amended by inserting “(in-  
13 cluding any MedicarePlus plan)” after “health in-  
14 surance policies”.

15 (3) MEDICAREPLUS PLANS NOT TREATED AS  
16 MEDICARE SUPPLEMENTARY POLICIES.—Section  
17 1882(g)(1) (42 U.S.C. 1395ss(g)(1)) is amended by  
18 inserting “or a MedicarePlus plan or” after “does  
19 not include”

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

24 “(u)(1) It is unlawful for a person to sell or issue  
25 a policy described in paragraph (2) to an individual with

1 knowledge that the individual has in effect under section  
2 1851 an election of an MSA plan.

3 “(2) A policy described in this subparagraph is a  
4 health insurance policy that provides for coverage of ex-  
5 penses that are otherwise required to be counted toward  
6 meeting the annual deductible amount provided under the  
7 MSA plan.”.

8 **Subchapter B—Special Rules for**  
9 **MedicarePlus Medical Savings Accounts**

10 **SEC. 4006. MEDICAREPLUS MSA.**

11 (a) IN GENERAL.—Part III of subchapter B of chap-  
12 ter 1 of the Internal Revenue Code of 1986 (relating to  
13 amounts specifically excluded from gross income) is  
14 amended by redesignating section 138 as section 139 and  
15 by inserting after section 137 the following new section:

16 **“SEC. 138. MEDICAREPLUS MSA.**

17 “(a) EXCLUSION.—Gross income shall not include  
18 any payment to the MedicarePlus MSA of an individual  
19 by the Secretary of Health and Human Services under  
20 part C of title XVIII of the Social Security Act.

21 “(b) MEDICAREPLUS MSA.—For purposes of this  
22 section, the term ‘MedicarePlus MSA’ means a medical  
23 savings account (as defined in section 220(d))—

24 “(1) which is designated as a MedicarePlus  
25 MSA,

1           “(2) with respect to which no contribution may  
2 be made other than—

3           “(A) a contribution made by the Secretary  
4 of Health and Human Services pursuant to  
5 part C of title XVIII of the Social Security Act,  
6 or

7           “(B) a trustee-to-trustee transfer described  
8 in subsection (c)(4),

9           “(3) the governing instrument of which pro-  
10 vides that trustee-to-trustee transfers described in  
11 subsection (c)(4) may be made to and from such ac-  
12 count, and

13           “(4) which is established in connection with an  
14 MSA plan described in section 1859(b)(2) of the So-  
15 cial Security Act.

16           “(c) SPECIAL RULES FOR DISTRIBUTIONS.—

17           “(1) DISTRIBUTIONS FOR QUALIFIED MEDICAL  
18 EXPENSES.—In applying section 220 to a  
19 MedicarePlus MSA—

20           “(A) qualified medical expenses shall not  
21 include amounts paid for medical care for any  
22 individual other than the account holder, and

23           “(B) section 220(d)(2)(C) shall not apply.

24           “(2) PENALTY FOR DISTRIBUTIONS FROM  
25 MEDICAREPLUS MSA NOT USED FOR QUALIFIED

1 MEDICAL EXPENSES IF MINIMUM BALANCE NOT  
2 MAINTAINED.—

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

10 “(i) the amount of such payment or  
11 distribution, over

12 “(ii) the excess (if any) of—

13 “(I) the fair market value of the  
14 assets in such MSA as of the close of  
15 the calendar year preceding the cal-  
16 endar year in which the taxable year  
17 begins, over

18 “(II) an amount equal to 60 per-  
19 cent of the deductible under the  
20 MedicarePlus MSA plan covering the  
21 account holder as of January 1 of the  
22 calendar year in which the taxable  
23 year begins.

24 Section 220(f)(2) shall not apply to any pay-  
25 ment or distribution from a MedicarePlus MSA.

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

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

6           “(ii) dies.

7           “(C) SPECIAL RULES.—For purposes of  
8 subparagraph (A)—

9           “(i) all MedicarePlus MSAs of the ac-  
10 count holder shall be treated as 1 account,

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

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

19           “(3) WITHDRAWAL OF ERRONEOUS CONTRIBU-  
20 TIONS.—Section 220(f)(2) and paragraph (2) of this  
21 subsection shall not apply to any payment or dis-  
22 tribution from a MedicarePlus MSA to the Secretary  
23 of Health and Human Services of an erroneous con-  
24 tribution to such MSA and of the net income attrib-  
25 utable to such contribution.

1           “(4) TRUSTEE-TO-TRUSTEE TRANSFERS.—Sec-  
2           tion 220(f)(2) and paragraph (2) of this subsection  
3           shall not apply to any trustee-to-trustee transfer  
4           from a MedicarePlus MSA of an account holder to  
5           another MedicarePlus MSA of such account holder.

6           “(d) SPECIAL RULES FOR TREATMENT OF ACCOUNT  
7           AFTER DEATH OF ACCOUNT HOLDER.—In applying sec-  
8           tion 220(f)(8)(A) to an account which was a MedicarePlus  
9           MSA of a decedent, the rules of section 220(f) shall apply  
10          in lieu of the rules of subsection (c) of this section with  
11          respect to the spouse as the account holder of such  
12          MedicarePlus MSA.

13          “(e) REPORTS.—In the case of a MedicarePlus MSA,  
14          the report under section 220(h)—

15                 “(1) shall include the fair market value of the  
16                 assets in such MedicarePlus MSA as of the close of  
17                 each calendar year, and

18                 “(2) shall be furnished to the account holder—

19                         “(A) not later than January 31 of the cal-  
20                         endar year following the calendar year to which  
21                         such reports relate, and

22                         “(B) in such manner as the Secretary pre-  
23                         scribes in such regulations.

24          “(f) COORDINATION WITH LIMITATION ON NUMBER  
25          OF TAXPAYERS HAVING MEDICAL SAVINGS ACCOUNTS.—

1 Subsection (i) of section 220 shall not apply to an individ-  
2 ual with respect to a MedicarePlus MSA, and  
3 MedicarePlus MSA's shall not be taken into account in  
4 determining whether the numerical limitations under sec-  
5 tion 220(j) are exceeded.”

6 (b) TECHNICAL AMENDMENTS.—

7 (1) The last sentence of section 4973(d) of such  
8 Code is amended by inserting “or section 138(c)(3)”  
9 after “section 220(f)(3)”.

10 (2) Subsection (b) of section 220 of such Code  
11 is amended by adding at the end the following new  
12 paragraph:

13 “(7) MEDICARE ELIGIBLE INDIVIDUALS.—The  
14 limitation under this subsection for any month with  
15 respect to an individual shall be zero for the first  
16 month such individual is entitled to benefits under  
17 title XVIII of the Social Security Act and for each  
18 month thereafter.”

19 (3) The table of sections for part III of sub-  
20 chapter B of chapter 1 of such Code is amended by  
21 striking the last item and inserting the following:

“Sec. 138. MedicarePlus MSA.

“Sec. 139. Cross references to other Acts.”

22 (c) EFFECTIVE DATE.—The amendments made by  
23 this section shall apply to taxable years beginning after  
24 December 31, 1998.



1           **Subchapter C—GME, IME, and DSH**  
2           **Payments for Managed Care Enrollees**

3   **SEC. 4008. GRADUATE MEDICAL EDUCATION AND INDIRECT**  
4                   **MEDICAL EDUCATION PAYMENTS FOR MAN-**  
5                   **AGED CARE ENROLLEES.**

6           (a) PAYMENTS TO MANAGED CARE ORGANIZATIONS  
7 OPERATING GRADUATE MEDICAL EDUCATION PRO-  
8 GRAMS.—Section 1853 (as inserted by section 4001) is  
9 amended by adding at the end the following:

10           “(h) PAYMENTS FOR DIRECT COSTS OF GRADUATE  
11 MEDICAL EDUCATION PROGRAMS.—

12                   “(1) ADDITIONAL PAYMENT TO BE MADE.—Ef-  
13 fective January 1, 1998, each contract with a  
14 MedicarePlus organization under this section (and  
15 each risk-sharing contract with an eligible organiza-  
16 tion under section 1876) shall provide for an addi-  
17 tional payment for Medicare’s share of allowable di-  
18 rect graduate medical education costs incurred by  
19 such an organization for an approved medical resi-  
20 dency program.

21                   “(2) ALLOWABLE COSTS.—If the organization  
22 has an approved medical residency program that in-  
23 curs all or substantially all of the costs of the pro-  
24 gram, subject to section 1858(a)(3), the allowable  
25 costs for such a program shall equal the national av-

1 erage per resident amount times the number of full-  
2 time-equivalent residents in the program in non-hos-  
3 pital settings.

4 “(3) DEFINITIONS.—As used in this subsection:

5 “(A) The terms ‘approved medical resi-  
6 dency program’, ‘direct graduate medical edu-  
7 cation costs’, and ‘full-time-equivalent residents’  
8 have the same meanings as under section  
9 1886(h).

10 “(B) The term ‘Medicare’s share’ means,  
11 with respect to a MedicarePlus or eligible orga-  
12 nization, the ratio of the number of individuals  
13 enrolled with the organization under this part  
14 (or enrolled under a risk-sharing contract under  
15 section 1876, respectively) to the total number  
16 of individuals enrolled with the organization.

17 “(C) The term ‘national average per resi-  
18 dent amount’ means an amount estimated by  
19 the Secretary to equal the weighted average  
20 amount that would be paid per full-time-equiva-  
21 lent resident under section 1886(h) for the cal-  
22 endar year (determined separately for primary  
23 care residency programs as defined under sec-  
24 tion 1886(h) (including obstetrics and gyne-

1           cology residency programs) and for other resi-  
2           dency programs).”.

3           (b) PAYMENTS TO HOSPITALS FOR DIRECT AND IN-  
4 DIRECT COSTS OF GRADUATE MEDICAL EDUCATION PRO-  
5 GRAMS ATTRIBUTABLE TO MANAGED CARE ENROLL-  
6 EES.—Part C of title XVIII, as amended by section 4001,  
7 is amended by inserting after section 1857 the following  
8 new section:

9           “PAYMENTS TO HOSPITALS FOR CERTAIN COSTS  
10           ATTRIBUTABLE TO MANAGED CARE ENROLLEES  
11           “SEC. 1858. (a) COSTS OF GRADUATE MEDICAL  
12 EDUCATION.—

13           “(1) IN GENERAL.—For portions of cost report-  
14           ing periods occurring on or after January 1, 1998,  
15           the Secretary shall provide for an additional pay-  
16           ment amount for each subsection (d) hospital (as de-  
17           fined in section 1886(d)(1)(B)), each PPS-exempt  
18           hospital described in clause (i) through (v) of such  
19           section, and for each hospital reimbursed under a re-  
20           imbursement system authorized section 1814(b)(3)  
21           that—

22           “(A) furnishes services to individuals who  
23           are enrolled under a risk-sharing contract with  
24           an eligible organization under section 1876 and  
25           who are entitled to part A and to individuals

1 who are enrolled with a MedicarePlus organiza-  
2 tion under part C, and

3 “(B) has an approved medical residency  
4 training program.

5 “(2) PAYMENT AMOUNT.—

6 “(A) IN GENERAL.—Subject to paragraph  
7 (3)(B), the amount of the payment under this  
8 subsection shall be the sum of—

9 “(i) the amount determined under  
10 subparagraph (B), and

11 “(ii) the amount determined under  
12 subparagraph (C).

13 Clause (ii) shall not apply in the case of a hos-  
14 pital that is not a PPS-exempt hospital de-  
15 scribed in clause (i) through (v) of section  
16 1886(d)(1)(B),

17 “(B) DIRECT AMOUNT.—The amount de-  
18 termined under this subparagraph for a period  
19 is equal to the product of—

20 “(i) the aggregate approved amount  
21 (as defined in section 1886(h)(3)(B)) for  
22 that period; and

23 “(ii) the fraction of the total number  
24 of inpatient-bed-days (as established by the  
25 Secretary) during the period which are at-

1           tributable to individuals described in para-  
2           graph (1).

3           “(C) INDIRECT AMOUNT.—The amount de-  
4           termined under this subparagraph is equal to  
5           the product of—

6                   “(i) the amount of the indirect teach-  
7                   ing adjustment factor applicable to the  
8                   hospital under section 1886(d)(5)(B); and

9                   “(ii) the product of—

10                           “(I) the number of discharges at-  
11                           tributable to individuals described in  
12                           paragraph (1), and

13                           “(II) the estimated average per  
14                           discharge amount that would other-  
15                           wise have been paid under section  
16                           1886(d)(1)(A) if the individuals had  
17                           not been enrolled as described in such  
18                           paragraph.

19           “(D) SPECIAL RULE.—The Secretary shall  
20           establish rules for the application of subpara-  
21           graph (B) and for the computation of the  
22           amounts described in subparagraph (C)(i)) and  
23           subparagraph (C)(ii)(I) to a hospital reim-  
24           bursed under a reimbursement system author-  
25           ized under section 1814(b)(3) in a manner simi-

1 lar to the manner of applying such subpara-  
2 graph and computing such amounts as if the  
3 hospital were not reimbursed under such sec-  
4 tion.

5 “(3) LIMITATION.—

6 “(A) DETERMINATIONS.—At the beginning  
7 of each year, the Secretary shall—

8 “(i) estimate the sum of the amount  
9 of the payments under this subsection and  
10 the payments under section 1853(h), for  
11 services or discharges occurring in the  
12 year, and

13 “(ii) determine the amount of the an-  
14 nual payment limit under subparagraph  
15 (C) for such year.

16 “(B) IMPOSITION OF LIMIT.—If the  
17 amount estimated under subparagraph (A)(i)  
18 for a year exceeds the amount determined  
19 under subparagraph (A)(ii) for the year, then  
20 the Secretary shall adjust the amounts of the  
21 payments described in subparagraph (A)(i) for  
22 the year in a pro rata manner so that the total  
23 of such payments in the year do not exceed the  
24 annual payment limit determined under sub-  
25 paragraph (A)(ii) for that year.

1 “(C) ANNUAL PAYMENT LIMIT.—

2 “(i) IN GENERAL.—The annual pay-  
3 ment limit under this subparagraph for a  
4 year is the sum, over all counties or  
5 MedicarePlus payment areas, of the prod-  
6 uct of—

7 “(I) the annual GME per capita  
8 payment rate (described in clause (ii))  
9 for the county or area, and

10 “(II) the Secretary’s projection  
11 of average enrollment of individuals  
12 described in paragraph (1) who are  
13 residents of that county or area, ad-  
14 justed to reflect the relative demo-  
15 graphic or risk characteristics of such  
16 enrollees.

17 “(ii) GME PER CAPITA PAYMENT  
18 RATE.—The GME per capita payment rate  
19 described in this clause for a particular  
20 county or MedicarePlus payment area for  
21 a year is the GME proportion (as specified  
22 in clause (iii)) of the annual MedicarePlus  
23 capitation rate (as calculated under section  
24 1853(c)) for the county or area and year  
25 involved.

1           “(iii) GME PROPORTION.—For pur-  
2           poses of clause (ii), the GME proportion  
3           for a county or area and a year is equal to  
4           the phase-in percentage (specified in clause  
5           (vi)) of the ratio of (I) the projected GME  
6           payment amount for the county or area (as  
7           determined under clause (v)), to (II) the  
8           average per capita cost for the county or  
9           area for the year (determined under clause  
10          (vi)).

11          “(iv) PHASE-IN PERCENTAGE.—The  
12          phase-in percentage specified in this clause  
13          for—

14                       “(I) 1998 is 20 percent,

15                       “(II) 1999 is 40 percent,

16                       “(III) 2000 is 60 percent,

17                       “(IV) 2001 is 80 percent, or

18                       “(V) any subsequent year is 100  
19          percent.

20          “(v) PROJECTED GME PAYMENT  
21          AMOUNT.—the projected GME payment  
22          amount for a county or area—

23                       “(I) for 1998, is the amount in-  
24                       cluded in the per capita rate of pay-  
25                       ment for 1997 determined under sec-



1           tion 1876(a)(1)(C) for the payment  
2           adjustments described in section  
3           1886(d)(5)(B) and section 1886(h)  
4           for that county or area, adjusted by  
5           the general GME update factor (as  
6           defined in clause (vii)) for 1998, or

7                   “(II) for a subsequent year, is  
8           the projected GME payment amount  
9           for the county or area for the previous  
10          year, adjusted by the general GME  
11          update factor for such subsequent  
12          year.

13   The Secretary shall determine the amount described in  
14   subclause (I) for a county or other area that includes hos-  
15   pitals reimbursed under section 1814(b)(3) as though  
16   such hospitals had not been reimbursed under such sec-  
17   tion.

18                   “(vi) AVERAGE PER CAPITA COST.—  
19           The average per capita cost for the county  
20           or area determined under this clause for—

21                   “(I) 1998 is the annual per cap-  
22           ita rate of payment for 1997 deter-  
23           mined under section 1876(a)(1)(C)  
24           for the county or area, increased by  
25           the national per capita MedicarePlus

1 growth percentage for 1998 (as de-  
2 fined in section 1853(c)(6), but deter-  
3 mined without regard to the adjust-  
4 ment described in subparagraph (B)  
5 of such section); or

6 “(II) a subsequent year is the av-  
7 erage per capita cost determined  
8 under this clause for the previous year  
9 increased by the national per capita  
10 MedicarePlus growth percentage for  
11 the year involved (as defined in sec-  
12 tion 1853(c)(6), but determined with-  
13 out regard to the adjustment de-  
14 scribed in subparagraph (B) of such  
15 section).

16 “(vii) GENERAL GME UPDATE FAC-  
17 TOR.—For purposes of clause (v), the ‘gen-  
18 eral GME update factor’ for a year is  
19 equal to the Secretary’s estimate of the na-  
20 tional average percentage change in aver-  
21 age per capita payments under sections  
22 1886(d)(5)(B) and 1886(h) from the pre-  
23 vious year to the year involved. Such  
24 amount takes into account changes in law

1                   and regulation affecting payment amounts  
2                   under such sections.”.

3 **SEC. 4009. DISPROPORTIONATE SHARE HOSPITAL PAY-**  
4 **MENTS FOR MANAGED CARE ENROLLEES.**

5           Section 1858, as inserted by section 4008(b), is fur-  
6 ther amended by adding at the end the following new sub-  
7 section:

8           “(b) DISPROPORTIONATE SHARE HOSPITAL PAY-  
9 MENTS.—

10                   “(1) IN GENERAL.—For portions of cost report-  
11 ing periods occurring on or after January 1, 1998,  
12 the Secretary shall provide for an additional pay-  
13 ment amount for each subsection (d) hospital (as de-  
14 fined in section 1886(d)(1)(B)) and for each hospital  
15 reimbursed a demonstration project reimbursement  
16 system under section 1814(b)(3) that—

17                           “(A) furnishes services to individuals who are  
18 enrolled under a risk-sharing contract with an  
19 eligible organization under section 1876 and  
20 who are entitled to part A and to individuals  
21 who are enrolled with a MedicarePlus organiza-  
22 tion under this part, and

23                           “(B) is (or, if it were not reimbursed  
24 under section 1814(b)(3), would qualify as) a

1 disproportionate share hospital described in sec-  
2 tion 1886(d)(5)(F)(i).

3 “(2) AMOUNT OF PAYMENT.—Subject to para-  
4 graph (3)(B), the amount of the payment under this  
5 subsection shall be the product of—

6 “(A) the amount of the disproportionate  
7 share adjustment percentage applicable to the  
8 hospital under section 1886(d)(5)(F); and

9 “(B) the product described in subsection  
10 (a)(2)(C)(ii).

11 The Secretary shall establish rules for the computa-  
12 tion of the amount described in subparagraph (A)  
13 for a hospital reimbursed under section 1814(b)(3).

14 “(3) LIMIT.—

15 “(A) DETERMINATION.—At the beginning  
16 of each year, the Secretary shall—

17 “(i) estimate the sum of the payments  
18 under this subsection for services or dis-  
19 charges occurring in the year, and

20 “(ii) determine the amount of the an-  
21 nual payment limit under subparagraph  
22 (C) for such year.

23 “(B) IMPOSITION OF LIMIT.—If the  
24 amount estimated under subparagraph (A)(i)  
25 for a year exceeds the amount determined

1 under subparagraph (A)(ii) for the year, then  
2 the Secretary shall adjust the amounts of the  
3 payments under this subsection for the year in  
4 a pro rata manner so that the total of such  
5 payments in the year do not exceed the annual  
6 payment limit determined under subparagraph  
7 (A)(ii) for that year.

8 “(C) ANNUAL PAYMENT LIMIT.—The an-  
9 nual payment limit under this subparagraph for  
10 a year shall be determined in the same manner  
11 as the annual payment limit is determined  
12 under clause (i) of subsection (a)(3)(C), except  
13 that, for purposes of this clause, any reference  
14 in clauses (i) through (vii) of such subsection—

15 “(i) to a payment adjustment under  
16 subsection (a) is deemed a reference to a  
17 payment adjustment under this subsection,  
18 or

19 “(ii) to payments or payment adjust-  
20 ments under section 1886(d)(5)(B) and  
21 1886(h) is deemed a reference to payments  
22 and payment adjustments under section  
23 1886(d)(5)(F).”.

1     **CHAPTER 2—INTEGRATED LONG-TERM**  
2                     **CARE PROGRAMS**

3     **Subchapter A—Programs of All-inclusive**  
4                     **Care for the Elderly (PACE)**

5     **SEC. 4011. REFERENCE TO COVERAGE OF PACE UNDER THE**  
6                     **MEDICARE PROGRAM.**

7             For provision amending title XVIII of the Social Se-  
8     curity Act to provide for payments to, and coverage of ben-  
9     efits under, Programs of All-inclusive Care for the Elderly  
10  (PACE), see section 3431.

11  **SEC. 4012. REFERENCE TO ESTABLISHMENT OF PACE PRO-**  
12                     **GRAM AS MEDICAID STATE OPTION.**

13             For provision amending title XIX of the Social Secu-  
14  rity Act to establish the PACE program as a medicaid  
15  State option, see section 3432.

16  **Subchapter B—Social Health Maintenance**  
17                     **Organizations**

18  **SEC. 4015. SOCIAL HEALTH MAINTENANCE ORGANIZATIONS**  
19                     **(SHMOS).**

20             (a) EXTENSION OF DEMONSTRATION PROJECT AU-  
21  THORITIES.—Section 4018(b) of the Omnibus Budget  
22  Reconciliation Act of 1987 is amended—

23                     (1) in paragraph (1), by striking “1997” and  
24             inserting “2000”, and

1           (2) in paragraph (4), by striking “1998” and  
2           inserting “2001”.

3           (b) EXPANSION OF CAP.—Section 13567(c) of the  
4 Omnibus Budget Reconciliation Act of 1993 is amended  
5 by striking “12,000” and inserting “36,000”.

6           (b) REPORT ON INTEGRATION AND TRANSITION.—

7           (1) IN GENERAL.—The Secretary of Health and  
8 Human Services shall submit to Congress, by not  
9 later than January 1, 1999, a plan for the integra-  
10 tion of health plans offered by social health mainte-  
11 nance organizations (including SHMO I and SHMO  
12 II sites developed under section 2355 of the Deficit  
13 Reduction Act of 1984 and under the amendment  
14 made by section 4207(b)(3)(B)(i) of OBRA–1990,  
15 respectively) and similar plans as an option under  
16 the MedicarePlus program under part C of title  
17 XVIII of the Social Security Act.

18           (2) PROVISION FOR TRANSITION.—Such plan  
19 shall include a transition for social health mainte-  
20 nance organizations operating under demonstration  
21 project authority under such section.

22           (3) PAYMENT POLICY.—The report shall also  
23 include recommendations on appropriate payment  
24 levels for plans offered by such organizations, includ-  
25 ing an analysis of the application of risk adjustment

1 factors appropriate to the population served by such  
2 organizations.

3 **Subchapter C—Other Programs**

4 **SEC. 4018. ORDERLY TRANSITION OF MUNICIPAL HEALTH**  
5 **SERVICE DEMONSTRATION PROJECTS.**

6 Section 9215 of the Consolidated Omnibus Budget  
7 Reconciliation Act of 1985, as amended by section 6135  
8 of OBRA–1989 and section 13557 of OBRA–1993, is fur-  
9 ther amended—

10 (1) by inserting “(a)” before “The Secretary”,  
11 and

12 (2) by adding at the end the following: “Subject  
13 to subsection (c), the Secretary may further extend  
14 such demonstration projects through December 31,  
15 2000, but only with respect to individuals are en-  
16 rolled with such projects before January 1, 1998.

17 “(b) The Secretary shall work with each such dem-  
18 onstration project to develop a plan, to be submitted to  
19 the Committee on Ways and Means of the House of Rep-  
20 resentatives and the Committee on Finance of the Senate  
21 by March 31, 1998, for the orderly transition of dem-  
22 onstration projects and the project enrollees to a non-dem-  
23 onstration project health care delivery system, such as  
24 through integration with private or public health plan, in-  
25 cluding a medicaid managed care or MedicarePlus plan.



1       “(c) A demonstration project under subsection (a)  
 2 which does not develop and submit a transition plan under  
 3 subsection (b) by March 31, 1998, or, if later, 6 months  
 4 after the date of the enactment of this Act, shall be discon-  
 5 tinued as of December 31, 1998. The Secretary shall pro-  
 6 vide appropriate technical assistance to assist in the tran-  
 7 sition so that disruption of medical services to project en-  
 8 rollees may be minimized.”.

9       **SEC. 4019. EXTENSION OF CERTAIN MEDICARE COMMUNITY**  
 10                               **NURSING ORGANIZATION DEMONSTRATION**  
 11                               **PROJECTS.**

12       Notwithstanding any other provision of law, dem-  
 13 onstration projects conducted under section 4079 of the  
 14 Omnibus Budget Reconciliation Act of 1987 may be con-  
 15 ducted for an additional period of 2 years, and the dead-  
 16 line for any report required relating to the results of such  
 17 projects shall be not later than 6 months before the end  
 18 of such additional period.

19                               **CHAPTER 3—MEDICARE PAYMENT**  
 20                               **ADVISORY COMMISSION**

21       **SEC. 4021. MEDICARE PAYMENT ADVISORY COMMISSION.**

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

1 “MEDICARE PAYMENT ADVISORY COMMISSION

2 “SEC. 1805. (a) ESTABLISHMENT.—There is hereby  
3 established the Medicare Payment Advisory Commission  
4 (in this section referred to as the ‘Commission’).

5 “(b) DUTIES.—

6 “(1) REVIEW OF PAYMENT POLICIES AND AN-  
7 NUAL REPORTS.—The Commission shall—

8 “(A) review payment policies under this  
9 title, including the topics described in para-  
10 graph (2);

11 “(B) make recommendations to Congress  
12 concerning such payment policies; and

13 “(C) by not later than March 1 of each  
14 year (beginning with 1998), submit a report to  
15 Congress containing the results of such reviews  
16 and its recommendations concerning such poli-  
17 cies and an examination of issues affecting the  
18 medicare program.

19 “(2) SPECIFIC TOPICS TO BE REVIEWED.—

20 “(A) MEDICAREPLUS PROGRAM.—Specifi-  
21 cally, the Commission shall review, with respect  
22 to the MedicarePlus program under part C, the  
23 following:

24 “(i) The methodology for making pay-  
25 ment to plans under such program, includ-

1 ing the making of differential payments  
2 and the distribution of differential updates  
3 among different payment areas.

4 “(ii) The mechanisms used to adjust  
5 payments for risk and the need to adjust  
6 such mechanisms to take into account  
7 health status of beneficiaries.

8 “(iii) The implications of risk selec-  
9 tion both among MedicarePlus organiza-  
10 tions and between the MedicarePlus option  
11 and the medicare fee-for-service option.

12 “(iv) The development and implemen-  
13 tation of mechanisms to assure the quality  
14 of care for those enrolled with  
15 MedicarePlus organizations.

16 “(v) The impact of the MedicarePlus  
17 program on access to care for medicare  
18 beneficiaries.

19 “(vi) The appropriate role for the  
20 medicare program in addressing the needs  
21 of individuals with chronic illnesses.

22 “(vii) Other major issues in imple-  
23 mentation and further development of the  
24 MedicarePlus program.

1           “(B) FEE-FOR-SERVICE SYSTEM.—Specifi-  
2 cally, the Commission shall review payment  
3 policies under parts A and B, including—

4                   “(i) the factors affecting expenditures  
5 for services in different sectors, including  
6 the process for updating hospital, skilled  
7 nursing facility, physician, and other fees,

8                   “(ii) payment methodologies, and

9                   “(iii) their relationship to access and  
10 quality of care for medicare beneficiaries.

11           “(C) INTERACTION OF MEDICARE PAY-  
12 MENT POLICIES WITH HEALTH CARE DELIVERY  
13 GENERALLY.—Specifically, the Commission  
14 shall review the effect of payment policies under  
15 this title on the delivery of health care services  
16 other than under this title and assess the impli-  
17 cations of changes in health care delivery in the  
18 United States and in the general market for  
19 health care services on the medicare program.

20           “(3) COMMENTS ON CERTAIN SECRETARIAL RE-  
21 PORTS.—If the Secretary submits to Congress (or a  
22 committee of Congress) a report that is required by  
23 law and that relates to payment policies under this  
24 title, the Secretary shall transmit a copy of the re-  
25 port to the Commission. The Commission shall re-

1 view the report and, not later than 6 months after  
2 the date of submittal of the Secretary's report to  
3 Congress, shall submit to the appropriate commit-  
4 tees of Congress written comments on such report.  
5 Such comments may include such recommendations  
6 as the Commission deems appropriate.

7 “(4) AGENDA AND ADDITIONAL REVIEWS.—The  
8 Commission shall consult periodically with the chair-  
9 men and ranking minority members of the appro-  
10 priate committees of Congress regarding the Com-  
11 mission's agenda and progress towards achieving the  
12 agenda. The Commission may conduct additional re-  
13 views, and submit additional reports to the appro-  
14 priate committees of Congress, from time to time on  
15 such topics relating to the program under this title  
16 as may be requested by such chairmen and members  
17 and as the Commission deems appropriate.

18 “(5) AVAILABILITY OF REPORTS.—The Com-  
19 mission shall transmit to the Secretary a copy of  
20 each report submitted under this subsection and  
21 shall make such reports available to the public.

22 “(6) APPROPRIATE COMMITTEES.—For pur-  
23 poses of this section, the term ‘appropriate commit-  
24 tees of Congress’ means the Committees on Ways  
25 and Means and Commerce of the House of Rep-

1 representatives and the Committee on Finance of the  
2 Senate.

3 “(c) MEMBERSHIP.—

4 “(1) NUMBER AND APPOINTMENT.—The Com-  
5 mission shall be composed of 11 members appointed  
6 by the Comptroller General.

7 “(2) QUALIFICATIONS.—

8 “(A) IN GENERAL.—The membership of  
9 the Commission shall include individuals with  
10 national recognition for their expertise in health  
11 finance and economics, actuarial science, health  
12 facility management, health plans and inte-  
13 grated delivery systems, reimbursement of  
14 health facilities, allopathic and osteopathic phy-  
15 sicians, and other providers of health services,  
16 and other related fields, who provide a mix of  
17 different professionals, broad geographic rep-  
18 resentation, and a balance between urban and  
19 rural representatives.

20 “(B) INCLUSION.—The membership of the  
21 Commission shall include (but not be limited to)  
22 physicians and other health professionals, em-  
23 ployers, third party payers, individuals skilled  
24 in the conduct and interpretation of biomedical,  
25 health services, and health economics research

1 and expertise in outcomes and effectiveness re-  
2 search and technology assessment. Such mem-  
3 bership shall also include representatives of con-  
4 sumers and the elderly.

5 “(C) MAJORITY NONPROVIDERS.—Individ-  
6 uals who are directly involved in the provision,  
7 or management of the delivery, of items and  
8 services covered under this title shall not con-  
9 stitute a majority of the membership of the  
10 Commission.

11 “(D) ETHICAL DISCLOSURE.—The Comp-  
12 troller General shall establish a system for pub-  
13 lic disclosure by members of the Commission of  
14 financial and other potential conflicts of interest  
15 relating to such members.

16 “(3) TERMS.—

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

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

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

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



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

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

8           “(6) MEETINGS.—The Commission shall meet  
9       at the call of the Chairman.

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

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

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

23           “(3) enter into contracts or make other ar-  
24       rangements, as may be necessary for the conduct of

1 the work of the Commission (without regard to sec-  
2 tion 3709 of the Revised Statutes (41 U.S.C. 5));

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

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

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

10 “(e) POWERS.—

11 “(1) OBTAINING OFFICIAL DATA.—The Com-  
12 mission may secure directly from any department or  
13 agency of the United States information necessary  
14 to enable it to carry out this section. Upon request  
15 of the Chairman, the head of that department or  
16 agency shall furnish that information to the Com-  
17 mission on an agreed upon schedule.

18 “(2) DATA COLLECTION.—In order to carry out  
19 its functions, the Commission shall—

20 “(A) utilize existing information, both pub-  
21 lished and unpublished, where possible, collected  
22 and assessed either by its own staff or under  
23 other arrangements made in accordance with  
24 this section,

1           “(B) carry out, or award grants or con-  
2           tracts for, original research and experimen-  
3           tation, where existing information is inad-  
4           equate, and

5           “(C) adopt procedures allowing any inter-  
6           ested party to submit information for the Com-  
7           mission’s use in making reports and rec-  
8           ommendations.

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

13          “(4) PERIODIC AUDIT.—The Commission shall  
14          be subject to periodic audit by the Comptroller Gen-  
15          eral.

16          “(f) AUTHORIZATION OF APPROPRIATIONS.—

17          “(1) REQUEST FOR APPROPRIATIONS.—The  
18          Commission shall submit requests for appropriations  
19          in the same manner as the Comptroller General sub-  
20          mits requests for appropriations, but amounts ap-  
21          propriated for the Commission shall be separate  
22          from amounts appropriated for the Comptroller Gen-  
23          eral.

24          “(2) AUTHORIZATION.—There are authorized to  
25          be appropriated such sums as may be necessary to

1 carry out the provisions of this section. 60 percent  
2 of such appropriation shall be payable from the Fed-  
3 eral Hospital Insurance Trust Fund, and 40 percent  
4 of such appropriation shall be payable from the Fed-  
5 eral Supplementary Medical Insurance Trust  
6 Fund.”.

7 (b) ABOLITION OF PROPAC AND PPRC.—

8 (1) PROPAC.—

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

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

12 and

13 (ii) in paragraph (3), by striking “(A)  
14 The Commission” and all that follows  
15 through “(B)”.

16 (B) CONFORMING AMENDMENT.—Section  
17 1862 (42 U.S.C. 1395y) is amended by striking  
18 “Prospective Payment Assessment Commis-  
19 sion” each place it appears in subsection  
20 (a)(1)(D) and subsection (i) and inserting  
21 “Medicare Payment Advisory Commission”.

22 (2) PPRC.—

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

1 (B) ELIMINATION OF CERTAIN RE-  
2 PORTS.—Section 1848 (42 U.S.C. 1395w-4) is  
3 amended by striking subparagraph (B) of sub-  
4 section (f)(1).

5 (C) CONFORMING AMENDMENTS.—Section  
6 1848 (42 U.S.C. 1395w-4) is amended by  
7 striking “Physician Payment Review Commis-  
8 sion” and inserting “Medicare Payment Advi-  
9 sory Commission” each place it appears in sub-  
10 sections (c)(2)(B)(iii), (g)(6)(C), and (g)(7)(C).

11 (c) EFFECTIVE DATE; TRANSITION.—

12 (1) IN GENERAL.—The Comptroller General  
13 shall first provide for appointment of members to  
14 the Medicare Payment Advisory Commission (in this  
15 subsection referred to as “MedPAC”) by not later  
16 than September 30, 1997.

17 (2) TRANSITION.—As quickly as possible after  
18 the date a majority of members of MedPAC are first  
19 appointed, the Comptroller General, in consultation  
20 with the Prospective Payment Assessment Commis-  
21 sion (in this subsection referred to as “ProPAC”) and  
22 the Physician Payment Review Commission (in  
23 this subsection referred to as “PPRC”), shall pro-  
24 vide for the termination of the ProPAC and the  
25 PPRC. As of the date of termination of the respec-

1       tive Commissions, the amendments made by para-  
2       graphs (1) and (2), respectively, of subsection (b)  
3       become effective. The Comptroller General, to the  
4       extent feasible, shall provide for the transfer to the  
5       MedPAC of assets and staff of the ProPAC and the  
6       PPRC, without any loss of benefits or seniority by  
7       virtue of such transfers. Fund balances available to  
8       the ProPAC or the PPRC for any period shall be  
9       available to the MedPAC for such period for like  
10      purposes.

11           (3) CONTINUING RESPONSIBILITY FOR RE-  
12      PORTS.—The MedPAC shall be responsible for the  
13      preparation and submission of reports required by  
14      law to be submitted (and which have not been sub-  
15      mitted by the date of establishment of the MedPAC)  
16      by the ProPAC and the PPRC, and, for this pur-  
17      pose, any reference in law to either such Commission  
18      is deemed, after the appointment of the MedPAC, to  
19      refer to the MedPAC.

## 20      **CHAPTER 4—MEDIGAP PROTECTIONS**

### 21      **SEC. 4031. MEDIGAP PROTECTIONS.**

22           (a) GUARANTEEING ISSUE WITHOUT PREEXISTING  
23      CONDITIONS FOR CONTINUOUSLY COVERED INDIVID-  
24      UALS.—Section 1882(s) (42 U.S.C. 1395ss(s)) is amend-  
25      ed—

1           (1) in paragraph (3), by striking “paragraphs  
2           (1) and (2)” and inserting “this subsection”,

3           (2) by redesignating paragraph (3) as para-  
4           graph (4), and

5           (3) by inserting after paragraph (2) the follow-  
6           ing new paragraph:

7           “(3)(A) The issuer of a medicare supplemental pol-  
8           icy—

9           “(i) may not deny or condition the issuance or  
10          effectiveness of a medicare supplemental policy de-  
11          scribed in subparagraph (C) that is offered and is  
12          available for issuance to new enrollees by such is-  
13          suer;

14          “(ii) may not discriminate in the pricing of  
15          such policy, because of health status, claims experi-  
16          ence, receipt of health care, or medical condition;  
17          and

18          “(iii) may not impose an exclusion of benefits  
19          based on a pre-existing condition under such policy,  
20          in the case of an individual described in subparagraph (B)  
21          who seeks to enroll under the policy not later than 63 days  
22          after the date of the termination of enrollment described  
23          in such subparagraph and who submits evidence of the  
24          date of termination or disenrollment along with the appli-  
25          cation for such medicare supplemental policy.

1       “(B) An individual described in this subparagraph is  
2 an individual described in any of the following clauses:

3           “(i) The individual is enrolled under an em-  
4 ployee welfare benefit plan that provides health ben-  
5 efits that supplement the benefits under this title  
6 and the plan terminates or ceases to provide all such  
7 supplemental health benefits to the individual.

8           “(ii) The individual is enrolled with a  
9 MedicarePlus organization under a MedicarePlus  
10 plan under part C, and there are circumstances per-  
11 mitting discontinuance of the individual’s election of  
12 the plan under section 1851(e)(4).

13           “(iii) The individual is enrolled with an eligible  
14 organization under a contract under section 1876, a  
15 similar organization operating under demonstration  
16 project authority, with an organization under an  
17 agreement under section 1833(a)(1)(A), or with an  
18 organization under a policy described in subsection  
19 (t), and such enrollment ceases under the same cir-  
20 cumstances that would permit discontinuance of an  
21 individual’s election of coverage under section  
22 1851(e)(4) and, in the case of a policy described in  
23 subsection (t), there is no provision under applicable  
24 State law for the continuation of coverage under  
25 such policy.



1           “(iv) The individual is enrolled under a medi-  
2           care supplemental policy under this section and such  
3           enrollment ceases because—

4                   “(I) of the bankruptcy or insolvency of the  
5           issuer or because of other involuntary termi-  
6           nation of coverage or enrollment under such  
7           policy and there is no provision under applica-  
8           ble State law for the continuation of such cov-  
9           erage;

10                   “(II) the issuer of the policy substantially  
11           violated a material provision of the policy; or

12                   “(III) the issuer (or an agent or other en-  
13           tity acting on the issuer’s behalf) materially  
14           misrepresented the policy’s provisions in mar-  
15           keting the policy to the individual.

16           “(v) The individual—

17                   “(I) was enrolled under a medicare supple-  
18           mental policy under this section,

19                   “(II) subsequently terminates such enroll-  
20           ment and enrolls, for the first time, with any  
21           MedicarePlus organization under a  
22           MedicarePlus plan under part C, any eligible  
23           organization under a contract under section  
24           1876, any similar organization operating under  
25           demonstration project authority, any organiza-

1           tion under an agreement under section  
2           1833(a)(1)(A), or any policy described in sub-  
3           section (t), and

4           “(III) the subsequent enrollment under  
5           subclause (II) is terminated by the enrollee dur-  
6           ing the first 6 months (or 3 months for termi-  
7           nations occurring on or after January 1, 2003)  
8           of such enrollment.

9           “(vi) The individual—

10           “(I) was enrolled under a medicare supple-  
11           mental policy under this section,

12           “(II) subsequently terminates such enroll-  
13           ment and enrolls, for the first time, during or  
14           after the annual, coordinated election period  
15           under section 1851(e)(3)(B) occurring during  
16           2002, with an organization or policy described  
17           in clause (v)(II), and

18           “(III) the subsequent enrollment under  
19           subclause (II) is terminated by the enrollee dur-  
20           ing the next annual, coordinated election period  
21           under such section.

22           “(C)(i) Subject to clauses (ii) and (iii), a medicare  
23           supplemental policy described in this subparagraph has a  
24           benefit package classified as ‘A’, ‘B’, ‘C’, or ‘F’ under the  
25           standards established under subsection (p)(2).

1       “(ii) Only for purposes of an individual described in  
2 subparagraph (B)(v), a medicare supplemental policy de-  
3 scribed in this subparagraph also includes (if available  
4 from the same issuer) the same medicare supplemental  
5 policy referred to in such subparagraph in which the indi-  
6 vidual was most recently previously enrolled.

7       “(iii) For purposes of applying this paragraph in the  
8 case of a State that provides for offering of benefit pack-  
9 ages other than under the classification referred to in  
10 clause (i), the references to benefit packages in such clause  
11 are deemed references to comparable benefit packages of-  
12 fered in such State.

13       “(D) At the time of an event described in subpara-  
14 graph (B) because of which an individual ceases enroll-  
15 ment or loses coverage or benefits under a contract or  
16 agreement, policy, or plan, the organization that offers the  
17 contract or agreement, the insurer offering the policy, or  
18 the administrator of the plan, respectively, shall notify the  
19 individual of the rights of the individual, and obligations  
20 of issuers of medicare supplemental policies, under sub-  
21 paragraph (A).”.

22       (b) LIMITATION ON IMPOSITION OF PREEXISTING  
23 CONDITION EXCLUSION DURING INITIAL OPEN ENROLL-  
24 MENT PERIOD.—Section 1882(s)(2) (42 U.S.C.  
25 1395ss(s)(2)) is amended—

1           (1) in subparagraph (B), by striking “subpara-  
2           graph (C)” and inserting “subparagraphs (C) and  
3           (D)”, and

4           (2) by adding at the end the following new sub-  
5           paragraph:

6           “(D) In the case of a policy issued during the 6-  
7           month period described in subparagraph (A) to an individ-  
8           ual who is 65 years of age or older as of the date of issu-  
9           ance and who as of the date of the application for enroll-  
10          ment has a continuous period of creditable coverage (as  
11          defined in 2701(c) of the Public Health Service Act) of—

12           “(i) at least 6 months, the policy may not ex-  
13          clude benefits based on a pre-existing condition; or

14           “(ii) of less than 6 months, if the policy ex-  
15          cludes benefits based on a preexisting condition, the  
16          policy shall reduce the period of any preexisting con-  
17          dition exclusion by the aggregate of the periods of  
18          creditable coverage (if any, as so defined) applicable  
19          to the individual as of the enrollment date.

20          The Secretary shall specify the manner of the reduction  
21          under clause (ii), based upon the rules used by the Sec-  
22          retary in carrying out section 2701(a)(3) of such Act.”.

23          (c) EFFECTIVE DATES.—

1           (1) GUARANTEED ISSUE.—The amendment  
2           made by subsection (a) shall take effect on July 1,  
3           1998.

4           (2) LIMIT ON PREEXISTING CONDITION EXCLU-  
5           SIONS.—The amendment made by subsection (b)  
6           shall apply to policies issued on or after July 1,  
7           1998.

8           (d) TRANSITION PROVISIONS.—

9           (1) IN GENERAL.—If the Secretary of Health  
10          and Human Services identifies a State as requiring  
11          a change to its statutes or regulations to conform its  
12          regulatory program to the changes made by this sec-  
13          tion, the State regulatory program shall not be con-  
14          sidered to be out of compliance with the require-  
15          ments of section 1882 of the Social Security Act due  
16          solely to failure to make such change until the date  
17          specified in paragraph (4).

18          (2) NAIC STANDARDS.—If, within 9 months  
19          after the date of the enactment of this Act, the Na-  
20          tional Association of Insurance Commissioners (in  
21          this subsection referred to as the “NAIC”) modifies  
22          its NAIC Model Regulation relating to section 1882  
23          of the Social Security Act (referred to in such sec-  
24          tion as the 1991 NAIC Model Regulation, as modi-  
25          fied pursuant to section 171(m)(2) of the Social Se-

1 security Act Amendments of 1994 (Public Law 103–  
2 432) and as modified pursuant to section  
3 1882(d)(3)(A)(vi)(IV) of the Social Security Act, as  
4 added by section 271(a) of the Health Insurance  
5 Portability and Accountability Act of 1996 (Public  
6 Law 104–191) to conform to the amendments made  
7 by this section, such revised regulation incorporating  
8 the modifications shall be considered to be the appli-  
9 cable NAIC model regulation (including the revised  
10 NAIC model regulation and the 1991 NAIC Model  
11 Regulation) for the purposes of such section.

12 (3) SECRETARY STANDARDS.—If the NAIC  
13 does not make the modifications described in para-  
14 graph (2) within the period specified in such para-  
15 graph, the Secretary of Health and Human Services  
16 shall make the modifications described in such para-  
17 graph and such revised regulation incorporating the  
18 modifications shall be considered to be the appro-  
19 priate Regulation for the purposes of such section.

20 (4) DATE SPECIFIED.—

21 (A) IN GENERAL.—Subject to subpara-  
22 graph (B), the date specified in this paragraph  
23 for a State is the earlier of—

24 (i) the date the State changes its stat-  
25 utes or regulations to conform its regu-

1 latory program to the changes made by  
2 this section, or

3 (ii) 1 year after the date the NAIC or  
4 the Secretary first makes the modifications  
5 under paragraph (2) or (3), respectively.

6 (B) ADDITIONAL LEGISLATIVE ACTION RE-  
7 QUIRED.—In the case of a State which the Sec-  
8 retary identifies as—

9 (i) requiring State legislation (other  
10 than legislation appropriating funds) to  
11 conform its regulatory program to the  
12 changes made in this section, but

13 (ii) having a legislature which is not  
14 scheduled to meet in 1999 in a legislative  
15 session in which such legislation may be  
16 considered,

17 the date specified in this paragraph is the first  
18 day of the first calendar quarter beginning after  
19 the close of the first legislative session of the  
20 State legislature that begins on or after July 1,  
21 1999. For purposes of the previous sentence, in  
22 the case of a State that has a 2-year legislative  
23 session, each year of such session shall be  
24 deemed to be a separate regular session of the  
25 State legislature.

1 **SEC. 4032. MEDICARE PREPAID COMPETITIVE PRICING**  
2 **DEMONSTRATION PROJECT.**

3 (a) ESTABLISHMENT OF PROJECT.—The Secretary  
4 of Health and Human Services shall provide, beginning  
5 not later than 1 year after the date of the enactment of  
6 this Act, for implementation of a project (in this section  
7 referred to as the “project”) to demonstrate the applica-  
8 tion of, and the consequences of applying, a market-ori-  
9 ented pricing system for the provision of a full range of  
10 medicare benefits in a geographic area.

11 (b) RESEARCH DESIGN ADVISORY COMMITTEE.—

12 (1) IN GENERAL.—Before implementing the  
13 project under this section, the Secretary shall ap-  
14 point a national advisory committee, including inde-  
15 pendent actuaries and individuals with expertise in  
16 competitive health plan pricing, to make rec-  
17 ommendations to the Secretary concerning the ap-  
18 propriate research design for implementing the  
19 project.

20 (2) INITIAL RECOMMENDATIONS.—The commit-  
21 tee initially shall submit recommendations respecting  
22 the method for area selection, benefit design among  
23 plans offered, structuring choice among health plans  
24 offered, methods for setting the price to be paid to  
25 plans, collection of plan information (including infor-  
26 mation concerning quality and access to care), infor-



1 mation dissemination, and methods of evaluating the  
2 results of the project.

3 (3) **ADVICE DURING IMPLEMENTATION.**—Upon  
4 implementation of the project, the committee shall  
5 continue to advise the Secretary on the application  
6 of the design in different areas and changes in the  
7 project based on experience with its operations.

8 (c) **AREA SELECTION.**—

9 (1) **IN GENERAL.**—Taking into account the rec-  
10 ommendations of the advisory committee submitted  
11 under subsection (b), the Secretary shall designate  
12 areas in which the project will operate.

13 (2) **APPOINTMENT OF AREA ADVISORY COMMIT-**  
14 **TEE.**—Upon the designation of an area for inclusion  
15 in the project, the Secretary shall appoint an area  
16 advisory committee, composed of representatives of  
17 health plans, providers, and medicare beneficiaries in  
18 the area, to advise the Secretary concerning how the  
19 project will actually be implemented in the area.  
20 Such advice may include advice concerning the mar-  
21 keting and pricing of plans in the area and other sa-  
22 lient factors relating.

23 (d) **MONITORING AND REPORT.**—

24 (1) **MONITORING IMPACT.**—Taking into consid-  
25 eration the recommendations of the general advisory

1 committee (appointed under subsection (b)), the Sec-  
2 retary shall closely monitor the impact of projects in  
3 areas on the price and quality of, and access to,  
4 medicare covered services, choice of health plan,  
5 changes in enrollment, and other relevant factors.

6 (2) REPORT.—The Secretary shall periodically  
7 report to Congress on the progress under the project  
8 under this section.

9 (e) WAIVER AUTHORITY.—The Secretary of Health  
10 and Human Services may waive such requirements of sec-  
11 tion 1876 (and such requirements of part C of title XVIII,  
12 as amended by chapter 1), of the Social Security Act as  
13 may be necessary for the purposes of carrying out the  
14 project.

15 (f) RELATIONSHIP TO OTHER AUTHORITY.—Except  
16 pursuant to this section the Secretary of Health and  
17 Human Services may not conduct or continue any medi-  
18 care demonstration project relating to payment of health  
19 maintenance organizations, MedicarePlus organizations,  
20 or similar prepaid managed care entities on the basis of  
21 a competitive bidding process or pricing system described  
22 in subsection (a) rather than on the bases described in  
23 section 1853 or 1876 of the Social Security Act.

## 1 **Subtitle B—Prevention Initiatives**

### 2 **SEC. 4101. SCREENING MAMMOGRAPHY.**

3 (a) PROVIDING ANNUAL SCREENING MAMMOGRAPHY  
4 FOR WOMEN OVER AGE 39.—Section 1834(c)(2)(A) (42  
5 U.S.C. 1395m(c)(2)(A)) is amended—

6 (1) in clause (iii), to read as follows:

7 “(iii) In the case of a woman over 39  
8 years of age, payment may not be made  
9 under this part for screening mammo-  
10 graphy performed within 11 months follow-  
11 ing the month in which a previous screen-  
12 ing mammography was performed.”; and

13 (2) by striking clauses (iv) and (v).

14 (b) WAIVER OF DEDUCTIBLE.—The first sentence of  
15 section 1833(b) (42 U.S.C. 1395l(b)) is amended—

16 (1) by striking “and” before “(4)”, and

17 (2) by inserting before the period at the end the  
18 following: “, and (5) such deductible shall not apply  
19 with respect to screening mammography (as de-  
20 scribed in section 1861(jj))”.

21 (c) CONFORMING AMENDMENT.—Section  
22 1834(c)(1)(C) of such Act (42 U.S.C. 1395m(c)(1)(C)) is  
23 amended by striking “, subject to the deductible estab-  
24 lished under section 1833(b),”.

1 (d) EFFECTIVE DATE.—The amendments made by  
2 this section shall apply to items and services furnished on  
3 or after January 1, 1998.

4 **SEC. 4102. SCREENING PAP SMEAR AND PELVIC EXAMS.**

5 (a) COVERAGE OF PELVIC EXAM; INCREASING FRE-  
6 QUENCY OF COVERAGE OF PAP SMEAR.—Section  
7 1861(nn) (42 U.S.C. 1395x(nn)) is amended—

8 (1) in the heading, by striking “Smear” and in-  
9 serting “Smear; Screening Pelvic Exam”;

10 (2) by inserting “or vaginal” after “cervical”  
11 each place it appears;

12 (3) by striking “(nn)” and inserting “(nn)(1)”;

13 (4) by striking “3 years” and all that follows  
14 and inserting “3 years, or during the preceding year  
15 in the case of a woman described in paragraph (3).”;  
16 and

17 (5) by adding at the end the following new  
18 paragraphs:

19 “(2) The term ‘screening pelvic exam’ means an pel-  
20 vic examination provided to a woman if the woman in-  
21 volved has not had such an examination during the preced-  
22 ing 3 years, or during the preceding year in the case of  
23 a woman described in paragraph (3), and includes a clini-  
24 cal breast examination.

1 “(3) A woman described in this paragraph is a  
2 woman who—

3 “(A) is of childbearing age and has not had a  
4 test described in this subsection during each of the  
5 preceding 3 years that did not indicate the presence  
6 of cervical or vaginal cancer; or

7 “(B) is at high risk of developing cervical or  
8 vaginal cancer (as determined pursuant to factors  
9 identified by the Secretary).”.

10 (b) WAIVER OF DEDUCTIBLE.—The first sentence of  
11 section 1833(b) (42 U.S.C. 1395l(b)), as amended by sec-  
12 tion 4101(b), is amended—

13 (1) by striking “and” before “(5)”, and

14 (2) by inserting before the period at the end the  
15 following: “, and (6) such deductible shall not apply  
16 with respect to screening pap smear and screening  
17 pelvic exam (as described in section 1861(nn))”.

18 (c) CONFORMING AMENDMENTS.—Sections  
19 1861(s)(14) and 1862(a)(1)(F) (42 U.S.C. 1395x(s)(14),  
20 1395y(a)(1)(F)) are each amended by inserting “and  
21 screening pelvic exam” after “screening pap smear”.

22 (d) PAYMENT UNDER PHYSICIAN FEE SCHEDULE.—  
23 Section 1848(j)(3)(42 U.S.C. 1395w-4(j)(3)) is amended  
24 by striking “and (4)” and inserting “, (4) and (14) (with  
25 respect to services described in section 1861(nn)(2))”.

1 (e) EFFECTIVE DATE.—The amendments made by  
2 this section shall apply to items and services furnished on  
3 or after January 1, 1998.

4 (f) REPORT ON RESCREENING PAP SMEARS.—Not  
5 later than 6 months after the date of the enactment of  
6 this Act, the Secretary of Health and Human Services  
7 shall submit to Congress a report on the extent to which  
8 the use of supplemental computer-assisted diagnostic tests  
9 consisting of interactive automated computer-imaging of  
10 an exfoliative cytology test, in conjunction with the pap  
11 smears, improves the early detection of cervical or vaginal  
12 cancer and the costs implications for coverage of such sup-  
13 plemental tests under the medicare program.

14 **SEC. 4103. PROSTATE CANCER SCREENING TESTS.**

15 (a) COVERAGE.—Section 1861 (42 U.S.C. 1395x) is  
16 amended—

17 (1) in subsection (s)(2)—

18 (A) by striking “and” at the end of sub-  
19 paragraphs (N) and (O), and

20 (B) by inserting after subparagraph (O)  
21 the following new subparagraph:

22 “(P) prostate cancer screening tests (as defined  
23 in subsection (oo)); and”; and

24 (2) by adding at the end the following new sub-  
25 section:

## 1                   “Prostate Cancer Screening Tests

2           “(oo)(1) The term ‘prostate cancer screening test’  
3 means a test that consists of any (or all) of the procedures  
4 described in paragraph (2) provided for the purpose of  
5 early detection of prostate cancer to a man over 50 years  
6 of age who has not had such a test during the preceding  
7 year.

8           “(2) The procedures described in this paragraph are  
9 as follows:

10                   “(A) A digital rectal examination.

11                   “(B) A prostate-specific antigen blood test.

12                   “(C) For years beginning after 2001, such  
13 other procedures as the Secretary finds appropriate  
14 for the purpose of early detection of prostate cancer,  
15 taking into account changes in technology and  
16 standards of medical practice, availability, effective-  
17 ness, costs, and such other factors as the Secretary  
18 considers appropriate.”.

19           (b) PAYMENT FOR PROSTATE-SPECIFIC ANTIGEN  
20 BLOOD TEST UNDER CLINICAL DIAGNOSTIC LABORA-  
21 TORY TEST FEE SCHEDULES.—Section 1833(h)(1)(A)  
22 (42 U.S.C. 1395l(h)(1)(A)) is amended by inserting after  
23 “laboratory tests” the following: “(including prostate can-  
24 cer screening tests under section 1861(oo) consisting of  
25 prostate-specific antigen blood tests)”.

1 (c) CONFORMING AMENDMENT.—Section 1862(a)  
2 (42 U.S.C. 1395y(a)) is amended—

3 (1) in paragraph (1)—

4 (A) in subparagraph (E), by striking  
5 “and” at the end,

6 (B) in subparagraph (F), by striking the  
7 semicolon at the end and inserting “, and”, and

8 (C) by adding at the end the following new  
9 subparagraph:

10 “(G) in the case of prostate cancer screening  
11 tests (as defined in section 1861(oo)), which are per-  
12 formed more frequently than is covered under such  
13 section;”; and

14 (2) in paragraph (7), by striking “paragraph  
15 (1)(B) or under paragraph (1)(F)” and inserting  
16 “subparagraphs (B), (F), or (G) of paragraph (1)”.

17 (d) PAYMENT UNDER PHYSICIAN FEE SCHEDULE.—  
18 Section 1848(j)(3)(42 U.S.C. 1395w-4(j)(3)), as amended  
19 by section 4102, is amended by inserting “(2)(P) (with  
20 respect to services described in subparagraphs (A) and (C)  
21 of section 1861(oo),” after “(2)(G)”

22 (e) EFFECTIVE DATE.—The amendments made by  
23 this section shall apply to items and services furnished on  
24 or after January 1, 1998.



1 **SEC. 4104. COVERAGE OF COLORECTAL SCREENING.**

2 (a) COVERAGE.—

3 (1) IN GENERAL.—Section 1861 (42 U.S.C.  
4 1395x), as amended by section 4103(a), is amend-  
5 ed—

6 (A) in subsection (s)(2)—

7 (i) by striking “and” at the end of  
8 subparagraph (P);

9 (ii) by adding “and” at the end of  
10 subparagraph (Q); and

11 (iii) by adding at the end the follow-  
12 ing new subparagraph:

13 “(R) colorectal cancer screening tests (as de-  
14 fined in subsection (pp)); and”; and

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

17 “Colorectal Cancer Screening Tests

18 “(pp)(1) The term ‘colorectal cancer screening test’  
19 means any of the following procedures furnished to an in-  
20 dividual for the purpose of early detection of colorectal  
21 cancer:

22 “(A) Screening fecal-occult blood test.

23 “(B) Screening flexible sigmoidoscopy.

24 “(C) In the case of an individual at high risk  
25 for colorectal cancer, screening colonoscopy.

1           “(D) Screening barium enema, if found by the  
2           Secretary to be an appropriate alternative to screen-  
3           ing flexible sigmoidoscopy under subparagraph (B)  
4           or screening colonoscopy under subparagraph (C).

5           “(E) For years beginning after 2002, such  
6           other procedures as the Secretary finds appropriate  
7           for the purpose of early detection of colorectal can-  
8           cer, taking into account changes in technology and  
9           standards of medical practice, availability, effective-  
10          ness, costs, and such other factors as the Secretary  
11          considers appropriate.

12          “(2) In paragraph (1)(C), an ‘individual at high risk  
13          for colorectal cancer’ is an individual who, because of fam-  
14          ily history, prior experience of cancer or precursor neo-  
15          plastic polyps, a history of chronic digestive disease condi-  
16          tion (including inflammatory bowel disease, Crohn’s Dis-  
17          ease, or ulcerative colitis), the presence of any appropriate  
18          recognized gene markers for colorectal cancer, or other  
19          predisposing factors, faces a high risk for colorectal can-  
20          cer.”.

21                 (2) DEADLINE FOR DECISION ON COVERAGE OF  
22                 SCREENING BARIUM ENEMA.—Not later than 2  
23                 years after the date of the enactment of this section,  
24                 the Secretary of Health and Human Services shall  
25                 issue and publish a determination on the treatment

1 of screening barium enema as a colorectal cancer  
2 screening test under section 1861(pp) (as added by  
3 subparagraph (B)) as an alternative procedure to a  
4 screening flexible sigmoidoscopy or screening  
5 colonoscopy.

6 (b) FREQUENCY AND PAYMENT LIMITS.—

7 (1) IN GENERAL.—Section 1834 (42 U.S.C.  
8 1395m) is amended by inserting after subsection (c)  
9 the following new subsection:

10 “(d) FREQUENCY AND PAYMENT LIMITS FOR  
11 COLORECTAL CANCER SCREENING TESTS.—

12 “(1) SCREENING FECAL-OCCULT BLOOD  
13 TESTS.—

14 “(A) PAYMENT LIMIT.—In establishing fee  
15 schedules under section 1833(h) with respect to  
16 colorectal cancer screening tests consisting of  
17 screening fecal-occult blood tests, except as pro-  
18 vided by the Secretary under paragraph (4)(A),  
19 the payment amount established for tests per-  
20 formed—

21 “(i) in 1998 shall not exceed \$5; and

22 “(ii) in a subsequent year, shall not  
23 exceed the limit on the payment amount  
24 established under this subsection for such  
25 tests for the preceding year, adjusted by

1 the applicable adjustment under section  
2 1833(h) for tests performed in such year.

3 “(B) FREQUENCY LIMIT.—Subject to revision  
4 sion by the Secretary under paragraph (4)(B),  
5 no payment may be made under this part for  
6 colorectal cancer screening test consisting of a  
7 screening fecal-occult blood test—

8 “(i) if the individual is under 50 years  
9 of age; or

10 “(ii) if the test is performed within  
11 the 11 months after a previous screening  
12 fecal-occult blood test.

13 “(2) SCREENING FLEXIBLE  
14 SIGMOIDOSCOPIES.—

15 “(A) FEE SCHEDULE.—The Secretary  
16 shall establish a payment amount under section  
17 1848 with respect to colorectal cancer screening  
18 tests consisting of screening flexible  
19 sigmoidoscopies that is consistent with payment  
20 amounts under such section for similar or relat-  
21 ed services, except that such payment amount  
22 shall be established without regard to sub-  
23 section (a)(2)(A) of such section.

24 “(B) PAYMENT LIMIT.—In the case of  
25 screening flexible sigmoidoscopy services—

1           “(i) the payment amount may not ex-  
2           ceed such amount as the Secretary speci-  
3           fies, based upon the rates recognized under  
4           this part for diagnostic flexible  
5           sigmoidoscopy services; and

6           “(ii) that, in accordance with regula-  
7           tions, may be performed in an ambulatory  
8           surgical center and for which the Secretary  
9           permits ambulatory surgical center pay-  
10          ments under this part and that are per-  
11          formed in an ambulatory surgical center or  
12          hospital outpatient department, the pay-  
13          ment amount under this part may not ex-  
14          ceed the lesser of (I) the payment rate that  
15          would apply to such services if they were  
16          performed in a hospital outpatient depart-  
17          ment, or (II) the payment rate that would  
18          apply to such services if they were per-  
19          formed in an ambulatory surgical center.

20          “(C) SPECIAL RULE FOR DETECTED LE-  
21          SIONS.—If during the course of such screening  
22          flexible sigmoidoscopy, a lesion or growth is de-  
23          tected which results in a biopsy or removal of  
24          the lesion or growth, payment under this part  
25          shall not be made for the screening flexible

1 sigmoidoscopy but shall be made for the proce-  
2 dure classified as a flexible sigmoidoscopy with  
3 such biopsy or removal.

4 “(D) FREQUENCY LIMIT.—Subject to revi-  
5 sion by the Secretary under paragraph (4)(B),  
6 no payment may be made under this part for  
7 a colorectal cancer screening test consisting of  
8 a screening flexible sigmoidoscopy—

9 “(i) if the individual is under 50 years  
10 of age; or

11 “(ii) if the procedure is performed  
12 within the 47 months after a previous  
13 screening flexible sigmoidoscopy.

14 “(3) SCREENING COLONOSCOPY FOR INDIVID-  
15 UALS AT HIGH RISK FOR COLORECTAL CANCER.—

16 “(A) FEE SCHEDULE.—The Secretary  
17 shall establish a payment amount under section  
18 1848 with respect to colorectal cancer screening  
19 test consisting of a screening colonoscopy for  
20 individuals at high risk for colorectal cancer (as  
21 defined in section 1861(pp)(2)) that is consist-  
22 ent with payment amounts under such section  
23 for similar or related services, except that such  
24 payment amount shall be established without  
25 regard to subsection (a)(2)(A) of such section.

1           “(B) PAYMENT LIMIT.—In the case of  
2 screening colonoscopy services—

3           “(i) the payment amount may not ex-  
4 ceed such amount as the Secretary speci-  
5 fies, based upon the rates recognized under  
6 this part for diagnostic colonoscopy serv-  
7 ices; and

8           “(ii) that are performed in an ambula-  
9 tory surgical center or hospital outpatient  
10 department, the payment amount under  
11 this part may not exceed the lesser of (I)  
12 the payment rate that would apply to such  
13 services if they were performed in a hos-  
14 pital outpatient department, or (II) the  
15 payment rate that would apply to such  
16 services if they were performed in an am-  
17 bulatory surgical center.

18           “(C) SPECIAL RULE FOR DETECTED LE-  
19 SIONS.—If during the course of such screening  
20 colonoscopy, a lesion or growth is detected  
21 which results in a biopsy or removal of the le-  
22 sion or growth, payment under this part shall  
23 not be made for the screening colonoscopy but  
24 shall be made for the procedure classified as a  
25 colonoscopy with such biopsy or removal.

1           “(D) FREQUENCY LIMIT.—Subject to revi-  
2           sion by the Secretary under paragraph (4)(B),  
3           no payment may be made under this part for  
4           a colorectal cancer screening test consisting of  
5           a screening colonoscopy for individuals at high  
6           risk for colorectal cancer if the procedure is  
7           performed within the 23 months after a pre-  
8           vious screening colonoscopy.

9           “(4) REDUCTIONS IN PAYMENT LIMIT AND RE-  
10          VISION OF FREQUENCY.—

11           “(A) REDUCTIONS IN PAYMENT LIMIT FOR  
12          SCREENING FECAL-OCCULT BLOOD TESTS.—  
13          The Secretary shall review from time to time  
14          the appropriateness of the amount of the pay-  
15          ment limit established for screening fecal-occult  
16          blood tests under paragraph (1)(A). The Sec-  
17          retary may, with respect to tests performed in  
18          a year after 2000, reduce the amount of such  
19          limit as it applies nationally or in any area to  
20          the amount that the Secretary estimates is re-  
21          quired to assure that such tests of an appro-  
22          priate quality are readily and conveniently  
23          available during the year.

24           “(B) REVISION OF FREQUENCY.—



1           “(i) REVIEW.—The Secretary shall re-  
2 view periodically the appropriate frequency  
3 for performing colorectal cancer screening  
4 tests based on age and such other factors  
5 as the Secretary believes to be pertinent.

6           “(ii) REVISION OF FREQUENCY.—The  
7 Secretary, taking into consideration the re-  
8 view made under clause (i), may revise  
9 from time to time the frequency with  
10 which such tests may be paid for under  
11 this subsection, but no such revision shall  
12 apply to tests performed before January 1,  
13 2001.

14           “(5) LIMITING CHARGES OF NONPARTICIPATING  
15 PHYSICIANS.—

16           “(A) IN GENERAL.—In the case of a  
17 colorectal cancer screening test consisting of a  
18 screening flexible sigmoidoscopy or a screening  
19 colonoscopy provided to an individual at high  
20 risk for colorectal cancer for which payment  
21 may be made under this part, if a nonpartici-  
22 pating physician provides the procedure to an  
23 individual enrolled under this part, the physi-  
24 cian may not charge the individual more than

1 the limiting charge (as defined in section  
2 1848(g)(2)).

3 “(B) ENFORCEMENT.—If a physician or  
4 supplier knowing and willfully imposes a charge  
5 in violation of subparagraph (A), the Secretary  
6 may apply sanctions against such physician or  
7 supplier in accordance with section  
8 1842(j)(2).”.

9 (2) SPECIAL RULE FOR SCREENING BARIUM  
10 ENEMA.—If the Secretary of Health and Human  
11 Services issues a determination under subsection  
12 (a)(2) that screening barium enema should be cov-  
13 ered as a colorectal cancer screening test under sec-  
14 tion 1861(pp) (as added by subsection (a)(1)(B)),  
15 the Secretary shall establish frequency limits (in-  
16 cluding revisions of frequency limits) for such proce-  
17 dure consistent with the frequency limits for other  
18 colorectal cancer screening tests under section  
19 1834(d) (as added by subsection (b)(1)), and shall  
20 establish payment limits (including limits on charges  
21 of nonparticipating physicians) for such procedure  
22 consistent with the payment limits under part B of  
23 title XVIII for diagnostic barium enema procedures.

24 (c) CONFORMING AMENDMENTS.—(1) Paragraphs  
25 (1)(D) and (2)(D) of section 1833(a) (42 U.S.C. 1395l(a))

1 are each amended by inserting “or section 1834(d)(1)”  
2 after “subsection (h)(1)”.

3 (2) Section 1833(h)(1)(A) (42 U.S.C.  
4 1395l(h)(1)(A)) is amended by striking “The Secretary”  
5 and inserting “Subject to paragraphs (1) and (4)(A) of  
6 section 1834(d), the Secretary”.

7 (3) Clauses (i) and (ii) of section 1848(a)(2)(A) (42  
8 U.S.C. 1395w-4(a)(2)(A)) are each amended by inserting  
9 after “a service” the following: “(other than a colorectal  
10 cancer screening test consisting of a screening colonoscopy  
11 provided to an individual at high risk for colorectal cancer  
12 or a screening flexible sigmoidoscopy)”.

13 (4) Section 1862(a) (42 U.S.C. 1395y(a)), as amend-  
14 ed by section 4103(c), is amended—

15 (A) in paragraph (1)—

16 (i) in subparagraph (F), by striking “and”  
17 at the end,

18 (ii) in subparagraph (G), by striking the  
19 semicolon at the end and inserting “, and”, and

20 (iii) by adding at the end the following new  
21 subparagraph:

22 “(H) in the case of colorectal cancer screening  
23 tests, which are performed more frequently than is  
24 covered under section 1834(d);”; and

1 (B) in paragraph (7), by striking “or (G)” and  
2 inserting “(G), or (H)”.

3 (d) EFFECTIVE DATE.—The amendments made by  
4 this section shall apply to items and services furnished on  
5 or after January 1, 1998.

6 **SEC. 4105. DIABETES SCREENING TESTS.**

7 (a) COVERAGE OF DIABETES OUTPATIENT SELF-  
8 MANAGEMENT TRAINING SERVICES.—

9 (1) IN GENERAL.—Section 1861 (42 U.S.C.  
10 1395x), as amended by sections 4103(a) and  
11 4104(a), is amended—

12 (A) in subsection (s)(2)—

13 (i) by striking “and” at the end of  
14 subparagraph (Q);

15 (ii) by adding “and” at the end of  
16 subparagraph (R); and

17 (iii) by adding at the end the follow-  
18 ing new subparagraph:

19 “(S) diabetes outpatient self-management train-  
20 ing services (as defined in subsection (qq)); and”;  
21 and

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

1 “Diabetes Outpatient Self-Management Training Services

2 “(qq)(1) The term ‘diabetes outpatient self-manage-  
3 ment training services’ means educational and training  
4 services furnished to an individual with diabetes by a cer-  
5 tified provider (as described in paragraph (2)(A)) in an  
6 outpatient setting by an individual or entity who meets  
7 the quality standards described in paragraph (2)(B), but  
8 only if the physician who is managing the individual’s dia-  
9 betic condition certifies that such services are needed  
10 under a comprehensive plan of care related to the individ-  
11 ual’s diabetic condition to provide the individual with nec-  
12 essary skills and knowledge (including skills related to the  
13 self-administration of injectable drugs) to participate in  
14 the management of the individual’s condition.

15 “(2) In paragraph (1)—

16 “(A) a ‘certified provider’ is a physician, or  
17 other individual or entity designated by the Sec-  
18 retary, that, in addition to providing diabetes out-  
19 patient self-management training services, provides  
20 other items or services for which payment may be  
21 made under this title; and

22 “(B) a physician, or such other individual or  
23 entity, meets the quality standards described in this  
24 paragraph if the physician, or individual or entity,  
25 meets quality standards established by the Sec-

1       retary, except that the physician or other individual  
2       or entity shall be deemed to have met such stand-  
3       ards if the physician or other individual or entity  
4       meets applicable standards originally established by  
5       the National Diabetes Advisory Board and subse-  
6       quently revised by organizations who participated in  
7       the establishment of standards by such Board, or is  
8       recognized by an organization that represents indi-  
9       viduals (including individuals under this title) with  
10      diabetes as meeting standards for furnishing the  
11      services.”.

12           (2) PAYMENT UNDER PHYSICIAN FEE SCHED-  
13      ULE.—Section 1848(j)(3)(42 U.S.C. 1395w-4(j)(3))  
14      as amended in sections 4102 and 4103, is amended  
15      by inserting “(2)(S),” before “(3),”.

16           (3) CONSULTATION WITH ORGANIZATIONS IN  
17      ESTABLISHING PAYMENT AMOUNTS FOR SERVICES  
18      PROVIDED BY PHYSICIANS.—In establishing payment  
19      amounts under section 1848 of the Social Security  
20      Act for physicians’ services consisting of diabetes  
21      outpatient self-management training services, the  
22      Secretary of Health and Human Services shall con-  
23      sult with appropriate organizations, including such  
24      organizations representing individuals or medicare  
25      beneficiaries with diabetes, in determining the rel-

1       ative value for such services under section  
2       1848(e)(2) of such Act.

3       (b) BLOOD-TESTING STRIPS FOR INDIVIDUALS WITH  
4       DIABETES.—

5               (1) INCLUDING STRIPS AND MONITORS AS DU-  
6       RABLE MEDICAL EQUIPMENT.—The first sentence of  
7       section 1861(n) (42 U.S.C. 1395x(n)) is amended by  
8       inserting before the semicolon the following: “, and  
9       includes blood-testing strips and blood glucose mon-  
10      itors for individuals with diabetes without regard to  
11      whether the individual has Type I or Type II diabe-  
12      tes or to the individual’s use of insulin (as deter-  
13      mined under standards established by the Secretary  
14      in consultation with the appropriate organizations)”.

15              (2) 10 PERCENT REDUCTION IN PAYMENTS FOR  
16      TESTING STRIPS.—Section 1834(a)(2)(B)(iv) (42  
17      U.S.C. 1395m(a)(2)(B)(iv)) is amended by adding  
18      before the period the following: “(reduced by 10 per-  
19      cent, in the case of a blood glucose testing strip fur-  
20      nished after 1997 for an individual with diabetes)”.

21       (c) ESTABLISHMENT OF OUTCOME MEASURES FOR  
22      BENEFICIARIES WITH DIABETES.—

23              (1) IN GENERAL.—The Secretary of Health and  
24      Human Services, in consultation with appropriate  
25      organizations, shall establish outcome measures, in-

1 including glycosylated hemoglobin (past 90-day average  
2 blood sugar levels), for purposes of evaluating the  
3 improvement of the health status of medicare bene-  
4 ficiaries with diabetes mellitus.

5 (2) RECOMMENDATIONS FOR MODIFICATIONS  
6 TO SCREENING BENEFITS.—Taking into account in-  
7 formation on the health status of medicare bene-  
8 ficiaries with diabetes mellitus as measured under  
9 the outcome measures established under subpara-  
10 graph (A), the Secretary shall from time to time  
11 submit recommendations to Congress regarding  
12 modifications to the coverage of services for such  
13 beneficiaries under the medicare program.

14 (d) EFFECTIVE DATE.—The amendments made by  
15 this section shall apply to items and services furnished on  
16 or after January 1, 1998.

17 **SEC. 4106. STANDARDIZATION OF MEDICARE COVERAGE OF**  
18 **BONE MASS MEASUREMENTS.**

19 (a) IN GENERAL.—Section 1861 (42 U.S.C. 1395x),  
20 as amended by sections 4103(a), 4104(a), 4105(a), is  
21 amended—

22 (1) in subsection (s)—

23 (A) in paragraph (12)(C), by striking  
24 “and” at the end,



1 (B) by striking the period at the end of  
2 paragraph (14) and inserting “; and”,

3 (C) by redesignating paragraphs (15) and  
4 (16) as paragraphs (16) and (17), respectively,  
5 and

6 (D) by inserting after paragraph (14) the  
7 following new paragraph:

8 “(15) bone mass measurement (as defined in  
9 subsection (rr)).”; and

10 (2) by inserting after subsection (qq) the follow-  
11 ing new subsection:

12 “Bone Mass Measurement

13 “(rr)(1) The term ‘bone mass measurement’ means  
14 a radiologic or radioisotopic procedure or other procedure  
15 approved by the Food and Drug Administration performed  
16 on a qualified individual (as defined in paragraph (2)) for  
17 the purpose of identifying bone mass or detecting bone  
18 loss or determining bone quality, and includes a physi-  
19 cian’s interpretation of the results of the procedure.

20 “(2) For purposes of this subsection, the term ‘quali-  
21 fied individual’ means an individual who is (in accordance  
22 with regulations prescribed by the Secretary)—

23 “(A) an estrogen-deficient woman at clinical  
24 risk for osteoporosis;

25 “(B) an individual with vertebral abnormalities;

1           “(C) an individual receiving long-term  
2 glucocorticoid steroid therapy;

3           “(D) an individual with primary  
4 hyperparathyroidism; or

5           “(E) an individual being monitored to assess  
6 the response to or efficacy of an approved  
7 osteoporosis drug therapy.

8           “(3) The Secretary shall establish such standards re-  
9 garding the frequency with which a qualified individual  
10 shall be eligible to be provided benefits for bone mass  
11 measurement under this title.”.

12           (b) PAYMENT UNDER PHYSICIAN FEE SCHEDULE.—  
13 Section 1848(j)(3) (42 U.S.C. 1395w-4(j)(3)), as amend-  
14 ed by sections 4102, 4103, and 4105, is amended—

15           (1) by striking “(4) and (14)” and inserting  
16 “(4), (14)” and

17           (2) by inserting “ and (15)” after  
18 “1861(mn)(2))”.

19           (c) CONFORMING AMENDMENTS.—Sections 1864(a),  
20 1902(a)(9)(C), and 1915(a)(1)(B)(ii)(I) (42 U.S.C.  
21 1395aa(a), 1396a(a)(9)(C), and 1396n(a)(1)(B)(ii)(I))  
22 are amended by striking “paragraphs (15) and (16)” each  
23 place it appears and inserting “paragraphs (16) and  
24 (17)”.

1 (d) EFFECTIVE DATE.—The amendments made by  
2 this section shall apply to bone mass measurements per-  
3 formed on or after July 1, 1998.

4 **SEC. 4107. VACCINES OUTREACH EXPANSION.**

5 (a) EXTENSION OF INFLUENZA AND PNEUMOCOCCAL  
6 VACCINATION CAMPAIGN.—In order to increase utilization  
7 of pneumococcal and influenza vaccines in medicare bene-  
8 ficiaries, the Influenza and Pneumococcal Vaccination  
9 Campaign carried out by the Health Care Financing Ad-  
10 ministration in conjunction with the Centers for Disease  
11 Control and Prevention and the National Coalition for  
12 Adult Immunization, is extended until the end of fiscal  
13 year 2002.

14 (b) APPROPRIATION.—There are hereby appropriated  
15 for each of fiscal years 1998 through 2002, \$8,000,000  
16 to the Campaign described in subsection (a). Of the  
17 amount of such appropriation in each fiscal year, 60 per-  
18 cent of such appropriation shall be payable from the Fed-  
19 eral Hospital Insurance Trust Fund, and 40 percent shall  
20 be payable from the Federal Supplementary Medical In-  
21 surance Trust Fund under title XVIII of the Social Secu-  
22 rity Act (42 U.S.C. 1395i, 1395t).

23 **SEC. 4108. STUDY ON PREVENTIVE BENEFITS.**

24 (a) STUDY.—The Secretary of Health and Human  
25 Services shall request the National Academy of Sciences,

1 in conjunction with the United States Preventive Services  
2 Task Force, to analyze the expansion or modification of  
3 preventive benefits provided to medicare beneficiaries  
4 under title XVIII of the Social Security Act. The analysis  
5 shall consider both the short term and long term benefits,  
6 and costs to the medicare program, of such expansion or  
7 modification,

8 (b) REPORT.—

9 (1) INITIAL REPORT.—Not later than 2 years  
10 after the date of the enactment of this Act, the Sec-  
11 retary shall submit a report on the findings of the  
12 analysis conducted under subsection (a) to the Com-  
13 mittee on Ways and Means and the Committee on  
14 Commerce of the House of Representatives and the  
15 Committee on Finance of the Senate.

16 (2) CONTENTS.—Such report shall include spe-  
17 cific findings with respect to coverage of the follow-  
18 ing preventive benefits:

19 (A) Nutrition therapy, including parenteral  
20 and enteral nutrition.

21 (B) Skin cancer screening.

22 (C) Medically necessary dental care.

23 (D) Routine patient care costs for bene-  
24 ficiaries enrolled in approved clinical trial pro-  
25 grams.

1 (E) Elimination of time limitation for cov-  
2 erage of immunosuppressive drugs for trans-  
3 plant patients.

4 (3) FUNDING.—From funds appropriated to the  
5 Department of Health and Human Services for fis-  
6 cal years 1998 and 1999, the Secretary shall provide  
7 for such funding as may be necessary for the con-  
8 duct of the analysis by the National Academy of  
9 Sciences under this section.

## 10 **Subtitle C—Rural Initiatives**

### 11 **SEC. 4206. INFORMATICS, TELEMEDICINE, AND EDUCATION**

#### 12 **DEMONSTRATION PROJECT.**

13 (a) PURPOSE AND AUTHORIZATION.—

14 (1) IN GENERAL.—Not later than 9 months  
15 after the date of enactment of this section, the Sec-  
16 retary of Health and Human Services shall provide  
17 for a demonstration project described in paragraph  
18 (2).

19 (2) DESCRIPTION OF PROJECT.—

20 (A) IN GENERAL.—The demonstration  
21 project described in this paragraph is a single  
22 demonstration project to use eligible health care  
23 provider telemedicine networks to apply high-  
24 capacity computing and advanced networks to  
25 improve primary care (and prevent health care

1 complications) to medicare beneficiaries with di-  
2 abetes mellitus who are residents of medically  
3 underserved rural areas or residents of medi-  
4 cally underserved inner-city areas.

5 (B) MEDICALLY UNDERSERVED DE-  
6 FINED.—As used in this paragraph, the term  
7 “medically underserved” has the meaning given  
8 such term in section 330(b)(3) of the Public  
9 Health Service Act (42 U.S.C. 254b(b)(3)).

10 (3) WAIVER.—The Secretary shall waive such  
11 provisions of title XVIII of the Social Security Act  
12 as may be necessary to provide for payment for serv-  
13 ices under the project in accordance with subsection  
14 (d).

15 (4) DURATION OF PROJECT.—The project shall  
16 be conducted over a 4-year period.

17 (b) OBJECTIVES OF PROJECT.—The objectives of the  
18 project include the following:

19 (1) Improving patient access to and compliance  
20 with appropriate care guidelines for individuals with  
21 diabetes mellitus through direct telecommunications  
22 link with information networks in order to improve  
23 patient quality-of-life and reduce overall health care  
24 costs.

1           (2) Developing a curriculum to train, and pro-  
2           viding standards for credentialing and licensure of,  
3           health professionals (particularly primary care  
4           health professionals) in the use of medical  
5           informatics and telecommunications.

6           (3) Demonstrating the application of advanced  
7           technologies, such as video-conferencing from a pa-  
8           tient’s home, remote monitoring of a patient’s medi-  
9           cal condition, interventional informatics, and apply-  
10          ing individualized, automated care guidelines, to as-  
11          sist primary care providers in assisting patients with  
12          diabetes in a home setting.

13          (4) Application of medical informatics to resi-  
14          dents with limited English language skills.

15          (5) Developing standards in the application of  
16          telemedicine and medical informatics.

17          (6) Developing a model for the cost-effective de-  
18          livery of primary and related care both in a managed  
19          care environment and in a fee-for-service environ-  
20          ment.

21          (c) ELIGIBLE HEALTH CARE PROVIDER TELEMEDI-  
22          CINE NETWORK DEFINED.—For purposes of this section,  
23          the term “eligible health care provider telemedicine net-  
24          work” means a consortium that includes at least one ter-  
25          tiary care hospital (but no more than 2 such hospitals),

1 at least one medical school, no more than 4 facilities in  
2 rural or urban areas, and at least one regional tele-  
3 communications provider and that meets the following re-  
4 quirements:

5 (1) The consortium is located in an area with  
6 one of the highest concentrations of medical schools  
7 and tertiary care facilities in the United States and  
8 has appropriate arrangements (within or outside the  
9 consortium) with such schools and facilities, univer-  
10 sities, and telecommunications providers, in order to  
11 conduct the project.

12 (2) The consortium submits to the Secretary an  
13 application at such time, in such manner, and con-  
14 taining such information as the Secretary may re-  
15 quire, including a description of the use to which the  
16 consortium would apply any amounts received under  
17 the project and the source and amount of non-Fed-  
18 eral funds used in the project.

19 (3) The consortium guarantees that it will be  
20 responsible for payment for all costs of the project  
21 that are not paid under this section and that the  
22 maximum amount of payment that may be made to  
23 the consortium under this section shall not exceed  
24 the amount specified in subsection (d)(3).

25 (d) COVERAGE AS MEDICARE PART B SERVICES.—



1           (1) IN GENERAL.—Subject to the succeeding  
2 provisions of this subsection, services related to the  
3 treatment or management of (including prevention  
4 of complications from) diabetes for medicare bene-  
5 ficiaries furnished under the project shall be consid-  
6 ered to be services covered under part B of title  
7 XVIII of the Social Security Act.

8           (2) PAYMENTS.—

9           (A) IN GENERAL.—Subject to paragraph  
10 (3), payment for such services shall be made at  
11 a rate of 50 percent of the costs that are rea-  
12 sonable and related to the provision of such  
13 services. In computing such costs, the Secretary  
14 shall include costs described in subparagraph  
15 (B), but may not include costs described in sub-  
16 paragraph (C).

17           (B) COSTS THAT MAY BE INCLUDED.—The  
18 costs described in this subparagraph are the  
19 permissible costs (as recognized by the Sec-  
20 retary) for the following:

21           (i) The acquisition of telemedicine  
22 equipment for use in patients' homes (but  
23 only in the case of patients located in  
24 medically underserved areas).

1           (ii) Curriculum development and  
2 training of health professionals in medical  
3 informatics and telemedicine.

4           (iii) Payment of telecommunications  
5 costs (including salaries and maintenance  
6 of equipment), including costs of tele-  
7 communications between patients' homes  
8 and the eligible network and between the  
9 network and other entities under the ar-  
10 rangements described in subsection (c)(1).

11           (iv) Payments to practitioners and  
12 providers under the medicare programs.

13           (C) COSTS NOT INCLUDED.—The costs de-  
14 scribed in this subparagraph are costs for any  
15 of the following:

16           (i) The purchase or installation of  
17 transmission equipment (other than such  
18 equipment used by health professionals to  
19 deliver medical informatics services under  
20 the project).

21           (ii) The establishment or operation of  
22 a telecommunications common carrier net-  
23 work.

24           (iii) Construction (except for minor  
25 renovations related to the installation of

1 reimbursable equipment) or the acquisition  
2 or building of real property.

3 (3) LIMITATION.—The total amount of the pay-  
4 ments that may be made under this section shall not  
5 exceed \$30,000,000.

6 (4) LIMITATION ON COST-SHARING.—The  
7 project may not impose cost sharing on a medicare  
8 beneficiary for the receipt of services under the  
9 project in excess of 20 percent of the recognized  
10 costs of the project attributable to such services.

11 (e) REPORTS.—The Secretary shall submit to the  
12 Committees on Ways and Means and Commerce of the  
13 House of Representatives and the Committee on Finance  
14 of the Senate interim reports on the project and a final  
15 report on the project within 6 months after the conclusion  
16 of the project. The final report shall include an evaluation  
17 of the impact of the use of telemedicine and medical  
18 informatics on improving access of medicare beneficiaries  
19 to health care services, on reducing the costs of such serv-  
20 ices, and on improving the quality of life of such bene-  
21 ficiaries.

22 (f) DEFINITIONS.—For purposes of this section:

23 (1) INTERVENTIONAL INFORMATICS.—The term  
24 “interventional informatics” means using informa-

1       tion technology and virtual reality technology to in-  
2       tervene in patient care.

3               (2) **MEDICAL INFORMATICS.**—The term “medi-  
4       cal informatics” means the storage, retrieval, and  
5       use of biomedical and related information for prob-  
6       lem solving and decision-making through computing  
7       and communications technologies.

8               (3) **PROJECT.**—The term “project” means the  
9       demonstration project under this section.

## 10       **Subtitle D—Anti-Fraud and Abuse** 11                               **Provisions**

### 12       **SEC. 4301. PERMANENT EXCLUSION FOR THOSE CON-** 13                               **VICTED OF 3 HEALTH CARE RELATED** 14                               **CRIMES.**

15       Section 1128(c)(3) (42 U.S.C. 1320a–7(c)(3)) is  
16       amended—

17               (1) in subparagraph (A), by inserting “or in the  
18       case described in subparagraph (G)” after “sub-  
19       section (b)(12)”;

20               (2) in subparagraphs (B) and (D), by striking  
21       “In the case” and inserting “Subject to subpara-  
22       graph (G), in the case”; and

23               (3) by adding at the end the following new sub-  
24       paragraph:

1 “(G) In the case of an exclusion of an individual  
2 under subsection (a) based on a conviction occurring on  
3 or after the date of the enactment of this subparagraph,  
4 if the individual has (before, on, or after such date and  
5 before the date of the conviction for which the exclusion  
6 is imposed) been convicted—

7 “(i) on one previous occasion of one or more of-  
8 fenses for which an exclusion may be effected under  
9 such subsection, the period of the exclusion shall be  
10 not less than 10 years, or

11 “(ii) on 2 or more previous occasions of one or  
12 more offenses for which an exclusion may be effected  
13 under such subsection, the period of the exclusion  
14 shall be permanent.”.

15 **SEC. 4302. AUTHORITY TO REFUSE TO ENTER INTO MEDI-**  
16 **CARE AGREEMENTS WITH INDIVIDUALS OR**  
17 **ENTITIES CONVICTED OF FELONIES.**

18 (a) **MEDICARE PART A.**—Section 1866(b)(2) (42  
19 U.S.C. 1395cc(b)(2)) is amended—

20 (1) by striking “or” at the end of subparagraph  
21 (B);

22 (2) by striking the period at the end of sub-  
23 paragraph (C) and inserting “, or”; and

24 (3) by adding after subparagraph (C) the fol-  
25 lowing new subparagraph:

1           “(D) has ascertained that the provider has  
2           been convicted of a felony under Federal or  
3           State law for an offense which the Secretary de-  
4           termines is inconsistent with the best interests  
5           of program beneficiaries.”.

6           (b) MEDICARE PART B.—Section 1842 (42 U.S.C.  
7           1395u) is amended by adding after subsection (r) the fol-  
8           lowing new subsection:

9           “(s) The Secretary may refuse to enter into an agree-  
10          ment with a physician or supplier under subsection (h)  
11          or may terminate or refuse to renew such agreement, in  
12          the event that such physician or supplier has been con-  
13          victed of a felony under Federal or State law for an of-  
14          fense which the Secretary determines is inconsistent with  
15          the best interests of program beneficiaries.”.

16          (c) MEDICAID.—Section 1902(a)(23) (42 U.S.C.  
17          1396(a)) is amended—

18                 (1) by relocating the matter that precedes “pro-  
19                 vide that, (A)” immediately before the semicolon;

20                 (2) by inserting a semicolon after “1915”;

21                 (3) by striking the comma after “Guam” and  
22                 inserting a semicolon; and

23                 (4) by inserting before the semicolon at the end  
24                 the following: “and except that this provision does  
25                 not require a State to provide medical assistance for

1 such services furnished by a person or entity con-  
2 victed of a felony under Federal or State law for an  
3 offense which the State agency determines is incon-  
4 sistent with the best interests of beneficiaries under  
5 the State plan”.

6 (d) EFFECTIVE DATE.—The amendments made by  
7 this section shall take effect on the date of the enactment  
8 of this Act and apply to the entry and renewal of contracts  
9 on or after such date.

10 **SEC. 4303. INCLUSION OF TOLL-FREE NUMBER TO REPORT**  
11 **MEDICARE WASTE, FRAUD, AND ABUSE IN EX-**  
12 **PLANATION OF BENEFITS FORMS.**

13 (a) IN GENERAL.—Section 1842(h)(7) (42 U.S.C.  
14 1395u(h)(7)) is amended—

15 (1) by striking “and” at the end of subpara-  
16 graph (D),

17 (2) by striking the period at the end of sub-  
18 paragraph (E), and

19 (3) by adding at the end the following new sub-  
20 paragraph:

21 “(E) a toll-free telephone number maintained  
22 by the Inspector General in the Department of  
23 Health and Human Services for the receipt of com-  
24 plaints and information about waste, fraud, and

1 abuse in the provision or billing of services under  
2 this title.”.

3 (b) **EFFECTIVE DATE.**—The amendments made by  
4 subsection (a) shall apply to explanations of benefits pro-  
5 vided on or after such date (not later than January 1,  
6 1999) as the Secretary of Health and Human Services  
7 shall provide.

8 **SEC. 4304. LIABILITY OF MEDICARE CARRIERS AND FISCAL**  
9 **INTERMEDIARIES FOR CLAIMS SUBMITTED**  
10 **BY EXCLUDED PROVIDERS.**

11 (a) **REIMBURSEMENT TO THE SECRETARY FOR**  
12 **AMOUNTS PAID TO EXCLUDED PROVIDERS.**—

13 (1) **REQUIREMENTS FOR FISCAL**  
14 **INTERMEDIARIES.**—

15 (A) **IN GENERAL.**—Section 1816 (42  
16 U.S.C. 1395h) is amended by adding at the end  
17 the following new subsection:

18 “(m) An agreement with an agency or organization  
19 under this section shall require that such agency or orga-  
20 nization reimburse the Secretary for any amounts paid by  
21 the agency or organization for a service under this title  
22 which is furnished, directed, or prescribed by an individual  
23 or entity during any period for which the individual or  
24 entity is excluded pursuant to section 1128, 1128A, or  
25 1156, from participation in the program under this title,



1 if the amounts are paid after the Secretary notifies the  
2 agency or organization of the exclusion.”.

3 (B) CONFORMING AMENDMENT.—Sub-  
4 section (i) of such section is amended by adding  
5 at the end the following new paragraph:

6 “(4) Nothing in this subsection shall be construed to  
7 prohibit reimbursement by an agency or organization  
8 under subsection (m).”.

9 (2) REQUIREMENTS FOR CARRIERS.—Section  
10 1842(b)(3) (42 U.S.C. 1395u(b)(3)) is amended—

11 (A) by striking “and” at the end of sub-  
12 paragraph (I); and

13 (B) by inserting after subparagraph (I) the  
14 following new subparagraph:

15 “(J) will reimburse the Secretary for any  
16 amounts paid by the carrier for an item or service  
17 under this part which is furnished, directed, or pre-  
18 scribed by an individual or entity during any period  
19 for which the individual or entity is excluded pursu-  
20 ant to section 1128, 1128A, or 1156, from partici-  
21 pation in the program under this title, if the  
22 amounts are paid after the Secretary notifies the  
23 carrier of the exclusion, and”.

24 (3) MEDICAID PROVISION.—Section  
25 1902(a)(39) (42 U.S.C. 1396a(a)(39)) is amended

1 by inserting before the semicolon at the end the fol-  
2 lowing: “, and provide further for reimbursement to  
3 the Secretary of any payments made under the plan  
4 or any item or service furnished, directed, or pre-  
5 scribed by the excluded individual or entity during  
6 such period, after the Secretary notifies the State of  
7 such exclusion”.

8 (b) CONFORMING REPEAL OF MANDATORY PAYMENT  
9 RULE.—Paragraph (2) of section 1862(e) (42 U.S.C.  
10 1395y(e)) is amended to read as follows:

11 “(2) No individual or entity may bill (or collect any  
12 amount from) any individual for any item or service for  
13 which payment is denied under paragraph (1). No person  
14 is liable for payment of any amounts billed for such an  
15 item or service in violation of the previous sentence.”.

16 (c) EFFECTIVE DATES.—The amendments made by  
17 this section shall apply to contracts and agreements en-  
18 tered into, renewed, or extended after the date of the en-  
19 actment of this Act, but only with respect to claims sub-  
20 mitted on or after the later of January 1, 1998, or the  
21 date such entry, renewal, or extension becomes effective.

22 **SEC. 4305. EXCLUSION OF ENTITY CONTROLLED BY FAMILY**  
23 **MEMBER OF A SANCTIONED INDIVIDUAL.**

24 (a) IN GENERAL.—Section 1128 (42 U.S.C. 1320a-  
25 7) is amended—

1 (1) in subsection (b)(8)(A)—

2 (A) by striking “or” at the end of clause  
3 (i), and

4 (B) by striking the dash at the end of  
5 clause (ii) and inserting “; or”, and

6 (C) by inserting after clause (ii) the follow-  
7 ing:

8 “(iii) who was described in clause (i) but  
9 is no longer so described because of a transfer  
10 of ownership or control interest, in anticipation  
11 of (or following) a conviction, assessment, or ex-  
12 clusion described in subparagraph (B) against  
13 the person, to an immediate family member (as  
14 defined in subsection (j)(1)) or a member of the  
15 household of the person (as defined in sub-  
16 section (j)(2)) who continues to maintain an in-  
17 terest described in such clause—”; and

18 (2) by adding after subsection (i) the following  
19 new subsection:

20 “(j) DEFINITION OF IMMEDIATE FAMILY MEMBER  
21 AND MEMBER OF HOUSEHOLD.—For purposes of sub-  
22 section (b)(8)(A)(iii):

23 “(1) The term ‘immediate family member’  
24 means, with respect to a person—

25 “(A) the husband or wife of the person;

1           “(B) the natural or adoptive parent, child,  
2           or sibling of the person;

3           “(C) the stepparent, stepchild, stepbrother,  
4           or stepsister of the person;

5           “(D) the father-, mother-, daughter-,  
6           son-, brother-, or sister-in-law of the person;

7           “(E) the grandparent or grandchild of the  
8           person; and

9           “(F) the spouse of a grandparent or  
10          grandchild of the person.

11          “(2) The term ‘member of the household’  
12          means, with respect to an person, any individual  
13          sharing a common abode as part of a single family  
14          unit with the person, including domestic employees  
15          and others who live together as a family unit, but  
16          not including a roomer or boarder.”.

17          (b) EFFECTIVE DATE.—The amendments made by  
18          subsection (a) shall take effect on the date that is 45 days  
19          after the date of the enactment of this Act.

20          **SEC. 4306. IMPOSITION OF CIVIL MONEY PENALTIES.**

21          (a) CIVIL MONEY PENALTIES FOR PERSONS THAT  
22          CONTRACT WITH EXCLUDED INDIVIDUALS.—Section  
23          1128A(a) (42 U.S.C. 1320a–7a(a)) is amended—

24                  (1) by striking “or” at the end of paragraph  
25                  (4);

1 (2) by adding “or” at the end of paragraph (5);

2 and

3 (3) by adding after paragraph (5) the following

4 new paragraph:

5 “(6) arranges or contracts (by employment or  
6 otherwise) with an individual or entity that the per-  
7 son knows or should know is excluded from partici-  
8 pation in a Federal health care program (as defined  
9 in section 1128B(f)), for the provision of items or  
10 services for which payment may be made under such  
11 a program;”.

12 (b) EFFECTIVE DATES.—The amendments made by  
13 subsection (a) shall apply to arrangements and contracts  
14 entered into after the date of the enactment of this Act.

15 **SEC. 4307. DISCLOSURE OF INFORMATION AND SURETY**

16 **BONDS.**

17 (a) DISCLOSURE OF INFORMATION AND SURETY  
18 BOND REQUIREMENT FOR SUPPLIERS OF DURABLE MED-  
19 ICAL EQUIPMENT.—Section 1834(a) (42 U.S.C.  
20 1395m(a)) is amended by inserting after paragraph (15)  
21 the following new paragraph:

22 “(16) CONDITIONS FOR ISSUANCE OF PROVIDER  
23 NUMBER.—The Secretary shall not provide for the  
24 issuance (or renewal) of a provider number for a  
25 supplier of durable medical equipment, for purposes

1 of payment under this part for durable medical  
2 equipment furnished by the supplier, unless the sup-  
3 plier provides the Secretary on a continuing basis  
4 with—

5 “(A)(i) full and complete information as to  
6 the identity of each person with an ownership  
7 or control interest (as defined in section  
8 1124(a)(3)) in the supplier or in any sub-  
9 contractor (as defined by the Secretary in regu-  
10 lations) in which the supplier directly or indi-  
11 rectly has a 5 percent or more ownership inter-  
12 est, and

13 “(ii) to the extent determined to be feasible  
14 under regulations of the Secretary, the name of  
15 any disclosing entity (as defined in section  
16 1124(a)(2)) with respect to which a person with  
17 such an ownership or control interest in the  
18 supplier is a person with such an ownership or  
19 control interest in the disclosing entity; and

20 “(B) a surety bond in a form specified by  
21 the Secretary and in an amount that is not less  
22 than \$50,000.

23 The Secretary may waive the requirement of a bond  
24 under subparagraph (B) in the case of a supplier

1 that provides a comparable surety bond under State  
2 law.”.

3 (b) SURETY BOND REQUIREMENT FOR HOME  
4 HEALTH AGENCIES.—

5 (1) IN GENERAL.—Section 1861(o) (42 U.S.C.  
6 1395x(o)) is amended—

7 (A) in paragraph (7), by inserting “and in-  
8 cluding providing the Secretary on a continuing  
9 basis with a surety bond in a form specified by  
10 the Secretary and in an amount that is not less  
11 than \$50,000,” after “financial security of the  
12 program”, and

13 (B) by adding at the end the following:  
14 “The Secretary may waive the requirement of a  
15 bond under paragraph (7) in the case of an  
16 agency or organization that provides a com-  
17 parable surety bond under State law.”.

18 (2) CONFORMING AMENDMENTS.—Section  
19 1861(v)(1)(H) (42 U.S.C. 1395x(v)(1)(H)) is  
20 amended—

21 (A) in clause (i), by striking “the financial  
22 security requirement” and inserting “the finan-  
23 cial security and surety bond requirements”;  
24 and

1 (B) in clause (ii), by striking “the financial  
2 security requirement described in subsection  
3 (o)(7) applies” and inserting “the financial se-  
4 curity and surety bond requirements described  
5 in subsection (o)(7) apply”.

6 (3) REFERENCE TO CURRENT DISCLOSURE RE-  
7 QUIREMENT.—For provision of current law requiring  
8 home health agencies to disclose information on  
9 ownership and control interests, see section 1124 of  
10 the Social Security Act.

11 (c) AUTHORIZING APPLICATION OF DISCLOSURE AND  
12 SURETY BOND REQUIREMENTS TO AMBULANCE SERV-  
13 ICES AND CERTAIN CLINICS.—Section 1834(a)(16) (42  
14 U.S.C. 1395m(a)(16)), as added by subsection (a), is  
15 amended by adding at the end the following: “The Sec-  
16 retary, in the Secretary’s discretion, may impose the re-  
17 quirements of the previous sentence with respect to some  
18 or all classes of suppliers of ambulance services described  
19 in section 1861(s)(7) and clinics that furnish medical and  
20 other health services (other than physicians’ services)  
21 under this part.”.

22 (d) APPLICATION TO COMPREHENSIVE OUTPATIENT  
23 REHABILITATION FACILITIES (CORFs).—Section  
24 1861(cc)(2) (42 U.S.C. 1395x(cc)(2)) is amended—



1           (1) in subparagraph (I), by inserting before the  
2           period at the end the following: “and providing the  
3           Secretary on a continuing basis with a surety bond  
4           in a form specified by the Secretary and in an  
5           amount that is not less than \$50,000”, and

6           (2) by adding after and below subparagraph (I)  
7           the following:

8           “The Secretary may waive the requirement of a bond  
9           under subparagraph (I) in the case of a facility that pro-  
10          vides a comparable surety bond under State law.”.

11          (e) APPLICATION TO REHABILITATION AGENCIES.—  
12          Section 1861(p) (42 U.S.C. 1395x(p)) is amended—

13               (1) in paragraph (4)(A)(v), by inserting after  
14               “as the Secretary may find necessary,” the follow-  
15               ing: “and provides the Secretary, to the extent re-  
16               quired by the Secretary, on a continuing basis with  
17               a surety bond in a form specified by the Secretary  
18               and in an amount that is not less than \$50,000”,  
19               and

20               (2) by adding at the end the following: “The  
21               Secretary may waive the requirement of a bond  
22               under paragraph (4)(A)(v) in the case of a clinic or  
23               agency that provides a comparable surety bond  
24               under State law.”.

1 (f) EFFECTIVE DATES.—(1) The amendment made  
2 by subsection (a) shall apply to suppliers of durable medi-  
3 cal equipment with respect to such equipment furnished  
4 on or after January 1, 1998.

5 (2) The amendments made by subsection (b) shall  
6 apply to home health agencies with respect to services fur-  
7 nished on or after such date. The Secretary of Health and  
8 Human Services shall modify participation agreements  
9 under section 1866(a)(1) of the Social Security Act with  
10 respect to home health agencies to provide for implementa-  
11 tion of such amendments on a timely basis.

12 (3) The amendments made by subsections (c)  
13 through (e) shall take effect on the date of the enactment  
14 of this Act and may be applied with respect to items and  
15 services furnished on or after the date specified in para-  
16 graph (1).

17 **SEC. 4308. PROVISION OF CERTAIN IDENTIFICATION NUM-**  
18 **BERS.**

19 (a) REQUIREMENTS TO DISCLOSE EMPLOYER IDEN-  
20 TIFICATION NUMBERS (EINS) AND SOCIAL SECURITY AC-  
21 COUNT NUMBERS (SSNs).—Section 1124(a)(1) (42  
22 U.S.C. 1320a–3(a)(1)) is amended by inserting before the  
23 period at the end the following: “and supply the Secretary  
24 with the both the employer identification number (as-  
25 signed pursuant to section 6109 of the Internal Revenue

1 Code of 1986) and social security account number (as-  
2 signed under section 205(c)(2)(B)) of the disclosing en-  
3 tity, each person with an ownership or control interest (as  
4 defined in subsection (a)(3)), and any subcontractor in  
5 which the entity directly or indirectly has a 5 percent or  
6 more ownership interest. Use of the social security account  
7 number under this section shall be limited to identity ver-  
8 ification and identity matching purposes only. The social  
9 security account number shall not be disclosed to any per-  
10 son or entity other than the Secretary, the Social Security  
11 Administration, or the Secretary of the Treasury, In ob-  
12 taining the social security account numbers of the disclos-  
13 ing entity and other persons described in this section, the  
14 Secretary shall comply with section 7 of the Privacy Act  
15 of 1974 (5 U.S.C. 552a note)”.

16 (b) OTHER MEDICARE PROVIDERS.—Section 1124A  
17 (42 U.S.C. 1320a–3a) is amended—

18 (1) in subsection (a)—

19 (A) by striking “and” at the end of para-  
20 graph (1);

21 (B) by striking the period at the end of  
22 paragraph (2) and inserting “; and”; and

23 (C) by adding at the end the following new  
24 paragraph:

1           “(3) including the employer identification num-  
2           ber (assigned pursuant to section 6109 of the Inter-  
3           nal Revenue Code of 1986) and social security ac-  
4           count number (assigned under section 205(c)(2)(B))  
5           of the disclosing part B provider and any person,  
6           managing employee, or other entity identified or de-  
7           scribed under paragraph (1) or (2).”; and

8           (2) in subsection (c) by inserting “(or, for pur-  
9           poses of subsection (a)(3), any entity receiving pay-  
10          ment)” after “on an assignment-related basis”.

11          (c) VERIFICATION BY SOCIAL SECURITY ADMINIS-  
12          TRATION (SSA).—Section 1124A (42 U.S.C. 1320a–3a)  
13          is amended—

14                 (1) by redesignating subsection (c) as sub-  
15                 section (d); and

16                 (2) by inserting after subsection (b) the follow-  
17                 ing new subsection:

18                 “(c) VERIFICATION.—

19                         “(1) TRANSMITTAL BY HHS.—The Secretary  
20                         shall transmit—

21                                 “(A) to the Commissioner of Social Secu-  
22                                 rity information concerning each social security  
23                                 account number (assigned under section  
24                                 205(c)(2)(B)), and

1           “(B) to the Secretary of the Treasury in-  
2           formation concerning each employer identifica-  
3           tion number (assigned pursuant to section 6109  
4           of the Internal Revenue Code of 1986),  
5           supplied to the Secretary pursuant to subsection  
6           (a)(3) or section 1124(c) to the extent necessary for  
7           verification of such information in accordance with  
8           paragraph (2).

9           “(2) VERIFICATION.—The Commissioner of So-  
10          cial Security and the Secretary of the Treasury shall  
11          verify the accuracy of, or correct, the information  
12          supplied by the Secretary to such official pursuant  
13          to paragraph (1), and shall report such verifications  
14          or corrections to the Secretary.

15          “(3) FEES FOR VERIFICATION.—The Secretary  
16          shall reimburse the Commissioner and Secretary of  
17          the Treasury, at a rate negotiated between the Sec-  
18          retary and such official, for the costs incurred by  
19          such official in performing the verification and cor-  
20          rection services described in this subsection.”.

21          (d) REPORT.—Before this subsection shall be effec-  
22          tive, the Secretary of Health and Human Services shall  
23          submit to Congress a report on steps the Secretary has  
24          taken to assure the confidentiality of social security ac-  
25          count numbers that will be provided to the Secretary

1 under the amendments made by this section. If Congress  
2 determines that the Secretary has not taken adequate  
3 steps to assure the confidentiality of social security ac-  
4 count numbers to be provided to the Secretary under the  
5 amendments made by this section, the amendments made  
6 by this section shall not take effect.

7 (e) EFFECTIVE DATES.—Subject to subsection (d)—

8 (1) the amendment made by subsection (a)  
9 shall apply to the application of conditions of partici-  
10 pation, and entering into and renewal of contracts  
11 and agreements, occurring more than 90 days after  
12 the date of submission of the report under sub-  
13 section (d); and

14 (2) the amendments made by subsection (b)  
15 shall apply to payment for items and services fur-  
16 nished more than 90 days after the date of submis-  
17 sion of such report.

18 **SEC. 4309. ADVISORY OPINIONS REGARDING CERTAIN PHY-**

19 **SICIAN SELF-REFERRAL PROVISIONS.**

20 Section 1877(g) (42 U.S.C. 1395nn(g)) is amended  
21 by adding at the end the following new paragraph:

22 “(6) ADVISORY OPINIONS.—

23 “(A) IN GENERAL.—The Secretary shall  
24 issue written advisory opinions concerning  
25 whether a referral relating to designated health

1 services (other than clinical laboratory services)  
2 is prohibited under this section.

3 “(B) BINDING AS TO SECRETARY AND  
4 PARTIES INVOLVED.—Each advisory opinion is-  
5 sued by the Secretary shall be binding as to the  
6 Secretary and the party or parties requesting  
7 the opinion.

8 “(C) APPLICATION OF CERTAIN PROCE-  
9 DURES.—The Secretary shall, to the extent  
10 practicable, apply the regulations promulgated  
11 under section 1128D(b)(5) to the issuance of  
12 advisory opinions under this paragraph.

13 “(D) APPLICABILITY.—This paragraph  
14 shall apply to requests for advisory opinions  
15 made during the period described in section  
16 1128D(b)(6).”.

17 **SEC. 4310. NONDISCRIMINATION IN POST-HOSPITAL RE-**  
18 **FERRAL TO HOME HEALTH AGENCIES.**

19 (a) NOTIFICATION OF AVAILABILITY OF HOME  
20 HEALTH AGENCIES AS PART OF DISCHARGE PLANNING  
21 PROCESS.—Section 1861(ee)(2) (42 U.S.C. 1395x(ee)(2))  
22 is amended—

23 (1) in subparagraph (D), by inserting before  
24 the period the following: “, including the availability  
25 of home health services through individuals and enti-

1 ties that participate in the program under this title  
2 and that serve the area in which the patient resides  
3 and that request to be listed by the hospital as avail-  
4 able”; and

5 (2) by adding at the end the following:

6 “(H) Consistent with section 1802, the dis-  
7 charge plan shall—

8 “(i) not specify or otherwise limit the  
9 qualified provider which may provide post-hos-  
10 pital home health services, and

11 “(ii) identify (in a form and manner speci-  
12 fied by the Secretary) any home health agency  
13 (to whom the individual is referred) in which  
14 the hospital has a disclosable financial interest  
15 (as specified by the Secretary consistent with  
16 section 1866(a)(1)(R)) or which has such an in-  
17 terest in the hospital.”.

18 (b) MAINTENANCE AND DISCLOSURE OF INFORMA-  
19 TION ON POST-HOSPITAL HOME HEALTH AGENCIES.—  
20 Section 1866(a)(1) (42 U.S.C. 1395cc(a)(1)) is amend-  
21 ed—

22 (1) by striking “and” at the end of subpara-  
23 graph (Q),

24 (2) by striking the period at the end of sub-  
25 paragraph (R), and



1 (3) by adding at the end the following:

2 “(S) in the case of a hospital that has a finan-  
3 cial interest (as specified by the Secretary in regula-  
4 tions) in a home health agency, or in which such an  
5 agency has such a financial interest, or in which an-  
6 other entity has such a financial interest (directly or  
7 indirectly) with such hospital and such an agency, to  
8 maintain and disclose to the Secretary (in a form  
9 and manner specified by the Secretary) information  
10 on—

11 “(i) the nature of such financial interest,

12 “(ii) the number of individuals who were  
13 discharged from the hospital and who were  
14 identified as requiring home health services,  
15 and

16 “(iii) the percentage of such individuals  
17 who received such services from such provider  
18 (or another such provider).”.

19 (c) DISCLOSURE OF INFORMATION TO THE PUB-  
20 LIC.—Title XI is amended by inserting after section 1145  
21 the following new section:

22 “PUBLIC DISCLOSURE OF CERTAIN INFORMATION ON  
23 HOSPITAL FINANCIAL INTEREST AND REFERRAL  
24 PATTERNS

25 “SEC. 1146. The Secretary shall make available to  
26 the public, in a form and manner specified by the Sec-

1 retary, information disclosed to the Secretary pursuant to  
2 section 1866(a)(1)(R).”.

3 (d) EFFECTIVE DATES.—

4 (1) The amendments made by subsection (a)  
5 shall apply to discharges occurring on or after 90  
6 days after the date of the enactment of this Act.

7 (2) The Secretary of Health and Human Serv-  
8 ices shall issue regulations by not later than 1 year  
9 after the date of the enactment of this Act to carry  
10 out the amendments made by subsections (b) and  
11 (c) and such amendments shall take effect as of  
12 such date (on or after the issuance of such regula-  
13 tions) as the Secretary specifies in such regulations.

14 **SEC. 4311. OTHER FRAUD AND ABUSE RELATED PROVI-**  
15 **SIONS.**

16 (a) REFERENCE CORRECTION.—(1) Section  
17 1128D(b)(2)(D) (42 U.S.C. 1320a–7d(b)(2)(D)), as  
18 added by section 205 of the Health Insurance Portability  
19 and Accountability Act of 1996, is amended by striking  
20 “1128B(b)” and inserting “1128A(b)”.

21 (2) Section 1128E(g)(3)(C) (42 U.S.C. 1320a–  
22 7e(g)(3)(C)) is amended by striking “Veterans’ Adminis-  
23 tration” and inserting “Department of Veterans Affairs”.

24 (b) LANGUAGE IN DEFINITION OF CONVICTION.—  
25 Section 1128E(g)(5) (42 U.S.C. 1320a–7e(g)(5)), as in-

1 sserted by section 221(a) of the Health Insurance Port-  
2 ability and Accountability Act of 1996, is amended by  
3 striking “paragraph (4)” and inserting “paragraphs (1)  
4 through (4)”.

5 (c) IMPLEMENTATION OF EXCLUSIONS.—Section  
6 1128 (42 U.S.C. 1320a–7) is amended—

7 (1) in subsection (a), by striking “any program  
8 under title XVIII and shall direct that the following  
9 individuals and entities be excluded from participa-  
10 tion in any State health care program (as defined in  
11 subsection (h))” and inserting “any Federal health  
12 care program (as defined in section 1128B(f))”; and

13 (2) in subsection (b), by striking “any program  
14 under title XVIII and may direct that the following  
15 individuals and entities be excluded from participa-  
16 tion in any State health care program” and inserting  
17 “any Federal health care program (as defined in  
18 section 1128B(f))”.

19 (d) SANCTIONS FOR FAILURE TO REPORT.—Section  
20 1128E(b) (42 U.S.C. 1320a–7e(b)), as inserted by section  
21 221(a) of the Health Insurance Portability and Account-  
22 ability Act of 1996, is amended by adding at the end the  
23 following:

24 “(6) SANCTIONS FOR FAILURE TO REPORT.—

1           “(A) HEALTH PLANS.—Any health plan  
2           that fails to report information on an adverse  
3           action required to be reported under this sub-  
4           section shall be subject to a civil money penalty  
5           of not more than \$25,000 for each such adverse  
6           action not reported. Such penalty shall be im-  
7           posed and collected in the same manner as civil  
8           money penalties under subsection (a) of section  
9           1128A are imposed and collected under that  
10          section.

11          “(B) GOVERNMENTAL AGENCIES.—The  
12          Secretary shall provide for a publication of a  
13          public report that identifies those Government  
14          agencies that have failed to report information  
15          on adverse actions as required to be reported  
16          under this subsection.”.

17          (e) EFFECTIVE DATES.—

18           (1) IN GENERAL.—Except as provided in this  
19           subsection, the amendments made by this section  
20           shall be effective as if included in the enactment of  
21           the Health Insurance Portability and Accountability  
22           Act of 1996.

23           (2) FEDERAL HEALTH PROGRAM.—The amend-  
24           ments made by subsection (c) shall take effect on  
25           the date of the enactment of this Act.



1 (1) by striking “of 80 percent”, and

2 (2) by inserting before the period at the end the  
3 following: “, less the amount a provider may charge  
4 as described in clause (ii) of section 1866(a)(2)(A)”.

5 (c) EFFECTIVE DATE.—The amendments made by  
6 this section shall apply to services furnished during por-  
7 tions of cost reporting periods occurring on or after Octo-  
8 ber 1, 1997.

9 **SEC. 4412. EXTENSION OF REDUCTIONS IN PAYMENTS FOR**  
10 **COSTS OF HOSPITAL OUTPATIENT SERVICES.**

11 (a) REDUCTION IN PAYMENTS FOR CAPITAL-RELAT-  
12 ED COSTS.—Section 1861(v)(1)(S)(ii)(I) (42 U.S.C.  
13 1395x(v)(1)(S)(ii)(I)) is amended by striking “through  
14 1998” and inserting “through 1999 and during fiscal year  
15 2000 before January 1, 2000”.

16 (b) REDUCTION IN PAYMENTS FOR OTHER COSTS.—  
17 Section 1861(v)(1)(S)(ii)(II) (42 U.S.C.  
18 1395x(v)(1)(S)(ii)(II)) is amended by striking “through  
19 1998” and inserting “through 1999 and during fiscal year  
20 2000 before January 1, 2000”.

21 **SEC. 4413. PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL**  
22 **OUTPATIENT DEPARTMENT SERVICES.**

23 (a) IN GENERAL.—Section 1833 (42 U.S.C. 1395l)  
24 is amended by adding at the end the following:

1       “(t) PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL  
2       OUTPATIENT DEPARTMENT SERVICES.—

3               “(1) IN GENERAL.—With respect to hospital  
4       outpatient services designated by the Secretary (in  
5       this section referred to as ‘covered OPD services’)  
6       and furnished during a year beginning with 1999,  
7       the amount of payment under this part shall be de-  
8       termined under a prospective payment system estab-  
9       lished by the Secretary in accordance with this sub-  
10      section.

11              “(2) SYSTEM REQUIREMENTS.—Under the pay-  
12      ment system—

13                      “(A) the Secretary shall develop a classi-  
14      fication system for covered OPD services;

15                      “(B) the Secretary may establish groups of  
16      covered OPD services, within the classification  
17      system described in subparagraph (A), so that  
18      services classified within each group are com-  
19      parable clinically and with respect to the use of  
20      resources;

21                      “(C) the Secretary shall, using data on  
22      claims from 1996 and using data from the most  
23      recent available cost reports, establish relative  
24      payment weights for covered OPD services (and  
25      any groups of such services described in sub-

1 paragraph (B)) based on median hospital costs  
2 and shall determine projections of the frequency  
3 of utilization of each such service (or group of  
4 services) in 1999;

5 “(D) the Secretary shall determine a wage  
6 adjustment factor to adjust the portion of pay-  
7 ment and coinsurance attributable to labor-re-  
8 lated costs for relative differences in labor and  
9 labor-related costs across geographic regions in  
10 a budget neutral manner;

11 “(E) the Secretary shall establish other ad-  
12 justments, in a budget neutral manner, as de-  
13 termined to be necessary to ensure equitable  
14 payments, such as outlier adjustments, adjust-  
15 ments to account for variations in coinsurance  
16 payments for procedures with similar resource  
17 costs, or adjustments for certain classes of hos-  
18 pitals; and

19 “(F) the Secretary shall develop a method  
20 for controlling unnecessary increases in the vol-  
21 ume of covered OPD services.

22 “(3) CALCULATION OF BASE AMOUNTS.—

23 “(A) AGGREGATE AMOUNTS THAT WOULD  
24 BE PAYABLE IF DEDUCTIBLES WERE DIS-  
25 REGARDED.—The Secretary shall estimate the



1 total amounts that would be payable from the  
2 Trust Fund under this part for covered OPD  
3 services in 1999, determined without regard to  
4 this subsection, as though the deductible under  
5 section 1833(b) did not apply, and as though  
6 the coinsurance described in section  
7 1866(a)(2)(A)(ii) (as in effect before the date  
8 of the enactment of this subsection) continued  
9 to apply.

10 “(B) UNADJUSTED COPAYMENT  
11 AMOUNT.—

12 “(i) IN GENERAL.—For purposes of  
13 this subsection, subject to clause (ii), the  
14 ‘unadjusted copayment amount’ applicable  
15 to a covered OPD service (or group of such  
16 services) is 20 percent of national median  
17 of the charges for the service (or services  
18 within the group) furnished during 1996,  
19 updated to 1999 using the Secretary’s esti-  
20 mate of charge growth during the period.

21 “(ii) ADJUSTED TO BE 20 PERCENT  
22 WHEN FULLY PHASED IN.—If the pre-de-  
23 ductible payment percentage for a covered  
24 OPD service (or group of such services)  
25 furnished in a year would be equal to or

1 exceed 80 percent, then the unadjusted co-  
2 payment amount shall be 25 percent of  
3 amount determined under subparagraph  
4 (D)(i).

5 “(iii) RULES FOR NEW SERVICES.—

6 The Secretary shall establish rules for es-  
7 tablishment of an unadjusted copayment  
8 amount for a covered OPD service not fur-  
9 nished during 1996, based upon its classi-  
10 fication within a group of such services.

11 “(C) CALCULATION OF CONVERSION FAC-  
12 TORS.—

13 “(I) IN GENERAL.—The Sec-  
14 retary shall establish a 1999 conver-  
15 sion factor for determining the medi-  
16 care pre-deductible OPD fee payment  
17 amounts for each covered OPD serv-  
18 ice (or group of such services) fur-  
19 nished in 1999. Such conversion fac-  
20 tor shall be established on the basis of  
21 the weights and frequencies described  
22 in paragraph (2)(C) and in a manner  
23 such that the sum for all services and  
24 groups of the products (described in  
25 subclause (II) for each such service or

1           group) equals the total projected  
2           amount described in subparagraph  
3           (A).

4           “(II) PRODUCT DESCRIBED.—The  
5           product described in this subclause, for a  
6           service or group, is the product of the med-  
7           icare pre-deductible OPD fee payment  
8           amounts (taking into account appropriate  
9           adjustments described in paragraphs  
10          (2)(D) and (2)(E)) and the frequencies for  
11          such service or group.

12          “(ii) SUBSEQUENT YEARS.—Subject  
13          to paragraph (8)(B), the Secretary shall  
14          establish a conversion factor for covered  
15          OPD services furnished in subsequent  
16          years in an amount equal to the conversion  
17          factor established under this subparagraph  
18          and applicable to such services furnished in  
19          the previous year increased by the OPD  
20          payment increase factor specified under  
21          clause (iii) for the year involved.

22          “(iii) OPD PAYMENT INCREASE FAC-  
23          TOR.—For purposes of this subparagraph,  
24          the ‘OPD payment increase factor’ for

1 services furnished in a year is equal to the  
2 sum of—

3 “(I) market basket percentage in-  
4 crease (applicable under section  
5 1886(b)(3)(B)(iii) to hospital dis-  
6 charges occurring during the fiscal  
7 year ending in such year, and

8 “(II) in the case of a covered  
9 OPD service (or group of such serv-  
10 ices) furnished in a year in which the  
11 pre-deductible payment percentage  
12 would not exceed 80 percent, 3.5 per-  
13 centage points, but in no case greater  
14 than such number of percentage  
15 points as will result in the pre-deduct-  
16 ible payment percentage exceeding 80  
17 percent.

18 In applying the previous sentence for years  
19 beginning with 2000, the Secretary may  
20 substitute for the market basket percent-  
21 age increase under subclause (I) an annual  
22 percentage increase that is computed and  
23 applied with respect to covered OPD serv-  
24 ices furnished in a year in the same man-  
25 ner as the market basket percentage in-

1           crease is determined and applied to inpa-  
2           tient hospital services for discharges occur-  
3           ring in a fiscal year.

4           “(D) PRE-DEDUCTIBLE PAYMENT PER-  
5           CENTAGE.—The pre-deductible payment per-  
6           centage for a covered OPD service (or group of  
7           such services) furnished in a year is equal to  
8           the ratio of—

9                   “(i) the conversion factor established  
10                   under subparagraph (C) for the year, mul-  
11                   tplied by the weighting factor established  
12                   under paragraph (2)(C) for the service (or  
13                   group), to

14                   “(ii) the sum of the amount deter-  
15                   mined under clause (i) and the unadjusted  
16                   copayment amount determined under sub-  
17                   paragraph (B) for such service or group.

18           “(E) CALCULATION OF MEDICARE OPD  
19           FEE SCHEDULE AMOUNTS.—The Secretary  
20           shall compute a medicare OPD fee schedule  
21           amount for each covered OPD service (or group  
22           of such services) furnished in a year, in an  
23           amount equal to the product of—

24                   “(i) the conversion factor computed  
25                   under subparagraph (C) for the year, and

1           “(ii) the relative payment weight (de-  
2           termined under paragraph (2)(C)) for the  
3           service or group.

4           “(4) MEDICARE PAYMENT AMOUNT.—The  
5           amount of payment made from the Trust Fund  
6           under this part for a covered OPD service (and such  
7           services classified within a group) furnished in a  
8           year is determined as follows:

9           “(A) FEE SCHEDULE AND COPAYMENT  
10          AMOUNT.—Add (i) the medicare OPD fee  
11          schedule amount (computed under paragraph  
12          (3)(E)) for the service or group and year, and  
13          (ii) the unadjusted copayment amount (deter-  
14          mined under paragraph (3)(B)) for the service  
15          or group.

16          “(B) SUBTRACT APPLICABLE DEDUCT-  
17          IBLE.—Reduce the adjusted sum by the amount  
18          of the deductible under section 1833(b), to the  
19          extent applicable.

20          “(C) APPLY PAYMENT PROPORTION TO RE-  
21          MAINDER.—Multiply the amount so determined  
22          under subparagraph (B) by the pre-deductible  
23          payment percentage (as determined under para-  
24          graph (3)(D)) for the service or group and year  
25          involved.

1           “(D) LABOR-RELATED ADJUSTMENT.—

2           The amount of payment is the product deter-  
3           mined under subparagraph (C) with the labor-  
4           related portion of such product adjusted for rel-  
5           ative differences in the cost of labor and other  
6           factors determined by the Secretary, as com-  
7           puted under paragraph (2)(D).

8           “(5) COPAYMENT AMOUNT.—

9           “(A) IN GENERAL.—Except as provided in  
10          subparagraph (B), the copayment amount  
11          under this subsection is determined as follows:

12          “(i) UNADJUSTED COPAYMENT.—

13          Compute the amount by which the amount  
14          described in paragraph (4)(B) exceeds the  
15          amount of payment determined under  
16          paragraph (4)(C).

17          “(ii) LABOR ADJUSTMENT.—The co-

18          payment amount is the difference deter-  
19          mined under clause (i) with the labor-relat-  
20          ed portion of such difference adjusted for  
21          relative differences in the cost of labor and  
22          other factors determined by the Secretary,  
23          as computed under paragraphs (2)(D).

24          The adjustment under this clause shall be  
25          made in a manner that does not result in

1           any change in the aggregate copayments  
2           made in any year if the adjustment had  
3           not been made.

4           “(B) ELECTION TO OFFER REDUCED CO-  
5           PAYMENT AMOUNT.—The Secretary shall estab-  
6           lish a procedure under which a hospital, before  
7           the beginning of a year (beginning with 1999),  
8           may elect to reduce the copayment amount oth-  
9           erwise established under subparagraph (A) for  
10          some or all covered OPD services to an amount  
11          that is not less than 25 percent of the medicare  
12          OPD fee schedule amount (computed under  
13          paragraph (3)(E)) for the service involved, ad-  
14          justed for relative differences in the cost of  
15          labor and other factors determined by the Sec-  
16          retary, as computed under subparagraphs (D)  
17          and (E) of paragraph (2). Under such proce-  
18          dures, such reduced copayment amount may  
19          not be further reduced or increased during the  
20          year involved and the hospital may disseminate  
21          information on the reduction of copayment  
22          amount effected under this subparagraph.

23          “(C) NO IMPACT ON DEDUCTIBLES.—  
24          Nothing in this paragraph shall be construed as



1 affecting a hospital's authority to waive the  
2 charging of a deductible under section 1833(b).

3 “(6) PERIODIC REVIEW AND ADJUSTMENTS  
4 COMPONENTS OF PROSPECTIVE PAYMENT SYSTEM.—

5 “(A) PERIODIC REVIEW.—The Secretary  
6 may periodically review and revise the groups,  
7 the relative payment weights, and the wage and  
8 other adjustments described in paragraph (2) to  
9 take into account changes in medical practice,  
10 changes in technology, the addition of new serv-  
11 ices, new cost data, and other relevant informa-  
12 tion and factors.

13 “(B) BUDGET NEUTRALITY ADJUST-  
14 MENT.—If the Secretary makes adjustments  
15 under subparagraph (A), then the adjustments  
16 for a year may not cause the estimated amount  
17 of expenditures under this part for the year to  
18 increase or decrease from the estimated amount  
19 of expenditures under this part that would have  
20 been made if the adjustments had not been  
21 made.

22 “(C) UPDATE FACTOR.—If the Secretary  
23 determines under methodologies described in  
24 subparagraph (2)(F) that the volume of services  
25 paid for under this subsection increased beyond

1 amounts established through those methodolo-  
2 gies, the Secretary may appropriately adjust the  
3 update to the conversion factor otherwise appli-  
4 cable in a subsequent year.

5 “(7) SPECIAL RULE FOR AMBULANCE SERV-  
6 ICES.—The Secretary shall pay for hospital out-  
7 patient services that are ambulance services on the  
8 basis described in the matter in subsection (a)(1)  
9 preceding subparagraph (A).

10 “(8) SPECIAL RULES FOR CERTAIN HOS-  
11 PITALS.—In the case of hospitals described in sec-  
12 tion 1886(d)(1)(B)(v)—

13 “(A) the system under this subsection shall  
14 not apply to covered OPD services furnished be-  
15 fore January 1, 2000; and

16 “(B) the Secretary may establish a sepa-  
17 rate conversion factor for such services in a  
18 manner that specifically takes into account the  
19 unique costs incurred by such hospitals by vir-  
20 tue of their patient population and service in-  
21 tensity.

22 “(9) LIMITATION ON REVIEW.—There shall be  
23 no administrative or judicial review under section  
24 1869, 1878, or otherwise of—

1           “(A) the development of the classification  
2           system under paragraph (2), including the es-  
3           tablishment of groups and relative payment  
4           weights for covered OPD services, of wage ad-  
5           justment factors, other adjustments, and meth-  
6           ods described in paragraph (2)(F);

7           “(B) the calculation of base amounts  
8           under paragraph (3);

9           “(C) periodic adjustments made under  
10          paragraph (6); and

11          “(D) the establishment of a separate con-  
12          version factor under paragraph (8)(B).”.

13          (b) COINSURANCE.—Section 1866(a)(2)(A)(ii) (42  
14 U.S.C. 1395cc(a)(2)(A)(ii)) is amended by adding at the  
15 end the following: “In the case of items and services for  
16 which payment is made under part B under the prospec-  
17 tive payment system established under section 1833(t),  
18 clause (ii) of the first sentence shall be applied by sub-  
19 stituting for 20 percent of the reasonable charge, the ap-  
20 plicable copayment amount established under section  
21 1833(t)(5).”.

22          (c) TREATMENT OF REDUCTION IN COPAYMENT  
23 AMOUNT.—Section 1128A(i)(6) (42 U.S.C. 1320a-  
24 7a(i)(6)) is amended—

1           (1) by striking “or” at the end of subparagraph  
2           (B),

3           (2) by striking the period at the end of sub-  
4           paragraph (C) and inserting “; or”, and

5           (3) by adding at the end the following new sub-  
6           paragraph:

7                     “(D) a reduction in the copayment amount  
8                     for covered OPD services under section  
9                     1833(t)(5)(B).”.

10          (d) CONFORMING AMENDMENTS.—

11           (1) APPROVED ASC PROCEDURES PERFORMED  
12          IN HOSPITAL OUTPATIENT DEPARTMENTS.—

13                     (A)(i) Section 1833(i)(3)(A) (42 U.S.C.  
14                     13951(i)(3)(A)) is amended—

15                             (I) by inserting “before January 1,  
16                             1999,” after “furnished”, and

17                             (II) by striking “in a cost reporting  
18                             period”.

19                     (ii) The amendment made by clause (i)  
20                     shall apply to services furnished on or after  
21                     January 1, 1999.

22                     (B) Section 1833(a)(4) (42 U.S.C.  
23                     13951(a)(4)) is amended by inserting “or sub-  
24                     section (t)” before the semicolon.

1           (2) RADIOLOGY AND OTHER DIAGNOSTIC PRO-  
2           CEDURES.—

3           (A) Section 1833(n)(1)(A) (42 U.S.C.  
4           1395l(n)(1)(A)) is amended by inserting “and  
5           before January 1, 1999,” after “October 1,  
6           1988,” and after “October 1, 1989,”.

7           (B) Section 1833(a)(2)(E) (42 U.S.C.  
8           1395l(a)(2)(E)) is amended by inserting “or,  
9           for services or procedures performed on or after  
10          January 1, 1999, (t)” before the semicolon.

11          (3) OTHER HOSPITAL OUTPATIENT SERV-  
12          ICES.—Section 1833(a)(2)(B) (42 U.S.C.  
13          1395l(a)(2)(B)) is amended—

14           (A) in clause (i), by inserting “furnished  
15           before January 1, 1999,” after “(i),”

16           (B) in clause (ii), by inserting “before Jan-  
17           uary 1, 1999,” after “furnished”,

18           (C) by redesignating clause (iii) as clause  
19           (iv),and

20           (D) by inserting after clause (ii), the fol-  
21           lowing new clause:

22           “(iii) if such services are furnished on  
23           or after January 1, 1999, the amount de-  
24           termined under subsection (t), or”.

1       **Subchapter B—Rehabilitation Services**

2       **SEC. 4421. REHABILITATION AGENCIES AND SERVICES.**

3       (a) PAYMENT BASED ON FEE SCHEDULE.—

4           (1) SPECIAL PAYMENT RULES.—Section  
5       1833(a) (42 U.S.C. 1395l(a)) is amended—

6           (A) in paragraph (2) in the matter before  
7       subparagraph (A), by inserting “(C),” before  
8       “(D)”;

9           (B) in paragraph (6), by striking “and” at  
10       the end;

11          (C) in paragraph (7), by striking the pe-  
12       riod at the end and inserting “; and”;

13          (D) by adding at the end the following new  
14       paragraph:

15        “(8) in the case of services described in section  
16       1832(a)(2)(C) (that are not described in section  
17       1832(a)(2)(B)), the amounts described in section  
18       1834(k).”.

19          (2) PAYMENT RATES.—Section 1834 (42  
20       U.S.C. 1395m) is amended by adding at the end the  
21       following new subsection:

22        “(k) PAYMENT FOR OUTPATIENT THERAPY SERV-  
23       ICES.—

24           “(1) IN GENERAL.—With respect to outpatient  
25       physical therapy services (which includes outpatient

1 speech-language pathology services) and outpatient  
2 occupational therapy services for which payment is  
3 determined under this subsection, the payment basis  
4 shall be—

5 “(A) for services furnished during 1998,  
6 the amount determined under paragraph (2); or

7 “(B) for services furnished during a subse-  
8 quent year, 80 percent of the lesser of—

9 “(i) the actual charge for the services,

10 or

11 “(ii) the applicable fee schedule  
12 amount (as defined in paragraph (3)) for  
13 the services.

14 “(2) PAYMENT IN 1998 BASED UPON CHARGES  
15 OR ADJUSTED REASONABLE COSTS.—The amount  
16 under this paragraph for services is the lesser of—

17 “(A) the charges imposed for the services,

18 or

19 “(B) the adjusted reasonable costs (as de-  
20 fined in paragraph (4)) for the services,

21 less 20 percent of the amount of the charges im-  
22 posed for such services.

23 “(3) APPLICABLE FEE SCHEDULE AMOUNT.—

24 In this paragraph, the term ‘applicable fee schedule  
25 amount’ means, with respect to services furnished in

1 a year, the fee schedule amount established under  
2 section 1848 for such services furnished during the  
3 year or, if there is no such fee schedule amount es-  
4 tablished for such services, for such comparable  
5 services as the Secretary specifies.

6 “(4) ADJUSTED REASONABLE COSTS.—In para-  
7 graph (2), the term ‘adjusted reasonable costs’  
8 means reasonable costs determined reduced by—

9 “(A) 5.8 percent of the reasonable costs  
10 for operating costs, and

11 “(B) 10 percent of the reasonable costs for  
12 capital costs.

13 “(5) UNIFORM CODING.—For claims for serv-  
14 ices submitted on or after April 1, 1998, for which  
15 the amount of payment is determined under this  
16 subsection, the claim shall include a code (or codes)  
17 under a uniform coding system specified by the Sec-  
18 retary that identifies the services furnished.

19 “(6) RESTRAINT ON BILLING.—The provisions  
20 of subparagraphs (A) and (B) of section  
21 1842(b)(18) shall apply to therapy services for  
22 which payment is made under this subsection in the  
23 same manner as they apply to services provided by  
24 a practitioner described in section 1842(b)(18)(C).”.



1 (b) APPLICATION OF STANDARDS TO OUTPATIENT  
2 OCCUPATIONAL AND PHYSICAL THERAPY SERVICES PRO-  
3 VIDED AS AN INCIDENT TO A PHYSICIAN'S PROFESSIONAL  
4 SERVICES.—Section 1862(a), as amended by section  
5 4401(b), (42 U.S.C. 1395y(a)) is amended—

6 (1) by striking “or” at the end of paragraph  
7 (16);

8 (2) by striking the period at the end of para-  
9 graph (17) and inserting “; or”; and

10 (3) by inserting after paragraph (17) the fol-  
11 lowing:

12 “(18) in the case of outpatient occupational  
13 therapy services or outpatient physical therapy serv-  
14 ices furnished as an incident to a physician's profes-  
15 sional services (as described in section  
16 1861(s)(2)(A)), that do not meet the standards and  
17 conditions under the second sentence of section  
18 1861(g) or 1861(p) as such standards and condi-  
19 tions would apply to such therapy services if fur-  
20 nished by a therapist.”.

21 (c) APPLYING FINANCIAL LIMITATION TO ALL RE-  
22 HABILITATION SERVICES.—Section 1833(g) (42 U.S.C.  
23 1395l(g)) is amended—

24 (1) in the first sentence, by striking “services  
25 described in the second sentence of section 1861(p)”

1 and inserting “physical therapy services of the type  
2 described in section 1861(p) (regardless of who fur-  
3 nishes the services or whether the services may be  
4 covered as physicians’ services so long as the serv-  
5 ices are furnished other than in a hospital setting)”,  
6 and

7 (2) in the second sentence, by striking “out-  
8 patient occupational therapy services which are de-  
9 scribed in the second sentence of section 1861(p)  
10 through the operation of section 1861(g)” and in-  
11 sserting “occupational therapy services (of the type  
12 that are described in section 1861(p) through the  
13 operation of section 1861(g)), regardless of who fur-  
14 nishes the services or whether the services may be  
15 covered as physicians’ services so long as the serv-  
16 ices are furnished other than in a hospital setting”.

17 (d) EFFECTIVE DATE.—The amendments made by  
18 this section apply to services furnished on or after Janu-  
19 ary 1, 1998; except that the amendments made by sub-  
20 section (c) apply to services furnished on or after January  
21 1, 1999.

22 **SEC. 4422. COMPREHENSIVE OUTPATIENT REHABILITA-**  
23 **TION FACILITIES (CORF).**

24 (a) PAYMENT BASED ON FEE SCHEDULE.—

1           (1) SPECIAL PAYMENT RULES.—Section  
2 1833(a) (42 U.S.C. 1395l(a)), as amended by sec-  
3 tion 4421(a), is amended—

4           (A) in paragraph (3), by striking “sub-  
5 paragraphs (D) and (E) of section 1832(a)(2)”  
6 and inserting “section 1832(a)(2)(E)”;

7           (B) in paragraph (7), by striking “and” at  
8 the end;

9           (C) in paragraph (8), by striking the pe-  
10 riod at the end and inserting “; and”;

11           (D) by adding at the end the following new  
12 paragraph:

13           “(9) in the case of services described in section  
14 1832(a)(2)(E), the amounts described in section  
15 1834(k).”.

16           (2) PAYMENT RATES.—Section 1834(k) (42  
17 U.S.C. 1395m(k)), as added by section 4421(a), is  
18 amended—

19           (A) in the heading, by inserting “AND  
20 COMPREHENSIVE OUTPATIENT REHABILITA-  
21 TION FACILITY SERVICES” after “THERAPY  
22 SERVICES”; and

23           (B) in paragraph (1), by inserting “and  
24 with respect to comprehensive outpatient reha-

1           bilitation facility services” after “occupational  
2           therapy services”.

3           (b) EFFECTIVE DATE.—The amendments made by  
4 subsection (a) shall apply to services furnished on or after  
5 January 1, 1998, and to portions of cost reporting periods  
6 occurring on or after such date.

## 7           **Subchapter C—Ambulance Services**

### 8           **SEC. 4431. PAYMENTS FOR AMBULANCE SERVICES.**

9           (a) INTERIM REDUCTIONS.—

10           (1) PAYMENTS DETERMINED ON REASONABLE  
11 COST BASIS.—Section 1861(v)(1) (42 U.S.C.  
12 1395x(v)(1)) is amended by adding at the end the  
13 following new subparagraph:

14           “(U) In determining the reasonable cost of am-  
15 bulance services (as described in subsection (s)(7))  
16 provided during a fiscal year (beginning with fiscal  
17 year 1998 and ending with fiscal year 2002), the  
18 Secretary shall not recognize the costs per trip in ex-  
19 cess of costs recognized as reasonable for ambulance  
20 services provided on a per trip basis during the pre-  
21 vious fiscal year after application of this subpara-  
22 graph, increased by the percentage increase in the  
23 consumer price index for all urban consumers (U.S.  
24 city average) as estimated by the Secretary for the  
25 12-month period ending with the midpoint of the fis-

1 cal year involved reduced (in the case of each of fis-  
2 cal years 1998 and 1999) by 1 percentage point.”.

3 (2) PAYMENTS DETERMINED ON REASONABLE  
4 CHARGE BASIS.—Section 1842(b) (42 U.S.C.  
5 1395u(b)) is amended by adding at the end the fol-  
6 lowing new paragraph:

7 “(19) For purposes of section 1833(a)(1), the reason-  
8 able charge for ambulance services (as described in section  
9 1861(s)(7)) provided during a fiscal year (beginning with  
10 fiscal year 1998 and ending with fiscal year 2002) may  
11 not exceed the reasonable charge for such services pro-  
12 vided during the previous fiscal year after the application  
13 of this subparagraph, increased by the percentage increase  
14 in the consumer price index for all urban consumers (U.S.  
15 city average) as estimated by the Secretary for the 12-  
16 month period ending with the midpoint of the year in-  
17 volved reduced (in the case of each of fiscal years 1998  
18 and 1999) by 1 percentage point.”.

19 (b) ESTABLISHMENT OF PROSPECTIVE FEE SCHED-  
20 ULE.—

21 (1) PAYMENT IN ACCORDANCE WITH FEE  
22 SCHEDULE.—Section 1833(a)(1) (42 U.S.C.  
23 1395l(a)(1)), as amended by section 4619(b)(1), is  
24 amended—

1 (A) by striking “and (P)” and inserting  
2 “(P)”; and

3 (B) by striking the semicolon at the end  
4 and inserting the following: “, and (Q) with re-  
5 spect to ambulance service, the amounts paid  
6 shall be 80 percent of the lesser of the actual  
7 charge for the services or the amount deter-  
8 mined by a fee schedule established by the Sec-  
9 retary under section 1834(l);”.

10 (2) ESTABLISHMENT OF SCHEDULE.—Section  
11 1834 (42 U.S.C. 1395m), as amended by section  
12 4421(a)(2), is amended by adding at the end the fol-  
13 lowing new subsection:

14 “(1) ESTABLISHMENT OF FEE SCHEDULE FOR AM-  
15 BULANCE SERVICES.—

16 “(1) IN GENERAL.—The Secretary shall estab-  
17 lish a fee schedule for payment for ambulance serv-  
18 ices under this part through a negotiated rulemaking  
19 process described in title 5, United States Code, and  
20 in accordance with the requirements of this sub-  
21 section.

22 “(2) CONSIDERATIONS.—In establishing such  
23 fee schedule the Secretary shall—

1           “(A) establish mechanisms to control in-  
2 creases in expenditures for ambulance services  
3 under this part;

4           “(B) establish definitions for ambulance  
5 services which link payments to the type of  
6 services provided;

7           “(C) consider appropriate regional and  
8 operational differences;

9           “(D) consider adjustments to payment  
10 rates to account for inflation and other relevant  
11 factors; and

12           “(E) phase in the application of the pay-  
13 ment rates under the fee schedule in an effi-  
14 cient and fair manner.

15           “(3) SAVINGS.—In establishing such fee sched-  
16 ule the Secretary shall—

17           “(A) ensure that the aggregate amount of  
18 payments made for ambulance services under  
19 this part during 2000 does not exceed the ag-  
20 gregate amount of payments which would have  
21 been made for such services under this part  
22 during such year if the amendments made by  
23 section 4431 of the Balanced Budget Act of  
24 1997 had not been made; and

1           “(B) set the payment amounts provided  
2           under the fee schedule for services furnished in  
3           2001 and each subsequent year at amounts  
4           equal to the payment amounts under the fee  
5           schedule for service furnished during the pre-  
6           vious year, increased by the percentage increase  
7           in the consumer price index for all urban con-  
8           sumers (U.S. city average) for the 12-month  
9           period ending with June of the previous year.

10           “(4) CONSULTATION.—In establishing the fee  
11           schedule for ambulance services under this sub-  
12           section, the Secretary shall consult with various na-  
13           tional organizations representing individuals and en-  
14           tities who furnish and regulate ambulance services  
15           and share with such organizations relevant data in  
16           establishing such schedule.

17           “(5) LIMITATION ON REVIEW.—There shall be  
18           no administrative or judicial review under section  
19           1869 or otherwise of the amounts established under  
20           the fee schedule for ambulance services under this  
21           subsection, including matters described in paragraph  
22           (2).

23           “(6) RESTRAINT ON BILLING.—The provisions  
24           of subparagraphs (A) and (B) of section  
25           1842(b)(18) shall apply to ambulance services for



1       which payment is made under this subsection in the  
2       same manner as they apply to services provided by  
3       a practitioner described in section 1842(b)(18)(C).”.

4               (3) EFFECTIVE DATE.—The amendments made  
5       by this section apply to ambulance services furnished  
6       on or after January 1, 2000.

7       (c) AUTHORIZING PAYMENT FOR PARAMEDIC INTER-  
8       CEPT SERVICE PROVIDERS IN RURAL COMMUNITIES.—In  
9       promulgating regulations to carry out section 1861(s)(7)  
10      of the Social Security Act (42 U.S.C. 1395x(s)(7)) with  
11      respect to the coverage of ambulance service, the Secretary  
12      of Health and Human Services may include coverage of  
13      advanced life support services (in this subsection referred  
14      to as “ALS intercept services”) provided by a paramedic  
15      intercept service provider in a rural area if the following  
16      conditions are met:

17              (1) The ALS intercept services are provided  
18      under a contract with one or more volunteer ambu-  
19      lance services and are medically necessary based on  
20      the health condition of the individual being trans-  
21      ported.

22              (2) The volunteer ambulance service involved—  
23                  (A) is certified as qualified to provide am-  
24                  bulance service for purposes of such section,

1 (B) provides only basic life support serv-  
2 ices at the time of the intercept, and

3 (C) is prohibited by State law from billing  
4 for any services.

5 (3) The entity supplying the ALS intercept  
6 services—

7 (A) is certified as qualified to provide such  
8 services under the medicare program under title  
9 XVIII of the Social Security Act, and

10 (B) bills all recipients who receive ALS  
11 intercept services from the entity, regardless of  
12 whether or not such recipients are medicare  
13 beneficiaries.

14 **SEC. 4432. DEMONSTRATION OF COVERAGE OF AMBU-**  
15 **LANCE SERVICES UNDER MEDICARE**  
16 **THROUGH CONTRACTS WITH UNITS OF**  
17 **LOCAL GOVERNMENT.**

18 (a) DEMONSTRATION PROJECT CONTRACTS WITH  
19 LOCAL GOVERNMENTS.—The Secretary of Health and  
20 Human Services shall establish up to 3 demonstration  
21 projects under which, at the request of a county or parish,  
22 the Secretary enters into a contract with the county or  
23 parish under which—

24 (1) the county or parish furnishes (or arranges  
25 for the furnishing) of ambulance services for which

1 payment may be made under part B of title XVIII  
2 of the Social Security Act for individuals residing in  
3 the county or parish who are enrolled under such  
4 part, except that the county or parish may not enter  
5 into the contract unless the contract covers at least  
6 80 percent of the individuals residing in the county  
7 or parish who are enrolled under such part;

8 (2) any individual or entity furnishing ambu-  
9 lance services under the contract meets the require-  
10 ments otherwise applicable to individuals and enti-  
11 ties furnishing such services under such part; and

12 (3) for each month during which the contract is  
13 in effect, the Secretary makes a capitated payment  
14 to the county or parish in accordance with sub-  
15 section (b).

16 The projects may extend over a period of not to exceed  
17 3 years each.

18 (b) AMOUNT OF PAYMENT.—

19 (1) IN GENERAL.—The amount of the monthly  
20 payment made for months occurring during a cal-  
21 endar year to a county or parish under a demonstra-  
22 tion project contract under subsection (a) shall be  
23 equal to the product of—

1 (A) the Secretary's estimate of the number  
2 of individuals covered under the contract for the  
3 month; and

4 (B)  $\frac{1}{12}$  of the capitated payment rate for  
5 the year established under paragraph (2).

6 (2) CAPITATED PAYMENT RATE DEFINED.—In  
7 this subsection, the “capitated payment rate” appli-  
8 cable to a contract under this subsection for a cal-  
9 endar year is equal to 95 percent of—

10 (A) for the first calendar year for which  
11 the contract is in effect, the average annual per  
12 capita payment made under part B of title  
13 XVIII of the Social Security Act with respect to  
14 ambulance services furnished to such individ-  
15 uals during the 3 most recent calendar years  
16 for which data on the amount of such payment  
17 is available; and

18 (B) for a subsequent year, the amount pro-  
19 vided under this paragraph for the previous  
20 year increased by the percentage increase in the  
21 consumer price index for all urban consumers  
22 (U.S. city average) for the 12-month period  
23 ending with June of the previous year.

24 (c) OTHER TERMS OF CONTRACT.—The Secretary  
25 and the county or parish may include in a contract under

1 this section such other terms as the parties consider ap-  
2 propriate, including—

3           (1) covering individuals residing in additional  
4           counties or parishes (under arrangements entered  
5           into between such counties or parishes and the coun-  
6           ty or parish involved);

7           (2) permitting the county or parish to transport  
8           individuals to non-hospital providers if such provid-  
9           ers are able to furnish quality services at a lower  
10          cost than hospital providers; or

11          (3) implementing such other innovations as the  
12          county or parish may propose to improve the quality  
13          of ambulance services and control the costs of such  
14          services.

15          (d) CONTRACT PAYMENTS IN LIEU OF OTHER BENE-  
16          FITS.—Payments under a contract to a county or parish  
17          under this section shall be instead of the amounts which  
18          (in the absence of the contract) would otherwise be pay-  
19          able under part B of title XVIII of the Social Security  
20          Act for the services covered under the contract which are  
21          furnished to individuals who reside in the county or parish.

22          (e) REPORT ON EFFECTS OF CAPITATED CON-  
23          TRACTS.—

24                (1) STUDY.—The Secretary shall evaluate the  
25                demonstration projects conducted under this section.

1 Such evaluation shall include an analysis of the  
2 quality and cost-effectiveness of ambulance services  
3 furnished under the projects.

4 (2) REPORT.—Not later than January 1, 2000,  
5 the Secretary shall submit a report to Congress on  
6 the study conducted under paragraph (1), and shall  
7 include in the report such recommendations as the  
8 Secretary considers appropriate, including rec-  
9 ommendations regarding modifications to the meth-  
10 odology used to determine the amount of payments  
11 made under such contracts and extending or expand-  
12 ing such projects.

13 **CHAPTER 3—PAYMENT UNDER PARTS A**  
14 **AND B**

15 **SEC. 4441. PROSPECTIVE PAYMENT FOR HOME HEALTH**  
16 **SERVICES.**

17 (a) IN GENERAL.—Title XVIII (42 U.S.C. 1395 et  
18 seq.), as amended by section 4011, is amended by adding  
19 at the end the following new section:

20 “PROSPECTIVE PAYMENT FOR HOME HEALTH SERVICES

21 “SEC. 1895. (a) IN GENERAL.—Notwithstanding sec-  
22 tion 1861(v), the Secretary shall provide, for cost report-  
23 ing periods beginning on or after October 1, 1999, for pay-  
24 ments for home health services in accordance with a pro-  
25 spective payment system established by the Secretary  
26 under this section.

1       “(b) SYSTEM OF PROSPECTIVE PAYMENT FOR HOME  
2 HEALTH SERVICES.—

3               “(1) IN GENERAL.—The Secretary shall estab-  
4 lish under this subsection a prospective payment sys-  
5 tem for payment for all costs of home health serv-  
6 ices. Under the system under this subsection all  
7 services covered and paid on a reasonable cost basis  
8 under the medicare home health benefit as of the  
9 date of the enactment of the this section, including  
10 medical supplies, shall be paid for on the basis of a  
11 prospective payment amount determined under this  
12 subsection and applicable to the services involved. In  
13 implementing the system, the Secretary may provide  
14 for a transition (of not longer than 4 years) during  
15 which a portion of such payment is based on agency-  
16 specific costs, but only if such transition does not re-  
17 sult in aggregate payments under this title that ex-  
18 ceed the aggregate payments that would be made if  
19 such a transition did not occur.

20               “(2) UNIT OF PAYMENT.—In defining a pro-  
21 spective payment amount under the system under  
22 this subsection, the Secretary shall consider an ap-  
23 propriate unit of service and the number, type, and  
24 duration of visits provided within that unit, potential  
25 changes in the mix of services provided within that

1 unit and their cost, and a general system design that  
2 provides for continued access to quality services.

3 “(3) PAYMENT BASIS.—

4 “(A) INITIAL BASIS.—

5 “(i) IN GENERAL.—Under such sys-  
6 tem the Secretary shall provide for com-  
7 putation of a standard prospective pay-  
8 ment amount (or amounts). Such amount  
9 (or amounts) shall initially be based on the  
10 most current audited cost report data  
11 available to the Secretary and shall be  
12 computed in a manner so that the total  
13 amounts payable under the system for fis-  
14 cal year 2000 shall be equal to the total  
15 amount that would have been made if the  
16 system had not been in effect but if the re-  
17 duction in limits described in clause (ii)  
18 had been in effect. Such amount shall be  
19 standardized in a manner that eliminates  
20 the effect of variations in relative case mix  
21 and wage levels among different home  
22 health agencies in a budget neutral manner  
23 consistent with the case mix and wage level  
24 adjustments provided under paragraph  
25 (4)(A). Under the system, the Secretary



1 may recognize regional differences or dif-  
2 ferences based upon whether or not the  
3 services or agency are in an urbanized  
4 area.

5 “(ii) REDUCTION.—The reduction de-  
6 scribed in this clause is a reduction by 15  
7 percent in the cost limits and per bene-  
8 ficiary limits described in section  
9 1861(v)(1)(L), as those limits are in effect  
10 on September 30, 1999.

11 “(B) ANNUAL UPDATE.—

12 “(i) IN GENERAL.—The standard pro-  
13 spective payment amount (or amounts)  
14 shall be adjusted for each fiscal year (be-  
15 ginning with fiscal year 2001) in a pro-  
16 spective manner specified by the Secretary  
17 by the home health market basket percent-  
18 age increase applicable to the fiscal year  
19 involved.

20 “(ii) HOME HEALTH MARKET BASKET  
21 PERCENTAGE INCREASE.—For purposes of  
22 this subsection, the term ‘home health  
23 market basket percentage increase’ means,  
24 with respect to a fiscal year, a percentage  
25 (estimated by the Secretary before the be-

1           ginning of the fiscal year) determined and  
2           applied with respect to the mix of goods  
3           and services included in home health serv-  
4           ices in the same manner as the market  
5           basket percentage increase under section  
6           1886(b)(3)(B)(iii) is determined and ap-  
7           plied to the mix of goods and services com-  
8           prising inpatient hospital services for the  
9           fiscal year.

10           “(C) ADJUSTMENT FOR OUTLIERS.—The  
11           Secretary shall reduce the standard prospective  
12           payment amount (or amounts) under this para-  
13           graph applicable to home health services fur-  
14           nished during a period by such proportion as  
15           will result in an aggregate reduction in pay-  
16           ments for the period equal to the aggregate in-  
17           crease in payments resulting from the applica-  
18           tion of paragraph (5) (relating to outliers).

19           “(4) PAYMENT COMPUTATION.—

20           “(A) IN GENERAL.—The payment amount  
21           for a unit of home health services shall be the  
22           applicable standard prospective payment  
23           amount adjusted as follows:

24           “(i) CASE MIX ADJUSTMENT.—The  
25           amount shall be adjusted by an appro-

1           appropriate case mix adjustment factor (estab-  
2           lished under subparagraph (B)).

3           “(ii) AREA WAGE ADJUSTMENT.—The  
4           portion of such amount that the Secretary  
5           estimates to be attributable to wages and  
6           wage-related costs shall be adjusted for ge-  
7           ographic differences in such costs by an  
8           area wage adjustment factor (established  
9           under subparagraph (C)) for the area in  
10          which the services are furnished or such  
11          other area as the Secretary may specify.

12          “(B) ESTABLISHMENT OF CASE MIX AD-  
13          JUSTMENT FACTORS.—The Secretary shall es-  
14          tablish appropriate case mix adjustment factors  
15          for home health services in a manner that ex-  
16          plains a significant amount of the variation in  
17          cost among different units of services.

18          “(C) ESTABLISHMENT OF AREA WAGE AD-  
19          JUSTMENT FACTORS.—The Secretary shall es-  
20          tablish area wage adjustment factors that re-  
21          flect the relative level of wages and wage-related  
22          costs applicable to the furnishing of home  
23          health services in a geographic area compared  
24          to the national average applicable level. Such

1 factors may be the factors used by the Sec-  
2 retary for purposes of section 1886(d)(3)(E).

3 “(5) OUTLIERS.—The Secretary may provide  
4 for an addition or adjustment to the payment  
5 amount otherwise made in the case of outliers be-  
6 cause of unusual variations in the type or amount of  
7 medically necessary care. The total amount of the  
8 additional payments or payment adjustments made  
9 under this paragraph with respect to a fiscal year  
10 may not exceed 5 percent of the total payments pro-  
11 jected or estimated to be made based on the prospec-  
12 tive payment system under this subsection in that  
13 year.

14 “(6) PRORATION OF PROSPECTIVE PAYMENT  
15 AMOUNTS.—If a beneficiary elects to transfer to, or  
16 receive services from, another home health agency  
17 within the period covered by the prospective payment  
18 amount, the payment shall be prorated between the  
19 home health agencies involved.

20 “(c) REQUIREMENTS FOR PAYMENT INFORMA-  
21 TION.—With respect to home health services furnished on  
22 or after October 1, 1998, no claim for such a service may  
23 be paid under this title unless—

24 “(1) the claim has the unique identifier (pro-  
25 vided under section 1842(r)) for the physician who

1 prescribed the services or made the certification de-  
2 scribed in section 1814(a)(2) or 1835(a)(2)(A); and

3 “(2) in the case of a service visit described in  
4 paragraph (1), (2), (3), or (4) of section 1861(m),  
5 the claim has information (coded in an appropriate  
6 manner) on the length of time of the service visit,  
7 as measured in 15 minute increments.

8 “(d) LIMITATION ON REVIEW.—There shall be no ad-  
9 ministrative or judicial review under section 1869, 1878,  
10 or otherwise of—

11 “(1) the establishment of a transition period  
12 under subsection (b)(1);

13 “(2) the definition and application of payment  
14 units under subsection (b)(2);

15 “(3) the computation of initial standard pro-  
16 spective payment amounts under subsection  
17 (b)(3)(A) (including the reduction described in  
18 clause (ii) of such subsection);

19 “(4) the adjustment for outliers under sub-  
20 section (b)(3)(C);

21 “(5) case mix and area wage adjustments under  
22 subsection (b)(4);

23 “(6) any adjustments for outliers under sub-  
24 section (b)(5); and

1           “(7) the amounts or types of exceptions or ad-  
2           justments under subsection (b)(7).”.

3           (b) ELIMINATION OF PERIODIC INTERIM PAYMENTS  
4 FOR HOME HEALTH AGENCIES.—Section 1815(e)(2) (42  
5 U.S.C. 1395g(e)(2)) is amended—

6           (1) by inserting “and” at the end of subpara-  
7           graph (C),

8           (2) by striking subparagraph (D), and

9           (3) by redesignating subparagraph (E) as sub-  
10          paragraph (D).

11          (c) CONFORMING AMENDMENTS.—

12           (1) PAYMENTS UNDER PART A.—Section  
13          1814(b) (42 U.S.C. 1395f(b)) is amended in the  
14          matter preceding paragraph (1) by striking “and  
15          1886” and inserting “1886, and 1895”.

16           (2) TREATMENT OF ITEMS AND SERVICES PAID  
17          UNDER PART B.—

18           (A) PAYMENTS UNDER PART B.—Section  
19          1833(a)(2) (42 U.S.C. 1395l(a)(2)) is amend-  
20          ed—

21           (i) by amending subparagraph (A) to  
22          read as follows:

23           “(A) with respect to home health services  
24          (other than a covered osteoporosis drug) (as de-  
25          fined in section 1861(kk)), the amount deter-

1           mined under the prospective payment system  
2           under section 1895;”;

3                   (ii) by striking “and” at the end of  
4                   subparagraph (E);

5                   (iii) by adding “and” at the end of  
6                   subparagraph (F); and

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

9                   “(G) with respect to items and services de-  
10                  scribed in section 1861(s)(10)(A), the lesser  
11                  of—

12                           “(i) the reasonable cost of such serv-  
13                           ices, as determined under section 1861(v),  
14                           or

15                                   “(ii) the customary charges with re-  
16                                   spect to such services,

17                  or, if such services are furnished by a public  
18                  provider of services, or by another provider  
19                  which demonstrates to the satisfaction of the  
20                  Secretary that a significant portion of its pa-  
21                  tients are low-income (and requests that pay-  
22                  ment be made under this provision), free of  
23                  charge or at nominal charges to the public, the  
24                  amount determined in accordance with section  
25                  1814(b)(2);”.

1 (B) REQUIRING PAYMENT FOR ALL ITEMS  
2 AND SERVICES TO BE MADE TO AGENCY.—

3 (i) IN GENERAL.—The first sentence  
4 of section 1842(b)(6) (42 U.S.C.  
5 1395u(b)(6)), as amended by section  
6 4401(b)(2), is amended—

7 (I) by striking “and (E)” and in-  
8 serting “(E)”; and

9 (II) by striking the period at the  
10 end and inserting the following: “,  
11 and (F) in the case of home health  
12 services furnished to an individual  
13 who (at the time the item or service is  
14 furnished) is under a plan of care of  
15 a home health agency, payment shall  
16 be made to the agency (without re-  
17 gard to whether or not the item or  
18 service was furnished by the agency,  
19 by others under arrangement with  
20 them made by the agency, or when  
21 any other contracting or consulting  
22 arrangement, or otherwise).”.

23 (ii) CONFORMING AMENDMENT.—Sec-  
24 tion 1832(a)(1) (42 U.S.C. 1395k(a)(1)),  
25 as amended by section 4401(b), is amend-



1 ed by striking “and section 1842(b)(6)(E)”  
2 and inserting “, section 1842(b)(6)(E),  
3 and section 1842(b)(6)(F)”.

4 (C) EXCLUSIONS FROM COVERAGE.—Sec-  
5 tion 1862(a) (42 U.S.C. 1395y(a)), as amended  
6 by sections 4401(b) and 4421(b), is amended—

7 (i) by striking “or” at the end of  
8 paragraph (17);

9 (ii) by striking the period at the end  
10 of paragraph (18) and inserting “; or”;  
11 and

12 (iii) inserting after paragraph (18) the  
13 following new paragraph:

14 “(19) where such expenses are for home health  
15 services furnished to an individual who is under a  
16 plan of care of the home health agency if the claim  
17 for payment for such services is not submitted by  
18 the agency.”.

19 (d) EFFECTIVE DATE.—Except as otherwise pro-  
20 vided, the amendments made by this section shall apply  
21 to cost reporting periods beginning on or after October  
22 1, 1999.

1 **Subtitle G—Provisions Relating to**  
2 **Part B Only**

3 **CHAPTER 1—PHYSICIANS’ SERVICES**

4 **SEC. 4601. ESTABLISHMENT OF SINGLE CONVERSION FAC-**  
5 **TOR FOR 1998.**

6 (a) IN GENERAL.—Section 1848(d)(1) (42 U.S.C.  
7 1395w–4(d)(1)) is amended—

8 (1) by redesignating subparagraph (C) as sub-  
9 paragraph (D), and

10 (2) by inserting after subparagraph (B) the fol-  
11 lowing:

12 “(C) SPECIAL RULES FOR 1998.—The sin-  
13 gle conversion factor for 1998 under this sub-  
14 section shall be the conversion factor for pri-  
15 mary care services for 1997, increased by the  
16 Secretary’s estimate of the weighted average of  
17 the three separate updates that would otherwise  
18 occur were it not for the enactment of chapter  
19 1 of subtitle G of title X of the Balanced Bud-  
20 get Act of 1997.”.

21 (b) CONFORMING AMENDMENTS.—Section 1848 (42  
22 U.S.C. 1395w–4) is amended—

23 (1) by striking “(or factors)” each place it ap-  
24 pears in subsection (d)(1)(A) and (d)(1)(D)(ii) (as  
25 redesignated by subsection (a)(1)),

1           (2) in subsection (d)(1)(A), by striking “or up-  
2           dates”,

3           (3) in subsection (d)(1)(D) (as redesignated by  
4           subsection (a)(1)), by striking “(or updates)” each  
5           place it appears, and

6           (4) in subsection (i)(1)(C), by striking “conver-  
7           sion factors” and inserting “the conversion factor”.

8 **SEC. 4602. ESTABLISHING UPDATE TO CONVERSION FAC-**  
9                                   **TOR TO MATCH SPENDING UNDER SUSTAIN-**  
10                                   **ABLE GROWTH RATE.**

11           (a) UPDATE.—

12           (1) IN GENERAL.—Section 1848(d)(3) (42  
13           U.S.C. 1395w-4(d)(3)) is amended to read as fol-  
14           lows:

15           “(3) UPDATE.—

16           “(A) IN GENERAL.—Unless otherwise pro-  
17           vided by law, subject to subparagraph (D) and  
18           the budget-neutrality factor determined by the  
19           Secretary under subsection (c)(2)(B)(ii), the  
20           update to the single conversion factor estab-  
21           lished in paragraph (1)(C) for a year beginning  
22           with 1999 is equal to the product of—

23           “(i) 1 plus the Secretary’s estimate of  
24           the percentage increase in the MEI (as de-

1                    fined in section 1842(i)(3)) for the year  
2                    (divided by 100), and

3                    “(ii) 1 plus the Secretary’s estimate of  
4                    the update adjustment factor for the year  
5                    (divided by 100),

6                    minus 1 and multiplied by 100.

7                    “(B) UPDATE ADJUSTMENT FACTOR.—For  
8                    purposes of subparagraph (A)(ii), the ‘update  
9                    adjustment factor’ for a year is equal to the  
10                   quotient (as estimated by the Secretary) of—

11                   “(i) the difference between (I) the  
12                   sum of the allowed expenditures for physi-  
13                   cians’ services (as determined under sub-  
14                   paragraph (C)) during the period begin-  
15                   ning July 1, 1997, and ending on June 30  
16                   of the year involved, and (II) the sum of  
17                   the amount of actual expenditures for phy-  
18                   sicians’ services furnished during the pe-  
19                   riod beginning July 1, 1997, and ending  
20                   on June 30 of the preceding year; divided  
21                   by

22                   “(ii) the actual expenditures for physi-  
23                   cians’ services for the 12-month period  
24                   ending on June 30 of the preceding year,  
25                   increased by the sustainable growth rate

1 under subsection (f) for the fiscal year  
2 which begins during such 12-month period.

3 “(C) DETERMINATION OF ALLOWED EX-  
4 PENDITURES.—For purposes of this paragraph,  
5 the allowed expenditures for physicians’ services  
6 for the 12-month period ending with June 30  
7 of—

8 “(i) 1997 is equal to the actual ex-  
9 penditures for physicians’ services fur-  
10 nished during such 12-month period, as es-  
11 timated by the Secretary; or

12 “(ii) a subsequent year is equal to the  
13 allowed expenditures for physicians’ serv-  
14 ices for the previous year, increased by the  
15 sustainable growth rate under subsection  
16 (f) for the fiscal year which begins during  
17 such 12-month period.

18 “(D) RESTRICTION ON VARIATION FROM  
19 MEDICARE ECONOMIC INDEX.—Notwithstanding  
20 the amount of the update adjustment factor de-  
21 termined under subparagraph (B) for a year,  
22 the update in the conversion factor under this  
23 paragraph for the year may not be—

1                   “(i) greater than 100 times the fol-  
2                   lowing amount:  $(1.03 + (\text{MEI percentage}/$   
3                    $100)) - 1$ ; or

4                   “(ii) less than 100 times the following  
5                   amount:  $(0.93 + (\text{MEI percentage}/100))$   
6                    $- 1$ ,

7                   where ‘MEI percentage’ means the Secretary’s  
8                   estimate of the percentage increase in the MEI  
9                   (as defined in section 1842(i)(3)) for the year  
10                  involved.”.

11                  (2) EFFECTIVE DATE.—The amendment made  
12                  by paragraph (1) shall apply to the update for years  
13                  beginning with 1999.

14                  (b) ELIMINATION OF REPORT.—Section 1848(d) (42  
15                  U.S.C. 1395w-4(d)) is amended by striking paragraph  
16                  (2).

17                  **SEC. 4603. REPLACEMENT OF VOLUME PERFORMANCE**  
18                  **STANDARD WITH SUSTAINABLE GROWTH**  
19                  **RATE.**

20                  (a) IN GENERAL.—Section 1848(f) (42 U.S.C.  
21                  1395w-4(f)) is amended by striking paragraphs (2)  
22                  through (5) and inserting the following:

23                  “(2) SPECIFICATION OF GROWTH RATE.—The  
24                  sustainable growth rate for all physicians’ services

1 for a fiscal year (beginning with fiscal year 1998)  
2 shall be equal to the product of—

3 “(A) 1 plus the Secretary’s estimate of the  
4 weighted average percentage increase (divided  
5 by 100) in the fees for all physicians’ services  
6 in the fiscal year involved,

7 “(B) 1 plus the Secretary’s estimate of the  
8 percentage change (divided by 100) in the aver-  
9 age number of individuals enrolled under this  
10 part (other than MedicarePlus plan enrollees)  
11 from the previous fiscal year to the fiscal year  
12 involved,

13 “(C) 1 plus the Secretary’s estimate of the  
14 projected percentage growth in real gross do-  
15 mestic product per capita (divided by 100) from  
16 the previous fiscal year to the fiscal year in-  
17 volved, and

18 “(D) 1 plus the Secretary’s estimate of the  
19 percentage change (divided by 100) in expendi-  
20 tures for all physicians’ services in the fiscal  
21 year (compared with the previous fiscal year)  
22 which will result from changes in law and regu-  
23 lations, determined without taking into account  
24 estimated changes in expenditures due to  
25 changes in the volume and intensity of physi-

1           cians’ services resulting from changes in the up-  
2           date to the conversion factor under subsection  
3           (d)(3),

4           minus 1 and multiplied by 100.

5           “(3) DEFINITIONS.—In this subsection:

6                   “(A) SERVICES INCLUDED IN PHYSICIANS’  
7                   SERVICES.—The term ‘physicians’ services’ in-  
8                   cludes other items and services (such as clinical  
9                   diagnostic laboratory tests and radiology serv-  
10                   ices), specified by the Secretary, that are com-  
11                   monly performed or furnished by a physician or  
12                   in a physician’s office, but does not include  
13                   services furnished to a MedicarePlus plan en-  
14                   rollee.

15                   “(B) MEDICAREPLUS PLAN ENROLLEE.—  
16                   The term ‘MedicarePlus plan enrollee’ means,  
17                   with respect to a fiscal year, an individual en-  
18                   rolled under this part who has elected to receive  
19                   benefits under this title for the fiscal year  
20                   through a MedicarePlus plan offered under part  
21                   C, and also includes an individual who is receiv-  
22                   ing benefits under this part through enrollment  
23                   with an eligible organization with a risk-sharing  
24                   contract under section 1876.”.



1 (b) CONFORMING AMENDMENTS.—Section 1848(f)  
2 (42 U.S.C. 1395w–4(f)) is amended—

3 (1) in the heading, by striking “VOLUME PER-  
4 FORMANCE STANDARD RATES OF INCREASE” and  
5 inserting “SUSTAINABLE GROWTH RATE”; and

6 (2) in paragraph (1)—

7 (A) in the heading, by striking “VOLUME  
8 PERFORMANCE STANDARD RATES OF IN-  
9 CREASE” and inserting “SUSTAINABLE GROWTH  
10 RATE”,

11 (B) by striking subparagraphs (A) and  
12 (B); and

13 (C) in paragraph (1)(C)—

14 (i) in the heading, by striking “PER-  
15 FORMANCE STANDARD RATES OF IN-  
16 CREASE” and inserting “SUSTAINABLE  
17 GROWTH RATE”;

18 (ii) in the first sentence, by striking  
19 “with 1991), the performance standard  
20 rates of increase” and all that follows  
21 through the first period and inserting  
22 “with 1999), the sustainable growth rate  
23 for the fiscal year beginning in that year.”;  
24 and

1 (iii) in the second sentence, by strik-  
2 ing “January 1, 1990, the performance  
3 standard rate of increase under subpara-  
4 graph (D) for fiscal year 1990” and insert-  
5 ing “January 1, 1999, the sustainable  
6 growth rate for fiscal year 1999”.

7 **SEC. 4604. PAYMENT RULES FOR ANESTHESIA SERVICES.**

8 (a) IN GENERAL.—Section 1848(d)(1) (42 U.S.C.  
9 1395w-4(d)(1)), as amended by section 4601, is amend-  
10 ed—

11 (A) in subparagraph (C), striking “The  
12 single” and inserting “Except as provided in  
13 subparagraph (D), the single”;

14 (B) by redesignating subparagraph (D) as  
15 subparagraph (E); and

16 (C) by inserting after subparagraph (C)  
17 the following new subparagraph:

18 “(D) SPECIAL RULES FOR ANESTHESIA  
19 SERVICES.—The separate conversion factor for  
20 anesthesia services for a year shall be equal to  
21 46 percent of the single conversion factor estab-  
22 lished for other physicians’ services, except as  
23 adjusted for changes in work, practice expense,  
24 or malpractice relative value units. ”.

1 (b) CLASSIFICATION OF ANESTHESIA SERVICES.—  
2 The first sentence of section 1848(j)(1) (42 U.S.C.  
3 1395w-4(j)(1)) is amended—

4 (1) by striking “and including anesthesia serv-  
5 ices”; and

6 (2) by inserting before the period the following:  
7 “(including anesthesia services)”.

8 (c) EFFECTIVE DATE.—The amendments made by  
9 this section shall apply to services furnished on or after  
10 January 1, 1998.

11 **SEC. 4605. IMPLEMENTATION OF RESOURCE-BASED PHYSI-  
12 CIAN PRACTICE EXPENSE.**

13 (a) 1-YEAR DELAY IN IMPLEMENTATION.—Section  
14 1848(c) (42 U.S.C. 1395w-4(c)) is amended—

15 (1) in paragraph (2)(C)(ii), in the matter before  
16 subclause (I) and after subclause (II), by striking  
17 “1998” and inserting “1999” each place it appears;  
18 and

19 (2) in paragraph (3)(C)(ii), by striking “1998”  
20 and inserting “1999”.

21 (b) PHASED-IN IMPLEMENTATION.—

22 (1) IN GENERAL.—Section 1848(c)(2)(C)(ii)  
23 (42 U.S.C. 1395w-4(c)(2)(C)(ii)) is further amend-  
24 ed—

1 (A) by striking the comma at the end of  
2 clause (ii) and inserting a period and the follow-  
3 ing:

4 “For 1999, such number of units shall be  
5 determined based 75 percent on such prod-  
6 uct and based 25 percent on the relative  
7 practice expense resources involved in fur-  
8 nishing the service. For 2000, such num-  
9 ber of units shall be determined based 50  
10 percent on such product and based 50 per-  
11 cent on such relative practice expense re-  
12 sources. For 2001, such number of units  
13 shall be determined based 25 percent on  
14 such product and based 75 percent on such  
15 relative practice expense resources. For a  
16 subsequent year, such number of units  
17 shall be determined based entirely on such  
18 relative practice expense resources.”.

19 (2) CONFORMING AMENDMENT.—Section  
20 1848(e)(3)(C)(ii) (42 U.S.C. 1395w-4(c)(3)(C)(ii)),  
21 as amended by subsection (a)(2), is amended by  
22 striking “1999” and inserting “2002”.

23 (c) REQUIREMENTS FOR DEVELOPING NEW RE-  
24 SOURCE-BASED PRACTICE EXPENSE RELATIVE VALUE  
25 UNITS.—

1           (1) DEVELOPMENT.—For purposes of section  
2           1848(e)(2)(C) of the Social Security Act, the Sec-  
3           retary of Health and Human Services shall develop  
4           new resource-based relative value units. In develop-  
5           ing such units the Secretary shall—

6                   (A) utilize, to the maximum extent prac-  
7                   ticable, generally accepted accounting principles  
8                   and standards which (i) recognize all staff,  
9                   equipment, supplies, and expenses, not just  
10                  those which can be tied to specific procedures,  
11                  and (ii) use actual data on equipment utiliza-  
12                  tion and other key assumptions, such as the  
13                  proportion of costs which are direct versus indi-  
14                  rect;

15                  (B) study whether hospital cost reduction  
16                  efforts and changing practice patterns may  
17                  have increased physician practice costs under  
18                  part B of the medicare program;

19                  (C) consider potential adverse effects on  
20                  patient access under the medicare program; and

21                  (D) consult with organizations represent-  
22                  ing physicians regarding methodology and data  
23                  to be used, including data for impact projec-  
24                  tions, in order to ensure that sufficient input

1           has been received by the affected physician  
2           community.

3           (2) REPORT.—The Secretary shall transmit a  
4           report by March 1, 1998, on the development of re-  
5           source-based relative value units under paragraph  
6           (1) to the Committee on Ways and Means and the  
7           Committee on Commerce of the House of Represent-  
8           atives and the Committee on Finance of the Senate.  
9           The report shall include a presentation of data to be  
10          used in developing the value units and an expla-  
11          nation of the methodology.

12          (3) NOTICE OF PROPOSED RULEMAKING.—The  
13          Secretary shall publish a notice of proposed rule-  
14          making with the new resource-based relative value  
15          units on or before May 1, 1998, and shall allow for  
16          a 90-day public comment period.

17          (4) ITEMS INCLUDED.—The proposed new rule  
18          shall include the following:

19                 (A) Detailed impact projections which com-  
20                 pare new proposed payment amounts on data  
21                 on actual physician practice expenses.

22                 (B) Impact projections for specialties and  
23                 subspecialties, geographic payment localities,  
24                 urban versus rural localities, and academic ver-  
25                 sus nonacademic medical staffs.

1 (C) Impact projections on access to care  
2 for medicare patients and physician employ-  
3 ment of clinical and administrative staff.

4 **SEC. 4606. DISSEMINATION OF INFORMATION ON HIGH PER**  
5 **DISCHARGE RELATIVE VALUES FOR IN-HOS-**  
6 **PITAL PHYSICIANS' SERVICES.**

7 (a) DETERMINATION AND NOTICE CONCERNING  
8 HOSPITAL-SPECIFIC PER DISCHARGE RELATIVE VAL-  
9 UES.—

10 (1) IN GENERAL.—For 1999 and 2001 the Sec-  
11 retary of Health and Human Services shall deter-  
12 mine for each hospital—

13 (A) the hospital-specific per discharge rel-  
14 ative value under subsection (b); and

15 (B) whether the hospital-specific relative  
16 value is projected to be excessive (as determined  
17 based on such value represented as a percent-  
18 age of the median of hospital-specific per dis-  
19 charge relative values determined under sub-  
20 section (b)).

21 (2) NOTICE TO MEDICAL STAFFS AND CAR-  
22 RIERS.—The Secretary shall notify the medical exec-  
23 utive committee of each hospital identifies under  
24 paragraph (1)(B) as having an excessive hospital-  
25 specific relative value, of the determinations made

1 with respect to the medical staff under paragraph  
2 (1).

3 (b) DETERMINATION OF HOSPITAL-SPECIFIC PER  
4 DISCHARGE RELATIVE VALUES.—

5 (1) IN GENERAL.—For purposes of this section,  
6 the hospital-specific per discharge relative value for  
7 the medical staff of a hospital (other than a teaching  
8 hospital) for a year, shall be equal to the average  
9 per discharge relative value (as determined under  
10 section 1848(c)(2) of the Social Security Act) for  
11 physicians' services furnished to inpatients of the  
12 hospital by the hospital's medical staff (excluding in-  
13 terns and residents) during the second year preced-  
14 ing that calendar year, adjusted for variations in  
15 case-mix and disproportionate share status among  
16 hospitals (as determined by the Secretary under  
17 paragraph (3)).

18 (2) SPECIAL RULE FOR TEACHING HOS-  
19 PITALS.—The hospital-specific relative value pro-  
20 jected for a teaching hospital in a year shall be equal  
21 to the sum of—

22 (A) the average per discharge relative  
23 value (as determined under section 1848(c)(2)  
24 of such Act) for physicians' services furnished  
25 to inpatients of the hospital by the hospital's



1           medical staff (excluding interns and residents)  
2           during the second year preceding that calendar  
3           year, and

4                   (B) the equivalent per discharge relative  
5           value (as determined under such section) for  
6           physicians' services furnished to inpatients of  
7           the hospital by interns and residents of the hos-  
8           pital during the second year preceding that cal-  
9           endar year, adjusted for variations in case-mix,  
10          disproportionate share status, and teaching sta-  
11          tus among hospitals (as determined by the Sec-  
12          retary under paragraph (3)).

13          The Secretary shall determine the equivalent relative  
14          value unit per discharge for interns and residents  
15          based on the best available data and may make such  
16          adjustment in the aggregate.

17                   (3) ADJUSTMENT FOR TEACHING AND DIS-  
18          PROPORTIONATE SHARE HOSPITALS.—The Secretary  
19          shall adjust the allowable per discharge relative val-  
20          ues otherwise determined under this subsection to  
21          take into account the needs of teaching hospitals  
22          and hospitals receiving additional payments under  
23          subparagraphs (F) and (G) of section 1886(d)(5) of  
24          the Social Security Act. The adjustment for teaching

1 status or disproportionate share shall not be less  
2 than zero.

3 (c) DEFINITIONS.—For purposes of this section:

4 (1) HOSPITAL.—The term “hospital” means a  
5 subsection (d) hospital as defined in section 1886(d)  
6 of the Social Security Act (42 U.S.C. 1395ww(d)).

7 (2) MEDICAL STAFF.—An individual furnishing  
8 a physician’s service is considered to be on the medi-  
9 cal staff of a hospital—

10 (A) if (in accordance with requirements for  
11 hospitals established by the Joint Commission  
12 on Accreditation of Health Organizations)—

13 (i) the individual is subject to bylaws,  
14 rules, and regulations established by the  
15 hospital to provide a framework for the  
16 self-governance of medical staff activities,

17 (ii) subject to the bylaws, rules, and  
18 regulations, the individual has clinical  
19 privileges granted by the hospital’s govern-  
20 ing body, and

21 (iii) under the clinical privileges, the  
22 individual may provide physicians’ services  
23 independently within the scope of the indi-  
24 vidual’s clinical privileges, or

1 (B) if the physician provides at least one  
2 service to an individual entitled to benefits  
3 under this title in that hospital.

4 (3) PHYSICIANS' SERVICES.—The term “physi-  
5 cians” services” means the services described in sec-  
6 tion 1848(j)(3) of the Social Security Act (42 U.S.C.  
7 1395w-4(j)(3)).

8 (4) RURAL AREA; URBAN AREA.—The terms  
9 “rural area” and “urban area” have the meaning  
10 given those terms under section 1886(d)(2)(D) of  
11 such Act (42 U.S.C. 1395ww(d)(2)(D)).

12 (5) SECRETARY.—The term “Secretary” means  
13 the Secretary of Health and Human Services.

14 (6) TEACHING HOSPITAL.—The term “teaching  
15 hospital” means a hospital which has a teaching pro-  
16 gram approved as specified in section 1861(b)(6) of  
17 the Social Security Act (42 U.S.C. 1395x(b)(6)).

18 **SEC. 4607. NO X-RAY REQUIRED FOR CHIROPRACTIC SERV-**

19 **ICES.**

20 (a) IN GENERAL.—Section 1861(r)(5) (42 U.S.C.  
21 1395x(r)(5)) is amended by striking “demonstrated by X-  
22 ray to exist”.

23 (b) EFFECTIVE DATE.—The amendment made by  
24 subsection (a) applies to services furnished on or after  
25 January 1, 1998.

1 (c) UTILIZATION GUIDELINES.—The Secretary of  
 2 Health and Human Services shall develop and implement  
 3 utilization guidelines relating to the coverage of chiroprac-  
 4 tic services under part B of title XVIII of the Social Secu-  
 5 rity Act in cases in which a subluxation has not been dem-  
 6 onstrated by X-ray to exist.

7 **SEC. 4608. TEMPORARY COVERAGE RESTORATION FOR**  
 8 **PORTABLE ELECTROCARDIOGRAM TRANS-**  
 9 **PORTATION.**

10 (a) IN GENERAL.—Effective for electrocardiogram  
 11 tests performed during 1998, the Secretary of Health and  
 12 Human Services shall restore separate payment, under  
 13 part B of title XVIII of the Social Security Act, for the  
 14 transportation of electrocardiogram equipment (HCPCS  
 15 code R0076) based upon the status code and relative value  
 16 units established for such service as of December 31,  
 17 1996.

18 (b) REPORT.—By not later than July 1, 1998, the  
 19 Comptroller General shall submit to Congress a report on  
 20 the appropriateness of continuing such payment.

21 **CHAPTER 2—OTHER PAYMENT**

22 **PROVISIONS**

23 **SEC. 4611. PAYMENTS FOR DURABLE MEDICAL EQUIPMENT.**

24 (a) REDUCTION IN PAYMENT AMOUNTS FOR ITEMS  
 25 OF DURABLE MEDICAL EQUIPMENT.—

1           (1) FREEZE IN UPDATE FOR COVERED  
2 ITEMS.—Section 1834(a)(14) (42 U.S.C.  
3 1395m(a)(14)) is amended—

4           (A) by striking “and” at the end of sub-  
5 paragraph (A);

6           (B) in subparagraph (B)—

7           (i) by striking “a subsequent year”  
8 and inserting “1993, 1994, 1995, 1996,  
9 and 1997”, and

10           (ii) by striking the period at the end  
11 and inserting a semicolon; and

12           (C) by adding at the end the following:

13           “(C) for each of the years 1998 through  
14 2002, 0 percentage points; and

15           “(D) for a subsequent year, the percentage  
16 increase in the consumer price index for all  
17 urban consumers (U.S. urban average) for the  
18 12-month period ending with June of the pre-  
19 vious year.”.

20           (2) UPDATE FOR ORTHOTICS AND PROSTHET-  
21 ICS.—Section 1834(h)(4)(A) (42 U.S.C.  
22 1395m(h)(4)(A)) is amended—

23           (A) by striking “, and” at the end of  
24 clause (iii) and inserting a semicolon;

1 (B) in clause (iv), by striking “a subse-  
2 quent year” and inserting “1996 and 1997”,  
3 and

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

6 “(v) for each of the years 1998  
7 through 2002, 1 percent, and

8 “(vi) for a subsequent year, the per-  
9 centage increase in the consumer price  
10 index for all urban consumers (United  
11 States city average) for the 12-month pe-  
12 riod ending with June of the previous  
13 year;”.

14 (c) PAYMENT FREEZE FOR PARENTERAL AND EN-  
15 TERAL NUTRIENTS, SUPPLIES, AND EQUIPMENT.—In de-  
16 termining the amount of payment under part B of title  
17 XVIII of the Social Security Act with respect to parenteral  
18 and enteral nutrients, supplies, and equipment during  
19 each of the years 1998 through 2002, the charges deter-  
20 mined to be reasonable with respect to such nutrients,  
21 supplies, and equipment may not exceed the charges deter-  
22 mined to be reasonable with respect to such nutrients,  
23 supplies, and equipment during 1995.

1 **SEC. 4612. OXYGEN AND OXYGEN EQUIPMENT.**

2 Section 1834(a)(9)(C) (42 U.S.C. 1395m(a)(9)(C))  
3 is amended—

4 (1) by striking “and” at the end of clause (iii);

5 (2) in clause (iv)—

6 (A) by striking “a subsequent year” and  
7 inserting “1993, 1994, 1995, 1996, and 1997”,  
8 and

9 (B) by striking the period at the end and  
10 inserting a semicolon; and

11 (3) by adding at the end the following new  
12 clauses:

13 “(v) in each of the years 1998  
14 through 2002, is 80 percent of the national  
15 limited monthly payment rate computed  
16 under subparagraph (B) for the item for  
17 the year; and

18 “(vi) in a subsequent year, is the na-  
19 tional limited monthly payment rate com-  
20 puted under subparagraph (B) for the item  
21 for the year.”.

22 **SEC. 4613. REDUCTION IN UPDATES TO PAYMENT AMOUNTS**  
23 **FOR CLINICAL DIAGNOSTIC LABORATORY**  
24 **TESTS.**

25 (a) CHANGE IN UPDATE.—Section  
26 1833(h)(2)(A)(ii)(IV) (42 U.S.C. 1395l(h)(2)(A)(ii)(IV))

1 is amended by inserting “and 1998 through 2002” after  
2 “1995”.

3 (b) LOWERING CAP ON PAYMENT AMOUNTS.—Sec-  
4 tion 1833(h)(4)(B) (42 U.S.C. 1395l(h)(4)(B)) is amend-  
5 ed—

6 (1) in clause (vi), by striking “and” at the end;

7 (2) in clause (vii)—

8 (A) by inserting “and before January 1,  
9 1998,” after “1995,” and

10 (B) by striking the period at the end and  
11 inserting “, and”; and

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

14 “(viii) after December 31, 1997, is equal to 72  
15 percent of such median.”.

16 **SEC. 4614. SIMPLIFICATION IN ADMINISTRATION OF LAB-**  
17 **ORATORY TESTS.**

18 (a) SELECTION OF REGIONAL CARRIERS.—

19 (1) IN GENERAL.—The Secretary of Health and  
20 Human Services (in this section referred to as the  
21 “Secretary”) shall—

22 (A) divide the United States into no more  
23 than 5 regions, and

24 (B) designate a single carrier for each such  
25 region,



1 for the purpose of payment of claims under part B  
2 of title XVIII of the Social Security Act with respect  
3 to clinical diagnostic laboratory tests (other than for  
4 tests performed in physician offices) furnished on or  
5 after such date (not later than January 1, 1999) as  
6 the Secretary specifies.

7 (2) DESIGNATION.—In designating such car-  
8 riers, the Secretary shall consider, among other cri-  
9 teria—

10 (A) a carrier's timeliness, quality, and ex-  
11 perience in claims processing, and

12 (B) a carrier's capacity to conduct elec-  
13 tronic data interchange with laboratories and  
14 data matches with other carriers.

15 (3) SINGLE DATA RESOURCE.—The Secretary  
16 may select one of the designated carriers to serve as  
17 a central statistical resource for all claims informa-  
18 tion relating to such clinical diagnostic laboratory  
19 tests handled by all the designated carriers under  
20 such part.

21 (4) ALLOCATION OF CLAIMS.—The allocation of  
22 claims for clinical diagnostic laboratory tests to par-  
23 ticular designated carriers shall be based on whether  
24 a carrier serves the geographic area where the lab-

1 oratory specimen was collected or other method  
2 specified by the Secretary.

3 (b) ADOPTION OF UNIFORM POLICIES FOR CLINICAL  
4 LABORATORY TESTS.—

5 (1) IN GENERAL.—Not later than July 1, 1998,  
6 the Secretary shall first adopt, consistent with para-  
7 graph (2), uniform coverage, administration, and  
8 payment policies for clinical diagnostic laboratory  
9 tests under part B of title XVIII of the Social Secu-  
10 rity Act, using a negotiated rulemaking process  
11 under subchapter III of chapter 5 of title 5, United  
12 States Code.

13 (2) CONSIDERATIONS IN DESIGN OF UNIFORM  
14 POLICIES.—The policies under paragraph (1) shall  
15 be designed to promote uniformity and program in-  
16 tegrity and reduce administrative burdens with re-  
17 spect to clinical diagnostic laboratory tests payable  
18 under such part in connection with the following:

19 (A) Beneficiary information required to be  
20 submitted with each claim or order for labora-  
21 tory tests.

22 (B) Physicians' obligations regarding docu-  
23 mentation requirements and recordkeeping.

24 (C) Procedures for filing claims and for  
25 providing remittances by electronic media.

1 (D) The documentation of medical neces-  
2 sity.

3 (E) Limitation on frequency of coverage  
4 for the same tests performed on the same indi-  
5 vidual.

6 (3) CHANGES IN CARRIER REQUIREMENTS  
7 PENDING ADOPTION OF UNIFORM POLICY.—During  
8 the period that begins on the date of the enactment  
9 of this Act and ends on the date the Secretary first  
10 implements uniform policies pursuant to regulations  
11 promulgated under this subsection, a carrier under  
12 such part may implement changes relating to re-  
13 quirements for the submission of a claim for clinical  
14 diagnostic laboratory tests.

15 (4) USE OF INTERIM REGIONAL POLICIES.—  
16 After the date the Secretary first implements such  
17 uniform policies, the Secretary shall permit any car-  
18 rier to develop and implement interim policies of the  
19 type described in paragraph (1), in accordance with  
20 guidelines established by the Secretary, in cases in  
21 which a uniform national policy has not been estab-  
22 lished under this subsection and there is a dem-  
23 onstrated need for a policy to respond to aberrant  
24 utilization or provision of unnecessary services. Ex-  
25 cept as the Secretary specifically permits, no policy

1 shall be implemented under this paragraph for a pe-  
2 riod of longer than 2 years.

3 (5) INTERIM NATIONAL POLICIES.—After the  
4 date the Secretary first designates regional carriers  
5 under subsection (a), the Secretary shall establish a  
6 process under which designated carriers can collec-  
7 tively develop and implement interim national stand-  
8 ards of the type described in paragraph (1). No such  
9 policy shall be implemented under this paragraph for  
10 a period of longer than 2 years.

11 (6) BIENNIAL REVIEW PROCESS.—Not less  
12 often than once every 2 years, the Secretary shall  
13 solicit and review comments regarding changes in  
14 the uniform policies established under this sub-  
15 section. As part of such biennial review process, the  
16 Secretary shall specifically review and consider  
17 whether to incorporate or supersede interim, re-  
18 gional, or national policies developed under para-  
19 graph (4) or (5). Based upon such review, the Sec-  
20 retary may provide for appropriate changes in the  
21 uniform policies previously adopted under this sub-  
22 section.

23 (7) NOTICE.— Before a carrier implements a  
24 change or policy under paragraph (3), (4), or (5),  
25 the carrier shall provide for advance notice to inter-

1       ested parties and a 45-day period in which such par-  
2       ties may submit comments on the proposed change.

3       (c) INCLUSION OF LABORATORY REPRESENTATIVE  
4 ON CARRIER ADVISORY COMMITTEES.—The Secretary  
5 shall direct that any advisory committee established by  
6 such a carrier, to advise with respect to coverage, adminis-  
7 tration or payment policies under part B of title XVIII  
8 of the Social Security Act, shall include an individual to  
9 represent the interest and views of independent clinical  
10 laboratories and such other laboratories as the Secretary  
11 deems appropriate. Such individual shall be selected by  
12 such committee from among nominations submitted by na-  
13 tional and local organizations that represent independent  
14 clinical laboratories.

15 **SEC. 4615. UPDATES FOR AMBULATORY SURGICAL SERV-**  
16 **ICES.**

17       Section 1833(i)(2)(C) (42 U.S.C. 1395l(i)(2)(C)) is  
18 amended by striking all that follows “shall be increased”  
19 and inserting the following: “as follows:

20               “(i) For fiscal years 1996 and 1997, by the  
21       percentage increase in the consumer price index for  
22       all urban consumers (U.S. city average) as estimated  
23       by the Secretary for the 12-month period ending  
24       with the midpoint of the year involved.

1           “(ii) For each of fiscal years 1998 through  
2           2002 by such percentage increase minus 2.0 percent-  
3           age points.

4           “(iii) For each succeeding fiscal year by such  
5           percentage increase.”.

6 **SEC. 4616. REIMBURSEMENT FOR DRUGS AND**  
7 **BIOLOGICALS.**

8           (a) IN GENERAL.—Section 1842 (42 U.S.C. 1395u)  
9 is amended by inserting after subsection (n) the following  
10 new subsection:

11           “(o) If a physician’s, supplier’s, or any other person’s  
12 bill or request for payment for services includes a charge  
13 for a drug or biological for which payment may be made  
14 under this part and the drug or biological is not paid on  
15 a cost or prospective payment basis as otherwise provided  
16 in this part, the amount payable for the drug or biological  
17 is equal to 95 percent of the average wholesale price.”.

18           (b) EFFECTIVE DATE.—The amendments made by  
19 subsection (a) apply to drugs and biologicals furnished on  
20 or after January 1, 1998.

21 **SEC. 4617. COVERAGE OF ORAL ANTI-NAUSEA DRUGS**  
22 **UNDER CHEMOTHERAPEUTIC REGIMEN.**

23           (a) IN GENERAL.—Section 1861(s)(2) (42 U.S.C.  
24 1395x(s)(2)), as amended, is amended by inserting after  
25 subparagraph (S) the following new subparagraph:

1           “(T) an oral drug (which is approved by the  
2           Federal Food and Drug Administration) prescribed  
3           for use as an acute anti-emetic used as part of an  
4           anticancer chemotherapeutic regimen if the drug is  
5           administered by a physician (or as prescribed by a  
6           physician)—

7                   “(i) for use immediately before, imme-  
8                   diately after, or at the time of the administra-  
9                   tion of the anticancer chemotherapeutic agent;  
10                  and

11                   “(ii) as a full replacement for the anti-  
12                   emetic therapy which would otherwise be ad-  
13                   ministered intravenously.”.

14           (b) PAYMENT LEVELS.—Section 1834 (42 U.S.C.  
15 1395m), as amended by sections 4421(a)(2) and  
16 4431(b)(2), is amended by adding at the end the following  
17 new subsection:

18           “(m) SPECIAL RULES FOR PAYMENT FOR ORAL  
19 ANTI-NAUSEA DRUGS.—

20                   “(1) LIMITATION ON PER DOSE PAYMENT  
21 BASIS.—Subject to paragraph (2), the per dose pay-  
22 ment basis under this part for oral anti-nausea  
23 drugs (as defined in paragraph (3)) administered  
24 during a year shall not exceed 90 percent of the av-  
25 erage per dose payment basis for the equivalent in-

1       travenous anti-emetics administered during the year,  
2       as computed based on the payment basis applied  
3       during 1996.

4           “(2) AGGREGATE LIMIT.—The Secretary shall  
5       make such adjustment in the coverage of, or pay-  
6       ment basis for, oral anti-nausea drugs so that cov-  
7       erage of such drugs under this part does not result  
8       in any increase in aggregate payments per capita  
9       under this part above the levels of such payments  
10      per capita that would otherwise have been made if  
11      there were no coverage for such drugs under this  
12      part.

13           “(3) ORAL ANTI-NAUSEA DRUGS DEFINED.—  
14      For purposes of this subsection, the term ‘oral anti-  
15      nausea drugs’ means drugs for which coverage is  
16      provided under this part pursuant to section  
17      1861(s)(2)(P).”.

18      (c) EFFECTIVE DATE.—The amendments made by  
19      this section shall apply to items and services furnished on  
20      or after January 1, 1998.

21      **SEC. 4618. RURAL HEALTH CLINIC SERVICES.**

22      (a) PER-VISIT PAYMENT LIMITS FOR PROVIDER-  
23      BASED CLINICS.—

24           (1) EXTENSION OF LIMIT.—



1           (A) IN GENERAL.—The matter in section  
2           1833(f) (42 U.S.C. 1395l(f)) preceding para-  
3           graph (1) is amended by striking “independent  
4           rural health clinics” and inserting “rural health  
5           clinics (other than such clinics in rural hospitals  
6           with less than 50 beds)”.

7           (B) EFFECTIVE DATE.—The amendment  
8           made by subparagraph (A) applies to services  
9           furnished after 1997.

10          (2) TECHNICAL CLARIFICATION.—Section  
11          1833(f)(1) (42 U.S.C. 1395l(f)(1)) is amended by  
12          inserting “per visit” after “\$46”.

13          (b) ASSURANCE OF QUALITY SERVICES.—

14           (1) IN GENERAL.—Subparagraph (I) of the  
15           first sentence of section 1861(aa)(2) (42 U.S.C.  
16           1395x(aa)(2)) is amended to read as follows:

17                   “(I) has a quality assessment and perform-  
18                   ance improvement program, and appropriate  
19                   procedures for review of utilization of clinic  
20                   services, as the Secretary may specify,”.

21           (2) EFFECTIVE DATE.—The amendment made  
22           by paragraph (1) shall take effect on January 1,  
23           1998.

24          (c) WAIVER OF CERTAIN STAFFING REQUIREMENTS  
25          LIMITED TO CLINICS IN PROGRAM.—

1           (1) IN GENERAL.—Section 1861(aa)(7)(B) (42  
2 U.S.C. 1395x(aa)(7)(B)) is amended by inserting  
3 before the period at the end the following: “, or if  
4 the facility has not yet been determined to meet the  
5 requirements (including subparagraph (J) of the  
6 first sentence of paragraph (2)) of a rural health  
7 clinic”.

8           (2) EFFECTIVE DATE.—The amendment made  
9 by paragraph (1) applies to waiver requests made  
10 after 1997.

11       (d) REFINEMENT OF SHORTAGE AREA REQUIRE-  
12 MENTS.—

13           (1) DESIGNATION REVIEWED TRIENNIALLY.—  
14 Section 1861(aa)(2) (42 U.S.C. 1395x(aa)(2)) is  
15 amended in the second sentence, in the matter in  
16 clause (i) preceding subclause (I)—

17               (A) by striking “and that is designated”  
18 and inserting “and that, within the previous  
19 three-year period, has been designated”; and

20               (B) by striking “or that is designated” and  
21 inserting “or designated”.

22           (2) AREA MUST HAVE SHORTAGE OF HEALTH  
23 CARE PRACTITIONERS.—Section 1861(aa)(2) (42  
24 U.S.C. 1395x(aa)(2)), as amended by paragraph (1),

1 is further amended in the second sentence, in the  
2 matter in clause (i) preceding subclause (I)—

3 (A) by striking the comma after “personal  
4 health services”; and

5 (B) by inserting “and in which there are  
6 insufficient numbers of needed health care prac-  
7 titioners (as determined by the Secretary),”  
8 after “Bureau of the Census”).

9 (3) PREVIOUSLY QUALIFYING CLINICS GRAND-  
10 FATHERED ONLY TO PREVENT SHORTAGE.—Section  
11 1861(aa)(2) (42 U.S.C. 1395x(aa)(2)) is amended in  
12 the third sentence by inserting before the period “if  
13 it is determined, in accordance with criteria estab-  
14 lished by the Secretary in regulations, to be essential  
15 to the delivery of primary care services that would  
16 otherwise be unavailable in the geographic area  
17 served by the clinic”.

18 (4) EFFECTIVE DATES; IMPLEMENTING REGU-  
19 LATIONS.—

20 (A) IN GENERAL.—Except as otherwise  
21 provided, the amendments made by the preced-  
22 ing paragraphs take effect on January 1 of the  
23 first calendar year beginning at least one month  
24 after enactment of this Act.

1 (B) CURRENT RURAL HEALTH CLINICS.—

2 The amendments made by the preceding para-  
3 graphs take effect, with respect to entities that  
4 are rural health clinics under title XVIII of the  
5 Social Security Act on the date of enactment of  
6 this Act, on January 1 of the second calendar  
7 year following the calendar year specified in  
8 subparagraph (A).

9 (C) GRANDFATHERED CLINICS.—

10 (i) IN GENERAL.—The amendment  
11 made by paragraph (3) shall take effect on  
12 the effective date of regulations issued by  
13 the Secretary under clause (ii).

14 (ii) REGULATIONS.—The Secretary  
15 shall issue final regulations implementing  
16 paragraph (3) that shall take effect no  
17 later than January 1 of the third calendar  
18 year beginning at least one month after en-  
19 actment of this Act.

20 **SEC. 4619. INCREASED MEDICARE REIMBURSEMENT FOR**  
21 **NURSE PRACTITIONERS AND CLINICAL**  
22 **NURSE SPECIALISTS.**

23 (a) REMOVAL OF RESTRICTIONS ON SETTINGS.—

1           (1) IN GENERAL.—Clause (ii) of section  
2   1861(s)(2)(K) (42 U.S.C. 1395x(s)(2)(K)) is  
3   amended to read as follows:

4           “(ii) services which would be physicians’ serv-  
5   ices if furnished by a physician (as defined in sub-  
6   section (r)(1)) and which are performed by a nurse  
7   practitioner or clinical nurse specialist (as defined in  
8   subsection (aa)(5)) working in collaboration (as de-  
9   fined in subsection (aa)(6)) with a physician (as de-  
10   fined in subsection (r)(1)) which the nurse practi-  
11   tioner or clinical nurse specialist is legally authorized  
12   to perform by the State in which the services are  
13   performed, and such services and supplies furnished  
14   as an incident to such services as would be covered  
15   under subparagraph (A) if furnished incident to a  
16   physician’s professional service, but only if no facil-  
17   ity or other provider charges or is paid any amounts  
18   with respect to the furnishing of such services;”.

19           (2) CONFORMING AMENDMENTS.—(A) Section  
20   1861(s)(2)(K) of such Act (42 U.S.C.  
21   1395x(s)(2)(K)) is further amended—

22           (i) in clause (i), by inserting “and such  
23   services and supplies furnished as incident to  
24   such services as would be covered under sub-  
25   paragraph (A) if furnished incident to a physi-

1           cian’s professional service; and” after “are per-  
2           formed,”; and

3                   (ii) by striking clauses (iii) and (iv).

4           (B)     Section     1861(b)(4)     (42     U.S.C.  
5     1395x(b)(4)) is amended by striking “clauses (i) or  
6     (iii) of subsection (s)(2)(K)” and inserting “sub-  
7     section (s)(2)(K)”.

8           (C)     Section     1862(a)(14)     (42     U.S.C.  
9     1395y(a)(14)) is amended by striking “section  
10    1861(s)(2)(K)(i) or 1861(s)(2)(K)(iii)” and insert-  
11    ing “section 1861(s)(2)(K)”.

12          (D)     Section     1866(a)(1)(H)     (42     U.S.C.  
13    1395cc(a)(1)(H)) is amended by striking “section  
14    1861(s)(2)(K)(i) or 1861(s)(2)(K)(iii)” and insert-  
15    ing “section 1861(s)(2)(K)”.

16          (E)     Section     1888(e)(2)(A)(ii)     (42     U.S.C.  
17    1395yy(e)(2)(A)(ii)), as added by section 10401(a),  
18    is amended by striking “through (iii)” and inserting  
19    “and (ii)”.

20    (b) INCREASED PAYMENT.—

21           (1) FEE SCHEDULE AMOUNT.—Clause (O) of  
22    section 1833(a)(1) (42 U.S.C. 1395l(a)(1)) is  
23    amended to read as follows: “(O) with respect to  
24    services described in section 1861(s)(2)(K)(ii) (relat-  
25    ing to nurse practitioner or clinical nurse specialist

1 services), the amounts paid shall be equal to 80 per-  
2 cent of (i) the lesser of the actual charge or 85 per-  
3 cent of the fee schedule amount provided under sec-  
4 tion 1848, or (ii) in the case of services as an assist-  
5 ant at surgery, the lesser of the actual charge or 85  
6 percent of the amount that would otherwise be rec-  
7 ognized if performed by a physician who is serving  
8 as an assistant at surgery; and”.

9 (2) CONFORMING AMENDMENTS.—(A) Section  
10 1833(r) (42 U.S.C. 1395l(r)) is amended—

11 (i) in paragraph (1), by striking “section  
12 1861(s)(2)(K)(iii) (relating to nurse practi-  
13 tioner or clinical nurse specialist services pro-  
14 vided in a rural area)” and inserting “section  
15 1861(s)(2)(K)(ii) (relating to nurse practitioner  
16 or clinical nurse specialist services)”;

17 (ii) by striking paragraph (2);

18 (iii) in paragraph (3), by striking “section  
19 1861(s)(2)(K)(iii)” and inserting “section  
20 1861(s)(2)(K)(ii)”;

21 (iv) by redesignating paragraph (3) as  
22 paragraph (2).

23 (B) Section 1842(b)(12)(A) (42 U.S.C.  
24 1395u(b)(12)(A)) is amended, in the matter preced-  
25 ing clause (i), by striking “clauses (i), (ii), or (iv) of

1 section 1861(s)(2)(K) (relating to a physician assist-  
2 ants and nurse practitioners)” and inserting “sec-  
3 tion 1861(s)(2)(K)(i) (relating to physician assist-  
4 ants)”.

5 (c) DIRECT PAYMENT FOR NURSE PRACTITIONERS  
6 AND CLINICAL NURSE SPECIALISTS.—

7 (1) IN GENERAL.—Section 1832(a)(2)(B)(iv)  
8 (42 U.S.C. 1395k(a)(2)(B)(iv)) is amended by strik-  
9 ing “provided in a rural area (as defined in section  
10 1886(d)(2)(D))” and inserting “but only if no facil-  
11 ity or other provider charges or is paid any amounts  
12 with respect to the furnishing of such services”.

13 (2) CONFORMING AMENDMENT.—Section  
14 1842(b)(6)(C) (42 U.S.C. 1395u(b)(6)(C)) is  
15 amended—

16 (A) by striking “clauses (i), (ii), or (iv)”  
17 and inserting “clause (i)”; and

18 (B) by striking “or nurse practitioner”.

19 (d) DEFINITION OF CLINICAL NURSE SPECIALIST  
20 CLARIFIED.—Section 1861(aa)(5) (42 U.S.C.  
21 1395x(aa)(5)) is amended—

22 (1) by inserting “(A)” after “(5)”;

23 (2) by striking “The term ‘physician assist-  
24 ant’” and all that follows through “who performs”  
25 and inserting “The term ‘physician assistant’ and



1 the term ‘nurse practitioner’ mean, for purposes of  
2 this title, a physician assistant or nurse practitioner  
3 who performs’; and

4 (3) by adding at the end the following new sub-  
5 paragraph:

6 “(B) The term ‘clinical nurse specialist’ means, for  
7 purposes of this title, an individual who—

8 “(i) is a registered nurse and is licensed to  
9 practice nursing in the State in which the clinical  
10 nurse specialist services are performed; and

11 “(ii) holds a master’s degree in a defined clini-  
12 cal area of nursing from an accredited educational  
13 institution.”.

14 (e) EFFECTIVE DATE.—The amendments made by  
15 this section shall apply with respect to services furnished  
16 and supplies provided on and after January 1, 1998.

17 **SEC. 4620. INCREASED MEDICARE REIMBURSEMENT FOR**  
18 **PHYSICIAN ASSISTANTS.**

19 (a) REMOVAL OF RESTRICTION ON SETTINGS.—Sec-  
20 tion 1861(s)(2)(K)(i) (42 U.S.C. 1395x(s)(2)(K)(i)) is  
21 amended—

22 (1) by striking “(I) in a hospital” and all that  
23 follows through “shortage area,” and

24 (2) by adding at the end the following: “but  
25 only if no facility or other provider charges or is

1       paid any amounts with respect to the furnishing of  
2       such services,”.

3       (b) INCREASED PAYMENT.—Paragraph (12) of sec-  
4       tion 1842(b) (42 U.S.C. 1395u(b)), as amended by section  
5       4619(b)(2)(B), is amended to read as follows:

6       “(12) With respect to services described in section  
7       1861(s)(2)(K)(i)—

8               “(A) payment under this part may only be  
9               made on an assignment-related basis; and

10              “(B) the amounts paid under this part shall be  
11              equal to 80 percent of (i) the lesser of the actual  
12              charge or 85 percent of the fee schedule amount  
13              provided under section 1848 for the same service  
14              provided by a physician who is not a specialist; or  
15              (ii) in the case of services as an assistant at surgery,  
16              the lesser of the actual charge or 85 percent of the  
17              amount that would otherwise be recognized if per-  
18              formed by a physician who is serving as an assistant  
19              at surgery.”.

20       (c) REMOVAL OF RESTRICTION ON EMPLOYMENT  
21       RELATIONSHIP.—Section 1842(b)(6) (42 U.S.C.  
22       1395u(b)(6)) is amended by adding at the end the follow-  
23       ing new sentence: “For purposes of clause (C) of the first  
24       sentence of this paragraph, an employment relationship  
25       may include any independent contractor arrangement, and

1 employer status shall be determined in accordance with  
2 the law of the State in which the services described in such  
3 clause are performed.”.

4 (d) EFFECTIVE DATE.—The amendments made by  
5 this section shall apply with respect to services furnished  
6 and supplies provided on and after January 1, 1998.

7 **SEC. 4621. RENAL DIALYSIS-RELATED SERVICES.**

8 (a) AUDITING OF COST REPORTS.—The Secretary  
9 shall audit a sample of cost reports of renal dialysis pro-  
10 viders for 1995 and for each third year thereafter.

11 (b) IMPLEMENTATION OF QUALITY STANDARDS.—  
12 The Secretary of Health and Human Services shall de-  
13 velop and implement, by not later than January 1, 1999,  
14 a method to measure and report quality of renal dialysis  
15 services provided under the medicare program under title  
16 XVIII of the Social Security Act in order to reduce pay-  
17 ments for inappropriate or low quality care.

18 **SEC. 4622. PAYMENT FOR COCHLEAR IMPLANTS AS CUS-**

19 **TOMIZED DURABLE MEDICAL EQUIPMENT.**

20 (a) IN GENERAL.—Section 1834(h)(1)(E) (42 U.S.C.  
21 1395m(h)(1)(E)) is amended by adding at the end the fol-  
22 lowing: “Payment for cochlear implants shall be made in  
23 accordance with subsection (a)(4), and, in applying such  
24 subsection to cochlear implants, carriers shall take into  
25 consideration technological innovations and data on

1 charges to the extent that such charges reflect such inno-  
2 vations.”.

3 (b) EFFECTIVE DATE.—The amendment made by  
4 subsection (a) applies to implants implanted on or after  
5 January 1, 1998.

## 6 **CHAPTER 3—PART B PREMIUM**

### 7 **SEC. 4631. PART B PREMIUM.**

8 (a) IN GENERAL.—The first, second and third sen-  
9 tences of section 1839(a)(3) (42 U.S.C. 1395r(a)(3)) are  
10 amended to read as follows: “The Secretary, during Sep-  
11 tember of each year, shall determine and promulgate a  
12 monthly premium rate for the succeeding calendar year.  
13 That monthly premium rate shall be equal to 50 percent  
14 of the monthly actuarial rate for enrollees age 65 and over,  
15 determined according to paragraph (1), for that succeed-  
16 ing calendar year.”.

17 (b) CONFORMING AND TECHNICAL AMENDMENTS.—

18 (1) SECTION 1839.—Section 1839 (42 U.S.C.  
19 1395r) is amended—

20 (A) in subsection (a)(2), by striking “(b)  
21 and (e)” and inserting “(b), (c), and (f)”,

22 (B) in the last sentence of subsection  
23 (a)(3)—

24 (i) by inserting “rate” after “pre-  
25 mium”, and

1 (ii) by striking “and the derivation of  
2 the dollar amounts specified in this para-  
3 graph”,

4 (C) by striking subsection (e), and

5 (D) by redesignating subsection (g) as sub-  
6 section (e) and inserting that subsection after  
7 subsection (d).

8 (2) SECTION 1844.—Subparagraphs (A)(i) and  
9 (B)(i) of section 1844(a)(1) (42 U.S.C.  
10 1395w(a)(1)) are each amended by striking “or  
11 1839(e), as the case may be”.

## 12 **Subtitle H—Provisions Relating to** 13 **Parts A and B**

### 14 **CHAPTER 1—PROVISIONS RELATING TO** 15 **MEDICARE SECONDARY PAYER**

#### 16 **SEC. 4701. PERMANENT EXTENSION AND REVISION OF CER-** 17 **TAIN SECONDARY PAYER PROVISIONS.**

18 (a) APPLICATION TO DISABLED INDIVIDUALS IN  
19 LARGE GROUP HEALTH PLANS.—

20 (1) IN GENERAL.—Section 1862(b)(1)(B) (42  
21 U.S.C. 1395y(b)(1)(B)) is amended—

22 (A) in clause (i), by striking “clause (iv)”  
23 and inserting “clause (iii)”,

24 (B) by striking clause (iii), and

1 (C) by redesignating clause (iv) as clause  
2 (iii).

3 (2) CONFORMING AMENDMENTS.—Paragraphs  
4 (1) through (3) of section 1837(i) (42 U.S.C.  
5 1395p(i)) and the second sentence of section  
6 1839(b) (42 U.S.C. 1395r(b)) are each amended by  
7 striking “1862(b)(1)(B)(iv)” each place it appears  
8 and inserting “1862(b)(1)(B)(iii)”.

9 (b) INDIVIDUALS WITH END STAGE RENAL DIS-  
10 EASE.—

11 (1) IN GENERAL.—Section 1862(b)(1)(C) (42  
12 U.S.C. 1395y(b)(1)(C)) is amended—

13 (A) in the first sentence, by striking “12-  
14 month” each place it appears and inserting  
15 “30-month”, and

16 (B) by striking the second sentence.

17 (2) EFFECTIVE DATE.—The amendments made  
18 by paragraph (1) shall apply to items and services  
19 furnished on or after the date of the enactment of  
20 this Act and with respect to periods beginning on or  
21 after the date that is 18 months prior to such date.

22 (c) IRS-SSA-HCFA DATA MATCH.—

23 (1) SOCIAL SECURITY ACT.—Section  
24 1862(b)(5)(C) (42 U.S.C. 1395y(b)(5)(C)) is  
25 amended by striking clause (iii).

1           (2) INTERNAL REVENUE CODE.—Section  
2           6103(l)(12) of the Internal Revenue Code of 1986 is  
3           amended by striking subparagraph (F).

4 **SEC. 4702. CLARIFICATION OF TIME AND FILING LIMITA-**  
5 **TIONS.**

6           (a) EXTENSION OF CLAIMS FILING PERIOD.—Sec-  
7           tion 1862(b)(2)(B) (42 U.S.C. 1395y(b)(2)(B)) is amend-  
8           ed by adding at the end the following new clause:

9                           “(v) CLAIMS-FILING PERIOD.—Not-  
10                           withstanding any other time limits that  
11                           may exist for filing a claim under an em-  
12                           ployer group health plan, the United  
13                           States may seek to recover conditional pay-  
14                           ments in accordance with this subpara-  
15                           graph where the request for payment is  
16                           submitted to the entity required or respon-  
17                           sible under this subsection to pay with re-  
18                           spect to the item or service (or any portion  
19                           thereof) under a primary plan within the  
20                           3-year period beginning on the date on  
21                           which the item or service was furnished.”.

22           (b) EFFECTIVE DATE.—The amendment made by  
23           subsection (a) applies to items and services furnished after  
24           1990. The previous sentence shall not be construed as per-  
25           mitting any waiver of the 3-year-period requirement (im-

1 posed by such amendment) in the case of items and serv-  
 2 ices furnished more than 3 years before the date of the  
 3 enactment of this Act.

4 **SEC. 4703. PERMITTING RECOVERY AGAINST THIRD PARTY**  
 5 **ADMINISTRATORS.**

6 (a) PERMITTING RECOVERY AGAINST THIRD PARTY  
 7 ADMINISTRATORS OF PRIMARY PLANS.—Section  
 8 1862(b)(2)(B)(ii) (42 U.S.C. 1395y(b)(2)(B)(ii)) is  
 9 amended—

10 (1) by striking “under this subsection to pay”  
 11 and inserting “(directly, as a third-party adminis-  
 12 trator, or otherwise) to make payment”, and

13 (2) by adding at the end the following: “The  
 14 United States may not recover from a third-party  
 15 administrator under this clause in cases where the  
 16 third-party administrator would not be able to re-  
 17 cover the amount at issue from the employer or  
 18 group health plan for whom it provides administra-  
 19 tive services due to the insolvency or bankruptcy of  
 20 the employer or plan.”.

21 (b) CLARIFICATION OF BENEFICIARY LIABILITY.—  
 22 Section 1862(b)(1) (42 U.S.C. 1395y(b)(1)) is amended  
 23 by adding at the end the following new subparagraph:

24 “(F) LIMITATION ON BENEFICIARY LIABIL-  
 25 ITY.—An individual who is entitled to benefits



1 under this title and is furnished an item or  
2 service for which such benefits are incorrectly  
3 paid is not liable for repayment of such benefits  
4 under this paragraph unless payment of such  
5 benefits was made to the individual.”.

6 (c) EFFECTIVE DATE.—The amendments made by  
7 this section apply to items and services furnished on or  
8 after the date of the enactment of this Act.

## 9 **CHAPTER 2—HOME HEALTH SERVICES**

### 10 **SEC. 4711. RECAPTURING SAVINGS RESULTING FROM TEM-** 11 **PORARY FREEZE ON PAYMENT INCREASES** 12 **FOR HOME HEALTH SERVICES.**

13 (a) BASING UPDATES TO PER VISIT COST LIMITS ON  
14 LIMITS FOR FISCAL YEAR 1993.—Section 1861(v)(1)(L)  
15 (42 U.S.C. 1395x(v)(1)(L)) is amended by adding at the  
16 end the following:

17 “(iv) In establishing limits under this subparagraph  
18 for cost reporting periods beginning after September 30,  
19 1997, the Secretary shall not take into account any  
20 changes in the home health market basket, as determined  
21 by the Secretary, with respect to cost reporting periods  
22 which began on or after July 1, 1994, and before July  
23 1, 1996.”.

24 (b) NO EXCEPTIONS PERMITTED BASED ON AMEND-  
25 MENT.—The Secretary of Health and Human Services

1 shall not consider the amendment made by subsection (a)  
2 in making any exemptions and exceptions pursuant to sec-  
3 tion 1861(v)(1)(L)(ii) of the Social Security Act (42  
4 U.S.C. 1395x(v)(1)(L)(ii)).

5 **SEC. 4712. INTERIM PAYMENTS FOR HOME HEALTH SERV-**  
6 **ICES.**

7 (a) **REDUCTIONS IN COST LIMITS.**—Section  
8 1861(v)(1)(L)(i) (42 U.S.C. 1395x(v)(1)(L)(i)) is amend-  
9 ed—

10 (1) by moving the indentation of subclauses (I)  
11 through (III) 2-ems to the left;

12 (2) in subclause (I), by inserting “of the mean  
13 of the labor-related and nonlabor per visit costs for  
14 freestanding home health agencies” before the  
15 comma at the end;

16 (3) in subclause (II), by striking “, or” and in-  
17 serting “of such mean,”;

18 (4) in subclause (III)—

19 (A) by inserting “and before October 1,  
20 1997,” after “July 1, 1987,” and

21 (B) by striking the comma at the end and  
22 inserting “of such mean, or”; and

23 (5) by striking the matter following subclause  
24 (III) and inserting the following:

1           “(IV) October 1, 1997, 105 percent of the me-  
2           dian of the labor-related and nonlabor per visit costs  
3           for freestanding home health agencies.”.

4           (b) DELAY IN UPDATES.—Section 1861(v)(1)(L)(iii)  
5           (42 U.S.C. 1395x(v)(1)(L)(iii)) is amended by inserting  
6           “, or on or after July 1, 1997, and before October 1,  
7           1997” after “July 1, 1996”.

8           (c) ADDITIONS TO COST LIMITS.—Section  
9           1861(v)(1)(L) (42 U.S.C. 1395x(v)(1)(L)), as amended by  
10          section 4711(a), is amended by inserting adding at the  
11          end the following new clauses:

12          “(v) For services furnished by home health agencies  
13          for cost reporting periods beginning on or after October  
14          1, 1997, the Secretary shall provide for an interim system  
15          of limits. Payment shall not exceed the costs determined  
16          under the preceding provisions of this subparagraph or,  
17          if lower, the product of—

18                 “(I) an agency-specific per beneficiary annual  
19                 limitation calculated based 75 percent on the reason-  
20                 able costs (including nonroutine medical supplies)  
21                 for the agency’s 12-month cost reporting period end-  
22                 ing during 1994, and based 25 percent on the stand-  
23                 ardized regional average of such costs for the agen-  
24                 cy’s region for cost reporting periods ending during

1 1994, such costs updated by the home health market  
2 basket index; and

3 “(II) the agency’s unduplicated census count of  
4 patients (entitled to benefits under this title) for the  
5 cost reporting period subject to the limitation.

6 “(vi) For services furnished by home health agencies  
7 for cost reporting periods beginning on or after October  
8 1, 1997, the following rules apply:

9 “(I) For new providers and those providers  
10 without a 12-month cost reporting period ending in  
11 calendar year 1994, the per beneficiary limitation  
12 shall be equal to the median of these limits (or the  
13 Secretary’s best estimates thereof) applied to other  
14 home health agencies as determined by the Sec-  
15 retary. A home health agency that has altered its  
16 corporate structure or name shall not be considered  
17 a new provider for this purpose.

18 “(II) For beneficiaries who use services fur-  
19 nished by more than one home health agency, the  
20 per beneficiary limitations shall be prorated among  
21 the agencies.”.

22 (d) DEVELOPMENT OF CASE MIX SYSTEM.—The  
23 Secretary of Health and Human Services shall expand re-  
24 search on a prospective payment system for home health  
25 agencies under the medicare program that ties prospective

1 payments to a unit of service, including an intensive effort  
2 to develop a reliable case mix adjuster that explains a sig-  
3 nificant amount of the variances in costs.

4 (e) SUBMISSION OF DATA FOR CASE MIX SYSTEM.—  
5 Effective for cost reporting periods beginning on or after  
6 October 1, 1997, the Secretary of Health and Human  
7 Services may require all home health agencies to submit  
8 additional information that the Secretary considers nec-  
9 essary for the development of a reliable case mix system.

10 **SEC. 4713. CLARIFICATION OF PART-TIME OR INTERMIT-**  
11 **TENT NURSING CARE.**

12 (a) IN GENERAL.—Section 1861(m) (42 U.S.C.  
13 1395x(m)) is amended by adding at the end the following:  
14 “For purposes of paragraphs (1) and (4), the term ‘part-  
15 time or intermittent services’ means skilled nursing and  
16 home health aide services furnished any number of days  
17 per week as long as they are furnished (combined) less  
18 than 8 hours each day and 28 or fewer hours each week  
19 (or, subject to review on a case-by-case basis as to the  
20 need for care, less than 8 hours each day and 35 or fewer  
21 hours per week). For purposes of sections 1814(a)(2)(C)  
22 and 1835(a)(2)(A), ‘intermittent’ means skilled nursing  
23 care that is either provided or needed on fewer than 7  
24 days each week, or less than 8 hours of each day for peri-  
25 ods of 21 days or less (with extensions in exceptional cir-

1 cumstances when the need for additional care is finite and  
2 predictable).”.

3 (b) **EFFECTIVE DATE.**—The amendment made by  
4 subsection (a) applies to services furnished on or after Oc-  
5 tober 1, 1997.

6 **SEC. 4714. STUDY ON DEFINITION OF HOMEBOUND.**

7 (a) **STUDY.**—The Secretary of Health and Human  
8 Services shall conduct a study of the criteria that should  
9 be applied, and the method of applying such criteria, in  
10 the determination of whether an individual is homebound  
11 for purposes of qualifying for receipt of benefits for home  
12 health services under the medicare program. Such criteria  
13 shall include the extent and circumstances under which  
14 a person may be absent from the home but nonetheless  
15 qualify.

16 (b) **REPORT.**—Not later than October 1, 1998, the  
17 Secretary shall submit a report to the Congress on the  
18 study conducted under subsection (a). The report shall in-  
19 clude specific recommendations on such criteria and meth-  
20 ods.

21 **SEC. 4715. PAYMENT BASED ON LOCATION WHERE HOME**  
22 **HEALTH SERVICE IS FURNISHED.**

23 (a) **CONDITIONS OF PARTICIPATION.**—Section 1891  
24 (42 U.S.C. 1395bbb) is amended by adding at the end  
25 the following:

1           “(g) PAYMENT ON BASIS OF LOCATION OF SERV-  
2 ICE.—A home health agency shall submit claims for pay-  
3 ment for home health services under this title only on the  
4 basis of the geographic location at which the service is fur-  
5 nished, as determined by the Secretary.”.

6           (b) WAGE ADJUSTMENT.—Section 1861(v)(1)(L)(iii)  
7 (42 U.S.C. 1395x(v)(1)(L)(iii)) is amended by striking  
8 “agency is located” and inserting “service is furnished”.

9           (c) EFFECTIVE DATE.—The amendments made by  
10 this section apply to cost reporting periods beginning on  
11 or after October 1, 1997.

12 **SEC. 4716. NORMATIVE STANDARDS FOR HOME HEALTH**  
13 **CLAIMS DENIALS,**

14           (a) IN GENERAL.—Section 1862(a)(1) (42 U.S.C.  
15 1395y(a)(1)), as amended by section 4103(c), is amend-  
16 ed—

17               (1) by striking “and” at the end of subpara-  
18 graph (G),

19               (2) by striking the semicolon at the end of sub-  
20 paragraph (H) and inserting “, and”, and

21               (3) by inserting after subparagraph (H) the fol-  
22 lowing new subparagraph:

23                       “(I) the frequency and duration of home health  
24 services which are in excess of normative guidelines  
25 that the Secretary shall establish by regulation;”.

1 (b) NOTIFICATION.—The Secretary of Health and  
2 Human Services may establish a process for notifying a  
3 physician in cases in which the number of home health  
4 service visits furnished under the medicare program pur-  
5 suant to a prescription or certification of the physician sig-  
6 nificantly exceeds such threshold (or thresholds) as the  
7 Secretary specifies. The Secretary may adjust such thresh-  
8 old to reflect demonstrated differences in the need for  
9 home health services among different beneficiaries.

10 (c) EFFECTIVE DATE.—The amendments made by  
11 this section apply to services furnished on or after October  
12 1, 1997.

13 **SEC. 4717. NO HOME HEALTH BENEFITS BASED SOLELY ON**  
14 **DRAWING BLOOD.**

15 (a) IN GENERAL.—Sections 1814(a)(2)(C) and  
16 1835(a)(2)(A) (42 U.S.C. 1395f(a)(2)(C),  
17 1395n(a)(2)(A)) are each amended by inserting “(other  
18 than solely venipuncture for the purpose of obtaining a  
19 blood sample)” after “skilled nursing care”.

20 (b) EFFECTIVE DATE.—The amendments made by  
21 subsection (a) apply to home health services furnished  
22 after the 6-month period beginning after the date of en-  
23 actment of this Act.



1 **SEC. 4718. MAKING PART B PRIMARY PAYOR FOR CERTAIN**  
2 **HOME HEALTH SERVICES.**

3 (a) IN GENERAL.—Section 1833(d) (42 U.S.C.  
4 1395l(d)) is amended—

5 (1) by striking “(d) No” and inserting “(d)(1)  
6 Subject to paragraph (2), no”, and

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

9 “(2) Payment shall be made under this part (rather  
10 than under part A), for an individual entitled to benefits  
11 under part A, for home health services, other than the first  
12 100 visits of post-hospital home health services furnished  
13 to an individual.”.

14 (b) POST-HOSPITAL HOME HEALTH SERVICES.—  
15 Section 1861 (42 U.S.C. 1395x) is amended by adding  
16 at the end the following:

17 “(ss) POST-HOSPITAL HOME HEALTH SERVICES.—  
18 The term ‘post-hospital home health services’ means home  
19 health services furnished to an individual under a plan of  
20 treatment established when the individual was an inpa-  
21 tient of a hospital or rural primary care hospital for not  
22 less than 3 consecutive days before discharge, or during  
23 a covered post-hospital extended care stay, if home health  
24 services are initiated for the individual within 30 days  
25 after discharge from the hospital, rural primary care hos-  
26 pital or extended care facility.”.

1 (c) PAYMENTS UNDER PART B.—Subparagraph (A)  
2 of section 1833(a)(2) (42 U.S.C. 1395l(a)(2)) is amended  
3 to read as follows:

4 “(A) with respect to home health services  
5 (other than a covered osteoporosis drug (as de-  
6 fined in section 1861(kk)), and to items and  
7 services described in section 1861(s)(10)(A),  
8 the amounts determined under section  
9 1861(v)(1)(L) or section 1893, or, if the serv-  
10 ices are furnished by a public provider of serv-  
11 ices, or by another provider which demonstrates  
12 to the satisfaction of the Secretary that a sig-  
13 nificant portion of its patients are low-income  
14 (and requests that payment be made under this  
15 provision), free of charge, or at nominal charges  
16 to the public, the amount determined in accord-  
17 ance with section 1814(b)(2);”.

18 (d) PHASE-IN OF ADDITIONAL PART B COSTS IN  
19 DETERMINATION OF PART B MONTHLY PREMIUM.—Sec-  
20 tion 1839(a) (42 U.S.C. 1395r(a)) is amended—

21 (1) in paragraph (3) in last the sentence in-  
22 serted by section 4631(a) of this title, by inserting  
23 “(except as provided in paragraph (5)(B))” before  
24 the period, and

25 (2) by adding after paragraph (4) the following:

1       “(5)(A) The Secretary shall, at the time of determin-  
2 ing the monthly actuarial rate under paragraph (1) for  
3 1998 through 2003, shall determine a transitional month-  
4 ly actuarial rate for enrollees age 65 and over in the same  
5 manner as such rate is determined under paragraph (1),  
6 except that there shall be excluded from such determina-  
7 tion an estimate of any benefits and administrative costs  
8 attributable to home health services for which payment  
9 would have been made under part A during the year but  
10 for paragraph (2) of section 1833(d).

11       “(B) The monthly premium for each individual en-  
12 rolled under this part for each month for a year (beginning  
13 with 1998 and ending with 2003) shall be equal to 50  
14 percent of the monthly actuarial rate determined under  
15 subparagraph (A) increased by the following proportion of  
16 the difference between such premium and the monthly pre-  
17 mium otherwise determined under paragraph (3) (without  
18 regard to this paragraph):

19               “(i) For a month in 1998,  $\frac{1}{7}$ .

20               “(ii) For a month in 1999,  $\frac{2}{7}$ .

21               “(iii) For a month in 2000,  $\frac{3}{7}$ .

22               “(iv) For a month in 2001,  $\frac{4}{7}$ .

23               “(v) For a month in 2002,  $\frac{5}{7}$ .

24               “(vi) For a month in 2003,  $\frac{6}{7}$ .”

1           (e) MAINTAINING APPEAL RIGHTS FOR HOME  
2 HEALTH SERVICES.—Section 1869(b)(2)(B) (42 U.S.C.  
3 1395ff(b)(2)(B)) is amended by inserting “(or \$100 in the  
4 case of home health services)” after “\$500”.

5           (f) REPORT.—Not later than October 1, 1999, the  
6 Secretary of Health and Human Services shall submit a  
7 report to the Committees on Commerce and Ways and  
8 Means of the House of Representatives and the Committee  
9 on Finance of the Senate on the impact on home health  
10 utilization and admissions to hospitals and skilled nursing  
11 facilities of the amendment made by subsection (b). The  
12 Secretary shall further reexamine and submit a report to  
13 such Committees on this impact 1 year after the full im-  
14 plementation of the prospective payment system for home  
15 health services into the medicare program, effected under  
16 the amendments made by section 4441.

17           (g) EFFECTIVE DATE.—The amendments made by  
18 this section apply to services furnished on or after October  
19 1, 1997.

1     **CHAPTER 3—BABY BOOM GENERATION**  
2                     **MEDICARE COMMISSION**

3     **SEC. 4721. BIPARTISAN COMMISSION ON THE EFFECT OF**  
4                     **THE BABY BOOM GENERATION ON THE MEDI-**  
5                     **CARE PROGRAM.**

6             (a) ESTABLISHMENT.—There is established a com-  
7 mission to be known as the Bipartisan Commission on the  
8 Effect of the Baby Boom Generation on the Medicare Pro-  
9 gram (in this section referred to as the “Commission”).

10            (b) DUTIES.—

11                (1) IN GENERAL.—The Commission shall—

12                    (A) examine the financial impact on the  
13 medicare program of the significant increase in  
14 the number of medicare eligible individuals  
15 which will occur beginning approximately dur-  
16 ing 2010 and lasting for approximately 25  
17 years, and

18                    (B) make specific recommendations to the  
19 Congress respecting a comprehensive approach  
20 to preserve the medicare program for the period  
21 during which such individuals are eligible for  
22 medicare.

23                (2) CONSIDERATIONS IN MAKING REC-  
24 OMMENDATIONS.—In making its recommendations,  
25 the Commission shall consider the following:

1           (A) The amount and sources of Federal  
2 funds to finance the medicare program, includ-  
3 ing the potential use of innovative financing  
4 methods.

5           (B) Methods used by other nations to re-  
6 spond to comparable demographic patterns in  
7 eligibility for health care benefits for elderly  
8 and disabled individuals.

9           (C) Modifying age-based eligibility to cor-  
10 respond to changes in age-based eligibility  
11 under the OASDI program.

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

15           (E) The role medicare should play in ad-  
16 dressing the needs of persons with chronic ill-  
17 ness.

18       (c) MEMBERSHIP.—

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

21           (A) The Majority Leader of the Senate  
22 shall appoint, after consultation with the minor-  
23 ity leader of the Senate, 6 members, of whom  
24 not more than 4 may be of the same political  
25 party.

1           (B) The Speaker of the House of Rep-  
2           representatives shall appoint, after consultation  
3           with the minority leader of the House of Rep-  
4           representatives, 6 members, of whom not more  
5           than 4 may be of the same political party.

6           (C) The 3 ex officio members of the Board  
7           of Trustees of the Federal Hospital Insurance  
8           Trust Fund and of the Federal Supplementary  
9           Medical Insurance Trust Fund who are Cabinet  
10          level officials.

11          (2) CHAIRMAN AND VICE CHAIRMAN.—As the  
12          first item of business at the Commission's first  
13          meeting (described in paragraph (5)(B)), the Com-  
14          mission shall elect a Chairman and Vice Chairman  
15          from among its members. The individuals elected as  
16          Chairman and Vice Chairman may not be of the  
17          same political party and may not have been ap-  
18          pointed to the Commission by the same appointing  
19          authority.

20          (3) VACANCIES.—Any vacancy in the member-  
21          ship of the Commission shall be filled in the manner  
22          in which the original appointment was made and  
23          shall not affect the power of the remaining members  
24          to execute the duties of the Commission.

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

4           (5) MEETINGS.—

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

7           (B) The Commission shall hold its first  
8 meeting not later than February 1, 1998.

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

15          (d) ADVISORY PANEL.—

16           (1) IN GENERAL.—The Chairman, in consulta-  
17 tion with the Vice Chairman, may establish a panel  
18 (in this section referred to as the “Advisory Panel”)  
19 consisting of health care experts, consumers, provid-  
20 ers, and others to advise and assist the members of  
21 the Commission in carrying out the duties described  
22 in subsection (b). The panel shall have only those  
23 powers that the Chairman, in consultation with the  
24 Vice Chairman, determines are necessary and appro-



1        appropriate to assist the Commission in carrying out such  
2        duties.

3            (2) COMPENSATION.—Members of the Advisory  
4        Panel are not entitled to receive compensation for  
5        service on the Advisory Panel. Subject to the ap-  
6        proval of the chairman of the Commission, members  
7        may be reimbursed for travel, subsistence, and other  
8        necessary expenses incurred in carrying out the du-  
9        ties of the Advisory Panel.

10        (e) STAFF AND CONSULTANTS.—

11            (1) STAFF.—The Commission may appoint and  
12        determine the compensation of such staff as may be  
13        necessary to carry out the duties of the Commission.  
14        Such appointments and compensation may be made  
15        without regard to the provisions of title 5, United  
16        States Code, that govern appointments in the com-  
17        petitive services, and the provisions of chapter 51  
18        and subchapter III of chapter 53 of such title that  
19        relate to classifications and the General Schedule  
20        pay rates.

21            (2) CONSULTANTS.—The Commission may pro-  
22        cure such temporary and intermittent services of  
23        consultants under section 3109(b) of title 5, United  
24        States Code, as the Commission determines to be  
25        necessary to carry out the duties of the Commission.

1 (f) POWERS.—

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

7 (2) STUDIES BY GAO.—Upon the request of the  
8 Commission, the Comptroller General shall conduct  
9 such studies or investigations as the Commission de-  
10 termines to be necessary to carry out its duties.

11 (3) COST ESTIMATES BY CONGRESSIONAL  
12 BUDGET OFFICE.—

13 (A) Upon the request of the Commission,  
14 the Director of the Congressional Budget Office  
15 shall provide to the Commission such cost esti-  
16 mates as the Commission determines to be nec-  
17 essary to carry out its duties.

18 (B) The Commission shall reimburse the  
19 Director of the Congressional Budget Office for  
20 expenses relating to the employment in the of-  
21 fice of the Director of such additional staff as  
22 may be necessary for the Director to comply  
23 with requests by the Commission under sub-  
24 paragraph (A).

1           (4) **DETAIL OF FEDERAL EMPLOYEES.**—Upon  
2 the request of the Commission, the head of any Fed-  
3 eral agency is authorized to detail, without reim-  
4 bursement, any of the personnel of such agency to  
5 the Commission to assist the Commission in carry-  
6 ing out its duties. Any such detail shall not interrupt  
7 or otherwise affect the civil service status or privi-  
8 leges of the Federal employee.

9           (5) **TECHNICAL ASSISTANCE.**—Upon the re-  
10 quest of the Commission, the head of a Federal  
11 agency shall provide such technical assistance to the  
12 Commission as the Commission determines to be  
13 necessary to carry out its duties.

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

20           (7) **OBTAINING INFORMATION.**—The Commis-  
21 sion may secure directly from any Federal agency  
22 information necessary to enable it to carry out its  
23 duties, if the information may be disclosed under  
24 section 552 of title 5, United States Code. Upon re-  
25 quest of the Chairman of the Commission, the head

1 of such agency shall furnish such information to the  
2 Commission.

3 (8) ADMINISTRATIVE SUPPORT SERVICES.—

4 Upon the request of the Commission, the Adminis-  
5 trator of General Services shall provide to the Com-  
6 mission on a reimbursable basis such administrative  
7 support services as the Commission may request.

8 (9) PRINTING.—For purposes of costs relating  
9 to printing and binding, including the cost of per-  
10 sonnel detailed from the Government Printing Of-  
11 fice, the Commission shall be deemed to be a com-  
12 mittee of the Congress.

13 (g) REPORT.—Not later than May 1, 1999, the Com-  
14 mission shall submit to Congress a report containing its  
15 findings and recommendations regarding how to protect  
16 and preserve the medicare program in a financially solvent  
17 manner until 2030 (or, if later, throughout the period of  
18 projected solvency of the Federal Old-Age and Survivors  
19 Insurance Trust Fund). The report shall include detailed  
20 recommendations for appropriate legislative initiatives re-  
21 specting how to accomplish this objective.

22 (h) TERMINATION.—The Commission shall terminate  
23 30 days after the date of submission of the report required  
24 in subsection (g).

1 (i) AUTHORIZATION OF APPROPRIATIONS.—There  
2 are authorized to be appropriated \$1,500,000 to carry out  
3 this section. 60 percent of such appropriation shall be pay-  
4 able from the Federal Hospital Insurance Trust Fund,  
5 and 40 percent of such appropriation shall be payable  
6 from the Federal Supplementary Medical Insurance Trust  
7 Fund under title XVIII of the Social Security Act (42  
8 U.S.C. 1395i, 1395t).

9 **CHAPTER 4—PROVISIONS RELATING TO**  
10 **DIRECT GRADUATE MEDICAL EDUCATION**

11 **SEC. 4731. LIMITATION ON PAYMENT BASED ON NUMBER**  
12 **OF RESIDENTS AND IMPLEMENTATION OF**  
13 **ROLLING AVERAGE FTE COUNT.**

14 Section 1886(h)(4) (42 U.S.C. 1395ww(h)(4)) is  
15 amended by adding after subparagraph (E) the following:

16 “(F) LIMITATION ON NUMBER OF RESI-  
17 DENTS FOR CERTAIN FISCAL YEARS.—Such  
18 rules shall provide that for purposes of a cost  
19 reporting period beginning on or after October  
20 1, 1997, the total number of full-time equiva-  
21 lent residents before application of weighting  
22 factors (as determined under this paragraph)  
23 with respect to a hospital’s approved medical  
24 residency training program may not exceed the  
25 number of full-time equivalent residents with

1           respect to the hospital's most recent cost re-  
2           porting period ending on or before December  
3           31, 1996.

4           “(G) COUNTING INTERNS AND RESIDENTS  
5           FOR FY 1998 AND SUBSEQUENT YEARS.—

6           “(i) FY 1998.—For the hospital's first  
7           cost reporting period beginning during fis-  
8           cal year 1998, subject to the limit de-  
9           scribed in subparagraph (F), the total  
10          number of full-time equivalent residents,  
11          for determining the hospital's graduate  
12          medical education payment, shall equal the  
13          average of the full-time equivalent resident  
14          counts for the cost reporting period and  
15          the preceding cost reporting period.

16          “(ii) SUBSEQUENT YEARS.—For each  
17          subsequent cost reporting period, subject  
18          to the limit described in subparagraph (F),  
19          the total number of full-time equivalent  
20          residents, for determining the hospital's  
21          graduate medical education payment, shall  
22          equal the average of the actual full-time  
23          equivalent resident counts for the cost re-  
24          porting period and preceding two cost re-  
25          porting periods.

1           “(iii) ADJUSTMENT FOR SHORT PERI-  
2           ODS.—If a hospital’s cost reporting period  
3           beginning on or after October 1, 1997, is  
4           not equal to twelve months, the Secretary  
5           shall make appropriate modifications to en-  
6           sure that the average full-time equivalent  
7           resident counts pursuant to clause (ii) are  
8           based on the equivalent of full 12-month  
9           cost reporting periods.

10           “(iv) EXCLUSION OF RESIDENTS IN  
11           DENTISTRY.—Residents in an approved  
12           medical residency training program in den-  
13           tistry shall not be counted for purposes of  
14           this subparagraph and subparagraph  
15           (F).”.

16 **SEC. 4732. PHASED-IN LIMITATION ON HOSPITAL OVER-**  
17 **HEAD AND SUPERVISORY PHYSICIAN COMPO-**  
18 **NENT OF DIRECT MEDICAL EDUCATION**  
19 **COSTS.**

20           (a) IN GENERAL.—Section 1886(h)(3) (42 U.S.C.  
21 1395ww(h)(3)) is amended—

22           (1) in subparagraph (B), by inserting “subject  
23           to subparagraph (D),” after “subparagraph (A)”,  
24           and

25           (2) by adding at the end the following:

1           “(D) PHASED-IN LIMITATION ON HOS-  
2           PITAL OVERHEAD AND SUPERVISORY PHYSICIAN  
3           COMPONENT.—

4           “(i) IN GENERAL.—In the case of a  
5           hospital for which the overhead GME  
6           amount (as defined in clause (ii)) for the  
7           base period exceeds an amount equal to  
8           the 75th percentile of the overhead GME  
9           amounts in such period for all hospitals  
10          (weighted to reflect the full-time equivalent  
11          resident counts for all approved medical  
12          residency training programs), subject to  
13          clause (iv), the hospital’s approved FTE  
14          resident amount (for periods beginning on  
15          or after October 1, 1997) shall be reduced  
16          from the amount otherwise applicable (as  
17          previously reduced under this subpara-  
18          graph) by an overhead reduction amount.  
19          The overhead reduction amount is equal to  
20          the lesser of—

21                       “(I) 20 percent of the reference  
22                       reduction amount (described in clause  
23                       (iii)) for the period, or

24                       “(II) 15 percent of the hospital’s  
25                       overhead GME amount for the period



1 (as otherwise determined before the  
2 reduction provided under this sub-  
3 paragraph for the period involved).

4 “(ii) OVERHEAD GME AMOUNT.—For  
5 purposes of this subparagraph, the term  
6 ‘overhead GME amount’ means, for a hos-  
7 pital for a period, the product of—

8 “(I) the percentage of the hos-  
9 pital’s approved FTE resident amount  
10 for the base period that is not attrib-  
11 utable to resident salaries and fringe  
12 benefits, and

13 “(II) the hospital’s approved  
14 FTE resident amount for the period  
15 involved.

16 “(iii) REFERENCE REDUCTION  
17 AMOUNT.—

18 “(I) IN GENERAL.—The ref-  
19 erence reduction amount described in  
20 this clause for a hospital for a cost re-  
21 porting period is the base difference  
22 (described in subclause (II)) updated,  
23 in a compounded manner for each pe-  
24 riod from the base period to the pe-  
25 riod involved, by the update applied

1 for such period to the hospital's ap-  
2 proved FTE resident amount.

3 “(II) BASE DIFFERENCE.—The  
4 base difference described in this sub-  
5 clause for a hospital is the amount by  
6 which the hospital's overhead GME  
7 amount in the base period exceeded  
8 the 75th percentile of such amounts  
9 (as described in clause (i)).

10 “(iv) MAXIMUM REDUCTION TO 75TH  
11 PERCENTILE.—In no case shall the reduc-  
12 tion under this subparagraph effected for a  
13 hospital for a period (below the amount  
14 that would otherwise apply for the period  
15 if this subparagraph did not apply for any  
16 period) exceed the reference reduction  
17 amount for the hospital for the period.

18 “(v) BASE PERIOD.—For purposes of  
19 this subparagraph, the term ‘base period’  
20 means the cost reporting period beginning  
21 in fiscal year 1984 or the period used to  
22 establish the hospital's approved FTE resi-  
23 dent amount for hospitals that did not  
24 have approved residency training programs  
25 in fiscal year 1984.

1                   “(vi) RULES FOR HOSPITALS INITIAT-  
2                   ING RESIDENCY TRAINING PROGRAMS.—  
3                   The Secretary shall establish rules for the  
4                   application of this subparagraph in the  
5                   case of a hospital that initiates medical  
6                   residency training programs during or  
7                   after the base period.”.

8           (b) EFFECTIVE DATE.—The amendments made by  
9           subsection (a) shall apply to per resident payment  
10           amounts attributable to periods beginning on or after Oc-  
11           tober 1, 1997.

12   **SEC. 4733. PERMITTING PAYMENT TO NON-HOSPITAL PRO-**  
13                   **VIDERS.**

14           (a) IN GENERAL.— Section 1886 (42 U.S.C.  
15   1395ww) is amended by adding at the end the following:

16           “(k) PAYMENT TO NON-HOSPITAL PROVIDERS.—

17                   “(1) REPORT.—The Secretary shall submit to  
18                   Congress, not later than 18 months after the date  
19                   of the enactment of this subsection, a proposal for  
20                   payment to qualified non-hospital providers for their  
21                   direct costs of medical education, if those costs are  
22                   incurred in the operation of an approved medical  
23                   residency training program described in subsection  
24                   (h). Such proposal shall specify the amounts, form,  
25                   and manner in which such payments will be made

1 and the portion of such payments that will be made  
2 from each of the trust funds under this title.

3 “(2) EFFECTIVENESS.—Except as otherwise  
4 provided in law, the Secretary may implement such  
5 proposal for residency years beginning not earlier  
6 than 6 months after the date of submittal of the re-  
7 port under paragraph (1).

8 “(3) QUALIFIED NON-HOSPITAL PROVIDERS.—  
9 For purposes of this subsection, the term ‘qualified  
10 non-hospital provider’ means—

11 “(A) a Federally qualified health center, as  
12 defined in section 1861(aa)(4);

13 “(B) a rural health clinic, as defined in  
14 section 1861(aa)(2); and

15 “(C) such other providers (other than hos-  
16 pitals) as the Secretary determines to be appro-  
17 priate.”.

18 (b) PROHIBITION ON DOUBLE PAYMENTS; BUDGET  
19 NEUTRALITY ADJUSTMENT.—Section 1886(h)(3)(B) (42  
20 U.S.C. 1395ww(h)(3)(B)) is amended by adding at the  
21 end the following:

22 “The Secretary shall reduce the aggregate ap-  
23 proved amount to the extent payment is made  
24 under subsection (k) for residents included in  
25 the hospital’s count of full-time equivalent resi-

1 dents and, in the case of residents not included  
2 in any such count, the Secretary shall provide  
3 for such a reduction in aggregate approved  
4 amounts under this subsection as will assure  
5 that the application of subsection (k) does not  
6 result in any increase in expenditures under  
7 this title in excess of those that would have oc-  
8 curred if subsection (k) were not applicable.”.

9 **SEC. 4734. INCENTIVE PAYMENTS UNDER PLANS FOR VOL-**  
10 **UNTARY REDUCTION IN NUMBER OF RESI-**  
11 **DENTS.**

12 Section 1886(h) (42 U.S.C. 1395ww(h)) is further  
13 amended by adding at the end the following new para-  
14 graph:

15 “(6) INCENTIVE PAYMENT UNDER PLANS FOR  
16 VOLUNTARY REDUCTION IN NUMBER OF RESI-  
17 DENTS.—

18 “(A) IN GENERAL.—In the case of a vol-  
19 untary residency reduction plan for which an  
20 application is approved under subparagraph  
21 (B), the qualifying entity submitting the plan  
22 shall be paid an applicable hold harmless per-  
23 centage (as specified in subparagraph (E)) of  
24 the sum of—

25 “(i) amount (if any) by which—

1           “(I) the amount of payment  
2           which would have been made under  
3           this subsection if there had been a 5  
4           percent reduction in the number of  
5           full-time equivalent residents in the  
6           approved medical education training  
7           programs of the qualifying entity as of  
8           June 30, 1997, exceeds

9           “(II) the amount of payment  
10          which is made under this subsection,  
11          taking into account the reduction in  
12          such number effected under the re-  
13          duction plan; and

14          “(ii) the amount of the reduction in  
15          payment under 1886(d)(5)(B) (for hos-  
16          pitals participating in the qualifying entity)  
17          that is attributable to the reduction in  
18          number of residents effected under the  
19          plan below 95 percent of the number of  
20          full-time equivalent residents in such pro-  
21          grams of such entity as of June 30, 1997.

22          “(B) APPROVAL OF PLAN APPLICA-  
23          TIONS.—The Secretary may not approve the ap-  
24          plication of an qualifying entity unless—

1           “(i) the application is submitted in a  
2 form and manner specified by the Sec-  
3 retary and by not later than March 1,  
4 2000,

5           “(ii) the application provides for the  
6 operation of a plan for the reduction in the  
7 number of full-time equivalent residents in  
8 the approved medical residency training  
9 programs of the entity consistent with the  
10 requirements of subparagraph (D);

11           “(iii) the entity elects in the applica-  
12 tion whether such reduction will occur  
13 over—

14                   “(I) a period of not longer than  
15 5 residency training years, or

16                   “(II) a period of 6 residency  
17 training years,

18 except that a qualifying entity described in  
19 subparagraph (C)(i)(III) may not make the  
20 election described in subclause (II); and

21           “(iv) the Secretary determines that  
22 the application and the entity and such  
23 plan meet such other requirements as the  
24 Secretary specifies in regulations.

25           “(C) QUALIFYING ENTITY.—

1           “(i) IN GENERAL.—For purposes of  
2 this paragraph, any of the following may  
3 be a qualifying entity:

4           “(I) Individual hospitals operat-  
5 ing one or more approved medical  
6 residency training programs.

7           “(II) Subject to clause (ii), two  
8 or more hospitals that operate such  
9 programs and apply for treatment  
10 under this paragraph as a single  
11 qualifying entity.

12           “(III) Subject to clause (iii), a  
13 qualifying consortium (as described in  
14 section 4735 of the Balanced Budget  
15 Act of 1997).

16           “(ii) ADDITIONAL REQUIREMENT FOR  
17 JOINT PROGRAMS.—In the case of an ap-  
18 plication by a qualifying entity described in  
19 clause (i)(II), the Secretary may not ap-  
20 prove the application unless the application  
21 represents that the qualifying entity ei-  
22 ther—

23           “(I) in the case of an entity that  
24 meets the requirements of clause (v)  
25 of subparagraph (D) will not reduce



1 the number of full-time equivalent  
2 residents in primary care during the  
3 period of the plan, or

4 “(II) in the case of another en-  
5 tity will not reduce the proportion of  
6 its residents in primary care (to the  
7 total number of residents) below such  
8 proportion as in effect as of the appli-  
9 cable time described in subparagraph  
10 (D)(vi).

11 “(iii) ADDITIONAL REQUIREMENT FOR  
12 CONSORTIA.—In the case of an application  
13 by a qualifying entity described in clause  
14 (i)(III), the Secretary may not approve the  
15 application unless the application rep-  
16 resents that the qualifying entity will not  
17 reduce the proportion of its residents in  
18 primary care (to the total number of resi-  
19 dents) below such proportion as in effect  
20 as of the applicable time described in sub-  
21 paragraph (D)(vi).

22 “(D) RESIDENCY REDUCTION REQUIRE-  
23 MENTS.—

24 “(i) INDIVIDUAL HOSPITAL APPLI-  
25 CANTS.—In the case of a qualifying entity

1 described in subparagraph (C)(i)(I), the  
2 number of full-time equivalent residents in  
3 all the approved medical residency training  
4 programs operated by or through the en-  
5 tity shall be reduced as follows:

6 “(I) If base number of residents  
7 exceeds 750 residents, by a number  
8 equal to at least 20 percent of such  
9 base number.

10 “(II) Subject to subclause (IV),  
11 if base number of residents exceeds  
12 500, but is less than 750, residents,  
13 by 150 residents.

14 “(III) Subject to subclause (IV),  
15 if base number of residents does not  
16 exceed 500 residents, by a number  
17 equal to at least 25 percent of such  
18 base number.

19 “(IV) In the case of a qualifying  
20 entity which is described in clause (v)  
21 and which elects treatment under this  
22 subclause, by a number equal to at  
23 least 20 percent of such base number.

24 “(ii) JOINT APPLICANTS.—In the case  
25 of a qualifying entity described in subpara-

1 graph (C)(i)(II), the number of full-time  
2 equivalent residents in all the approved  
3 medical residency training programs oper-  
4 ated by or through the entity shall be re-  
5 duced as follows:

6 “(I) Subject to subclause (II), by  
7 a number equal to at least 25 percent  
8 of such base number.

9 “(II) In the case of a qualifying  
10 entity which is described in clause (v)  
11 and which elects treatment under this  
12 subclause, by a number equal to at  
13 least 20 percent of such base number.

14 “(iii) CONSORTIA.—In the case of a  
15 qualifying entity described in subparagraph  
16 (C)(i)(III), the number of full-time equiva-  
17 lent residents in all the approved medical  
18 residency training programs operated by or  
19 through the entity shall be reduced by a  
20 number equal to at least 20 percent of  
21 such base number.

22 “(iv) MANNER OF REDUCTION.—The  
23 reductions specified under the preceding  
24 provisions of this subparagraph for a quali-  
25 fying entity shall be below the base number

1 of residents for that entity and shall be  
2 fully effective not later than—

3 “(I) the 5th residency training  
4 year in which the application under  
5 subparagraph (B) is effective, in the  
6 case of an entity making the election  
7 described in subparagraph (B)(iii)(I),  
8 or

9 “(II) the 6th such residency  
10 training year, in the case of an entity  
11 making the election described in sub-  
12 paragraph (B)(iii)(II).

13 “(v) ENTITIES PROVIDING ASSURANCE  
14 OF MAINTENANCE OF PRIMARY CARE RESI-  
15 DENTS.—An entity is described in this  
16 clause if—

17 “(I) the base number of residents  
18 for the entity is less than 750;

19 “(II) the number of full-time  
20 equivalent residents in primary care  
21 included in the base number of resi-  
22 dents for the entity is at least 10 per-  
23 cent of such base number; and

24 “(III) the entity represents in its  
25 application under subparagraph (B)

1           that there will be no reduction under  
2           the plan in the number of full-time  
3           equivalent residents in primary care.

4           If a qualifying entity fails to comply with  
5           the representation described in subclause  
6           (III), the entity shall be subject to repay-  
7           ment of all amounts paid under this para-  
8           graph, in accordance with procedures es-  
9           tablished to carry out subparagraph (F).

10           “(vi) BASE NUMBER OF RESIDENTS  
11           DEFINED.—For purposes of this para-  
12           graph, the term ‘base number of residents’  
13           means, with respect to a qualifying entity  
14           operating approved medical residency  
15           training programs, the number of full-time  
16           equivalent residents in such programs (be-  
17           fore application of weighting factors) of  
18           the entity as of the most recent cost re-  
19           porting period ending before June 30,  
20           1997, or, if less, for any subsequent cost  
21           reporting period that ends before the date  
22           the entity makes application under this  
23           paragraph.

24           “(E) APPLICABLE HOLD HARMLESS PER-  
25           CENTAGE.—

1           “(i) IN GENERAL.—For purposes of  
2           subparagraph (A), the ‘applicable hold  
3           harmless percentage’ is the percentages  
4           specified in clause (ii) or clause (iii), as  
5           elected by the qualifying entity in the ap-  
6           plication submitted under subparagraph  
7           (B).

8           “(ii) 5-YEAR REDUCTION PLAN.—In  
9           the case of an entity making the election  
10          described in subparagraph (B)(iii)(I), the  
11          percentages specified in this clause are, for  
12          the—

13                   “(I) first and second residency  
14                   training years in which the reduction  
15                   plan is in effect, 100 percent,

16                   “(II) third such year, 75 percent,

17                   “(III) fourth such year, 50 per-  
18                   cent, and

19                   “(IV) fifth such year, 25 percent.

20          “(iii) 6-YEAR REDUCTION PLAN.—In  
21          the case of an entity making the election  
22          described in subparagraph (B)(iii)(II), the  
23          percentages specified in this clause are, for  
24          the—

1                   “(I) first residency training year  
2                   in which the reduction plan is in ef-  
3                   fect, 100 percent,

4                   “(II) second such year, 95 per-  
5                   cent,

6                   “(III) third such year, 85 per-  
7                   cent,

8                   “(IV) fourth such year, 70 per-  
9                   cent,

10                  “(V) fifth such year, 50 percent,  
11                  and

12                  “(VI) sixth such year, 25 per-  
13                  cent.

14                  “(F) PENALTY FOR INCREASE IN NUMBER  
15                  OF RESIDENTS IN SUBSEQUENT YEARS.—If  
16                  payments are made under this paragraph to a  
17                  qualifying entity, if the entity (or any hospital  
18                  operating as part of the entity) increases the  
19                  number of full-time equivalent residents above  
20                  the number of such residents permitted under  
21                  the reduction plan as of the completion of the  
22                  plan, then, as specified by the Secretary, the  
23                  entity is liable for repayment to the Secretary  
24                  of the total amounts paid under this paragraph  
25                  to the entity.

1           “(G) TREATMENT OF ROTATING RESI-  
2           DENTS.—In applying this paragraph, the Sec-  
3           retary shall establish rules regarding the count-  
4           ing of residents who are assigned to institutions  
5           the medical residency training programs in  
6           which are not covered under approved applica-  
7           tions under this paragraph.”.

8           (b) RELATION TO DEMONSTRATION PROJECTS AND  
9           AUTHORITY.—

10           (1) Section 1886(h)(6) of the Social Security  
11           Act, added by subsection (a), shall not apply to any  
12           residency training program with respect to which a  
13           demonstration project described in paragraph (3)  
14           has been approved by the Health Care Financing  
15           Administration as of May 27, 1997. The Secretary  
16           of Health and Human Services shall take such ac-  
17           tions as may be necessary to assure that (in the  
18           manner described in subparagraph (A) of such sec-  
19           tion) in no case shall payments be made under such  
20           a project with respect to the first 5 percent reduc-  
21           tion in the base number of full-time equivalent resi-  
22           dents otherwise used under the project.

23           (2) Effective May 27, 1997, the Secretary of  
24           Health and Human Services is not authorized to ap-  
25           prove any demonstration project described in para-



1 graph (3) for any residency training year beginning  
2 before July 1, 2006.

3 (3) A demonstration project described in this  
4 paragraph is a project that provides for additional  
5 payments under title XVIII of the Social Security  
6 Act in connection with reduction in the number of  
7 residents in a medical residency training program.

8 (c) INTERIM, FINAL REGULATIONS.—In order to  
9 carry out the amendment made by subsection (a) in a  
10 timely manner, the Secretary of Health and Human Serv-  
11 ices may first promulgate regulations, that take effect on  
12 an interim basis, after notice and pending opportunity for  
13 public comment, by not later than 6 months after the date  
14 of the enactment of this Act.

15 **SEC. 4735. DEMONSTRATION PROJECT ON USE OF CONSOR-**

16 **TIA.**

17 (a) IN GENERAL.—The Secretary of Health and  
18 Human Services (in this section referred to as the Sec-  
19 retary) shall establish a demonstration project under  
20 which, instead of making payments to teaching hospitals  
21 pursuant to section 1886(h) of the Social Security Act,  
22 the Secretary shall make payments under this section to  
23 each consortium that meets the requirements of subsection  
24 (b).

1 (b) QUALIFYING CONSORTIA.—For purposes of sub-  
2 section (a), a consortium meets the requirements of this  
3 subsection if the consortium is in compliance with the fol-  
4 lowing:

5 (1) The consortium consists of an approved  
6 medical residency training program in a teaching  
7 hospital and one or more of the following entities:

8 (A) A school of allopathic medicine or os-  
9 teopathic medicine.

10 (B) Another teaching hospital, which may  
11 be a children’s hospital.

12 (C) Another approved medical residency  
13 training program.

14 (D) A Federally qualified health center.

15 (E) A medical group practice.

16 (F) A managed care entity.

17 (G) An entity furnishing outpatient serv-  
18 ices.

19 (I) Such other entity as the Secretary de-  
20 termines to be appropriate.

21 (2) The members of the consortium have agreed  
22 to participate in the programs of graduate medical  
23 education that are operated by the entities in the  
24 consortium.

1           (3) With respect to the receipt by the consor-  
2           tium of payments made pursuant to this section, the  
3           members of the consortium have agreed on a method  
4           for allocating the payments among the members.

5           (4) The consortium meets such additional re-  
6           quirements as the Secretary may establish.

7           (c) AMOUNT AND SOURCE OF PAYMENT.—The total  
8           of payments to a qualifying consortium for a fiscal year  
9           pursuant to subsection (a) shall not exceed the amount  
10          that would have been paid under section 1886(h) of the  
11          Social Security Act for the teaching hospital (or hospitals)  
12          in the consortium. Such payments shall be made in such  
13          proportion from each of the trust funds established under  
14          title XVIII of such Act as the Secretary specifies.

15   **SEC. 4736. RECOMMENDATIONS ON LONG-TERM PAYMENT**  
16                           **POLICIES REGARDING FINANCING TEACHING**  
17                           **HOSPITALS AND GRADUATE MEDICAL EDU-**  
18                           **CATION.**

19          (a) IN GENERAL.—The Medicare Payment Advisory  
20          Commission (established under section 1805 of the Social  
21          Security Act and in this section referred to as the “Com-  
22          mission”) shall examine and develop recommendations on  
23          whether and to what extent medicare payment policies and  
24          other Federal policies regarding teaching hospitals and  
25          graduate medical education should be reformed. Such rec-

1 ommendations shall include recommendations regarding  
2 each of the following:

3           (1) The financing of graduate medical edu-  
4 cation, including consideration of alternative broad-  
5 based sources of funding for such education and  
6 models for the distribution of payments under any  
7 all-payer financing mechanism.

8           (2) The financing of teaching hospitals, includ-  
9 ing consideration of the difficulties encountered by  
10 such hospitals as competition among health care en-  
11 tities increases. Matters considered under this para-  
12 graph shall include consideration of the effects on  
13 teaching hospitals of the method of financing used  
14 for the MedicarePlus program under part C of title  
15 XVIII of the Social Security Act.

16           (3) Possible methodologies for making pay-  
17 ments for graduate medical education and the selec-  
18 tion of entities to receive such payments. Matters  
19 considered under this paragraph shall include—

20                   (A) issues regarding children’s hospitals  
21 and approved medical residency training pro-  
22 grams in pediatrics, and

23                   (B) whether and to what extent payments  
24 are being made (or should be made) for train-  
25 ing in the various nonphysician health profes-

1           sions, including social workers and psycholo-  
2           gists.

3           (4) Federal policies regarding international  
4           medical graduates.

5           (5) The dependence of schools of medicine on  
6           service-generated income.

7           (6) Whether and to what extent the needs of  
8           the United States regarding the supply of physi-  
9           cians, in the aggregate and in different specialties,  
10          will change during the 10-year period beginning on  
11          October 1, 1997, and whether and to what extent  
12          any such changes will have significant financial ef-  
13          fects on teaching hospitals.

14          (7) Methods for promoting an appropriate num-  
15          ber, mix, and geographical distribution of health  
16          professionals.

17          (c) CONSULTATION.—In conducting the study under  
18          subsection (a), the Commission shall consult with the  
19          Council on Graduate Medical Education and individuals  
20          with expertise in the area of graduate medical education,  
21          including—

22                (1) deans from allopathic and osteopathic  
23                schools of medicine;

24                (2) chief executive officers (or equivalent ad-  
25                ministrative heads) from academic health centers,

1 integrated health care systems, approved medical  
2 residency training programs, and teaching hospitals  
3 that sponsor approved medical residency training  
4 programs;

5 (3) chairs of departments or divisions from  
6 allopathic and osteopathic schools of medicine,  
7 schools of dentistry, and approved medical residency  
8 training programs in oral surgery;

9 (4) individuals with leadership experience from  
10 representative fields of non-physician health profes-  
11 sionals;

12 (5) individuals with substantial experience in  
13 the study of issues regarding the composition of the  
14 health care workforce of the United States; and

15 (6) individuals with expertise on the financing  
16 of health care.

17 (d) REPORT.—Not later than 2 years after the date  
18 of the enactment of this Act, the Commission shall submit  
19 to the Congress a report providing its recommendations  
20 under this section and the reasons and justifications for  
21 such recommendations.

1 **SEC. 4737. MEDICARE SPECIAL REIMBURSEMENT RULE**  
2 **FOR CERTAIN COMBINED RESIDENCY PRO-**  
3 **GRAMS.**

4 (a) IN GENERAL.—Section 1886(h)(5)(G) (42 U.S.C.  
5 1395ww(h)(5)(G)) is amended—

6 (1) in clause (i), by striking “and (iii)” and in-  
7 serting “, (iii), and (iv)”;

8 (2) by adding at the end the following:

9 “(iv) SPECIAL RULE FOR CERTAIN  
10 COMBINED RESIDENCY PROGRAMS.—(I) In  
11 the case of a resident enrolled in a com-  
12 bined medical residency training program  
13 in which all of the individual programs  
14 (that are combined) are for training a pri-  
15 mary care resident (as defined in subpara-  
16 graph (H)), the period of board eligibility  
17 shall be the minimum number of years of  
18 formal training required to satisfy the re-  
19 quirements for initial board eligibility in  
20 the longest of the individual programs plus  
21 one additional year.

22 “(II) A resident enrolled in a com-  
23 bined medical residency training program  
24 that includes an obstetrics and gynecology  
25 program shall qualify for the period of  
26 board eligibility under subclause (I) if the

1           other programs such resident combines  
2           with such obstetrics and gynecology pro-  
3           gram are for training a primary care resi-  
4           dent.”.

5           (b) **EFFECTIVE DATE.**—The amendments made by  
6 subsection (a) apply to combined medical residency pro-  
7 grams for residency years beginning on or after July 1,  
8 1998.

## 9           **CHAPTER 5—OTHER PROVISIONS**

### 10 **SEC. 4741. CENTERS OF EXCELLENCE.**

11           (a) **IN GENERAL.**—Title XVIII is amended by insert-  
12 ing after section 1888 the following:

13                           “CENTERS OF EXCELLENCE

14           “SEC. 1889. (a) **IN GENERAL.**—The Secretary shall  
15 use a competitive process to contract with specific hos-  
16 pitals or other entities for furnishing services related to  
17 surgical procedures, and for furnishing services (unrelated  
18 to surgical procedures) to hospital inpatients that the Sec-  
19 retary determines to be appropriate. The services may in-  
20 clude any services covered under this title that the Sec-  
21 retary determines to be appropriate, including post-hos-  
22 pital services.

23           “(b) **QUALITY STANDARDS.**—

24                           “(1) **IN GENERAL.**—Only entities that meet  
25 quality standards established by the Secretary shall  
26 be eligible to contract under this section. Contract-



1       ing entities shall implement a quality improvement  
2       plan approved by the Secretary.

3               “(2) PARTICIPATION DECISION BASED ON  
4       QUALITY.—Subject to subsection (c), the Secretary  
5       shall consider quality as the primary factor in select-  
6       ing hospitals or other entities to enter into contracts  
7       under this section.

8               “(c) PAYMENT.—Payment under this section shall be  
9       made on the basis of negotiated all-inclusive rates. The  
10       amount of payment made by the Secretary to an entity  
11       under this title for services covered under a contract shall  
12       not exceed the aggregate amount of the payments that the  
13       Secretary would have otherwise made for the services.

14              “(d) CONTRACT PERIOD.—A contract period shall be  
15       3 years (subject to renewal), so long as the entity contin-  
16       ues to meet quality and other contractual standards.

17              “(e) INCENTIVES FOR USE OF CENTERS.—Entities  
18       under a contract under this section may furnish additional  
19       services (at no cost to an individual entitled to benefits  
20       under this title) or waive cost-sharing, subject to the ap-  
21       proval of the Secretary.

22              “(f) LIMIT ON NUMBER OF CENTERS.—The Sec-  
23       retary shall limit the number of centers in a geographic  
24       area to the number needed to meet projected demand for  
25       contracted services.”.

1 (b) EFFECTIVE DATE.—The amendment made by  
2 subsection (a) applies to services furnished on or after Oc-  
3 tober 1, 1997.

4 **SEC. 4742. MEDICARE PART B SPECIAL ENROLLMENT PE-**  
5 **RIOD AND WAIVER OF PART B LATE ENROLL-**  
6 **MENT PENALTY AND MEDIGAP SPECIAL**  
7 **OPEN ENROLLMENT PERIOD FOR CERTAIN**  
8 **MILITARY RETIREES AND DEPENDENTS.**

9 (a) MEDICARE PART B SPECIAL ENROLLMENT PE-  
10 RIOD; WAIVER OF PART B PENALTY FOR LATE ENROLL-  
11 MENT.—

12 (1) IN GENERAL.—In the case of any eligible  
13 individual (as defined in subsection (c)), the Sec-  
14 retary of Health and Human Services shall provide  
15 for a special enrollment period during which the in-  
16 dividual may enroll under part B of title XVIII of  
17 the Social Security Act. Such period shall be for a  
18 period of 6 months and shall begin with the first  
19 month that begins at least 45 days after the date of  
20 the enactment of this Act.

21 (2) COVERAGE PERIOD.—In the case of an eli-  
22 gible individual who enrolls during the special enroll-  
23 ment period provided under paragraph (1), the cov-  
24 erage period under part B of title XVIII of the So-  
25 cial Security Act shall begin on the first day of the

1 month following the month in which the individual  
2 enrolls.

3 (3) WAIVER OF PART B LATE ENROLLMENT  
4 PENALTY.—In the case of an eligible individual who  
5 enrolls during the special enrollment period provided  
6 under paragraph (1), there shall be no increase pur-  
7 suant to section 1839(b) of the Social Security Act  
8 in the monthly premium under part B of title XVIII  
9 of such Act.

10 (b) MEDIGAP SPECIAL OPEN ENROLLMENT PE-  
11 RIOD.—Notwithstanding any other provision of law, an is-  
12 suer of a medicare supplemental policy (as defined in sec-  
13 tion 1882(g) of the Social Security Act)—

14 (1) may not deny or condition the issuance or  
15 effectiveness of a medicare supplemental policy that  
16 has a benefit package classified as “A”, “B”, “C”,  
17 or “F” under the standards established under sec-  
18 tion 1882(p)(2) of the Social Security Act (42  
19 U.S.C. 1395rr(p)(2)); and

20 (2) may not discriminate in the pricing of the  
21 policy on the basis of the individual’s health status,  
22 medical condition (including both physical and men-  
23 tal illnesses), claims experience, receipt of health  
24 care, medical history, genetic information, evidence

1 of insurability (including conditions arising out of  
2 acts of domestic violence), or disability;  
3 in the case of an eligible individual who seeks to enroll  
4 (and is enrolled) during the 6-month period described in  
5 subsection (a)(1).

6 (c) ELIGIBLE INDIVIDUAL DEFINED.—In this sec-  
7 tion, the term “eligible individual” means an individual—

8 (1) who, as of the date of the enactment of this  
9 Act, has attained 65 years of age and was eligible  
10 to enroll under part B of title XVIII of the Social  
11 Security Act, and

12 (2) who at the time the individual first satisfied  
13 paragraph (1) or (2) of section 1836 of the Social  
14 Security Act—

15 (A) was a covered beneficiary (as defined  
16 in section 1072(5) of title 10, United States  
17 Code), and

18 (B) did not elect to enroll (or to be deemed  
19 enrolled) under section 1837 of the Social Secu-  
20 rity Act during the individual’s initial enroll-  
21 ment period.

22 The Secretary of Health and Human Services shall con-  
23 sult with the Secretary of Defense in the identification of  
24 eligible individuals.

1 **SEC. 4743. COMPETITIVE BIDDING FOR CERTAIN ITEMS**  
2 **AND SERVICES.**

3 (a) ESTABLISHMENT OF DEMONSTRATION.—Not  
4 later than 1 year after the date of the enactment of this  
5 Act, the Secretary of Health and Human Services shall  
6 establish and operate over a 2-year period a demonstration  
7 project in 2 geographic regions selected by the Secretary  
8 under which (notwithstanding any provision of title XVIII  
9 of the Social Security Act to the contrary) the amount  
10 of payment made under the medicare program for a se-  
11 lected item or service furnished in the region shall be equal  
12 to the price determined pursuant to a competitive bidding  
13 process which meets the requirements of subsection (b).

14 (b) REQUIREMENTS FOR COMPETITIVE BIDDING  
15 PROCESS.—The competitive bidding process used under  
16 the demonstration project under this section shall meet  
17 such requirements as the Secretary may impose to ensure  
18 the cost-effective delivery to medicare beneficiaries in the  
19 project region of items and services of high quality.

20 (c) DETERMINATION OF SELECTED ITEMS OR SERV-  
21 ICES.—The Secretary shall select items and services to be  
22 subject to the demonstration project under this section if  
23 the Secretary determines that the use of competitive bid-  
24 ding with respect to the item or service under the project  
25 will be appropriate and cost-effective. In determining the  
26 items or services to be selected, the Secretary shall consult

1 with an advisory taskforce which includes representatives  
2 of providers and suppliers of items and services (including  
3 small business providers and suppliers) in each geographic  
4 region in which the project will be effective.

5           **Subtitle I—Medical Liability**  
6                           **Reform**

7           **CHAPTER 1—GENERAL PROVISIONS**

8   **SEC. 4801. FEDERAL REFORM OF HEALTH CARE LIABILITY**  
9                           **ACTIONS.**

10           (a) **APPLICABILITY.**—This subtitle governs any  
11 health care liability action brought in any State or Federal  
12 court, except that this subtitle shall not apply to an action  
13 for damages arising from a vaccine-related injury or death  
14 to the extent that title XXI of the Public Health Service  
15 Act applies to the action.

16           (b) **PREEMPTION.**—This subtitle shall preempt any  
17 State or applicable Federal law to the extent such law is  
18 inconsistent with the limitations contained in this subtitle.  
19 This subtitle shall not preempt any State or applicable  
20 Federal law that provides for defenses or places limita-  
21 tions on a person’s liability in addition to those contained  
22 in this subtitle or otherwise imposes greater restrictions  
23 than those provided in this subtitle.

1           (c) EFFECT ON SOVEREIGN IMMUNITY AND CHOICE  
2 OF LAW OR VENUE.—Nothing in subsection (b) shall be  
3 construed to—

4           (1) waive or affect any defense of sovereign im-  
5 munity asserted by any State under any provision of  
6 law;

7           (2) waive or affect any defense of sovereign im-  
8 munity asserted by the United States;

9           (3) affect the applicability of any provision of  
10 chapter 97 of title 28, United States Code;

11           (4) preempt State choice-of-law rules with re-  
12 spect to claims brought by a foreign nation or a citi-  
13 zen of a foreign nation; or

14           (5) affect the right of any court to transfer  
15 venue or to apply the law of a foreign nation or to  
16 dismiss a claim of a foreign nation or of a citizen  
17 of a foreign nation on the ground of inconvenient  
18 forum.

19           (d) AMOUNT IN CONTROVERSY.—In an action to  
20 which this subtitle applies and which is brought under sec-  
21 tion 1332 of title 28, United States Code, the amount of  
22 noneconomic damages or punitive damages, and attorneys'  
23 fees or costs, shall not be included in determining whether  
24 the matter in controversy exceeds the sum or value of  
25 \$50,000.

1 (e) FEDERAL COURT JURISDICTION NOT ESTAB-  
2 LISHED ON FEDERAL QUESTION GROUNDS.—Nothing in  
3 this subtitle shall be construed to establish any jurisdiction  
4 in the district courts of the United States over health care  
5 liability actions on the basis of section 1331 or 1337 of  
6 title 28, United States Code.

7 **SEC. 4802. DEFINITIONS.**

8 As used in this subtitle:

9 (1) ACTUAL DAMAGES.—The term “actual dam-  
10 ages” means damages awarded to pay for economic  
11 loss.

12 (2) ALTERNATIVE DISPUTE RESOLUTION SYS-  
13 TEM; ADR.—The term “alternative dispute resolution  
14 system” or “ADR” means a system established  
15 under Federal or State law that provides for the res-  
16 olution of health care liability claims in a manner  
17 other than through health care liability actions.

18 (3) CLAIMANT.—The term “claimant” means  
19 any person who brings a health care liability action  
20 and any person on whose behalf such an action is  
21 brought. If such action is brought through or on be-  
22 half of an estate, the term includes the claimant’s  
23 decedent. If such action is brought through or on be-  
24 half of a minor or incompetent, the term includes  
25 the claimant’s legal guardian.



1           (4) CLEAR AND CONVINCING EVIDENCE.—The  
2 term “clear and convincing evidence” is that meas-  
3 ure or degree of proof that will produce in the mind  
4 of the trier of fact a firm belief or conviction as to  
5 the truth of the allegations sought to be established,  
6 except that such measure or degree of proof is more  
7 than that required under preponderance of the evi-  
8 dence but less than that required for proof beyond  
9 a reasonable doubt.

10           (5) COLLATERAL SOURCE PAYMENTS.—The  
11 term “collateral source payments” means any  
12 amount paid or reasonably likely to be paid in the  
13 future to or on behalf of a claimant, or any service,  
14 product, or other benefit provided or reasonably like-  
15 ly to be provided in the future to or on behalf of a  
16 claimant, as a result of an injury or wrongful death,  
17 pursuant to—

18                   (A) any State or Federal health, sickness,  
19 income-disability, accident or workers’ com-  
20 pensation Act;

21                   (B) any health, sickness, income-disability,  
22 or accident insurance that provides health bene-  
23 fits or income-disability coverage;

24                   (C) any contract or agreement of any  
25 group, organization, partnership, or corporation

1 to provide, pay for, or reimburse the cost of  
2 medical, hospital, dental, or income disability  
3 benefits; and

4 (D) any other publicly or privately funded  
5 program.

6 (6) DEVICE.—The term “device” has the same  
7 meaning given such term in section 201(h) of the  
8 Federal Food, Drug, and Cosmetic Act (21 U.S.C.  
9 321(h)).

10 (7) DRUG.—The term “drug” has the same  
11 meaning given such term in section 201(g)(1) of the  
12 Federal Food, Drug, and Cosmetic Act (21 U.S.C.  
13 321(g)(1)).

14 (8) ECONOMIC LOSS.—The term “economic  
15 loss” means any pecuniary loss resulting from harm  
16 (including the loss of earnings or other benefits re-  
17 lated to employment, medical expense loss, replace-  
18 ment services loss, loss due to death, burial costs,  
19 and loss of business or employment opportunities),  
20 to the extent recovery for such loss is allowed under  
21 applicable State or Federal law.

22 (9) HARM.—The term “harm” means—

23 (A) any physical injury, illness, or death of  
24 the claimant, or

1           (B) any mental anguish or emotional in-  
2           jury to the claimant caused by or causing the  
3           claimant physical injury or illness.

4           (10) HEALTH CARE LIABILITY ACTION.—The  
5           term “health care liability action” means a civil ac-  
6           tion brought in a State or Federal court against a  
7           health care provider, an entity which is obligated to  
8           provide or pay for health benefits under any health  
9           plan (including any person or entity acting under a  
10          contract or arrangement to provide or administer  
11          any health benefit), or the manufacturer, distributor,  
12          supplier, marketer, promoter, or seller of a medical  
13          product, in which the claimant alleges a health care  
14          liability claim.

15          (11) HEALTH CARE LIABILITY CLAIM.—The  
16          term “health care liability claim” means a claim in  
17          which the claimant alleges that harm was caused by  
18          the provision of (or the failure to provide) health  
19          care services or the use of a medical product, re-  
20          gardless of the theory of liability on which the claim  
21          is based.

22          (12) HEALTH CARE PROVIDER.—The term  
23          “health care provider” means any individual, organi-  
24          zation, or institution that is engaged in the delivery  
25          of health care services in a State and that is re-

1       quired by the laws or regulations of the State to be  
2       licensed or certified by the State to engage in the  
3       delivery of such services in the State.

4               (13) MANUFACTURER.—The term “manufac-  
5       turer” means—

6               (A) any person who is engaged in a busi-  
7       ness to produce, create, make, or construct any  
8       product (or component part of a product) and  
9       who (i) designs or formulates the product (or  
10      component part of the product), or (ii) has en-  
11      gaged another person to design or formulate  
12      the product (or component part of the product);

13              (B) a product seller, but only with respect  
14      to those aspects of a product (or component  
15      part of a product) which are created or affected  
16      when, before placing the product in the stream  
17      of commerce, the product seller produces, cre-  
18      ates, makes or constructs and designs, or for-  
19      mulates, or has engaged another person to de-  
20      sign or formulate, an aspect of the product (or  
21      component part of the product) made by an-  
22      other person; or

23              (C) any product seller not described in  
24      subparagraph (B) which holds itself out as a  
25      manufacturer to the user of the product.

1           (14) NONECONOMIC DAMAGES.—The term  
2 “noneconomic damages” means damages paid to an  
3 individual for pain and suffering, inconvenience,  
4 emotional distress, mental anguish, loss of society  
5 and companionship, injury to reputation, humilia-  
6 tion, and other subjective, nonpecuniary losses.

7           (15) PERSON.—The term “person” means any  
8 individual, corporation, company, association, firm,  
9 partnership, society, joint stock company, or any  
10 other entity, including any governmental entity.

11           (16) PRODUCT SELLER.—

12           (A) IN GENERAL.—The term “product sell-  
13 er” means a person who in the course of a busi-  
14 ness conducted for that purpose—

15                   (i) sells, distributes, rents, leases, pre-  
16 pares, blends, packages, labels, or other-  
17 wise is involved in placing a product in the  
18 stream of commerce; or

19                   (ii) installs, repairs, refurbishes, re-  
20 conditions, or maintains the harm-causing  
21 aspect of the product.

22           (B) EXCLUSION.—The term “product sell-  
23 er” does not include—

24                   (i) a seller or lessor of real property;

1 (ii) a provider of professional services  
2 in any case in which the sale or use of a  
3 product is incidental to the transaction and  
4 the essence of the transaction is the fur-  
5 nishing of judgment, skill, or services; or

6 (iii) any person who—

7 (I) acts in only a financial capac-  
8 ity with respect to the sale of a prod-  
9 uct; or

10 (II) leases a product under a  
11 lease arrangement in which the lessor  
12 does not initially select the leased  
13 product and does not during the lease  
14 term ordinarily control the daily oper-  
15 ations and maintenance of the prod-  
16 uct.

17 (17) PUNITIVE DAMAGES.—The term “punitive  
18 damages” means damages awarded against any per-  
19 son not to compensate for actual injury suffered, but  
20 to punish or deter such person or others from en-  
21 gaging in similar behavior in the future.

22 (18) STATE.—The term “State” means each of  
23 the several States, the District of Columbia, the  
24 Commonwealth of Puerto Rico, the Virgin Islands,  
25 Guam, American Samoa, the Northern Mariana Is-

1 lands, the Trust Territories of the Pacific Islands,  
2 and any other territory or possession of the United  
3 States or any political subdivision of any of the fore-  
4 going.

5 **SEC. 4803. EFFECTIVE DATE.**

6 This subtitle will apply to any health care liability ac-  
7 tion brought in a Federal or State court and to any health  
8 care liability claim subject to an alternative dispute resolu-  
9 tion system, that is initiated on or after the date of enact-  
10 ment of this subtitle.

11 **CHAPTER 2—UNIFORM STANDARDS FOR**  
12 **HEALTH CARE LIABILITY ACTIONS**

13 **SEC. 4811. STATUTE OF LIMITATIONS.**

14 (a) GENERAL RULE.—Except as provided in sub-  
15 section (b), a health care liability action may be filed not  
16 later than 2 years after the date on which the claimant  
17 discovered or, in the exercise of reasonable care, should  
18 have discovered—

19 (1) the harm that is the subject of the action;

20 and

21 (2) the cause of the harm.

22 (b) EXCEPTION.—A person with a legal disability (as  
23 determined under applicable law) may file a health care  
24 liability action not later than 2 years after the date on  
25 which the person ceases to have the legal disability.

1           (c) TRANSITIONAL PROVISION RELATING TO EXTEN-  
2   SION OF PERIOD FOR BRINGING CERTAIN ACTIONS.—If  
3   any provision of subsection (a) or (b) shortens the period  
4   during which a health care liability action could be other-  
5   wise brought pursuant to another provision of law, the  
6   claimant may, notwithstanding subsections (a) and (b),  
7   bring the health care liability action not later than 2 years  
8   after the date of enactment of this Act.

9   **SEC. 4812. CALCULATION AND PAYMENT OF DAMAGES.**

10          (a) TREATMENT OF NONECONOMIC DAMAGES.—

11               (1) LIMITATION ON NONECONOMIC DAMAGES.—

12           The total amount of noneconomic damages that may  
13           be awarded to a claimant for harm which is the sub-  
14           ject of a health care liability action may not exceed  
15           \$250,000, regardless of the number of parties  
16           against whom the action is brought or the number  
17           of actions brought with respect to the injury.

18               (2) FAIR SHARE RULE FOR NONECONOMIC DAM-  
19           AGES.—

20                   (A) GENERAL RULE.—In a health care li-  
21                   ability action, the liability of each defendant for  
22                   noneconomic damages shall be several only and  
23                   shall not be joint.

24                   (B) AMOUNT OF LIABILITY.—



1           (i) IN GENERAL.—Each defendant  
2           shall be liable only for the amount of non-  
3           economic damages attributable to the de-  
4           fendant in direct proportion to the percent-  
5           age of responsibility of the defendant (de-  
6           termined in accordance with paragraph  
7           (2)) for the harm to the claimant with re-  
8           spect to which the defendant is liable. The  
9           court shall render a separate judgment  
10          against each defendant in an amount de-  
11          termined pursuant to the preceding sen-  
12          tence.

13          (ii) PERCENTAGE OF RESPONSIBIL-  
14          ITY.—For purposes of determining the  
15          amount of noneconomic damages attrib-  
16          utable to a defendant under this section,  
17          the trier of fact shall determine the per-  
18          centage of responsibility of each person re-  
19          sponsible for the claimant’s harm, whether  
20          or not such person is a party to the action.

21          (b) TREATMENT OF PUNITIVE DAMAGES.—

22               (1) GENERAL RULE.—Punitive damages may,  
23               to the extent permitted by applicable law, be award-  
24               ed in a health care liability action against a defend-  
25               ant if the claimant establishes by clear and convinc-

1 ing evidence that the harm suffered was result of  
2 conduct manifesting a conscious, flagrant indiffer-  
3 ence to the rights or safety of others.

4 (2) REQUIRED PROPORTIONALITY.—The  
5 amount of punitive damages that may be awarded in  
6 a health care liability action shall not exceed 3 times  
7 the amount of damages awarded to the claimant for  
8 economic loss, or \$250,000, whichever is greater.  
9 This subsection shall be applied by the court, and  
10 application of this subsection shall not be disclosed  
11 to the jury.

12 (c) BIFURCATION AT REQUEST OF ANY PARTY.—

13 (1) IN GENERAL.—At the request of any party  
14 the trier of fact in any action that is subject to this  
15 section shall consider in a separate proceeding, held  
16 subsequent to the determination of the amount of  
17 compensatory damages, whether punitive damages  
18 are to be awarded for the harm that is the subject  
19 of the action and the amount of the award.

20 (2) INADMISSIBILITY OF EVIDENCE RELATIVE  
21 ONLY TO A CLAIM OF PUNITIVE DAMAGES IN A PRO-  
22 CEEDING CONCERNING COMPENSATORY DAMAGES.—  
23 If any party requests a separate proceeding under  
24 paragraph (1), in a proceeding to determine whether  
25 the claimant may be awarded compensatory dam-

1       ages, any evidence, argument, or contention that is  
2       relevant only to the claim of punitive damages, as  
3       determined by applicable law, shall be inadmissible.

4       (d) DRUGS AND DEVICES.—

5               (1)(A) Punitive damages shall not be awarded  
6       against a manufacturer or product seller of a drug  
7       or device which caused the claimant's harm where—

8                       (i) such drug or device was subject to pre-  
9                       market approval by the Food and Drug Admin-  
10                      istration with respect to the safety of the for-  
11                      mulation or performance of the aspect of such  
12                      drug or device which caused the claimant's  
13                      harm or the adequacy of the packaging or label-  
14                      ing of such drug or device, and such drug or  
15                      device was approved by the Food and Drug Ad-  
16                      ministration; or

17                      (ii) the drug or device is generally recog-  
18                      nized as safe and effective pursuant to condi-  
19                      tions established by the Food and Drug Admin-  
20                      istration and applicable regulations, including  
21                      packaging and labeling regulations.

22               (B) Subparagraph (A) shall not apply in any  
23       case in which the defendant, before or after pre-  
24       market approval of a drug or device—

1 (i) intentionally and wrongfully withheld  
2 from or misrepresented to the Food and Drug  
3 Administration information concerning such  
4 drug or device required to be submitted under  
5 the Federal Food, Drug, and Cosmetic Act (21  
6 U.S.C. 301 et seq.) or section 351 of the Public  
7 Health Service Act (42 U.S.C. 262) that is ma-  
8 terial and relevant to the harm suffered by the  
9 claimant, or

10 (ii) made an illegal payment to an official  
11 or employee of the Food and Drug Administra-  
12 tion for the purpose of securing or maintaining  
13 approval of such drug or device.

14 (2) PACKAGING.—In a health care liability ac-  
15 tion which is alleged to relate to the adequacy of the  
16 packaging (or labeling relating to such packaging) of  
17 a drug which is required to have tamper-resistant  
18 packaging under regulations of the Secretary of  
19 Health and Human Services (including labeling reg-  
20 ulations related to such packaging), the manufac-  
21 turer of the drug shall not be held liable for punitive  
22 damages unless the drug is found by the court by  
23 clear and convincing evidence to be substantially out  
24 of compliance with such regulations.

25 (e) PERIODIC PAYMENTS FOR FUTURE LOSSES.—

1           (1) GENERAL RULE.—In any health care liability  
2           action in which the damages awarded for future  
3           economic and noneconomic loss exceed \$50,000, a  
4           person shall not be required to pay such damages in  
5           a single, lump-sum payment, but shall be permitted  
6           to make such payments periodically based on when  
7           the damages are found likely to occur, with the  
8           amount and schedule of such payments determined  
9           by the court.

10           (2) FINALITY OF JUDGMENT.—The judgment  
11           of the court awarding periodic payments under this  
12           subsection may not, in the absence of fraud, be re-  
13           opened at any time to contest, amend, or modify the  
14           schedule or amount of the payments.

15           (3) LUMP-SUM SETTLEMENTS.—This sub-  
16           section shall not be construed to preclude a settle-  
17           ment providing for a single, lump-sum payment.

18           (f) TREATMENT OF COLLATERAL SOURCE PAY-  
19           MENTS.—

20           (1) INTRODUCTION INTO EVIDENCE.—In any  
21           health care liability action, any defendant may intro-  
22           duce evidence of collateral source payments. If a de-  
23           fendant elects to introduce such evidence, the claim-  
24           ant may introduce evidence of any amount paid or  
25           contributed or reasonably likely to be paid or con-

1       tributed in the future by or on behalf of the claim-  
2       ant to secure the right to such collateral source pay-  
3       ments.

4           (2) NO SUBROGATION.—No provider of collat-  
5       eral source payments shall recover any amount  
6       against the claimant or receive any lien or credit  
7       against the claimant’s recovery or be equitably or le-  
8       gally subrogated the right of the claimant in a  
9       health care liability action. This subsection shall  
10      apply to an action that is settled as well as an action  
11      that is resolved by a fact finder.

12 **SEC. 4813. ALTERNATIVE DISPUTE RESOLUTION.**

13      Any ADR used to resolve a health care liability action  
14      or claim shall contain provisions relating to statute of limi-  
15      tations, non-economic damages, joint and several liability,  
16      punitive damages, collateral source rule, and periodic pay-  
17      ments which are identical to the provisions relating to  
18      such matters in this subtitle.

1 **TITLE V—COMMITTEE ON EDU-**  
2 **CATION AND THE**  
3 **WORKFORCE**  
4 **Subtitle A—TANF Block Grant**

5 **SEC. 5001. WELFARE-TO-WORK GRANTS.**

6 (a) GRANTS TO STATES.—Section 403(a) of the So-  
7 cial Security Act (42 U.S.C. 603(a)) is amended by adding  
8 at the end the following:

9 “(5) WELFARE-TO-WORK GRANTS.—

10 “(A) FORMULA GRANTS.—

11 “(i) ENTITLEMENT.—A State shall be  
12 entitled to receive from the Secretary a  
13 grant for each fiscal year specified in sub-  
14 paragraph (H) of this paragraph for which  
15 the State is a welfare-to-work State, in an  
16 amount that does not exceed the lesser  
17 of—

18 “(I) 2 times the total of the ex-  
19 penditures by the State (excluding  
20 qualified State expenditures (as de-  
21 fined in section 409(a)(7)(B)(i)) and  
22 expenditures described in section  
23 409(a)(7)(B)(iv)) during the fiscal  
24 year for activities described in

1 subpagraph (C)(i) of this paragraph;  
2 or

3 “(II) the allotment of the State  
4 under clause (iii) of this subparagraph  
5 for the fiscal year.

6 “(ii) WELFARE-TO-WORK STATE.—A  
7 State shall be considered a welfare-to-work  
8 State for a fiscal year for purposes of this  
9 subparagraph if the Secretary, after con-  
10 sultation (and the sharing of any plan or  
11 amendment thereto submitted under this  
12 clause) with the Secretary of Health and  
13 Human Services and the Secretary of  
14 Housing and Urban Development, deter-  
15 mines that the State meets the following  
16 requirements:

17 “(I) The State has submitted to  
18 the Secretary (in the form of an ad-  
19 dendum to the State plan submitted  
20 under section 402) a plan which—

21 “(aa) describes how, consist-  
22 ent with this subparagraph, the  
23 State will use any funds provided  
24 under this subparagraph during  
25 the fiscal year;



1                   “(bb) specifies the formula  
2                   to be used pursuant to clause (vi)  
3                   to distribute funds in the State,  
4                   and describes the process by  
5                   which the formula was developed;  
6                   and

7                   “(cc) contains evidence that  
8                   the plan was developed through a  
9                   collaborative process that, at a  
10                  minimum, included sub-State  
11                  areas.

12                  “(II) The State has provided the  
13                  Secretary with an estimate of the  
14                  amount that the State intends to ex-  
15                  pend during the fiscal year (excluding  
16                  expenditures described in section  
17                  409(a)(7)(B)(iv)) for activities de-  
18                  scribed in subparagraph (C)(i) of this  
19                  paragraph.

20                  “(III) The State has agreed to  
21                  negotiate in good faith with the Sec-  
22                  retary of Health and Human Services  
23                  with respect to the substance of any  
24                  evaluation under section 413(j), and

1 to cooperate with the conduct of any  
2 such evaluation.

3 “(IV) The State is an eligible  
4 State for the fiscal year.

5 “(iii) ALLOTMENTS TO WELFARE-TO-  
6 WORK STATES.—The allotment of a wel-  
7 fare-to-work State for a fiscal year shall be  
8 the available amount for the fiscal year  
9 multiplied by the State percentage for the  
10 fiscal year.

11 “(iv) AVAILABLE AMOUNT.—As used  
12 in clause (iii), the term ‘available amount’  
13 means, for a fiscal year, 95 percent of—

14 “(I) the amount specified in sub-  
15 paragraph (H) for the fiscal year;  
16 minus

17 “(II) the total of the amounts re-  
18 served pursuant to subparagraphs (F)  
19 and (G) for the fiscal year.

20 “(v) STATE PERCENTAGE.—As  
21 used in clause (iii), the term ‘State  
22 percentage’ means, with respect to a  
23 fiscal year,  $\frac{1}{2}$  of the sum of—

24 “(aa) the percentage rep-  
25 resented by the number of indi-

1 individuals in the State whose in-  
2 come is less than the poverty line  
3 divided by the number of such in-  
4 dividuals in the United States;  
5 and

6 “(bb) the percentage rep-  
7 resented by the number of indi-  
8 viduals who are adult recipients  
9 of assistance under the State  
10 program funded under this part  
11 divided by the number of individ-  
12 uals in the United States who are  
13 adult recipients of assistance  
14 under any State program funded  
15 under this part.

16 “(vi) DISTRIBUTION OF FUNDS WITH-  
17 IN STATES.—

18 “(I) IN GENERAL.—A State to  
19 which a grant is made under this sub-  
20 paragraph shall distribute not less  
21 than 85 percent of the grant funds  
22 among the service delivery areas in  
23 the State, in accordance with a for-  
24 mula which—

1           “(aa) determines the  
2 amount to be distributed for the  
3 benefit of a service delivery area  
4 in proportion to the number (if  
5 any) by which the number of in-  
6 dividuals residing in the service  
7 delivery area with an income that  
8 is less than the poverty line ex-  
9 ceeds 5 percent of the population  
10 of the service delivery area, rel-  
11 ative to such number for the  
12 other service delivery areas in the  
13 State, and accords a weight of  
14 not less than 50 percent to this  
15 factor;

16           “(bb) may determine the  
17 amount to be distributed for the  
18 benefit of a service delivery area  
19 in proportion to the number of  
20 adults residing in the service de-  
21 livery area who are recipients of  
22 assistance under the State pro-  
23 gram funded under this part  
24 (whether in effect before or after  
25 the amendments made by section

1 103(a) of the Personal Respon-  
2 sibility and Work Opportunity  
3 Reconciliation Act first applied to  
4 the State) for at least 30 months  
5 (whether or not consecutive) rel-  
6 ative to the number of such  
7 adults residing in the other serv-  
8 ice delivery areas in the State;  
9 and

10 “(cc) may determine the  
11 amount to be distributed for the  
12 benefit of a service delivery area  
13 in proportion to the number of  
14 unemployed individuals residing  
15 in the service delivery area rel-  
16 ative to the number of such indi-  
17 viduals residing in the other serv-  
18 ice delivery areas in the State.

19 “(II) SPECIAL RULE.—Notwith-  
20 standing subclause (I), if the formula  
21 used pursuant to subclause (I) would  
22 result in the distribution of less than  
23 \$100,000 during a fiscal year for the  
24 benefit of a service delivery area, then  
25 in lieu of distributing such sum in ac-

1 cordance with the formula, such sum  
2 shall be available for distribution  
3 under subclause (III) during the fiscal  
4 year.

5 “(III) PROJECTS TO HELP LONG-  
6 TERM RECIPIENTS OF ASSISTANCE  
7 INTO THE WORK FORCE.—The Gov-  
8 ernor of a State to which a grant is  
9 made under this subparagraph may  
10 distribute not more than 15 percent of  
11 the grant funds (plus any amount re-  
12 quired to be distributed under this  
13 subclause by reason of subclause (II))  
14 to projects that appear likely to help  
15 long-term recipients of assistance  
16 under the State program funded  
17 under this part (whether in effect be-  
18 fore or after the amendments made by  
19 section 103(a) of the Personal Re-  
20 sponsibility and Work Opportunity  
21 Reconciliation Act first applied to the  
22 State) enter the work force.

23 “(vii) ADMINISTRATION.—

24 “(I) IN GENERAL.—A grant  
25 made under this subparagraph to a

1 State shall be administered by the  
2 State agency that is administering, or  
3 supervising the administration of, the  
4 State program funded under this part,  
5 or by another State agency designated  
6 by the Governor of the State.

7 “(II) SPENDING BY PRIVATE IN-  
8 DUSTRY COUNCILS.—The private in-  
9 dustry council for a service delivery  
10 area shall have sole authority, in co-  
11 ordination with the chief elected offi-  
12 cial (as described in section 103(c) of  
13 the Job Training Partnership Act) of  
14 the service delivery area, to expend  
15 the amounts provided for a service de-  
16 livery area under subparagraph  
17 (vi)(I).

18 “(B) DEMONSTRATION PROJECTS.—

19 “(i) IN GENERAL.—The Secretary, in  
20 consultation with the Secretary of Health  
21 and Human Services and the Secretary of  
22 Housing and Urban Development, shall  
23 make grants in accordance with this sub-  
24 paragraph among eligible applicants based  
25 on the likelihood that the applicant can

1           successfully make long-term placements of  
2           individuals into the work force.

3           “(ii) ELIGIBLE APPLICANTS.—As used  
4           in clause (i), the term ‘eligible applicant’  
5           means a private industry council or a polit-  
6           ical subdivision of a State.

7           “(iii) DETERMINATION OF GRANT  
8           AMOUNT.—In determining the amount of a  
9           grant to be made under this subparagraph  
10          for a demonstration project proposed by an  
11          applicant, the Secretary shall provide the  
12          applicant with an amount sufficient to en-  
13          sure that the project has a reasonable op-  
14          portunity to be successful, taking into ac-  
15          count the number of long-term recipients  
16          of assistance under a State program fund-  
17          ed under this part, the level of unemploy-  
18          ment, the job opportunities and job  
19          growth, the poverty rate, and such other  
20          factors as the Secretary deems appro-  
21          priate, in the area to be served by the  
22          project.

23          “(iv) FUNDING.—For grants under  
24          this subparagraph for each fiscal year  
25          specified in subparagraph (H), there shall



1 be available to the Secretary an amount  
2 equal to the sum of—

3 “(I) 5 percent of—

4 “(aa) the amount specified  
5 in subparagraph (H) for the fis-  
6 cal year; minus

7 “(bb) the total of the  
8 amounts reserved pursuant to  
9 subparagraphs (F) and (G) for  
10 the fiscal year;

11 “(II) any amount available for  
12 grants under this paragraph for the  
13 immediately preceding fiscal year that  
14 has not been obligated;

15 “(III) any amount reserved pur-  
16 suant to subparagraph (F) for the im-  
17 mediately preceding fiscal year that  
18 has not been obligated; and

19 “(IV) any available amount (as  
20 defined in subparagraph (A)(iv)) for  
21 the immediately preceding fiscal year  
22 that has not been obligated by a State  
23 or sub-State entity.

1 Amounts made available pursuant to this  
2 clause are authorized to remain available  
3 until the end of fiscal year 2001.

4 “(C) LIMITATIONS ON USE OF FUNDS.—

5 “(i) ALLOWABLE ACTIVITIES.—An en-  
6 tity to which funds are provided under this  
7 paragraph may use the funds to move into  
8 the work force recipients of assistance  
9 under the program funded under this part  
10 of the State in which the entity is located,  
11 by means of any of the following:

12 “(I) Job creation through public  
13 or private sector employment wage  
14 subsidies.

15 “(II) On-the-job training.

16 “(III) Contracts with job place-  
17 ment companies or public job place-  
18 ment programs.

19 “(IV) Job vouchers.

20 “(V) Job retention or support  
21 services if such services are not other-  
22 wise available.

23 “(ii) REQUIRED BENEFICIARIES.—An  
24 entity that operates a project with funds  
25 provided under this paragraph shall expend

1 at least 90 percent of all funds provided to  
2 the project for the benefit of recipients of  
3 assistance under the program funded  
4 under this part of the State in which the  
5 entity is located who meet the require-  
6 ments of any of the following subclauses:

7 “(I) The individual has received  
8 assistance under the State program  
9 funded under this part (whether in ef-  
10 fect before or after the amendments  
11 made by section 103 of the Personal  
12 Responsibility and Work Opportunity  
13 Reconciliation Act of 1996 first apply  
14 to the State) for at least 30 months  
15 (whether or not consecutive).

16 “(II) At least 2 of the following  
17 apply to the recipient:

18 “(aa) The individual has not  
19 completed secondary school or  
20 obtained a certificate of general  
21 equivalency, and has low skills in  
22 reading and mathematics.

23 “(bb) The individual re-  
24 quires substance abuse treatment  
25 for employment.

1                   “(cc) The individual has a  
2                   poor work history.

3                   The Secretary shall prescribe such  
4                   regulations as may be necessary to in-  
5                   terpret this subclause.

6                   “(III) Within 12 months, the in-  
7                   dividual will become ineligible for as-  
8                   sistance under the State program  
9                   funded under this part by reason of a  
10                  durational limit on such assistance,  
11                  without regard to any exemption pro-  
12                  vided pursuant to section  
13                  408(a)(7)(C) that may apply to the  
14                  individual.

15                  “(iii) LIMITATION ON APPLICABILITY  
16                  OF SECTION 404.—The rules of section  
17                  404, other than subsections (b), (f), and  
18                  (h) of section 404, shall not apply to a  
19                  grant made under this paragraph.

20                  “(iv) PROHIBITION AGAINST PROVI-  
21                  SION OF SERVICES BY PRIVATE INDUSTRY  
22                  COUNCIL.—A private industry council may  
23                  not directly provide services using funds  
24                  provided under this paragraph.

1           “(v) PROHIBITION AGAINST USE OF  
2           GRANT FUNDS FOR ANY OTHER FUND  
3           MATCHING REQUIREMENT.—An entity to  
4           which funds are provided under this para-  
5           graph shall not use any part of the funds  
6           to fulfill any obligation of any State, politi-  
7           cal subdivision, or private industry council  
8           to contribute funds under other Federal  
9           law.

10           “(vi) DEADLINE FOR EXPENDI-  
11           TURE.—An entity to which funds are pro-  
12           vided under this paragraph shall remit to  
13           the Secretary any part of the funds that  
14           are not expended within 3 years after the  
15           date the funds are so provided.

16           “(D) INDIVIDUALS WITH INCOME LESS  
17           THAN THE POVERTY LINE.—For purposes of  
18           this paragraph, the number of individuals with  
19           an income that is less than the poverty line  
20           shall be determined based on the methodology  
21           used by the Bureau of the Census to produce  
22           and publish intercensal poverty data for 1993  
23           for States and counties.

24           “(E) DEFINITIONS.—As used in this para-  
25           graph:

1           “(i) PRIVATE INDUSTRY COUNCIL.—  
2           The term ‘private industry council’ means,  
3           with respect to a service delivery area, the  
4           private industry council (or successor en-  
5           tity) established for the service delivery  
6           area pursuant to the Job Training Part-  
7           nership Act.

8           “(ii) SECRETARY.—The term ‘Sec-  
9           retary’ means the Secretary of Labor, ex-  
10          cept as otherwise expressly provided.

11          “(iii) SERVICE DELIVERY AREA.—The  
12          term ‘service delivery area’ shall have the  
13          meaning given such term for purposes of  
14          the Job Training Partnership Act (or suc-  
15          cessor area).

16          “(F) FUNDING FOR INDIAN TRIBES.—1  
17          percent of the amount specified in subpara-  
18          graph (H) for each fiscal year shall be reserved  
19          for grants to Indian tribes under section  
20          412(a)(3).

21          “(G) EVALUATIONS.—0.5 percent of the  
22          amount specified in subparagraph (H) for each  
23          fiscal year shall be reserved for use by the Sec-  
24          retary of Health and Human Services to carry  
25          out section 413(j).

1           “(H) FUNDING.—The amount specified in  
2 this subparagraph is—

3                   “(i) \$750,000,000 for fiscal year  
4 1998;

5                   “(ii) \$1,250,000,000 for fiscal year  
6 1999; and

7                   “(iii) \$1,000,000,000 for fiscal year  
8 2000.

9           “(I) BUDGET SCORING.—Notwithstanding  
10 section 457(b)(2) of the Balanced Budget and  
11 Emergency Deficit Control Act of 1985, the  
12 baseline shall assume that no grant shall be  
13 made under this paragraph or under section  
14 412(a)(3) after fiscal year 2001.”.

15       (b) GRANTS TO TERRITORIES.—Section 1108(a) of  
16 such Act (42 U.S.C. 1308(a)) is amended by inserting  
17 “(except section 403(a)(5))” after “title IV”.

18       (c) GRANTS TO INDIAN TRIBES.—Section 412(a) of  
19 such Act (42 U.S.C. 612(a)) is amended by adding at the  
20 end the following:

21                   “(3) WELFARE-TO-WORK GRANTS.—

22                           “(A) IN GENERAL.—The Secretary shall  
23 make a grant in accordance with this paragraph  
24 to an Indian tribe for each fiscal year specified  
25 in section 403(a)(5)(H) for which the Indian

1           tribe is a welfare-to-work tribe, in such amount  
2           as the Secretary deems appropriate, subject to  
3           subparagraph (B) of this paragraph.

4           “(B) WELFARE-TO-WORK TRIBE.—An In-  
5           dian tribe shall be considered a welfare-to-work  
6           tribe for a fiscal year for purposes of this para-  
7           graph if the Indian tribe meets the following re-  
8           quirements:

9                   “(i) The Indian tribe has submitted to  
10                   the Secretary (in the form of an addendum  
11                   to the tribal family assistance plan, if any,  
12                   of the Indian tribe) a plan which describes  
13                   how, consistent with section 403(a)(5), the  
14                   Indian tribe will use any funds provided  
15                   under this paragraph during the fiscal  
16                   year.

17                   “(ii) The Indian tribe has provided  
18                   the Secretary with an estimate of the  
19                   amount that the Indian tribe intends to ex-  
20                   pend during the fiscal year (excluding trib-  
21                   al expenditures described in section  
22                   409(a)(7)(B)(iv)) for activities described in  
23                   section 403(a)(5)(C)(i).

24                   “(iii) The Indian tribe has agreed to  
25                   negotiate in good faith with the Secretary



1 of Health and Human Services with re-  
2 spect to the substance of any evaluation  
3 under section 413(j), and to cooperate with  
4 the conduct of any such evaluation.

5 “(C) LIMITATIONS ON USE OF FUNDS.—  
6 Section 403(a)(5)(C) shall apply to funds pro-  
7 vided to Indian tribes under this paragraph in  
8 the same manner in which such section applies  
9 to funds provided under section 403(a)(5).”.

10 (d) FUNDS RECEIVED FROM GRANTS TO BE DIS-  
11 REGARDED IN APPLYING DURATIONAL LIMIT ON ASSIST-  
12 ANCE.—Section 408(a)(7) of such Act (42 U.S.C.  
13 608(a)(7)) is amended by adding at the end the following:

14 “(G) INAPPLICABILITY TO WELFARE-TO-  
15 WORK GRANTS AND ASSISTANCE.—For purposes  
16 of subparagraph (A) of this paragraph, a grant  
17 made under section 403(a)(5) shall not be con-  
18 sidered a grant made under section 403, and  
19 assistance from funds provided under section  
20 403(a)(5) shall not be considered assistance.”.

21 (e) EVALUATIONS.—Section 413 of such Act (42  
22 U.S.C. 613) is amended by adding at the end the follow-  
23 ing:

24 “(j) EVALUATION OF WELFARE-TO-WORK PRO-  
25 GRAMS.—The Secretary—

1           “(1) shall, in consultation with the Secretary of  
2 Labor, develop a plan to evaluate how grants made  
3 under sections 403(a)(5) and 412(a)(3) have been  
4 used; and

5           “(2) may evaluate the use of such grants by  
6 such grantees as the Secretary deems appropriate, in  
7 accordance with an agreement entered into with the  
8 grantees after good-faith negotiations.”.

9 **SEC. 5002. NONDISPLACEMENT.**

10          Section 407(f) of the Social Security Act (42 U.S.C.  
11 607(f)) is amended to read as follows:

12          “(f) NONDISPLACEMENT IN WORK ACTIVITIES.—

13               “(1) PROHIBITIONS.—

14                       “(A) GENERAL PROHIBITION.—A partici-  
15 pant in a work activity pursuant to section  
16 403(a)(5) or this section shall not displace (in-  
17 cluding a partial displacement, such as a reduc-  
18 tion in the hours of nonovertime work, wages,  
19 or employment benefits) any individual who, as  
20 of the date of the participation, is an employee.

21                       “(B) PROHIBITION ON IMPAIRMENT OF  
22 CONTRACTS.—A work activity shall not impair  
23 an existing contract for services or collective  
24 bargaining agreement, and a work activity that  
25 would be inconsistent with the terms of a collec-

1           tive bargaining agreement shall not be under-  
2           taken without the written concurrence of the  
3           labor organization and employer concerned.

4           “(C) OTHER PROHIBITIONS.—A partici-  
5           pant in a work activity shall not be employed in  
6           a job—

7                   “(i) when any other individual is on  
8                   layoff from the same or any substantially  
9                   equivalent job;

10                   “(ii) when the employer has termi-  
11                   nated the employment of any regular em-  
12                   ployee or otherwise reduced the workforce  
13                   of the employer with the intention of filling  
14                   the vacancy so created with the partici-  
15                   pant; or

16                   “(iii) which is created in a pro-  
17                   motional line that will infringe in any way  
18                   upon the promotional opportunities of em-  
19                   ployed individuals.

20           “(2) HEALTH AND SAFETY.—Health and safety  
21           standards established under Federal and State law  
22           otherwise applicable to working conditions of em-  
23           ployees shall be equally applicable to working condi-  
24           tions of participants engaged in a work activity. To  
25           the extent that a State workers’ compensation law

1 applies, workers' compensation shall be provided to  
2 participants on the same basis as the compensation  
3 is provided to other individuals in the State in simi-  
4 lar employment.

5 “(3) NONDISCRIMINATION.—In addition to the  
6 protections provided under the provisions of law  
7 specified in section 408(e), an individual may not be  
8 discriminated against with respect to participation in  
9 work activities by reason of gender.

10 “(4) GRIEVANCE PROCEDURE.—

11 “(A) IN GENERAL.—Each State to which a  
12 grant is made under section 403 shall establish  
13 and maintain a procedure for grievances or  
14 complaints alleging violations of paragraph (1),  
15 (2), or (3) from participants and other inter-  
16 ested or affected parties. The procedure shall  
17 include an opportunity for a hearing and be  
18 completed within 60 days after the grievance or  
19 complaint is filed.

20 “(B) INVESTIGATION.—

21 “(i) IN GENERAL.—The Secretary of  
22 Labor shall investigate an allegation of a  
23 violation of paragraph (1), (2), or (3) if—

24 “(I) a decision relating to the  
25 violation is not reached within 60

1 days after the date of the filing of the  
2 grievance or complaint, and either  
3 party appeals to the Secretary of  
4 Labor; or

5 “(II) a decision relating to the  
6 violation is reached within the 60-day  
7 period, and the party to which the de-  
8 cision is adverse appeals the decision  
9 to the Secretary of Labor.

10 “(ii) ADDITIONAL REQUIREMENT.—  
11 The Secretary of Labor shall make a final  
12 determination relating to an appeal made  
13 under clause (i) no later than 120 days  
14 after receiving the appeal.

15 “(C) REMEDIES.—Remedies for violation  
16 of paragraph (1), (2), or (3) shall be limited  
17 to—

18 “(i) suspension or termination of pay-  
19 ments under section 403;

20 “(ii) prohibition of placement of a  
21 participant with an employer that has vio-  
22 lated paragraph (1), (2), or (3);

23 “(iii) where applicable, reinstatement  
24 of an employee, payment of lost wages and  
25 benefits, and reestablishment of other rel-

1           evant terms, conditions and privileges of  
2           employment; and

3                   “(iv) where appropriate, other equi-  
4           table relief.”.

5 **SEC. 5003. CLARIFICATION OF LIMITATION ON NUMBER OF**  
6           **PERSONS WHO MAY BE TREATED AS EN-**  
7           **GAGED IN WORK BY REASON OF PARTICIPA-**  
8           **TION IN EDUCATIONAL ACTIVITIES.**

9           (a) IN GENERAL.—Section 407(c)(2)(D) of the Social  
10 Security Act (42 U.S.C. 607(c)(2)(D)) is amended to read  
11 as follows:

12                   “(D) LIMITATION ON NUMBER OF PER-  
13           SONS WHO MAY BE TREATED AS ENGAGED IN  
14           WORK BY REASON OF PARTICIPATION IN EDU-  
15           CATIONAL ACTIVITIES.—For purposes of deter-  
16           mining monthly participation rates under para-  
17           graphs (1)(B)(i) and (2)(B) of subsection (b),  
18           not more than 20 percent of the number of in-  
19           dividuals in all families and in 2-parent fami-  
20           lies, respectively, in a State who are treated as  
21           engaged in work for a month may consist of in-  
22           dividuals who are determined to be engaged in  
23           work for the month by reason of participation  
24           in vocational educational training, or deemed to

1           be engaged in work for the month by reason of  
2           subparagraph (C) of this paragraph.”.

3           (b) **RETROACTIVITY.**—The amendment made by sub-  
4 section (a) of this section shall take effect as if included  
5 in the enactment of section 103(a) of the Personal Re-  
6 sponsibility and Work Opportunity Reconciliation Act of  
7 1996.

8 **SEC. 5004. COMPENSATION; MAXIMUM REQUIRED HOURS**  
9 **OF WORK ACTIVITIES.**

10          (a) **IN GENERAL.**—Section 407 of the Social Security  
11 Act (42 U.S.C. 607) is amended by adding at the end the  
12 following:

13          “(j) **COMPENSATION.**—A State to which a grant is  
14 made under section 403 may not require a recipient of  
15 assistance under the State program funded under this  
16 part to participate in a work activity described in para-  
17 graph (1), (2), or (3) of subsection (d) unless the recipient  
18 is compensated at the same rates, including periodic in-  
19 creases, as trainees or employees who are similarly situ-  
20 ated in similar occupations by the same employer and who  
21 have similar training, experience and skills, and such rates  
22 shall be in accordance with applicable law.

23          “(k) **LIMITATION ON NUMBER OF HOURS PER**  
24 **MONTH THAT A RECIPIENT OF ASSISTANCE MAY BE RE-**  
25 **QUIRED TO PARTICIPATE IN ON-THE-JOB TRAINING, AND**

1 WITH A PUBLIC AGENCY OR NONPROFIT ORGANIZA-  
2 TION.—

3 “(1) IN GENERAL.—A State to which a grant  
4 is made under section 403 may not require a recipi-  
5 ent of assistance under the State program funded  
6 under this part to be assigned to on-the-job training,  
7 and to a work experience or community service posi-  
8 tion with a public agency or nonprofit organization  
9 during a month for more than the allowable number  
10 of hours determined for the month under paragraph  
11 (2).

12 “(2) ALLOWABLE NUMBER OF HOURS.—

13 “(A) IN GENERAL.—Subject to subpara-  
14 graph (B), the allowable number of hours deter-  
15 mined for a month under this paragraph is—

16 “(i) the value of the includible bene-  
17 fits provided by the State to the recipient  
18 during the month; divided by

19 “(ii) the minimum wage rate in effect  
20 during the month under section 6 of the  
21 Fair Labor Standards Act of 1938.

22 “(B) STATE OPTION TO TAKE ACCOUNT OF  
23 CERTAIN WORK ACTIVITIES.—

24 “(i) IN GENERAL.—In determining  
25 the allowable number of hours for a month



1 for a sufficiently employed recipient, the  
2 State may subtract from the allowable  
3 number of hours calculated under subpara-  
4 graph (A) the number of hours during the  
5 month for which the recipient participates  
6 in a work activity described in paragraph  
7 (6), (8), (9), or (11) of subsection (d).

8 “(ii) SUFFICIENTLY EMPLOYED RE-  
9 CIPIENT.—As used in clause (i), the term  
10 ‘sufficiently employed recipient’ means,  
11 with respect to a month, a recipient who is  
12 employed during the month for a number  
13 of hours that is not less than—

14 “(I) the sum of the dollar value  
15 of any assistance provided to the re-  
16 cipient during the month under the  
17 State program funded under this part,  
18 and the dollar value equivalent of any  
19 benefits provided to the recipient dur-  
20 ing the month under the food stamp  
21 program under the Food Stamp Act  
22 of 1977; divided by

23 “(II) the minimum wage rate in  
24 effect during the month under section

1                   6 of the Fair Labor Standards Act of  
2                   1938.

3                   “(3) DEFINITION OF VALUE OF THE INCLUD-  
4                   IBLE BENEFITS.—As used in paragraph (2)(A), the  
5                   term ‘value of the includible benefits’ means, with  
6                   respect to a recipient—

7                   “(A) the dollar value of any assistance  
8                   under the State program funded under this  
9                   part;

10                  “(B) the dollar value equivalent of any  
11                  benefits under the food stamp program under  
12                  the Food Stamp Act of 1977;

13                  “(C) at the option of the State, the dollar  
14                  value of benefits under the State plan approved  
15                  under title XIX, as determined in accordance  
16                  with paragraph (4);

17                  “(D) at the option of the State, the dollar  
18                  value of child care assistance; and

19                  “(E) at the option of the State, the dollar  
20                  value of housing benefits.

21                  “(4) VALUATION OF MEDICAID BENEFITS.—An-  
22                  nually, the Secretary shall publish a table that speci-  
23                  fies the dollar value of the insurance coverage pro-  
24                  vided under title XIX to a family of each size, which

1       may take account of geographical variations or other  
2       factors identified by the Secretary.

3               “(5) TREATMENT OF RECIPIENTS ASSIGNED TO  
4       CERTAIN POSITIONS WITH A PUBLIC AGENCY OR  
5       NONPROFIT ORGANIZATION.—A recipient of assist-  
6       ance under a State program funded under this part  
7       who is engaged in work experience or community  
8       service with a public agency or nonprofit organiza-  
9       tion shall not be considered an employee of the pub-  
10      lic agency or the nonprofit organization.”.

11      (b) RETROACTIVITY.—The amendment made by sub-  
12      section (a) of this section shall take effect as if included  
13      in the enactment of section 103(a) of the Personal Re-  
14      sponsibility and Work Opportunity Reconciliation Act of  
15      1996.

16      **SEC. 5005. PENALTY FOR FAILURE OF STATE TO REDUCE**  
17                               **ASSISTANCE FOR RECIPIENTS REFUSING**  
18                               **WITHOUT GOOD CAUSE TO WORK.**

19      (a) IN GENERAL.—Section 409(a) of the Social Secu-  
20      rity Act (42 U.S.C. 609(a)) is amended by adding at the  
21      end the following:

22               “(13) PENALTY FOR FAILURE TO REDUCE AS-  
23      SISTANCE FOR RECIPIENTS REFUSING WITHOUT  
24      GOOD CAUSE TO WORK.—

1           “(A) IN GENERAL.—If the Secretary deter-  
2 mines that a State to which a grant is made  
3 under section 403 in a fiscal year has violated  
4 section 407(e) during the fiscal year, the Sec-  
5 retary shall reduce the grant payable to the  
6 State under section 403(a)(1) for the imme-  
7 diately succeeding fiscal year by an amount  
8 equal to not less than 1 percent and not more  
9 than 5 percent of the State family assistance  
10 grant.

11           “(B) PENALTY BASED ON SEVERITY OF  
12 FAILURE.—The Secretary shall impose reduc-  
13 tions under subparagraph (A) with respect to a  
14 fiscal year based on the degree of noncompli-  
15 ance.”.

16           (b) RETROACTIVITY.—The amendment made by sub-  
17 section (a) of this section shall take effect as if included  
18 in the enactment of section 103(a) of the Personal Re-  
19 sponsibility and Work Opportunity Reconciliation Act of  
20 1996.

1           **Subtitle B—Higher Education**  
2                           **Programs**

3   **SEC. 5101. MANAGEMENT AND RECOVERY OF RESERVES.**

4           (a) AMENDMENT.—Section 422 of the Higher Edu-  
5 cation Act of 1965 (20 U.S.C. 1072) is amended by add-  
6 ing after subsection (g) the following new subsection:

7           “(h) RECALL OF RESERVES; LIMITATIONS ON USE  
8 OF RESERVE FUNDS AND ASSETS.—(1) Notwithstanding  
9 any other provision of law, the Secretary shall, except as  
10 otherwise provided in this subsection, recall  
11 \$1,000,000,000 from the reserve funds held by guaranty  
12 agencies on September 1, 2002.

13           “(2) Funds recalled by the Secretary under this sub-  
14 section shall be deposited in the Treasury.

15           “(3) The Secretary shall require each guaranty agen-  
16 cy to return reserve funds under paragraph (1) based on  
17 such agency’s required share of recalled reserve funds held  
18 by guaranty agencies as of September 30, 1996. For pur-  
19 poses of this paragraph, a guaranty agency’s required  
20 share of recalled reserve funds shall be determined as fol-  
21 lows:

22                   “(A) The Secretary shall compute each agency’s  
23 reserve ratio by dividing (i) the amount held in such  
24 agency’s reserve funds as of September 30, 1996  
25 (but reflecting later accounting or auditing adjust-

1       ments approved by the Secretary), by (ii) the origi-  
2       nal principal amount of all loans for which such  
3       agency has an outstanding insurance obligation as of  
4       such date.

5               “(B) If the reserve ratio of any agency as com-  
6       puted under subparagraph (A) exceeds 2.0 percent,  
7       the agency’s required share shall include so much of  
8       the amounts held in such agency’s reserve fund as  
9       exceed a reserve ratio of 2.0 percent.

10              “(C) If any additional amount is required to be  
11       recalled under paragraph (1) (after deducting the  
12       total of the required shares calculated under sub-  
13       paragraph (B)), the agencies’ required shares shall  
14       include additional amounts—

15                      “(i) determined by imposing on each such  
16       agency an equal percentage reduction in the  
17       amount of each agency’s reserve fund remain-  
18       ing after deduction of the amount recalled  
19       under subparagraph (B); and

20                      “(ii) the total of which equals the addi-  
21       tional amount that is required to be recalled  
22       under paragraph (1) (after deducting the total  
23       of the required shares calculated under sub-  
24       paragraph (B)).

1       “(4) Within 90 days after the beginning of each of  
2 fiscal years 1998 through 2002, each guaranty agency  
3 shall transfer a portion of each agency’s required share  
4 determined under paragraph (3) to a restricted account  
5 established by the guaranty agency that is of a type se-  
6 lected by the guaranty agency with the approval of the  
7 Secretary. Funds transferred to such restricted accounts  
8 shall be invested in obligations issued or guaranteed by  
9 the United States or in other similarly low-risk securities.  
10 A guaranty agency shall not use the funds in such a re-  
11 stricted account for any purpose without the express writ-  
12 ten permission of the Secretary, except that a guaranty  
13 agency may use the earnings from such restricted account  
14 to assist in meeting the agency’s operational expenses  
15 under this part. In each of fiscal years 1998 through  
16 2002, each agency shall transfer its required share to such  
17 restricted account in 5 equal annual installments, except  
18 that—

19               “(A) a guarantee agency that has a reserve  
20 ratio (as computed under subparagraph (3)(A))  
21 equal to or less than 1.10 percent may transfer its  
22 required share to such account in 4 equal install-  
23 ments beginning in fiscal year 1999; and

24               “(B) a guarantee agency may transfer such re-  
25 quired share to such account in accordance with

1       such other payment schedules as are approved by  
2       the Secretary.

3       “(5) If, on September 1, 2002, the total amount in  
4       the restricted accounts described in paragraph (4) is less  
5       than the amount the Secretary is required to recall under  
6       paragraph (1), the Secretary may require the return of  
7       the amount of the shortage from other reserve funds held  
8       by guaranty agencies under procedures established by the  
9       Secretary.

10       “(6) The Secretary may take such reasonable meas-  
11       ures, and require such information, as may be necessary  
12       to ensure that guaranty agencies comply with the require-  
13       ments of this subsection. Notwithstanding any other provi-  
14       sion of this part, if the Secretary determines that a guar-  
15       anty agency is not in compliance with the requirements  
16       of this subsection, such agency may not receive any other  
17       funds under this part until the Secretary determines that  
18       such agency is in compliance.

19       “(7) The Secretary shall not have any authority to  
20       direct a guaranty agency to return reserve funds under  
21       subsection (g)(1)(A) during the period from the date of  
22       enactment of this subsection through September 30, 2002,  
23       and any reserve funds otherwise returned under sub-  
24       section (g)(1) during such period shall be treated as



1 amounts recalled under this subsection and shall not be  
2 available under subsection (g)(4).

3 “(8) For purposes of this subsection, the term ‘re-  
4 serve funds’ when used with respect to a guaranty agen-  
5 cy—

6 “(A) includes any cash reserve funds held by  
7 the guaranty agency, or held by, or under the con-  
8 trol of, any other entity; and

9 “(B) does not include buildings, equipment, or  
10 other nonliquid assets.”.

11 (b) CONFORMING AMENDMENT.—Section  
12 428(c)(9)(A) of the Higher Education Act of 1965 (20  
13 U.S.C. 1078(c)(9)(A)) is amended—

14 (1) in the first sentence, by striking “for the  
15 fiscal year of the agency that begins in 1993”; and

16 (2) by striking the third sentence.

17 **SEC. 5102. REPEAL OF DIRECT LOAN ORIGINATION FEES TO**  
18 **INSTITUTIONS OF HIGHER EDUCATION.**

19 Section 452 of the Higher Education Act of 1965 (20  
20 U.S.C. 1087b) is amended—

21 (1) by striking subsection (b); and

22 (2) by redesignating subsections (c) and (d) as  
23 subsections (b) and (c), respectively.

1 **SEC. 5103. FUNDS FOR ADMINISTRATIVE EXPENSES.**

2 Subsection (a) of section 458 of the Higher Edu-  
3 cation Act of 1965 (20 U.S.C. 1087h(a)) is amended to  
4 read as follows:

5 “(a) IN GENERAL.—(1) Each fiscal year, there shall  
6 be available to the Secretary from funds not otherwise ap-  
7 propriated, funds to be obligated for—

8 “(A) administrative costs under this part and  
9 part B, including the costs of the direct student loan  
10 programs under this part, and

11 “(B) administrative cost allowances payable to  
12 guaranty agencies under part B and calculated in  
13 accordance with paragraph (2),

14 not to exceed (from such funds not otherwise appro-  
15 priated) \$532,000,000 in fiscal year 1998, \$610,000,000  
16 in fiscal year 1999, \$705,000,000 in fiscal year 2000,  
17 \$750,000,000 in fiscal year 2001, and \$750,000,000 in  
18 fiscal year 2002. Administrative cost allowances under  
19 subparagraph (B) of this paragraph shall be paid quar-  
20 terly and used in accordance with section 428(f). The Sec-  
21 retary may carry over funds available under this section  
22 to a subsequent fiscal year.

23 “(2) Administrative cost allowances payable to guar-  
24 anty agencies under paragraph (1)(B) shall be calculated  
25 on the basis of 0.85 percent of the total principal amount  
26 of loans upon which insurance is issued on or after the

1 date of enactment of the Balanced Budget Act of 1997,  
2 except that such allowances shall not exceed—

3 “(A) \$170,000,000 for each of the fiscal years  
4 1998 and 1999; or

5 “(B) \$150,000,000 for each of the fiscal years  
6 2000, 2001, and 2002.”.

7 **SEC. 5104. SECRETARY’S EQUITABLE SHARE OF COLLEC-**  
8 **TIONS ON CONSOLIDATED DEFAULTED**  
9 **LOANS.**

10 Section 428(c)(6)(A) of the Higher Education Act of  
11 1965 (20 U.S.C. 1078(c)(6)(A)) is amended—

12 (1) in the matter preceding clause (i), by strik-  
13 ing “made by the borrower” and inserting “made by  
14 or on behalf of the borrower, including payments  
15 made to discharge loans made under this title to ob-  
16 tain a consolidation loan pursuant to this part or  
17 part D,”; and

18 (2) in clause (ii), by striking “(ii) an amount  
19 equal to 27 percent of such payments (subject to  
20 subparagraph (D) of this paragraph) for costs relat-  
21 ed” and inserting the following:

22 “(ii) an amount equal to 27 percent of such  
23 payments for covered costs, except that the amount  
24 determined under this clause for such covered costs  
25 shall be (I) 18.5 percent of such payments for de-

1        faulted loans consolidated pursuant to this part or  
2        part D on or after July 1, 1997; and (II) 18.5 per-  
3        cent of such payments for defaulted loans consoli-  
4        dated pursuant to this part or part D on or after  
5        the date of enactment of the Higher Education  
6        Amendments of 1992 with respect to any guaranty  
7        agency that has, after such date, made deductions  
8        from such payments under this clause (ii) in an  
9        amount equal to 18.5 percent of such payments.

10      For purposes of clause (ii) of this subparagraph, the term  
11      ‘covered costs’ means costs related”.

12      **SEC. 5105. EXTENSION OF STUDENT AID PROGRAMS.**

13              Title IV of the Higher Education Act of 1965 (20  
14      U.S.C. 1070 et seq.) is amended—

15                      (1) in section 424(a), by striking “1998.” and  
16                      “2002.” and inserting “2002.” and “2006.”, respec-  
17                      tively;

18                      (2) in section 428(a)(5), by striking “1998,”  
19                      and “2002.” and inserting “2002,” and “2006.”, re-  
20                      spectively; and

21                      (3) in section 428C(e), by striking “1998.” and  
22                      inserting “2002.”.

1           **Subtitle C—Repeal of Smith-**  
 2           **Hughes Vocational Education Act**

3   **SEC. 5201. REPEAL OF SMITH-HUGHES VOCATIONAL EDU-**  
 4                           **CATION ACT.**

5           The Act of February 23, 1917 (39 Stat. 929; 20  
 6 U.S.C. 11) (commonly known as the “Smith-Hughes Vo-  
 7 cational Education Act”) is repealed.

8           **Subtitle D—Expansion of Port-**  
 9           **ability and Health Insurance**  
 10           **Coverage**

11   **SEC. 5301. SHORT TITLE OF SUBTITLE.**

12           This subtitle may be cited as the “Expansion of Port-  
 13 ability and Health Insurance Coverage Act of 1997”.

14   **SEC. 5302. RULES GOVERNING ASSOCIATION HEALTH**  
 15                           **PLANS.**

16           (a) **IN GENERAL.**—Subtitle B of title I of the Em-  
 17 ployee Retirement Income Security Act of 1974 is amend-  
 18 ed by adding after part 7 the following new part:

19           “**PART 8—RULES GOVERNING ASSOCIATION HEALTH**  
 20   **PLANS**

21           “**SEC. 801. ASSOCIATION HEALTH PLANS.**

22           “(a) **IN GENERAL.**—For purposes of this part, the  
 23 term ‘association health plan’ means a group health  
 24 plan—

1           “(1) whose sponsor is (or is deemed under this  
2 part to be) described in subsection (b), and

3           “(2) under which at least one option of health  
4 insurance coverage offered by a health insurance is-  
5 suer (which may include, among other options, man-  
6 aged care options, point of service options, and pre-  
7 ferred provider options) is provided to participants  
8 and beneficiaries.

9           “(b) SPONSORSHIP.—The sponsor of a group health  
10 plan is described in this subsection if such sponsor—

11           “(1) is organized and maintained in good faith,  
12 with a constitution and bylaws specifically stating its  
13 purpose and providing for periodic meetings on at  
14 least an annual basis, as a trade association, an in-  
15 dustry association (including a rural electric cooper-  
16 ative association or a rural telephone cooperative as-  
17 sociation), a professional association, or a chamber  
18 of commerce (or similar business group, including a  
19 corporation or similar organization that operates on  
20 a cooperative basis (within the meaning of section  
21 1381 of the Internal Revenue Code of 1986)), for  
22 substantial purposes other than that of obtaining or  
23 providing medical care,

24           “(2) is established as a permanent entity which  
25 receives the active support of its members and col-

1       lects from its members on a periodic basis dues or  
2       payments necessary to maintain eligibility for mem-  
3       bership in the sponsor, and

4               “(3) does not condition such dues or payments  
5       or coverage under the plan on the basis of health  
6       status-related factors with respect to the employees  
7       of its members (or affiliated members), or the de-  
8       pendents of such employees, and does not condition  
9       such dues or payments on the basis of group health  
10      plan participation.

11   Any sponsor consisting of an association of entities which  
12   meet the requirements of paragraphs (1) and (2) shall be  
13   deemed to be a sponsor described in this subsection.

14   **“SEC. 802. CERTIFICATION OF ASSOCIATION HEALTH**  
15               **PLANS.**

16       “(a) IN GENERAL.—The Secretary shall prescribe by  
17   regulation a procedure under which, subject to subsection  
18   (b), the Secretary shall certify association health plans  
19   which apply for certification as meeting the requirements  
20   of this part.

21       “(b) STANDARDS.—Under the procedure prescribed  
22   pursuant to subsection (a), the Secretary shall certify an  
23   association health plan as meeting the requirements of  
24   this part only if the Secretary is satisfied that—

25               “(1) such certification—

1           “(A) is administratively feasible,

2           “(B) is not adverse to the interests of the  
3 individuals covered under the plan, and

4           “(C) is protective of the rights and benefits  
5 of the individuals covered under the plan, and

6           “(2) the applicable requirements of this part  
7 are met (or, upon the date on which the plan is to  
8 commence operations, will be met) with respect to  
9 the plan.

10       “(c) REQUIREMENTS APPLICABLE TO CERTIFIED  
11 PLANS.—An association health plan with respect to which  
12 certification under this part is in effect shall meet the ap-  
13 plicable requirements of this part, effective on the date  
14 of certification (or, if later, on the date on which the plan  
15 is to commence operations).

16       “(d) REQUIREMENTS FOR CONTINUED CERTIFI-  
17 CATION.—The Secretary may provide by regulation for  
18 continued certification under this part, including require-  
19 ments relating to any commencement, by an association  
20 health plan which has been certified under this part, of  
21 a benefit option which does not consist of health insurance  
22 coverage.

23       “(e) CLASS CERTIFICATION FOR FULLY-INSURED  
24 PLANS.—The Secretary shall establish a class certification  
25 procedure for association health plans under which all ben-



1 efits consist of health insurance coverage. Under such pro-  
2 cedure, the Secretary shall provide for the granting of cer-  
3 tification under this part to the plans in each class of such  
4 association health plans upon appropriate filing under  
5 such procedure in connection with plans in such class and  
6 payment of the prescribed fee under section 807(a).

7 **“SEC. 803. REQUIREMENTS RELATING TO SPONSORS AND**  
8 **BOARDS OF TRUSTEES.**

9 “(a) SPONSOR.—The requirements of this subsection  
10 are met with respect to an association health plan if—

11 “(1) the sponsor (together with its immediate  
12 predecessor, if any) has met (or is deemed under  
13 this part to have met) for a continuous period of not  
14 less than 3 years ending with the date of the appli-  
15 cation for certification under this part, the require-  
16 ments of paragraphs (1) and (2) of section 801(b),  
17 and

18 “(2) the sponsor meets (or is deemed under this  
19 part to meet) the requirements of section 801(b)(3).

20 “(b) BOARD OF TRUSTEES.—The requirements of  
21 this subsection are met with respect to an association  
22 health plan if the following requirements are met:

23 “(1) FISCAL CONTROL.—The plan is operated,  
24 pursuant to a trust agreement, by a board of trust-  
25 ees which has complete fiscal control over the plan

1 and which is responsible for all operations of the  
2 plan.

3 “(2) RULES OF OPERATION AND FINANCIAL  
4 CONTROLS.—The board of trustees has in effect  
5 rules of operation and financial controls, based on a  
6 3-year plan of operation, adequate to carry out the  
7 terms of the plan and to meet all requirements of  
8 this title applicable to the plan.

9 “(3) RULES GOVERNING RELATIONSHIP TO  
10 PARTICIPATING EMPLOYERS AND TO CONTRAC-  
11 TORS.—

12 “(A) IN GENERAL.—Except as provided in  
13 subparagraph (B), the members of the board of  
14 trustees are individuals selected from individ-  
15 uals who are the owners, officers, directors, or  
16 employees of the participating employers or who  
17 are partners in the participating employers and  
18 actively participate in the business.

19 “(B) LIMITATION.—

20 “(i) GENERAL RULE.—Except as pro-  
21 vided in clauses (ii) and (iii), no such  
22 member is an owner, officer, director, or  
23 employee of, or partner in, a contract ad-  
24 ministrators or other service provider to the  
25 plan.

1           “(ii) LIMITED EXCEPTION FOR PRO-  
2           VIDERS OF SERVICES SOLELY ON BEHALF  
3           OF THE SPONSOR.—Officers or employees  
4           of a sponsor which is a service provider  
5           (other than a contract administrator) to  
6           the plan may be members of the board if  
7           they constitute not more than 25 percent  
8           of the membership of the board and they  
9           do not provide services to the plan other  
10          than on behalf of the sponsor.

11          “(iii) TREATMENT OF PROVIDERS OF  
12          MEDICAL CARE.—In the case of a sponsor  
13          which is an association whose membership  
14          consists primarily of providers of medical  
15          care, clause (i) shall not apply in the case  
16          of any service provider described in sub-  
17          paragraph (A) who is a provider of medical  
18          care under the plan.

19          “(C) SOLE AUTHORITY.—The board has  
20          sole authority to approve applications for par-  
21          ticipation in the plan and to contract with a  
22          service provider to administer the day-to-day af-  
23          fairs of the plan.

24          “(c) TREATMENT OF FRANCHISE NETWORKS.—In  
25          the case of a group health plan which is established and

1 maintained by a franchiser for a franchise network con-  
2 sisting of its franchisees—

3           “(1) the requirements of subsection (a) and sec-  
4 tion 801(a)(1) shall be deemed met if such require-  
5 ments would otherwise be met if the franchiser were  
6 deemed to be the sponsor referred to in section  
7 801(b), such network were deemed to be an associa-  
8 tion described in section 801(b), and each franchisee  
9 were deemed to be a member (of the association and  
10 the sponsor) referred to in section 801(b), and

11           “(2) the requirements of section 804(a)(1) shall  
12 be deemed met.

13           “(d) CERTAIN COLLECTIVELY BARGAINED PLANS.—

14           “(1) IN GENERAL.—In the case of a group  
15 health plan described in paragraph (2)—

16           “(A) the requirements of subsection (a)  
17 and section 801(a)(1) shall be deemed met,

18           “(B) the joint board of trustees shall be  
19 deemed a board of trustees with respect to  
20 which the requirements of subsection (b) are  
21 met, and

22           “(C) the requirements of section 804 shall  
23 be deemed met.

24           “(2) REQUIREMENTS.—A group health plan is  
25 described in this paragraph if—

1           “(A) the plan is a multiemployer plan,

2           “(B) the plan is in existence on April 1,  
3 1997, and would be described in section  
4 3(40)(A)(i) but solely for the failure to meet  
5 the requirements of section 3(40)(C)(ii) or (to  
6 the extent provided in regulations of the Sec-  
7 retary) solely for the failure to meet the re-  
8 quirements of subparagraph (D) of section  
9 3(40), or

10           “(C)(i) the plan is in existence on April 1,  
11 1997, has been in existence as of such date for  
12 at least 3 years, meets the requirements of  
13 paragraphs (2) and (3) of section 801(b), and  
14 would be described in section 3(40)(A)(i) but  
15 solely for the failure to meet the requirements  
16 of subparagraph (C)(i) or (C)(ii), and

17           “(ii) individuals who are members of the  
18 plan sponsor—

19           “(I) participate by elections in the or-  
20 ganizational governance of the plan spon-  
21 sor,

22           “(II) are eligible for appointment as  
23 trustee of the plan or for participation in  
24 the appointment of trustees of the plan,  
25 and

1                   “(III) if covered under the plan, have  
2                   full rights under the plan of a participant  
3                   in an employee welfare benefit plan.

4           “(e) CERTAIN PLANS NOT MEETING SINGLE EM-  
5 PLOYER REQUIREMENT.—

6                   “(1) IN GENERAL.—In any case in which the  
7                   majority of the employees covered under a group  
8                   health plan are employees of a single employer  
9                   (within the meaning of clauses (i) and (ii) of section  
10                  3(40)(B)), if all other employees covered under the  
11                  plan are employed by employers who are related to  
12                  such single employer—

13                   “(A) the requirements of subsection (a)  
14                   and section 801(a)(1) shall not apply if such  
15                   single employer is the sponsor of the plan, and

16                   “(B) the requirements of subsection (b)  
17                   shall be deemed met if the board of trustees is  
18                   the named fiduciary in connection with the  
19                   plan.

20                  “(2) RELATED EMPLOYERS.—For purposes of  
21                  paragraph (1), employers are ‘related’ if there is  
22                  among all such employers a common ownership in-  
23                  terest or a substantial commonality of business oper-  
24                  ations based on common suppliers or customers.

1 **“SEC. 804. PARTICIPATION AND COVERAGE REQUIRE-**  
2 **MENTS.**

3 “(a) COVERED EMPLOYERS AND INDIVIDUALS.—The  
4 requirements of this subsection are met with respect to  
5 an association health plan if, under the terms of the  
6 plan—

7 “(1) all participating employers must be mem-  
8 bers or affiliated members of the sponsor, except  
9 that, in the case of a sponsor which is a professional  
10 association or other individual-based association, if  
11 at least one of the officers, directors, or employees  
12 of an employer, or at least one of the individuals  
13 who are partners in an employer and who actively  
14 participates in the business, is a member or affili-  
15 ated member of the sponsor, participating employers  
16 may also include such employer, and

17 “(2) all individuals commencing coverage under  
18 the plan after certification under this part must  
19 be—

20 “(A) active or retired owners (including  
21 self-employed individuals), officers, directors, or  
22 employees of, or partners in, participating em-  
23 ployers, or

24 “(B) the beneficiaries of individuals de-  
25 scribed in subparagraph (A).

1       “(b) COVERAGE OF PREVIOUSLY UNINSURED EM-  
2 PLOYEES.—The requirements of this subsection are met  
3 with respect to an association health plan if, under the  
4 terms of the plan, no affiliated member of the sponsor may  
5 be offered coverage under the plan as a participating em-  
6 ployer unless—

7               “(1) the affiliated member was an affiliated  
8 member on the date of certification under this part,  
9 or

10              “(2) during the 12-month period preceding the  
11 date of the offering of such coverage, the affiliated  
12 member has not maintained or contributed to a  
13 group health plan with respect to any of its employ-  
14 ees who would otherwise be eligible to participate in  
15 such association health plan.

16       “(c) INDIVIDUAL MARKET UNAFFECTED.—The re-  
17 quirements of this subsection are met with respect to an  
18 association health plan if, under the terms of the plan,  
19 no participating employer may provide health insurance  
20 coverage in the individual market for any employee not  
21 covered under the plan which is similar to the coverage  
22 contemporaneously provided to employees of the employer  
23 under the plan, if such exclusion of the employee from cov-  
24 erage under the plan is based on a health status-related  
25 factor with respect to the employee and such employee



1 would, but for such exclusion on such basis, be eligible  
2 for coverage under the plan.

3 “(d) PROHIBITION OF DISCRIMINATION AGAINST  
4 EMPLOYERS AND EMPLOYEES ELIGIBLE TO PARTICI-  
5 PATE.—The requirements of this subsection are met with  
6 respect to an association health plan if—

7 “(1) under the terms of the plan, no employer  
8 meeting the preceding requirements of this section is  
9 excluded as a participating employer, unless—

10 “(A) participation or contribution require-  
11 ments of the type referred to in section 2711 of  
12 the Public Health Service Act are not met with  
13 respect to the excluded employer, or

14 “(B) the excluded employer does not sat-  
15 isfy a required minimum level of employment  
16 uniformly applicable to participating employers,

17 “(2) the applicable requirements of sections  
18 701, 702, and 703 are met with respect to the plan,  
19 and

20 “(3) applicable benefit options under the plan  
21 are actively marketed to all eligible participating em-  
22 ployers.

1 **“SEC. 805. OTHER REQUIREMENTS RELATING TO PLAN**  
2 **DOCUMENTS, CONTRIBUTION RATES, AND**  
3 **BENEFIT OPTIONS.**

4 “(a) IN GENERAL.—The requirements of this section  
5 are met with respect to an association health plan if the  
6 following requirements are met:

7 “(1) CONTENTS OF GOVERNING INSTRU-  
8 MENTS.—The instruments governing the plan in-  
9 clude a written instrument, meeting the require-  
10 ments of an instrument required under section  
11 402(a)(1), which—

12 “(A) provides that the board of trustees  
13 serves as the named fiduciary required for plans  
14 under section 402(a)(1) and serves in the ca-  
15 pacity of a plan administrator (referred to in  
16 section 3(16)(A)),

17 “(B) provides that the sponsor of the plan  
18 is to serve as plan sponsor (referred to in sec-  
19 tion 3(16)(B)), and

20 “(C) incorporates the requirements of sec-  
21 tion 806.

22 “(2) CONTRIBUTION RATES MUST BE NON-  
23 DISCRIMINATORY.—

24 “(A) The contribution rates for any par-  
25 ticipating employer do not vary significantly on  
26 the basis of the claims experience of such em-

1           ployer and do not vary on the basis of the type  
2           of business or industry in which such employer  
3           is engaged.

4           “(B) Nothing in this title or any other pro-  
5           vision of law shall be construed to preclude an  
6           association health plan, or a health insurance  
7           issuer offering health insurance coverage in  
8           connection with an association health plan,  
9           from setting contribution rates based on the  
10          claims experience of the plan, to the extent con-  
11          tribution rates under the plan meet the require-  
12          ments of section 702(b).

13          “(3) FLOOR FOR NUMBER OF COVERED INDI-  
14          VIDUALS WITH RESPECT TO CERTAIN PLANS.—If  
15          any benefit option under the plan does not consist  
16          of health insurance coverage, the plan has as of the  
17          beginning of the plan year not fewer than 1,000 par-  
18          ticipants and beneficiaries.

19          “(4) REGULATORY REQUIREMENTS.—Such  
20          other requirements as the Secretary may prescribe  
21          by regulation as necessary to carry out the purposes  
22          of this part.

23          “(b) ABILITY OF ASSOCIATION HEALTH PLANS TO  
24          DESIGN BENEFIT OPTIONS.—Nothing in this part or any  
25          provision of State law (as defined in section 514(c)(1))

1 shall be construed to preclude an association health plan,  
2 or a health insurance issuer offering health insurance cov-  
3 erage in connection with an association health plan, from  
4 exercising its sole discretion in selecting the specific items  
5 and services consisting of medical care to be included as  
6 benefits under such plan or coverage, except in the case  
7 of any law to the extent that it (1) prohibits an exclusion  
8 of a specific disease from such coverage, or (2) is not pre-  
9 empted under section 731(a)(1) with respect to matters  
10 governed by section 711 or 712.

11 **“SEC. 806. MAINTENANCE OF RESERVES AND PROVISIONS**  
12 **FOR SOLVENCY FOR PLANS PROVIDING**  
13 **HEALTH BENEFITS IN ADDITION TO HEALTH**  
14 **INSURANCE COVERAGE.**

15 “(a) IN GENERAL.—The requirements of this section  
16 are met with respect to an association health plan if—

17 “(1) the benefits under the plan consist solely  
18 of health insurance coverage, or

19 “(2) if the plan provides any additional benefit  
20 options which do not consist of health insurance cov-  
21 erage, the plan—

22 “(A) establishes and maintains reserves  
23 with respect to such additional benefit options,  
24 in amounts recommended by the qualified actu-  
25 ary, consisting of—

1                   “(i) a reserve sufficient for unearned  
2                   contributions,

3                   “(ii) a reserve sufficient for benefit li-  
4                   abilities which have been incurred, which  
5                   have not been satisfied, and for which risk  
6                   of loss has not yet been transferred, and  
7                   for expected administrative costs with re-  
8                   spect to such benefit liabilities,

9                   “(iii) a reserve sufficient for any other  
10                  obligations of the plan, and

11                  “(iv) a reserve sufficient for a margin  
12                  of error and other fluctuations, taking into  
13                  account the specific circumstances of the  
14                  plan,

15                  and

16                  “(B) establishes and maintains aggregate  
17                  excess/stop loss insurance and solvency indem-  
18                  nification, with respect to such additional bene-  
19                  fit options for which risk of loss has not yet  
20                  been transferred, as follows:

21                         “(i) The plan shall secure aggregate  
22                         excess/stop loss insurance for the plan with  
23                         an attachment point which is not greater  
24                         than 125 percent of expected gross annual  
25                         claims. The Secretary may by regulation

1 provide for upward adjustments in the  
2 amount of such percentage in specified cir-  
3 cumstances in which the plan specifically  
4 provides for and maintains reserves in ex-  
5 cess of the amounts required under sub-  
6 paragraph (A).

7 “(ii) The plan shall secure a means of  
8 indemnification for any claims which the  
9 plan is unable to satisfy by reason of a ter-  
10 mination pursuant to section 809(b) (relat-  
11 ing to mandatory termination).

12 Any regulations prescribed by the Secretary pursuant to  
13 paragraph (2)(B)(i) may allow for such adjustments in the  
14 required levels of excess/stop loss insurance as the quali-  
15 fied actuary may recommend, taking into account the spe-  
16 cific circumstances of the plan.

17 “(b) MINIMUM SURPLUS IN ADDITION TO CLAIMS  
18 RESERVES.—The requirements of this subsection are met  
19 if the plan establishes and maintains surplus in an amount  
20 at least equal to the excess of—

21 “(1) the greater of—

22 “(A) 25 percent of expected incurred  
23 claims and expenses for the plan year, or

24 “(B) \$400,000,

25 over

1           “(2) the amount required under subsection  
2           (a)(2)(A)(ii).

3           “(c) ADDITIONAL REQUIREMENTS.—In the case of  
4 any association health plan described in subsection (a)(2),  
5 the Secretary may provide such additional requirements  
6 relating to reserves and excess/stop loss insurance as the  
7 Secretary considers appropriate. Such requirements may  
8 be provided, by regulation or otherwise, with respect to  
9 any such plan or any class of such plans.

10          “(d) ADJUSTMENTS FOR EXCESS/STOP LOSS INSUR-  
11 ANCE.—The Secretary may provide for adjustments to the  
12 levels of reserves otherwise required under subsections (a)  
13 and (b) with respect to any plan or class of plans to take  
14 into account excess/stop loss insurance provided with re-  
15 spect to such plan or plans.

16          “(e) ALTERNATIVE MEANS OF COMPLIANCE.—The  
17 Secretary may permit an association health plan described  
18 in subsection (a)(2) to substitute, for all or part of the  
19 requirements of this section, such security, guarantee,  
20 hold-harmless arrangement, or other financial arrange-  
21 ment as the Secretary determines to be adequate to enable  
22 the plan to fully meet all its financial obligations on a  
23 timely basis and is otherwise no less protective of the in-  
24 terests of participants and beneficiaries than the require-  
25 ments for which it is substituted. The Secretary may take

1 into account, for purposes of this subsection, evidence pro-  
2 vided by the plan or sponsor which demonstrates an as-  
3 sumption of liability with respect to the plan. Such evi-  
4 dence may be in the form of a contract of indemnification,  
5 lien, bonding, insurance, letter of credit, recourse under  
6 applicable terms of the plan in the form of assessments  
7 of participating employers, security, or other financial ar-  
8 rangement.

9 “(f) **EXCESS/STOP LOSS INSURANCE.**—For purposes  
10 of this section, the term ‘excess/stop loss insurance’  
11 means, in connection with an association health plan, a  
12 contract under which an insurer (meeting such minimum  
13 standards as may be prescribed in regulations of the Sec-  
14 retary) provides for payment to the plan with respect to  
15 claims under the plan in excess of an amount or amounts  
16 specified in such contract.

17 **“SEC. 807. REQUIREMENTS FOR APPLICATION AND RELAT-**  
18 **ED REQUIREMENTS.**

19 “(a) **FILING FEE.**—Under the procedure prescribed  
20 pursuant to section 802(a), an association health plan  
21 shall pay to the Secretary at the time of filing an applica-  
22 tion for certification under this part a filing fee in the  
23 amount of \$5,000, which shall be available, to the extent  
24 provided in appropriation Acts, to the Secretary for the



1 sole purpose of administering the certification procedures  
2 applicable with respect to association health plans.

3 “(b) INFORMATION TO BE INCLUDED IN APPLICA-  
4 TION FOR CERTIFICATION.—An application for certifi-  
5 cation under this part meets the requirements of this sec-  
6 tion only if it includes, in a manner and form prescribed  
7 in regulations of the Secretary, at least the following infor-  
8 mation:

9 “(1) IDENTIFYING INFORMATION.—The names  
10 and addresses of—

11 “(A) the sponsor, and

12 “(B) the members of the board of trustees  
13 of the plan.

14 “(2) STATES IN WHICH PLAN INTENDS TO DO  
15 BUSINESS.—The States in which participants and  
16 beneficiaries under the plan are to be located and  
17 the number of them expected to be located in each  
18 such State.

19 “(3) BONDING REQUIREMENTS.—Evidence pro-  
20 vided by the board of trustees that the bonding re-  
21 quirements of section 412 will be met as of the date  
22 of the application or (if later) commencement of op-  
23 erations.

24 “(4) PLAN DOCUMENTS.—A copy of the docu-  
25 ments governing the plan (including any bylaws and

1 trust agreements), the summary plan description,  
2 and other material describing the benefits that will  
3 be provided to participants and beneficiaries under  
4 the plan.

5 “(5) AGREEMENTS WITH SERVICE PROVIDERS.—A copy of any agreements between the plan  
6 and contract administrators and other service pro-  
7 viders.  
8

9 “(6) FUNDING REPORT.—In the case of asso-  
10 ciation health plans providing benefits options in ad-  
11 dition to health insurance coverage, a report setting  
12 forth information with respect to such additional  
13 benefit options determined as of a date within the  
14 120-day period ending with the date of the applica-  
15 tion, including the following:

16 “(A) RESERVES.—A statement, certified  
17 by the board of trustees of the plan, and a  
18 statement of actuarial opinion, signed by a  
19 qualified actuary, that all applicable require-  
20 ments of section 806 are or will be met in ac-  
21 cordance with regulations which the Secretary  
22 shall prescribe.

23 “(B) ADEQUACY OF CONTRIBUTION  
24 RATES.—A statement of actuarial opinion,  
25 signed by a qualified actuary, which sets forth

1 a description of the extent to which contribution  
2 rates are adequate to provide for the payment  
3 of all obligations and the maintenance of re-  
4 quired reserves under the plan for the 12-  
5 month period beginning with such date within  
6 such 120-day period, taking into account the  
7 expected coverage and experience of the plan. If  
8 the contribution rates are not fully adequate,  
9 the statement of actuarial opinion shall indicate  
10 the extent to which the rates are inadequate  
11 and the changes needed to ensure adequacy.

12 “(C) CURRENT AND PROJECTED VALUE OF  
13 ASSETS AND LIABILITIES.—A statement of ac-  
14 tuarial opinion signed by a qualified actuary,  
15 which sets forth the current value of the assets  
16 and liabilities accumulated under the plan and  
17 a projection of the assets, liabilities, income,  
18 and expenses of the plan for the 12-month pe-  
19 riod referred to in subparagraph (B). The in-  
20 come statement shall identify separately the  
21 plan’s administrative expenses and claims.

22 “(D) COSTS OF COVERAGE TO BE  
23 CHARGED AND OTHER EXPENSES.—A state-  
24 ment of the costs of coverage to be charged, in-  
25 cluding an itemization of amounts for adminis-

1           tration, reserves, and other expenses associated  
2           with the operation of the plan.

3           “(E) OTHER INFORMATION.—Any other  
4           information which may be prescribed in regula-  
5           tions of the Secretary as necessary to carry out  
6           the purposes of this part.

7           “(c) FILING NOTICE OF CERTIFICATION WITH  
8           STATES.—A certification granted under this part to an  
9           association health plan shall not be effective unless written  
10          notice of such certification is filed with the applicable  
11          State authority of each State in which at least 25 percent  
12          of the participants and beneficiaries under the plan are  
13          located. For purposes of this subsection, an individual  
14          shall be considered to be located in the State in which a  
15          known address of such individual is located or in which  
16          such individual is employed.

17          “(d) NOTICE OF MATERIAL CHANGES.—In the case  
18          of any association health plan certified under this part,  
19          descriptions of material changes in any information which  
20          was required to be submitted with the application for the  
21          certification under this part shall be filed in such form  
22          and manner as shall be prescribed in regulations of the  
23          Secretary. The Secretary may require by regulation prior  
24          notice of material changes with respect to specified mat-

1 ters which might serve as the basis for suspension or rev-  
2 ocation of the certification.

3       “(e) REPORTING REQUIREMENTS FOR CERTAIN AS-  
4 SOCIATION HEALTH PLANS.—An association health plan  
5 certified under this part which provides benefit options in  
6 addition to health insurance coverage for such plan year  
7 shall meet the requirements of section 103 by filing an  
8 annual report under such section which shall include infor-  
9 mation described in subsection (b)(6) with respect to the  
10 plan year and, notwithstanding section 104(a)(1)(A), shall  
11 be filed not later than 90 days after the close of the plan  
12 year (or on such later date as may be prescribed by the  
13 Secretary).

14       “(f) ENGAGEMENT OF QUALIFIED ACTUARY.—The  
15 board of trustees of each association health plan which  
16 provides benefits options in addition to health insurance  
17 coverage and which is applying for certification under this  
18 part or is certified under this part shall engage, on behalf  
19 of all participants and beneficiaries, a qualified actuary  
20 who shall be responsible for the preparation of the mate-  
21 rials comprising information necessary to be submitted by  
22 a qualified actuary under this part. The qualified actuary  
23 shall utilize such assumptions and techniques as are nec-  
24 essary to enable such actuary to form an opinion as to

1 whether the contents of the matters reported under this  
2 part—

3 “(1) are in the aggregate reasonably related to  
4 the experience of the plan and to reasonable expecta-  
5 tions, and

6 “(2) represent such actuary’s best estimate of  
7 anticipated experience under the plan.

8 The opinion by the qualified actuary shall be made with  
9 respect to, and shall be made a part of, the annual report.

10 **“SEC. 808. NOTICE REQUIREMENTS FOR VOLUNTARY TER-**  
11 **MINATION.**

12 “Except as provided in section 809(b), an association  
13 health plan which is or has been certified under this part  
14 may terminate (upon or at any time after cessation of ac-  
15 cruals in benefit liabilities) only if the board of trustees—

16 “(1) not less than 60 days before the proposed  
17 termination date, provides to the participants and  
18 beneficiaries a written notice of intent to terminate  
19 stating that such termination is intended and the  
20 proposed termination date,

21 “(2) develops a plan for winding up the affairs  
22 of the plan in connection with such termination in  
23 a manner which will result in timely payment of all  
24 benefits for which the plan is obligated, and

1           “(3) submits such plan in writing to the Sec-  
2           retary.

3   Actions required under this section shall be taken in such  
4   form and manner as may be prescribed in regulations of  
5   the Secretary.

6   **“SEC. 809. CORRECTIVE ACTIONS AND MANDATORY TERMI-  
7                                    NATION.**

8           “(a) ACTIONS TO AVOID DEPLETION OF RE-  
9   SERVES.—An association health plan which is certified  
10   under this part and which provides benefits other than  
11   health insurance coverage shall continue to meet the re-  
12   quirements of section 806, irrespective of whether such  
13   certification continues in effect. The board of trustees of  
14   such plan shall determine quarterly whether the require-  
15   ments of section 806 are met. In any case in which the  
16   board determines that there is reason to believe that there  
17   is or will be a failure to meet such requirements, or the  
18   Secretary makes such a determination and so notifies the  
19   board, the board shall immediately notify the qualified ac-  
20   tuary engaged by the plan, and such actuary shall, not  
21   later than the end of the next following month, make such  
22   recommendations to the board for corrective action as the  
23   actuary determines necessary to ensure compliance with  
24   section 806. Not later than 30 days after receiving from  
25   the actuary recommendations for corrective actions, the

1 board shall notify the Secretary (in such form and manner  
2 as the Secretary may prescribe by regulation) of such rec-  
3 ommendations of the actuary for corrective action, to-  
4 gether with a description of the actions (if any) that the  
5 board has taken or plans to take in response to such rec-  
6 ommendations. The board shall thereafter report to the  
7 Secretary, in such form and frequency as the Secretary  
8 may specify to the board, regarding corrective action taken  
9 by the board until the requirements of section 806 are  
10 met.

11 “(b) MANDATORY TERMINATION.—In any case in  
12 which—

13 “(1) the Secretary has been notified under sub-  
14 section (a) of a failure of an association health plan  
15 which is or has been certified under this part and  
16 is described in section 806(a)(2) to meet the require-  
17 ments of section 806 and has not been notified by  
18 the board of trustees of the plan that corrective ac-  
19 tion has restored compliance with such require-  
20 ments, and

21 “(2) the Secretary determines that there is a  
22 reasonable expectation that the plan will continue to  
23 fail to meet the requirements of section 806,  
24 the board of trustees of the plan shall, at the direction  
25 of the Secretary, terminate the plan and, in the course



1 of the termination, take such actions as the Secretary may  
2 require, including satisfying any claims referred to in sec-  
3 tion 806(a)(2)(B)(ii) and recovering for the plan any li-  
4 ability under subsection (a)(2)(B)(ii) or (e) of section 806,  
5 as necessary to ensure that the affairs of the plan will  
6 be, to the maximum extent possible, wound up in a man-  
7 ner which will result in timely provision of all benefits for  
8 which the plan is obligated.

9 “(c) GUARANTEE FUND.—In any case in which  
10 claims against an association health plan terminated  
11 under subsection (b) remain outstanding after all actions  
12 required under subsection (b) have been undertaken in  
13 connection with the termination, the Secretary shall assess  
14 all ongoing association health plans which are or have been  
15 certified under this part and are described in section  
16 806(a)(2) in an amount—

17 “(1) expressed as a uniform percentage of  
18 claims paid by such plans per year for coverage,  
19 other than health insurance coverage, commencing  
20 with the last plan year ending before the date of the  
21 termination, and

22 “(2) equal, in the aggregate, to the total  
23 amount of such outstanding claims,

24 except that any such assessment shall not exceed 2 percent  
25 per year. The Secretary shall promptly pay such outstand-

1 ing claims with the amounts assessed pursuant to this  
2 subsection. The Secretary shall deposit and hold such as-  
3 sessments in a guarantee fund which shall be established  
4 by the Secretary for payment of such claims until such  
5 payment of such claims has been completed. The Secretary  
6 may invest amounts of the fund in such obligations as the  
7 Secretary considers appropriate.

8 **“SEC. 810. SPECIAL RULES FOR CHURCH PLANS.**

9       “(a) ELECTION FOR CHURCH PLANS.—Notwith-  
10 standing section 4(b)(2), if a church, a convention or asso-  
11 ciation of churches, or an organization described in section  
12 3(33)(C)(i) maintains a church plan which is a group  
13 health plan (as defined in section 733(a)(1)), and such  
14 church, convention, association, or organization makes an  
15 election with respect to such plan under this subsection  
16 (in such form and manner as the Secretary may by regula-  
17 tion prescribe), then the provisions of this section shall  
18 apply to such plan, with respect to benefits provided under  
19 such plan consisting of medical care, as if section 4(b)(2)  
20 did not contain an exclusion for church plans. Nothing in  
21 this paragraph shall be construed to render any other sec-  
22 tion of this title applicable to church plans, except to the  
23 extent that such other section is incorporated by reference  
24 in this section.

25       “(b) EFFECT OF ELECTION.—

1           “(1) PREEMPTION OF STATE INSURANCE LAWS  
2 REGULATING COVERED CHURCH PLANS.—Subject to  
3 paragraphs (2) and (3), this section shall supersede  
4 any and all State laws which regulate insurance in-  
5 sofar as they may now or hereafter regulate church  
6 plans to which this section applies or trusts estab-  
7 lished under such church plans.

8           “(2) GENERAL STATE INSURANCE REGULATION  
9 UNAFFECTED.—

10           “(A) IN GENERAL.—Except as provided in  
11 subparagraph (B) and paragraph (3), nothing  
12 in this section shall be construed to exempt or  
13 relieve any person from any provision of State  
14 law which regulates insurance.

15           “(B) CHURCH PLANS NOT TO BE DEEMED  
16 INSURANCE COMPANIES OR INSURERS.—Neither  
17 a church plan to which this section applies, nor  
18 any trust established under such a church plan,  
19 shall be deemed to be an insurance company or  
20 other insurer or to be engaged in the business  
21 of insurance for purposes of any State law pur-  
22 porting to regulate insurance companies or in-  
23 surance contracts.

24           “(3) PREEMPTION OF CERTAIN STATE LAWS  
25 RELATING TO PREMIUM RATE REGULATION AND

1 BENEFIT MANDATES.—The provisions of subsections  
2 (a)(2)(B) and (b) of section 805 shall apply with re-  
3 spect to a church plan to which this section applies  
4 in the same manner and to the same extent as such  
5 provisions apply with respect to association health  
6 plans.

7 “(4) DEFINITIONS.—For purposes of this sub-  
8 section—

9 “(A) STATE LAW.—The term ‘State law’  
10 includes all laws, decisions, rules, regulations,  
11 or other State action having the effect of law,  
12 of any State. A law of the United States appli-  
13 cable only to the District of Columbia shall be  
14 treated as a State law rather than a law of the  
15 United States.

16 “(B) STATE.—The term ‘State’ includes a  
17 State, any political subdivision thereof, or any  
18 agency or instrumentality of either, which  
19 purports to regulate, directly or indirectly, the  
20 terms and conditions of church plans covered by  
21 this section.

22 “(c) REQUIREMENTS FOR COVERED CHURCH  
23 PLANS.—

24 “(1) FIDUCIARY RULES AND EXCLUSIVE PUR-  
25 POSE.—A fiduciary shall discharge his duties with

1 respect to a church plan to which this section ap-  
2 plies—

3 “(A) for the exclusive purpose of:

4 “(i) providing benefits to participants  
5 and their beneficiaries; and

6 “(ii) defraying reasonable expenses of  
7 administering the plan;

8 “(B) with the care, skill, prudence and dili-  
9 gence under the circumstances then prevailing  
10 that a prudent man acting in a like capacity  
11 and familiar with such matters would use in the  
12 conduct of an enterprise of a like character and  
13 with like aims; and

14 “(C) in accordance with the documents  
15 and instruments governing the plan.

16 The requirements of this paragraph shall not be  
17 treated as not satisfied solely because the plan as-  
18 sets are commingled with other church assets, to the  
19 extent that such plan assets are separately ac-  
20 counted for.

21 “(2) CLAIMS PROCEDURE.—In accordance with  
22 regulations of the Secretary, every church plan to  
23 which this section applies shall—

24 “(A) provide adequate notice in writing to  
25 any participant or beneficiary whose claim for

1 benefits under the plan has been denied, setting  
2 forth the specific reasons for such denial, writ-  
3 ten in a manner calculated to be understood by  
4 the participant;

5 “(B) afford a reasonable opportunity to  
6 any participant whose claim for benefits has  
7 been denied for a full and fair review by the ap-  
8 propriate fiduciary of the decision denying the  
9 claim; and

10 “(C) provide a written statement to each  
11 participant describing the procedures estab-  
12 lished pursuant to this paragraph.

13 “(3) ANNUAL STATEMENTS.—In accordance  
14 with regulations of the Secretary, every church plan  
15 to which this section applies shall file with the Sec-  
16 retary an annual statement—

17 “(A) stating the names and addresses of  
18 the plan and of the church, convention, or asso-  
19 ciation maintaining the plan (and its principal  
20 place of business);

21 “(B) certifying that it is a church plan to  
22 which this section applies and that it complies  
23 with the requirements of paragraphs (1) and  
24 (2);

1           “(C) identifying the States in which par-  
2           ticipants and beneficiaries under the plan are or  
3           likely will be located during the 1-year period  
4           covered by the statement; and

5           “(D) containing a copy of a statement of  
6           actuarial opinion signed by a qualified actuary  
7           that the plan maintains capital, reserves, insur-  
8           ance, other financial arrangements, or any com-  
9           bination thereof adequate to enable the plan to  
10          fully meet all of its financial obligations on a  
11          timely basis.

12          “(4) DISCLOSURE.—At the time that the an-  
13          nual statement is filed by a church plan with the  
14          Secretary pursuant to paragraph (3), a copy of such  
15          statement shall be made available by the Secretary  
16          to the State insurance commissioner (or similar offi-  
17          cial) of any State. The name of each church plan  
18          and sponsoring organization filing an annual state-  
19          ment in compliance with paragraph (3) shall be pub-  
20          lished annually in the Federal Register.

21          “(c) ENFORCEMENT.—The Secretary may enforce  
22          the provisions of this section in a manner consistent with  
23          section 502, to the extent applicable with respect to ac-  
24          tions under section 502(a)(5), and with section 3(33)(D),  
25          except that, other than for the purpose of seeking a tem-

1 porary restraining order, a civil action may be brought  
2 with respect to the plan's failure to meet any requirement  
3 of this section only if the plan fails to correct its failure  
4 within the correction period described in section 3(33)(D).  
5 The other provisions of part 5 (except sections 501(a),  
6 503, 512, 514, and 515) shall apply with respect to the  
7 enforcement and administration of this section.

8       “(d) DEFINITIONS AND OTHER RULES.—For pur-  
9 poses of this section—

10           “(1) IN GENERAL.—Except as otherwise pro-  
11 vided in this section, any term used in this section  
12 which is defined in any provision of this title shall  
13 have the definition provided such term by such pro-  
14 vision.

15           “(2) SEMINARY STUDENTS.—Seminary students  
16 who are enrolled in an institution of higher learning  
17 described in section 3(33)(C)(iv) and who are treat-  
18 ed as participants under the terms of a church plan  
19 to which this section applies shall be deemed to be  
20 employees as defined in section 3(6) if the number  
21 of such students constitutes an insignificant portion  
22 of the total number of individuals who are treated  
23 as participants under the terms of the plan.

24 **“SEC. 811. DEFINITIONS AND RULES OF CONSTRUCTION.**

25       “(a) DEFINITIONS.—For purposes of this part—



1           “(1) GROUP HEALTH PLAN.—The term ‘group  
2 health plan’ has the meaning provided in section  
3 733(a)(1).

4           “(2) MEDICAL CARE.—The term ‘medical care’  
5 has the meaning provided in section 733(a)(2).

6           “(3) HEALTH INSURANCE COVERAGE.—The  
7 term ‘health insurance coverage’ has the meaning  
8 provided in section 733(b)(1).

9           “(4) HEALTH INSURANCE ISSUER.—The term  
10 ‘health insurance issuer’ has the meaning provided  
11 in section 733(b)(2).

12           “(5) HEALTH STATUS-RELATED FACTOR.—The  
13 term ‘health status-related factor’ has the meaning  
14 provided in section 733(d)(2).

15           “(6) INDIVIDUAL MARKET.—

16           “(A) IN GENERAL.—The term ‘individual  
17 market’ means the market for health insurance  
18 coverage offered to individuals other than in  
19 connection with a group health plan.

20           “(B) TREATMENT OF VERY SMALL  
21 GROUPS.—

22           “(i) IN GENERAL.—Subject to clause  
23 (ii), such term includes coverage offered in  
24 connection with a group health plan that  
25 has fewer than 2 participants as current

1 employees or participants described in sec-  
2 tion 732(d)(3) on the first day of the plan  
3 year.

4 “(ii) STATE EXCEPTION.—Clause (i)  
5 shall not apply in the case of health insur-  
6 ance coverage offered in a State if such  
7 State regulates the coverage described in  
8 such clause in the same manner and to the  
9 same extent as coverage in the small group  
10 market (as defined in section 2791(e)(5) of  
11 the Public Health Service Act) is regulated  
12 by such State.

13 “(7) PARTICIPATING EMPLOYER.—The term  
14 ‘participating employer’ means, in connection with  
15 an association health plan, any employer, if any indi-  
16 vidual who is an employee of such employer, a part-  
17 ner in such employer, or a self-employed individual  
18 who is such employer (or any dependent, as defined  
19 under the terms of the plan, of such individual) is  
20 or was covered under such plan in connection with  
21 the status of such individual as such an employee,  
22 partner, or self-employed individual in relation to the  
23 plan.

24 “(8) APPLICABLE STATE AUTHORITY.—The  
25 term ‘applicable State authority’ means, with respect

1 to a health insurance issuer in a State, the State in-  
2 surance commissioner or official or officials des-  
3 igned by the State to enforce the requirements of  
4 title XXVII of the Public Health Service Act for the  
5 State involved with respect to such issuer.

6 “(9) QUALIFIED ACTUARY.—The term ‘quali-  
7 fied actuary’ means an individual who is a member  
8 of the American Academy of Actuaries or meets  
9 such reasonable standards and qualifications as the  
10 Secretary may provide by regulation.

11 “(10) AFFILIATED MEMBER.—The term ‘affili-  
12 ated member’ means, in connection with a sponsor,  
13 a person eligible to be a member of the sponsor or,  
14 in the case of a sponsor with member associations,  
15 a person who is a member, or is eligible to be a  
16 member, of a member association.

17 “(b) RULES OF CONSTRUCTION.—

18 “(1) EMPLOYERS AND EMPLOYEES.—For pur-  
19 poses of determining whether a plan, fund, or pro-  
20 gram is an employee welfare benefit plan which is an  
21 association health plan, and for purposes of applying  
22 this title in connection with such plan, fund, or pro-  
23 gram so determined to be such an employee welfare  
24 benefit plan—

1           “(A) in the case of a partnership, the term  
2           ‘employer’ (as defined in section (3)(5)) in-  
3           cludes the partnership in relation to the part-  
4           ners, and the term ‘employee’ (as defined in  
5           section (3)(6)) includes any partner in relation  
6           to the partnership, and

7           “(B) in the case of a self-employed individ-  
8           ual, the term ‘employer’ (as defined in section  
9           3(5)) and the term ‘employee’ (as defined in  
10          section 3(6)) shall include such individual.

11          “(2) PLANS, FUNDS, AND PROGRAMS TREATED  
12          AS EMPLOYEE WELFARE BENEFIT PLANS.—In the  
13          case of any plan, fund, or program which was estab-  
14          lished or is maintained for the purpose of providing  
15          medical care (through the purchase of insurance or  
16          otherwise) for employees (or their dependents) cov-  
17          ered thereunder and which demonstrates to the Sec-  
18          retary that all requirements for certification under  
19          this part would be met with respect to such plan,  
20          fund, or program if such plan, fund, or program  
21          were a group health plan, such plan, fund, or pro-  
22          gram shall be treated for purposes of this title as an  
23          employee welfare benefit plan on and after the date  
24          of such demonstration.”.

1 (b) CONFORMING AMENDMENTS TO PREEMPTION  
2 RULES.—

3 (1) Section 514(b)(6) of such Act (29 U.S.C.  
4 1144(b)(6)) is amended by adding at the end the  
5 following new subparagraph:

6 “(E) The preceding subparagraphs of this paragraph  
7 do not apply with respect to any State law in the case  
8 of an association health plan which is certified under part  
9 8.”.

10 (2) Section 514 of such Act (29 U.S.C. 1144)  
11 is amended—

12 (A) in subsection (b)(4), by striking “Sub-  
13 section (a)” and inserting “Subsections (a) and  
14 (d)”;

15 (B) in subsection (b)(5), by striking “sub-  
16 section (a)” in subparagraph (A) and inserting  
17 “subsection (a) of this section and subsections  
18 (a)(2)(B) and (b) of section 805”, and by strik-  
19 ing “subsection (a)” in subparagraph (B) and  
20 inserting “subsection (a) of this section or sub-  
21 section (a)(2)(B) or (b) of section 805”;

22 (C) by redesignating subsection (d) as sub-  
23 section (e); and

24 (D) by inserting after subsection (c) the  
25 following new subsection:

1       “(d)(1) Except as provided in subsection (b)(4), the  
2 provisions of this title shall supersede any and all State  
3 laws insofar as they may now or hereafter preclude a  
4 health insurance issuer from offering health insurance cov-  
5 erage in connection with an association health plan which  
6 is certified under part 8.

7       “(2) Except as provided in paragraphs (4) and (5)  
8 of subsection (b) of this section—

9           “(A) In any case in which health insurance cov-  
10 erage of any policy type is offered under an associa-  
11 tion health plan certified under part 8 to a partici-  
12 pating employer operating in such State, the provi-  
13 sions of this title shall supersede any and all laws  
14 of such State insofar as they may preclude a health  
15 insurance issuer from offering health insurance cov-  
16 erage of the same policy type to other employers op-  
17 erating in the State which are eligible for coverage  
18 under such association health plan, whether or not  
19 such other employers are participating employers in  
20 such plan.

21           “(B) In any case in which health insurance cov-  
22 erage of any policy type is offered under an associa-  
23 tion health plan in a State and the filing, with the  
24 applicable State authority, of the policy form in con-  
25 nection with such policy type is approved by such

1 State authority, the provisions of this title shall su-  
2 persede any and all laws of any other State in which  
3 health insurance coverage of such type is offered, in-  
4 sofar as they may preclude, upon the filing in the  
5 same form and manner of such policy form with the  
6 applicable State authority in such other State, the  
7 approval of the filing in such other State.

8 “(3) For additional provisions relating to association  
9 health plans, see subsections (a)(2)(B) and (b) of section  
10 805.

11 “(4) For purposes of this subsection, the term ‘asso-  
12 ciation health plan’ has the meaning provided in section  
13 801(a), and the terms ‘health insurance coverage’, ‘par-  
14 ticipating employer’, and ‘health insurance issuer’ have  
15 the meanings provided such terms in section 811, respec-  
16 tively.”.

17 (3) Section 514(b)(6)(A) of such Act (29  
18 U.S.C. 1144(b)(6)(A)) is amended—

19 (A) in clause (i)(II), by striking “and” at  
20 the end;

21 (B) in clause (ii), by inserting “and which  
22 does not provide medical care (within the mean-  
23 ing of section 733(a)(2)),” after “arrange-  
24 ment,” and by striking “title.” and inserting  
25 “title, and”; and

1 (C) by adding at the end the following new  
2 clause:

3 “(iii) subject to subparagraph (E), in the case  
4 of any other employee welfare benefit plan which is  
5 a multiple employer welfare arrangement and which  
6 provides medical care (within the meaning of section  
7 733(a)(2)), any law of any State which regulates in-  
8 surance may apply.”.

9 (c) PLAN SPONSOR.—Section 3(16)(B) of such Act  
10 (29 U.S.C. 102(16)(B)) is amended by adding at the end  
11 the following new sentence: “Such term also includes a  
12 person serving as the sponsor of an association health plan  
13 under part 8.”.

14 (d) SAVINGS CLAUSE.—Section 731(e) of such Act  
15 is amended by inserting “or part 8” after “this part”.

16 (e) CLERICAL AMENDMENT.—The table of contents  
17 in section 1 of the Employee Retirement Income Security  
18 Act of 1974 is amended by inserting after the item relat-  
19 ing to section 734 the following new items:

“PART 8—RULES GOVERNING ASSOCIATION HEALTH PLANS

- “Sec. 801. Association health plans.
- “Sec. 802. Certification of association health plans.
- “Sec. 803. Requirements relating to sponsors and boards of trustees.
- “Sec. 804. Participation and coverage requirements.
- “Sec. 805. Other requirements relating to plan documents, contribution rates,  
and benefit options.
- “Sec. 806. Maintenance of reserves and provisions for solvency for plans pro-  
viding health benefits in addition to health insurance coverage.
- “Sec. 807. Requirements for application and related requirements.
- “Sec. 808. Notice requirements for voluntary termination.
- “Sec. 809. Corrective actions and mandatory termination.



“Sec. 810. Special rules for church plans.

“Sec. 811. Definitions and rules of construction.”

1 **SEC. 5303. CLARIFICATION OF TREATMENT OF SINGLE EM-**  
2 **PLOYER ARRANGEMENTS.**

3 Section 3(40)(B) of the Employee Retirement Income  
4 Security Act of 1974 (29 U.S.C. 1002(40)(B)) is amend-  
5 ed—

6 (1) in clause (i), by inserting “for any plan year  
7 of any such plan, or any fiscal year of any such  
8 other arrangement;” after “single employer”, and by  
9 inserting “during such year or at any time during  
10 the preceding 1-year period” after “control group”;

11 (2) in clause (iii)—

12 (A) by striking “common control shall not  
13 be based on an interest of less than 25 percent”  
14 and inserting “an interest of greater than 25  
15 percent may not be required as the minimum  
16 interest necessary for common control”; and

17 (B) by striking “similar to” and inserting  
18 “consistent and coextensive with”;

19 (3) by redesignating clauses (iv) and (v) as  
20 clauses (v) and (vi), respectively; and

21 (4) by inserting after clause (iii) the following  
22 new clause:

23 “(iv) in determining, after the application of  
24 clause (i), whether benefits are provided to employ-

1       ees of two or more employers, the arrangement shall  
2       be treated as having only 1 participating employer  
3       if, after the application of clause (i), the number of  
4       individuals who are employees and former employees  
5       of any one participating employer and who are cov-  
6       ered under the arrangement is greater than 75 per-  
7       cent of the aggregate number of all individuals who  
8       are employees or former employees of participating  
9       employers and who are covered under the arrange-  
10      ment.”.

11 **SEC. 5304. CLARIFICATION OF TREATMENT OF CERTAIN**  
12                   **COLLECTIVELY    BARGAINED    ARRANGE-**  
13                   **MENTS.**

14       (a) IN GENERAL.—Section 3(40)(A)(i) of the Em-  
15       ployee Retirement Income Security Act of 1974 (29  
16       U.S.C. 1002(40)(A)(i)) is amended to read as follows:

17               “(i)(I) under or pursuant to one or more collec-  
18       tive bargaining agreements which are reached pursu-  
19       ant to collective bargaining described in section 8(d)  
20       of the National Labor Relations Act (29 U.S.C.  
21       158(d)) or paragraph Fourth of section 2 of the  
22       Railway Labor Act (45 U.S.C. 152, paragraph  
23       Fourth) or which are reached pursuant to labor-  
24       management negotiations under similar provisions of

1 State public employee relations laws, and (II) in ac-  
2 cordance with subparagraphs (C), (D), and (E),”.

3 (b) LIMITATIONS.—Section 3(40) of such Act (29  
4 U.S.C. 1002(40)) is amended by adding at the end the  
5 following new subparagraphs:

6 “(C) For purposes of subparagraph (A)(i)(II), a plan  
7 or other arrangement shall be treated as established or  
8 maintained in accordance with this subparagraph only if  
9 the following requirements are met:

10 “(i) The plan or other arrangement, and the  
11 employee organization or any other entity sponsoring  
12 the plan or other arrangement, do not—

13 “(I) utilize the services of any licensed in-  
14 surance agent or broker for soliciting or enroll-  
15 ing employers or individuals as participating  
16 employers or covered individuals under the plan  
17 or other arrangement; or

18 “(II) pay a commission or any other type  
19 of compensation to a person, other than a full  
20 time employee of the employee organization (or  
21 a member of the organization to the extent pro-  
22 vided in regulations of the Secretary), that is  
23 related either to the volume or number of em-  
24 ployers or individuals solicited or enrolled as  
25 participating employers or covered individuals

1           under the plan or other arrangement, or to the  
2           dollar amount or size of the contributions made  
3           by participating employers or covered individ-  
4           uals to the plan or other arrangement;

5           except to the extent that the services used by the  
6           plan, arrangement, organization, or other entity con-  
7           sist solely of preparation of documents necessary for  
8           compliance with the reporting and disclosure re-  
9           quirements of part 1 or administrative, investment,  
10          or consulting services unrelated to solicitation or en-  
11          rollment of covered individuals.

12           “(ii) As of the end of the preceding plan year,  
13          the number of covered individuals under the plan or  
14          other arrangement who are identified to the plan or  
15          arrangement and who are neither—

16           “(I) employed within a bargaining unit  
17          covered by any of the collective bargaining  
18          agreements with a participating employer (nor  
19          covered on the basis of an individual’s employ-  
20          ment in such a bargaining unit); nor

21           “(II) present employees (or former employ-  
22          ees who were covered while employed) of the  
23          sponsoring employee organization, of an em-  
24          ployer who is or was a party to any of the col-  
25          lective bargaining agreements, or of the plan or

1           other arrangement or a related plan or arrange-  
2           ment (nor covered on the basis of such present  
3           or former employment);  
4           does not exceed 15 percent of the total number of  
5           individuals who are covered under the plan or ar-  
6           rangement and who are present or former employees  
7           who are or were covered under the plan or arrange-  
8           ment pursuant to a collective bargaining agreement  
9           with a participating employer. The requirements of  
10          the preceding provisions of this clause shall be treat-  
11          ed as satisfied if, as of the end of the preceding plan  
12          year, such covered individuals are comprised solely  
13          of individuals who were covered individuals under  
14          the plan or other arrangement as of the date of the  
15          enactment of the Expansion of Portability and  
16          Health Insurance Coverage Act of 1997 and, as of  
17          the end of the preceding plan year, the number of  
18          such covered individuals does not exceed 25 percent  
19          of the total number of present and former employees  
20          enrolled under the plan or other arrangement.

21               “(iii) The employee organization or other entity  
22               sponsoring the plan or other arrangement certifies  
23               to the Secretary each year, in a form and manner  
24               which shall be prescribed in regulations of the Sec-

1       retary that the plan or other arrangement meets the  
2       requirements of clauses (i) and (ii).

3       “(D) For purposes of subparagraph (A)(i)(II), a plan  
4       or arrangement shall be treated as established or main-  
5       tained in accordance with this subparagraph only if—

6               “(i) all of the benefits provided under the plan  
7       or arrangement consist of health insurance coverage;  
8       or

9               “(ii)(I) the plan or arrangement is a multiem-  
10       ployer plan; and

11              “(II) the requirements of clause (B) of the pro-  
12       viso to clause (5) of section 302(c) of the Labor  
13       Management Relations Act, 1947 (29 U.S.C.  
14       186(c)) are met with respect to such plan or other  
15       arrangement.

16       “(E) For purposes of subparagraph (A)(i)(II), a plan  
17       or arrangement shall be treated as established or main-  
18       tained in accordance with this subparagraph only if—

19              “(i) the plan or arrangement is in effect as of  
20       the date of the enactment of the Expansion of Port-  
21       ability and Health Insurance Coverage Act of 1997,  
22       or

23              “(ii) the employee organization or other entity  
24       sponsoring the plan or arrangement—

1           “(I) has been in existence for at least 3  
2           years or is affiliated with another employee or-  
3           organization which has been in existence for at  
4           least 3 years, or

5           “(II) demonstrates to the satisfaction of  
6           the Secretary that the requirements of subpara-  
7           graphs (C) and (D) are met with respect to the  
8           plan or other arrangement.”.

9           (c) CONFORMING AMENDMENTS TO DEFINITIONS OF  
10          PARTICIPANT AND BENEFICIARY.—Section 3(7) of such  
11          Act (29 U.S.C. 1002(7)) is amended by adding at the end  
12          the following new sentence: “Such term includes an indi-  
13          vidual who is a covered individual described in paragraph  
14          (40)(C)(ii).”.

15          **SEC. 5305. ENFORCEMENT PROVISIONS RELATING TO ASSO-**  
16                                **CIATION HEALTH PLANS.**

17          (a) CRIMINAL PENALTIES FOR CERTAIN WILLFUL  
18          MISREPRESENTATIONS.—Section 501 of the Employee  
19          Retirement Income Security Act of 1974 (29 U.S.C. 1131)  
20          is amended—

21                       (1) by inserting “(a)” after “SEC. 501.”; and

22                       (2) by adding at the end the following new sub-  
23          section:

24                       “(b) Any person who, either willfully or with willful  
25          blindness, falsely represents, to any employee, any employ-

1 ee’s beneficiary, any employer, the Secretary, or any State,  
2 a plan or other arrangement established or maintained for  
3 the purpose of offering or providing any benefit described  
4 in section 3(1) to employees or their beneficiaries as—

5 “(1) being an association health plan which has  
6 been certified under part 8;

7 “(2) having been established or maintained  
8 under or pursuant to one or more collective bargain-  
9 ing agreements which are reached pursuant to col-  
10 lective bargaining described in section 8(d) of the  
11 National Labor Relations Act (29 U.S.C. 158(d)) or  
12 paragraph Fourth of section 2 of the Railway Labor  
13 Act (45 U.S.C. 152, paragraph Fourth) or which are  
14 reached pursuant to labor-management negotiations  
15 under similar provisions of State public employee re-  
16 lations laws; or

17 “(3) being a plan or arrangement with respect  
18 to which the requirements of subparagraph (C), (D),  
19 or (E) of section 3(40) are met;

20 shall, upon conviction, be imprisoned not more than five  
21 years, be fined under title 18, United States Code, or  
22 both.”.

23 (b) CEASE ACTIVITIES ORDERS.—Section 502 of  
24 such Act (29 U.S.C. 1132) is amended by adding at the  
25 end the following new subsection:



1       “(n)(1) Subject to paragraph (2), upon application  
2 by the Secretary showing the operation, promotion, or  
3 marketing of an association health plan (or similar ar-  
4 rangement providing benefits consisting of medical care  
5 (as defined in section 733(a)(2))) that—

6               “(A) is not certified under part 8, is subject  
7 under section 514(b)(6) to the insurance laws of any  
8 State in which the plan or arrangement offers or  
9 provides benefits, and is not licensed, registered, or  
10 otherwise approved under the insurance laws of such  
11 State; or

12               “(B) is an association health plan certified  
13 under part 8 and is not operating in accordance with  
14 the requirements under part 8 for such certification,  
15 a district court of the United States shall enter an order  
16 requiring that the plan or arrangement cease activities.

17       “(2) Paragraph (1) shall not apply in the case of an  
18 association health plan or other arrangement if the plan  
19 or arrangement shows that—

20               “(A) all benefits under it referred to in para-  
21 graph (1) consist of health insurance coverage; and

22               “(B) with respect to each State in which the  
23 plan or arrangement offers or provides benefits, the  
24 plan or arrangement is operating in accordance with

1 applicable State laws that are not superseded under  
2 section 514.

3 “(3) The court may grant such additional equitable  
4 relief, including any relief available under this title, as it  
5 deems necessary to protect the interests of the public and  
6 of persons having claims for benefits against the plan.”.

7 (c) RESPONSIBILITY FOR CLAIMS PROCEDURE.—  
8 Section 503 of such Act (29 U.S.C. 1133) is amended by  
9 adding at the end (after and below paragraph (2)) the fol-  
10 lowing new sentence:

11 “The terms of each association health plan which is or  
12 has been certified under part 8 shall require the board  
13 of trustees or the named fiduciary (as applicable) to en-  
14 sure that the requirements of this section are met in con-  
15 nection with claims filed under the plan.”.

16 **SEC. 5306. COOPERATION BETWEEN FEDERAL AND STATE**  
17 **AUTHORITIES.**

18 Section 506 of the Employee Retirement Income Se-  
19 curity Act of 1974 (29 U.S.C. 1136) is amended by adding  
20 at the end the following new subsection:

21 “(c) RESPONSIBILITY OF STATES WITH RESPECT TO  
22 ASSOCIATION HEALTH PLANS.—

23 “(1) AGREEMENTS WITH STATES.—A State  
24 may enter into an agreement with the Secretary for  
25 delegation to the State of some or all of the Sec-

1       retary’s authority under sections 502 and 504 to en-  
2       force the requirements for certification under part 8.  
3       The Secretary shall enter into the agreement if the  
4       Secretary determines that the delegation provided  
5       for therein would not result in a lower level or qual-  
6       ity of enforcement of the provisions of this title.

7               “(2) DELEGATIONS.—Any department, agency,  
8       or instrumentality of a State to which authority is  
9       delegated pursuant to an agreement entered into  
10      under this paragraph may, if authorized under State  
11      law and to the extent consistent with such agree-  
12      ment, exercise the powers of the Secretary under  
13      this title which relate to such authority.

14              “(3) RECOGNITION OF PRIMARY DOMICILE  
15      STATE.—In entering into any agreement with a  
16      State under subparagraph (A), the Secretary shall  
17      ensure that, as a result of such agreement and all  
18      other agreements entered into under subparagraph  
19      (A), only one State will be recognized, with respect  
20      to any particular association health plan, as the pri-  
21      mary domicile State to which authority has been del-  
22      egated pursuant to such agreements.”.

23   **SEC. 5307. EFFECTIVE DATE AND TRANSITIONAL RULES.**

24              (a) EFFECTIVE DATE.—The amendments made by  
25      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.—

1 (A) The table of sections for chapter 20 of  
2 such title is amended by repealing the item re-  
3 lating to section 2004.

4 (B) Section 2003(e)(2) of such title is  
5 amended by striking “sections 2401 and 2004”  
6 each place it appears and inserting “section  
7 2401”.

8 (b) CLARIFICATION THAT LIABILITIES FORMERLY  
9 PAID PURSUANT TO SECTION 2004 REMAIN LIABILITIES  
10 PAYABLE BY THE POSTAL SERVICE.—Section 2003 of  
11 title 39, United States Code, is amended by adding at the  
12 end the following:

13 “(h) Liabilities of the former Post Office Department  
14 to the Employees’ Compensation Fund (appropriations for  
15 which were authorized by former section 2004, as in effect  
16 before the effective date of this subsection) shall be liabil-  
17 ities of the Postal Service payable out of the Fund.”.

18 (c) EFFECTIVE DATE.—

19 (1) IN GENERAL.—This section and the amend-  
20 ments made by this section shall take effect on the  
21 date of the enactment of this Act or October 1,  
22 1997, whichever is later.

23 (2) PROVISIONS RELATING TO PAYMENTS FOR  
24 FISCAL YEAR 1998.—

1 (A) AMOUNTS NOT YET PAID.—No pay-  
2 ment may be made to the Postal Service Fund,  
3 on or after the date of the enactment of this  
4 Act, pursuant to any appropriation for fiscal  
5 year 1998 authorized by section 2004 of title  
6 39, United States Code (as in effect before the  
7 effective date of this section).

8 (B) AMOUNTS PAID.—If any payment to  
9 the Postal Service Fund is or has been made  
10 pursuant to an appropriation for fiscal year  
11 1998 authorized by such section 2004, then, an  
12 amount equal to the amount of such payment  
13 shall be paid from such Fund into the Treasury  
14 as miscellaneous receipts before October 1,  
15 1998.

## 16 **Subtitle B—Civil Service**

### 17 **SEC. 6101. CONTRIBUTIONS UNDER THE CIVIL SERVICE RE-** 18 **TIREMENT SYSTEM.**

19 (a) INDIVIDUAL CONTRIBUTIONS.—

20 (1) IN GENERAL.—Subsection (c) of sec-  
21 tion 8334 of title 5, United States Code, is  
22 amended to read as follows:

23 “(c) Each employee or Member credited with civilian  
24 service after July 31, 1920, for which retirement deduc-  
25 tions or deposits have not been made, may deposit with

- 1 interest an amount equal to the following percentages of  
 2 his basic pay received for that service:

	“Per- centage 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 Octo- ber 31, 1956.
	6.50 .....	November 1, 1956, to December 31, 1969.
	7 .....	January 1, 1970, to De- cember 31, 1998.
	7.25 .....	January 1, 1999, to De- cember 31, 1999.
	7.40 .....	January 1, 2000, to De- cember 31, 2000.
	7.50 .....	January 1, 2001, to De- cember 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 Octo- ber 31, 1956.
	6.50 .....	November 1, 1956, to December 31, 1969.
	7.50 .....	January 1, 1970, to De- cember 31, 1998.
	7.75 .....	January 1, 1999, to De- cember 31, 1999.
	7.90 .....	January 1, 2000, to De- cember 31, 2000.
	8 .....	January 1, 2001, to De- cember 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.

	“Per- centage 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 June 30, 1926.
	3.50 .....	July 1, 1926, to June 30, 1942.
	5 .....	July 1, 1942, to June 30, 1948.
	6 .....	July 1, 1948, to October 31, 1956.
	6.50 .....	November 1, 1956, to December 31, 1969.
	7 .....	January 1, 1970, to December 31, 1974.
	7.50 .....	January 1, 1975, to December 31, 1998.
	7.75 .....	January 1, 1999, to December 31, 1999.
	7.90 .....	January 1, 2000, to December 31, 2000.
	8 .....	January 1, 2001, to December 31, 2002.
	7.50 .....	After December 31, 2002.
Bankruptcy judge .....	2.50 .....	August 1, 1920, to June 30, 1926.
	3.50 .....	July 3, 1926, to June 30, 1942.
	5 .....	July 1, 1942, to June 30, 1948.
	6 .....	July 1, 1948, to October 31, 1956.
	6.50 .....	November 1, 1956, to December 31, 1969.



	“Per- centage 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.

	“Per- centage 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.

1 Notwithstanding the preceding provisions of this sub-  
2 section and any provision of section 206(b)(3) of the Fed-  
3 eral Employees’ Retirement Contribution Temporary Ad-  
4 justment Act of 1983, the percentage of basic pay required  
5 under this subsection in the case of an individual described  
6 in section 8402(b)(2) shall, with respect to any covered  
7 service (as defined by section 203(a)(3) of such Act) per-  
8 formed by such individual after December 31, 1983, and

1 before January 1, 1987, be equal to 1.3 percent, and, with  
2 respect to any such service performed after December 31,  
3 1986, be equal to the amount that would have been de-  
4 ducted from the employee's basic pay under subsection (k)  
5 of this section if the employee's pay had been subject to  
6 that subsection during such period.”.

7           (2) DEDUCTIONS.—The first sentence of section  
8 8334(a)(1) of title 5, United States Code, is amend-  
9 ed to read as follows: “The employing agency shall  
10 deduct and withhold from the basic pay of an em-  
11 ployee, Member, Congressional employee, law en-  
12 forcement officer, firefighter, bankruptcy judge,  
13 judge of the United States Court of Appeals for the  
14 Armed Forces, United States magistrate, or Claims  
15 Court judge, as the case may be, the percentage of  
16 basic pay applicable under subsection (e).”.

17           (3) OTHER SERVICE.—

18           (A) MILITARY SERVICE.—Section 8334(j)  
19 of title 5, United States Code, is amended—

20           (i) in paragraph (1)(A) by inserting  
21 “and subject to paragraph (5),” after “Ex-  
22 cept as provided in subparagraph (B),”;  
23 and

24           (ii) by adding at the end the follow-  
25 ing:

1       “(5) Effective with respect to any period of military  
2 service performed after December 31, 1998, and before  
3 January 1, 2003, the percentage of basic pay under sec-  
4 tion 204 of title 37 payable under paragraph (1) shall be  
5 equal to the same percentage as would be applicable under  
6 section 8334(c) for that same period for service as an ‘em-  
7 ployee’, subject to paragraph (1)(B).”.

8                   (B)     VOLUNTEER     SERVICE.—Section  
9                   8334(l) of title 5, United States Code, is  
10                  amended—

11                           (i) in paragraph (1) by striking the  
12                           period at the end and inserting “, subject  
13                           to paragraph (4).”; and

14                           (ii) by adding at the end the follow-  
15                           ing:

16       “(4) Effective with respect to any period of service  
17 as a volunteer or volunteer leader performed after Decem-  
18 ber 31, 1998, and before January 1, 2003, the percentage  
19 of the readjustment allowance or stipend (as the case may  
20 be) payable under paragraph (1) shall be equal to the  
21 same percentage as would be applicable under section  
22 8334(c) for that same period for service as an ‘em-  
23 ployee’.”.

24                   (b) GOVERNMENT CONTRIBUTIONS.—

1           (1) IN GENERAL.—Section 8334 of title 5,  
2           United States Code, is amended by adding at the  
3           end the following:

4           “(m)(1) This subsection shall govern for purposes of  
5           determining the amount to be contributed under the sec-  
6           ond sentence of subsection (a)(1) with respect to any serv-  
7           ice—

8           “(A) which is performed after September 30,  
9           1997, and before January 1, 2003; and

10           “(B) as to which a contribution under such sen-  
11           tence would otherwise be payable.

12           “(2) The amount of the contribution required under  
13           the second sentence of subsection (a)(1) with respect to  
14           any service described in paragraph (1) shall (instead of  
15           the amount which would otherwise apply under such sen-  
16           tence) be equal to the amount of basic pay received for  
17           such service by the employee or Member involved, multi-  
18           plied by the percentage under paragraph (3).

19           “(3)(A) The percentage under this paragraph is, with  
20           respect to any service, equal to the sum of—

21           “(i) the percentage which would have been ap-  
22           plicable under subsection (c), with respect to such  
23           service, if it had been performed in fiscal year 1997,  
24           plus

1           “(ii) the applicable percentage under subpara-  
2           graph (B).

3           “(B) The applicable percentage under this subpara-  
4           graph is, with respect to service performed—

5           “(i) after September 30, 1997, and before Octo-  
6           ber 1, 2002, 1.51 percent; or

7           “(ii) after September 30, 2002, and before Jan-  
8           uary 1, 2003, 0 percent.

9           “(4) An amount determined under this subsection  
10          with respect to any period of service shall, for purposes  
11          of subsection (k)(1)(B) (and any other provision of law  
12          which similarly refers to contributions under the second  
13          sentence of subsection (a)(1)), be treated as the amount  
14          required under such sentence with respect to such service.

15          “(5)(A) Notwithstanding paragraphs (1) through (4),  
16          the amount to be contributed by the Postal Service by rea-  
17          son of the second sentence of subsection (a)(1) with re-  
18          spect to any service performed by an officer or employee  
19          of the Postal Service during the period described in sub-  
20          paragraph (A) of paragraph (1) shall be determined as  
21          if section 6101 of the Balanced Budget Act of 1997 had  
22          never been enacted.

23          “(B) For purposes of this paragraph, the term ‘Post-  
24          al Service’ means the United States Postal Service and  
25          the Postal Rate Commission.”.

1           (2) CONFORMING AMENDMENT.—The second  
 2 sentence of section 8334(a)(1) of title 5, United  
 3 States Code, is amended by striking the period and  
 4 inserting “, subject to subsection (m).”.

5 **SEC. 6102. CONTRIBUTIONS UNDER THE FEDERAL EMPLOY-**  
 6 **EES’ RETIREMENT SYSTEM.**

7 (a) INDIVIDUAL CONTRIBUTIONS.—

8           (1) IN GENERAL.—Subsection (a) of section  
 9 8422 of title 5, United States Code, is amended—

10           (A) in paragraph (1) by striking “para-  
 11 graph (2).” and inserting “paragraph (2) or  
 12 (3), as applicable.”;

13           (B) in paragraph (2) by striking “The ap-  
 14 plicable” and inserting “Subject to paragraph  
 15 (3), the applicable”; and

16           (C) by adding at the end the following:

17           “(3)(A) The applicable percentage under this sub-  
 18 section shall, for purposes of service performed after De-  
 19 cember 31, 1998, and before January 1, 2003, be equal  
 20 to—

21           “(i) the applicable percentage under subpara-  
 22 graph (B), minus

23           “(ii) the percentage then in effect under section  
 24 3101(a) of the Internal Revenue Code of 1986 (re-

1 relating to rate of tax for old-age, survivors, and dis-  
 2 ability insurance).

3 “(B) The applicable percentage under this subpara-  
 4 graph shall be as follows:

	“Per- centage of basic pay	Service period
Employee .....	7.25 .....	January 1, 1999, to De- cember 31, 1999.
	7.40 .....	January 1, 2000, to De- cember 31, 2000.
	7.50 .....	January 1, 2001, to De- cember 31, 2002.
Congressional employee .....	7.75 .....	January 1, 1999, to De- cember 31, 1999.
	7.90 .....	January 1, 2000, to De- cember 31, 2000.
	8 .....	January 1, 2001, to De- cember 31, 2002.
Member .....	7.75 .....	January 1, 1999, to De- cember 31, 1999.
	7.90 .....	January 1, 2000, to De- cember 31, 2000.
	8 .....	January 1, 2001, to De- cember 31, 2002.
Law enforcement officer .....	7.75 .....	January 1, 1999, to De- cember 31, 1999.
	7.90 .....	January 1, 2000, to De- cember 31, 2000.
	8 .....	January 1, 2001, to De- cember 31, 2002.
Firefighter .....	7.75 .....	January 1, 1999, to De- cember 31, 1999.
	7.90 .....	January 1, 2000, to De- cember 31, 2000.
	8 .....	January 1, 2001, to De- cember 31, 2002.
Air traffic controller .....	7.75 .....	January 1, 1999, to De- cember 31, 1999.
	7.90 .....	January 1, 2000, to De- cember 31, 2000.
	8 .....	January 1, 2001, to De- cember 31, 2002.”.

5 (2) OTHER SERVICE.—



1 (A) MILITARY SERVICE.—Section 8422(e)  
2 of title 5, United States Code, is amended—

3 (i) in paragraph (1)(A) by inserting  
4 “and subject to paragraph (5),” after “Ex-  
5 cept as provided in subparagraph (B),”;  
6 and

7 (ii) by adding at the end the follow-  
8 ing:

9 “(5) Effective with respect to any period of military  
10 service performed after December 31, 1998, and before  
11 January 1, 2003, the percentage of basic pay under sec-  
12 tion 204 of title 37 payable under paragraph (1) shall be  
13 equal to the sum of the percentage specified in paragraph  
14 (1), plus—

15 “(A) .25 percent, if performed after December  
16 31, 1998, and before January 1, 2000;

17 “(B) .40 percent, if performed after December  
18 31, 1999, and before January 1, 2001;

19 “(C) .50 percent, if performed after December  
20 31, 2000, and before January 1, 2003.”.

21 (B) VOLUNTEER SERVICE.—Section  
22 8422(f) of title 5, United States Code, is  
23 amended—

1 (i) in paragraph (1) by striking the  
2 period at the end and inserting “, subject  
3 to paragraph (4).”; and

4 (ii) by adding at the end the follow-  
5 ing:

6 “(4) Effective with respect to any period of service  
7 as a volunteer or volunteer leader performed after Decem-  
8 ber 31, 1998, and before January 1, 2003, the percentage  
9 of the readjustment allowance or stipend (as the case may  
10 be) payable under paragraph (1) shall be equal to the sum  
11 of the percentage specified in paragraph (1), plus—

12 “(A) .25 percent, if performed after December  
13 31, 1998, and before January 1, 2000;

14 “(B) .40 percent, if performed after December  
15 31, 1999, and before January 1, 2001;

16 “(C) .50 percent, if performed after December  
17 31, 2000, and before January 1, 2003.”.

18 (b) GOVERNMENT CONTRIBUTIONS.—

19 (1) IN GENERAL.—Section 8423 of title 5,  
20 United States Code, is amended by adding at the  
21 end the following:

22 “(d)(1) This subsection shall govern for purposes of  
23 determining the amount to be contributed by an employing  
24 agency for any period (or portion thereof)—

1           “(A) which is occurs after September 30, 1997,  
2           and before January 1, 2003; and

3           “(B) as to which a contribution under sub-  
4           section (a) would otherwise be payable by such agen-  
5           cy.

6           “(2) The amount of the contribution required under  
7           subsection (a) with respect to any period (or portion there-  
8           of) described in paragraph (1) shall (instead of the  
9           amount which would otherwise apply) be equal to the  
10          amount which would be required under subsection (a) if  
11          section 6102(a) of the Balanced Budget Act of 1997 had  
12          never been enacted.”.

13           (2)       CONFORMING        AMENDMENT.—Section  
14           8423(a)(1) of title 5, United States Code, is amend-  
15           ed by striking “Each” and inserting “Subject to  
16           subsection (d), each”.

17   **SEC. 6103. GOVERNMENT CONTRIBUTION FOR HEALTH**  
18                           **BENEFITS.**

19           (a) IN GENERAL.—Section 8906 of title 5, United  
20           States Code, is amended by striking subsection (a) and  
21           all that follows through the end of paragraph (1) of sub-  
22           section (b) and inserting the following:

23           “(a)(1) The Office of Personnel Management shall,  
24           not later than October 1 of each year, determine the  
25           weighted average of the subscription charges that will be

1 in effect during the following contract year with respect  
2 to—

3           “(A) enrollments under this chapter for self  
4           alone; and

5           “(B) enrollments under this chapter for self  
6           and family.

7           “(2) In determining each weighted average under  
8 paragraph (1), the weight to be given to a particular sub-  
9 scription charge shall, with respect to each plan (and op-  
10 tion) to which it is to apply, be commensurate with the  
11 number of enrollees enrolled in such plan (and option) as  
12 of March 31 of the year in which the determination is  
13 being made.

14           “(3) For purposes of paragraph (2), the term ‘en-  
15 rollee’ means any individual who, during the contract year  
16 for which the weighted average is to be used under this  
17 section, will be eligible for a Government contribution for  
18 health benefits.

19           “(b)(1) Except as provided in paragraphs (2) and  
20 (3), the biweekly Government contribution for health bene-  
21 fits for an employee or annuitant enrolled in a health bene-  
22 fits plan under this chapter is adjusted to an amount equal  
23 to 72 percent of the weighted average under subsection  
24 (a)(1)(A) or (B), as applicable. For an employee, the ad-  
25 justment begins on the first day of the employee’s first

1 pay period of each year. For an annuitant, the adjustment  
2 begins on the first day of the first period of each year  
3 for which an annuity payment is made.”.

4 (b) EFFECTIVE DATE.—This section and the amend-  
5 ment made by this section shall take effect on the first  
6 day of the contract year that begins in 1999, except that  
7 nothing in this subsection shall prevent the Office of Per-  
8 sonnel Management from taking any action, before such  
9 first day, which it considers necessary in order to ensure  
10 the timely implementation of such amendment.

11 **SEC. 6104. EFFECTIVE DATE.**

12 (a) IN GENERAL.—Except as provided in section  
13 6103, this subtitle shall take effect on—

14 (1) October 1, 1997; or

15 (2) if later, the date of the enactment of this  
16 Act.

17 (b) SPECIAL RULE.—If the date of the enactment of  
18 this Act is later than October 1, 1997, then, for purposes  
19 of applying the amendments made by sections 6101 and  
20 6102—

21 (1) any reference in any such amendment to  
22 “September 30, 1997” shall be treated as referring  
23 to the day before the date of the enactment of this  
24 Act; and

1           (2) any reference in any such amendment to  
2           “October 1, 1997” shall be treated as referring to  
3           the date of the enactment of this Act.

4   **TITLE       VII—COMMITTEE       ON**  
5           **TRANSPORTATION   AND   IN-**  
6           **FRASTRUCTURE**

7   **SEC. 7001. EXTENSION OF HIGHER VESSEL TONNAGE DU-**  
8           **TIES.**

9           (a) EXTENSION OF DUTIES.—Section 36 of the Act  
10 of August 5, 1909 (36 Stat. 111; 46 U.S.C. App. 121),  
11 is amended by striking “for fiscal years 1991, 1992, 1993,  
12 1994, 1995, 1996, 1997, 1998,” each place it appears and  
13 inserting “for fiscal years through fiscal year 2002,”.

14          (b) CONFORMING AMENDMENT.—The Act entitled  
15 “An Act concerning tonnage duties on vessels entering  
16 otherwise than by sea”, approved March 8, 1910 (36 Stat.  
17 234; 46 U.S.C. App. 132), is amended by striking “for  
18 fiscal years 1991, 1992, 1993, 1994, 1995, 1996, 1997,  
19 and 1998,” and inserting “for fiscal years through fiscal  
20 year 2002,”.

21   **SEC. 7002. SALE OF GOVERNORS ISLAND, NEW YORK.**

22          (a) IN GENERAL.—Notwithstanding any other provi-  
23 sion of law, no earlier than fiscal year 2002, the Adminis-  
24 trator of General Services shall dispose of by sale at fair  
25 market value all rights, title, and interests of the United

1 States in and to the land of, and improvements to, Gov-  
2 ernors Island, New York.

3 (b) RIGHT OF FIRST REFUSAL.—Before a sale is  
4 made under subsection (a) to any other parties, the State  
5 of New York and the city of New York shall be given the  
6 right of first refusal to purchase all or part of Governors  
7 Island. Such right may be exercised by either the State  
8 of New York or the city of New York or by both parties  
9 acting jointly.

10 (c) PROCEEDS.—Proceeds from the disposal of Gov-  
11 ernors Island under subsection (a) shall be deposited in  
12 the general fund of the Treasury and credited as mis-  
13 cellaneous receipts.

14 **SEC. 7003. SALE OF AIR RIGHTS.**

15 (a) IN GENERAL.—Notwithstanding any other provi-  
16 sion of law, the Administrator of General Services shall  
17 sell, at fair market value and in a manner to be deter-  
18 mined by the Administrator, the air rights adjacent to  
19 Washington Union Station described in subsection (b), in-  
20 cluding air rights conveyed to the Administrator under  
21 subsection (d). The Administrator shall complete the sale  
22 by such date as is necessary to ensure that the proceeds  
23 from the sale will be deposited in accordance with sub-  
24 section (c).

1 (b) DESCRIPTION.—The air rights referred to in sub-  
2 section (a) total approximately 16.5 acres and are depicted  
3 on the plat map of the District of Columbia as follows:

4 (1) Part of lot 172, square 720.

5 (2) Part of lots 172 and 823, square 720.

6 (3) Part of lot 811, square 717.

7 (c) PROCEEDS.—Before September 30, 2002, pro-  
8 ceeds from the sale of air rights under subsection (a) shall  
9 be deposited in the general fund of the Treasury and cred-  
10 ited as miscellaneous receipts.

11 (d) CONVEYANCE OF AMTRAK AIR RIGHTS.—

12 (1) GENERAL RULE.—As a condition of future  
13 Federal financial assistance, Amtrak shall convey to  
14 the Administrator of General Services on or before  
15 December 31, 1997, at no charge, all of the air  
16 rights of Amtrak described in subsection (b).

17 (2) FAILURE TO COMPLY.—If Amtrak does not  
18 meet the condition established by paragraph (1),  
19 Amtrak shall be prohibited from obligating Federal  
20 funds after March 1, 1998.

21 **TITLE VIII—COMMITTEE ON**  
22 **VETERANS' AFFAIRS**

23 **SEC. 8001. SHORT TITLE; TABLE OF CONTENTS.**

24 (a) SHORT TITLE.—This title may be cited as the  
25 “Veterans Reconciliation Act of 1997”.



1 (b) TABLE OF CONTENTS.—The table of contents for  
 2 this title is as follows:

Sec. 8001. Short title; table of contents.

Subtitle A—Extension of Temporary Authorities

Sec. 8011. Authority to require that certain veterans make copayments in exchange for receiving health-care benefits.

Sec. 8012. Medical care cost recovery for non-service-connected disabilities of service-connected veterans.

Sec. 8013. Department of Veterans Affairs medical-care receipts.

Sec. 8014. Income verification authority.

Sec. 8015. Limitation on pension for certain recipients of medicaid-covered nursing home care.

Sec. 8016. Home loan fees.

Sec. 8017. Procedures applicable to liquidation sales on defaulted home loans guaranteed by the Secretary of Veterans Affairs.

Sec. 8018. Enhanced loan asset sale authority.

Subtitle B—Other Matters

Sec. 8021. Rounding down of cost-of-living adjustments in compensation and DIC rates.

Sec. 8022. Withholding of payments and benefits.

3 **Subtitle A—Extension of**  
 4 **Temporary Authorities**

5 **SEC. 8011. AUTHORITY TO REQUIRE THAT CERTAIN VETER-**  
 6 **ANS MAKE COPAYMENTS IN EXCHANGE FOR**  
 7 **RECEIVING HEALTH-CARE BENEFITS.**

8 (a) HOSPITAL AND MEDICAL CARE.—

9 (1) EXTENSION.—Section 1710(f)(2)(B) of title  
 10 38, United States Code, is amended by inserting  
 11 “before September 30, 2002,” after “(B)”.

12 (2) REPEAL OF SUPERSEDED PROVISION.—Sec-  
 13 tion 8013(e) of the Omnibus Budget Reconciliation  
 14 Act of 1990 (38 U.S.C. 1710 note) is repealed.

1 (b) OUTPATIENT MEDICATIONS.—Section 1722A(c)  
2 of title 38, United States Code, is amended by striking  
3 out “September 30, 1998” and inserting in lieu thereof  
4 “September 30, 2002”.

5 **SEC. 8012. MEDICAL CARE COST RECOVERY FOR NON-SERV-**  
6 **ICE-CONNECTED DISABILITIES OF SERVICE-**  
7 **CONNECTED VETERANS.**

8 Section 1729(a)(2)(E) of title 38, United States  
9 Code, is amended by striking out “before October 1,  
10 1998,” and inserting “before October 1, 2002,”.

11 **SEC. 8013. DEPARTMENT OF VETERANS AFFAIRS MEDICAL-**  
12 **CARE RECEIPTS.**

13 (a) ALLOCATION OF RECEIPTS.—(1) Chapter 17 of  
14 title 38, United States Code, is amended by inserting after  
15 section 1729 the following new section:

16 **“§ 1729A. Department of Veterans Affairs Medical**  
17 **Care Collections Fund**

18 “(a) There is in the Treasury a fund to be known  
19 as the Department of Veterans Affairs Medical Care Col-  
20 lections Fund.

21 “(b) Amounts recovered or collected after September  
22 30, 1997, under any of the following provisions of law  
23 shall be deposited in the fund:

24 “(1) Section 1710(f) of this title.

25 “(2) Section 1710(g) of this title.

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1 “(3) Section 1711 of this title.

2 “(4) Section 1722A of this title.

3 “(5) Section 1729 of this title.

4 “(6) Public Law 87–693, popularly known as  
5 the ‘Federal Medical Care Recovery Act’ (42 U.S.C.  
6 2651 et seq.), to the extent that a recovery or collec-  
7 tion under that law is based on medical care or serv-  
8 ices furnished under this chapter.

9 “(c)(1) Amounts in the fund are available to the Sec-  
10 retary for the following purposes:

11 “(A) Furnishing medical care and services  
12 under this chapter, to be available during any fiscal  
13 year for the same purposes and subject to the same  
14 limitations as apply to amounts appropriated for  
15 that fiscal year for medical care.

16 “(B) Expenses of the Department for the iden-  
17 tification, billing, auditing, and collection of amounts  
18 owed the United States by reason of medical care  
19 and services furnished under this chapter.

20 “(2)(A) If for fiscal year 1998, 1999, or 2000 the  
21 Secretary determines that the total amount to be recov-  
22 ered for that fiscal year under the provisions of law speci-  
23 fied in subsection (b) will be less than the amount con-  
24 tained in the latest Congressional Budget Office baseline  
25 estimate (computed under section 257 of the Balanced

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1 Budget and Emergency Deficit Control Act of 1985) for  
2 the amount of such recoveries for that fiscal year by at  
3 least \$25,000,000, the Secretary shall promptly certify to  
4 the Secretary of the Treasury the amount of the shortfall  
5 (as estimated by the Secretary) that is in excess of  
6 \$25,000,000. Upon receipt of such a certification, the Sec-  
7 retary of the Treasury shall, not later than 30 days after  
8 receiving the certification, deposit in the fund, from any  
9 unobligated amounts in the Treasury, an amount equal  
10 to the amount certified by the Secretary.

11 “(B) For a fiscal year for which a deposit is made  
12 under subparagraph (A), if the Secretary subsequently de-  
13 termines that the actual amount recovered for that fiscal  
14 year under the provisions of law specified in subsection  
15 (b) is greater than the amount estimated by the Secretary  
16 that was used for purposes of the certification by the Sec-  
17 retary under subparagraph (A), the Secretary shall pay  
18 into the general fund of the Treasury, from amounts avail-  
19 able for medical care, an amount equal to the difference  
20 between the amount actually recovered and the amount  
21 so estimated (but not in excess of the amount of the de-  
22 posit under subparagraph (A) pursuant to such certifi-  
23 cation).

24 “(C) For a fiscal year for which a deposit is made  
25 under subparagraph (A), if the Secretary subsequently de-

1 terminates that the actual amount recovered for that fiscal  
2 year under the provisions of law specified in subsection  
3 (b) is less than the amount estimated by the Secretary  
4 that was used for purposes of the certification by the Sec-  
5 retary under subparagraph (A), the Secretary shall  
6 promptly certify to the Secretary of the Treasury the  
7 amount of the shortfall. Upon receipt of such a certifi-  
8 cation, the Secretary of the Treasury shall, not later than  
9 30 days after receiving the certification, deposit in the  
10 fund, from any unobligated amounts in the Treasury, an  
11 amount equal to the amount certified by the Secretary.

12 “(d)(1) The Secretary may allocate amounts available  
13 to the Secretary under subsection (c) among components  
14 of the Department in such manner as the Secretary con-  
15 siders appropriate.

16 “(2) The Secretary shall establish a policy for the al-  
17 location under paragraph (1) of amounts in the fund.  
18 Such policy shall be designed so as to facilitate the realiza-  
19 tion of the maximum feasible collections under the provi-  
20 sions of law specified in subsection (b). In developing the  
21 policy, the Secretary shall take into account any factors  
22 beyond the control of the Secretary that the Secretary con-  
23 siders may impede such collections.

24 “(e)(1) The Secretary shall submit to the Committees  
25 on Veterans’ Affairs of the Senate and House of Rep-

1 representatives quarterly reports on the operation of this sec-  
2 tion for fiscal years 1998, 1999, and 2000 and for the  
3 first quarter of fiscal year 2001. Each such report shall  
4 specify the amount collected under each of the provisions  
5 specified in subsection (b) during the preceding quarter  
6 and the amount originally estimated to be collected under  
7 each such provision during such quarter.

8 “(2) A report under paragraph (1) for a quarter shall  
9 be submitted not later than 45 days after the end of that  
10 quarter.”.

11 (2) The table of sections at the beginning of such  
12 chapter is amended by inserting after the item relating  
13 to section 1729 the following new item:

“1729A. Department of Veterans Affairs Medical Care Collections Fund.”.

14 (b) CONFORMING AMENDMENTS.—Chapter 17 of  
15 such title is amended as follows:

16 (1) Section 1710(f) is amended by striking out  
17 paragraph (4) and redesignating paragraph (5) as  
18 paragraph (4).

19 (2) Section 1710(g) is amended by striking out  
20 paragraph (4).

21 (3) Section 1722A(b) is amended by striking  
22 out “Department of Veterans Affairs Medical-Care  
23 Cost Recovery Fund” and inserting in lieu thereof  
24 “Department of Veterans Affairs Medical Care Col-  
25 lections Fund”.

1           (4) Section 1729 is amended by striking out  
2           subsection (g).

3           (c) TERMINATION OF MEDICAL-CARE COST RECOV-  
4           ERY FUND.—The amount of the unobligated balance re-  
5           maining in the Department of Veterans Affairs Medical-  
6           Care Cost Recovery Fund (established pursuant to section  
7           1729(g)(1) of title 38, United States Code), at the close  
8           of September 30, 1997, shall be deposited, not later than  
9           December 31, 1997, in the Treasury as miscellaneous re-  
10          ceipts, and that fund shall be terminated when the deposit  
11          occurs.

12          (d) DETERMINATION OF AMOUNTS SUBJECT TO RE-  
13          COVERY.—Section 1729 of title 38, United States Code,  
14          is amended—

15                (1) in subsection (a)(1), by striking out “the  
16                reasonable cost of” and inserting in lieu thereof  
17                “reasonable charges for”;

18                (2) in subsection (c)(2)—

19                    (A) by striking out “the reasonable cost  
20                    of” in the first sentence of subparagraph (A)  
21                    and in subparagraph (B) and inserting in lieu  
22                    thereof “reasonable charges for”; and

23                    (B) by striking out “cost” in the second  
24                    sentence of subparagraph (A) and inserting in  
25                    lieu thereof “charges”.

1 (e) TECHNICAL AMENDMENT.—Paragraph (2) of sec-  
2 tion 712(b) of title 38, United States Code, is amended—

3 (1) by striking out subparagraph (B); and

4 (2) by redesignating subparagraph (C) as sub-  
5 paragraph (B).

6 (f) IMPLEMENTATION.—(1) Not later than January  
7 1, 1999, the Secretary of Veterans Affairs shall submit  
8 to the Committees on Veterans' Affairs of the Senate and  
9 House of Representatives a report on the implementation  
10 of this section. The report shall describe the collections  
11 under each of the provisions specified in section 1729A(b)  
12 of title 38, United States Code, as added by subsection  
13 (a). Information on such collections shall be shown for  
14 each of the health service networks (known as Veterans  
15 Integrated Service Networks) and, to the extent prac-  
16 ticable for each facility within each such network. The  
17 Secretary shall include in the report an analysis of dif-  
18 ferences among the networks with respect to (A) the mar-  
19 ket in which the networks operates, (B) the effort ex-  
20 pended to achieve collections, (C) the efficiency of such  
21 effort, and (D) any other relevant information.

22 (2) The Secretary shall adjust the allocation policy  
23 established under section 1729A(d)(2) of title 38, United  
24 States Code, as added by subsection (a), to take account  
25 of differences in collections that the Secretary determines



1 are attributable to the different markets in which net-  
2 works operate and shall include in the report under para-  
3 graph (1) a description of such adjustments.

4 (g) EFFECTIVE DATE.—(1) Except as provided in  
5 paragraph (2), this section and the amendments made by  
6 this section shall take effect on October 1, 1997.

7 (2) The amendments made by subsection (d) shall  
8 take effect on the date of the enactment of this Act.

9 **SEC. 8014. INCOME VERIFICATION AUTHORITY.**

10 (a) EXTENSION.—Section 5317(g) of title 38, United  
11 States Code, is amended by striking out “September 30,  
12 1998” and inserting in lieu thereof “September 30,  
13 2002”.

14 (b) SOCIAL SECURITY AND TAX RETURN INFORMA-  
15 TION.—Section 6103(l)(7) of the Internal Revenue Code  
16 of 1986 is amended by striking out “Clause (viii) shall  
17 not apply after September 30, 1998” and inserting in lieu  
18 thereof “Clause (viii) shall not apply after September 30,  
19 2002”.

20 **SEC. 8015. LIMITATION ON PENSION FOR CERTAIN RECIPI-**  
21 **ENTS OF MEDICAID-COVERED NURSING**  
22 **HOME CARE.**

23 Section 5503(f)(7) of title 38, United States Code,  
24 is amended by striking out “September 30, 1998” and in-  
25 serting in lieu thereof “September 30, 2002”.

1 **SEC. 8016. HOME LOAN FEES.**

2 (a) INCREASE IN LOAN FEE UNDER PROPERTY  
3 MANAGEMENT PROGRAM.—Paragraph (2) of section  
4 3729(a) of title 38, United States Code, is amended—

5 (1) in subparagraph (A), by striking out “or  
6 3733(a)”;

7 (2) by striking out “and” at the end of sub-  
8 paragraph (D);

9 (3) by striking out the period at the end of sub-  
10 paragraph (E) and inserting in lieu thereof “; and”;  
11 and

12 (4) by adding at the end the following new sub-  
13 paragraph:

14 “(F) in the case of a loan made under section  
15 3733(a) of this title, the amount of such fee shall be  
16 2.25 percent of the total loan amount.”.

17 (b) EXTENSIONS.—Such section is further amend-  
18 ed—

19 (1) in paragraph (4)—

20 (A) by striking out “October 1, 1998” and  
21 inserting in lieu thereof “October 1, 2002”; and

22 (B) by striking out “or (E)” and inserting  
23 in lieu thereof “(E), or (F)”; and

24 (2) in paragraph (5)(C), by striking out “Octo-  
25 ber 1, 1998” and inserting in lieu thereof “October  
26 1, 2002”.

1 **SEC. 8017. PROCEDURES APPLICABLE TO LIQUIDATION**  
2 **SALES ON DEFAULTED HOME LOANS GUAR-**  
3 **ANTEED BY THE SECRETARY OF VETERANS**  
4 **AFFAIRS.**

5 Section 3732(c)(11) of title 38, United States Code,  
6 is amended by striking out “October 1, 1998” and insert-  
7 ing “October 1, 2002”.

8 **SEC. 8018. ENHANCED LOAN ASSET SALE AUTHORITY.**

9 Section 3720(h)(2) of title 38, United States Code,  
10 is amended by striking out “December 31, 1997” and in-  
11 serting in lieu thereof “September 30, 2002”.

12 **Subtitle B—Other Matters**

13 **SEC. 8021. ROUNDING DOWN OF COST-OF-LIVING ADJUST-**  
14 **MENTS IN COMPENSATION AND DIC RATES.**

15 (a) COMPENSATION COLAS.—(1) Chapter 11 of title  
16 38, United States Code, is amended by inserting after sec-  
17 tion 1102 the following new section:

18 **“§ 1103. Cost-of-living adjustments**

19 “(a) In the computation of cost-of-living adjustments  
20 for fiscal years 1998 through 2002 in the rates of, and  
21 dollar limitations applicable to, compensation payable  
22 under this chapter, such adjustments shall be made by a  
23 uniform percentage that is no more than the percentage  
24 equal to the social security increase for that fiscal year,  
25 with all increased monthly rates and limitations (other  
26 than increased rates or limitations equal to a whole dollar

1 amount) rounded down to the next lower whole dollar  
2 amount.

3 “(b) For purposes of this section, the term ‘social se-  
4 curity increase’ means the percentage by which benefit  
5 amounts payable under title II of the Social Security Act  
6 (42 U.S.C. 401 et seq.) are increased for any fiscal year  
7 as a result of a determination under section 215(i) of such  
8 Act (42 U.S.C. 415(i)).”.

9 (2) The table of sections at the beginning of such  
10 chapter is amended by inserting after the item relating  
11 to section 1102 the following new item:

“1103. Cost-of-living adjustments.”.

12 (b) OUT-YEAR DIC COLAS.—(1) Chapter 13 of title  
13 38, United States Code, is amended by inserting after sec-  
14 tion 1302 the following new section:

15 **“§ 1303. Cost-of-living adjustments**

16 “(a) In the computation of cost-of-living adjustments  
17 for fiscal years 1998 through 2002 in the rates of depend-  
18 ency and indemnity compensation payable under this  
19 chapter, such adjustments shall be made by a uniform per-  
20 centage that is no more than the percentage equal to the  
21 social security increase for that fiscal year, with all in-  
22 creased monthly rates (other than increased rates equal  
23 to a whole dollar amount) rounded down to the next lower  
24 whole dollar amount.

1 “(b) For purposes of this section, the term ‘social se-  
2 curity increase’ means the percentage by which benefit  
3 amounts payable under title II of the Social Security Act  
4 (42 U.S.C. 401 et seq.) are increased for any fiscal year  
5 as a result of a determination under section 215(i) of such  
6 Act (42 U.S.C. 415(i)).”.

7 (2) The table of sections at the beginning of such  
8 chapter is amended by inserting after the item relating  
9 to section 1302 the following new item:

“1303. Cost-of-living adjustments.”.

10 **SEC. 8022. WITHHOLDING OF PAYMENTS AND BENEFITS.**

11 (a) NOTICE REQUIRED IN LIEU OF CONSENT OR  
12 COURT ORDER.—Section 3726 of title 38, United States  
13 Code, is amended by striking out “unless” and all that  
14 follows and inserting in lieu thereof the following: “unless  
15 the Secretary provides such veteran or surviving spouse  
16 with notice by certified mail with return receipt requested  
17 of the authority of the Secretary to waive the payment  
18 of indebtedness under section 5302(b) of this title. If the  
19 Secretary does not waive the entire amount of the liability,  
20 the Secretary shall then determine whether the veteran or  
21 surviving spouse should be released from liability under  
22 section 3713(b) of this title. If the Secretary determines  
23 that the veteran or surviving spouse should not be released  
24 from liability, the Secretary shall notify the veteran or sur-  
25 viving spouse of that determination and provide a notice

1 of the procedure for appealing that determination, unless  
2 the Secretary has previously made such determination and  
3 notified the veteran or surviving spouse of the procedure  
4 for appealing the determination.”.

5 (b) CONFORMING AMENDMENT.—Section 5302(b) of  
6 such title is amended by inserting “with return receipt re-  
7 quested” after “certified mail”.

8 (c) EFFECTIVE DATE.—The amendments made by  
9 this section shall apply with respect to any indebtedness  
10 to the United States arising pursuant to chapter 37 of  
11 title 38, United States Code, before, on, or after the date  
12 of the enactment of this Act.

13 **TITLE IX—COMMITTEE ON WAYS**  
14 **AND MEANS—NONMEDICARE**

15 **SEC. 9000. TABLE OF CONTENTS.**

16 The table of contents of this title is as follows:

Sec. 9000. Table of contents.

Subtitle A—TANF Block Grant

Sec. 9001. Welfare-to-work grants.

Sec. 9002. Limitation on amount of Federal funds transferable to title XX pro-  
grams.

Sec. 9003. Clarification of limitation on number of persons who may be treated  
as engaged in work by reason of participation in vocational  
educational training.

Sec. 9004. Required hours of work; health and safety.

Sec. 9005. Penalty for failure of State to reduce assistance for recipients refus-  
ing without good cause to work.

Subtitle B—Supplemental Security Income

Sec. 9101. Requirement to perform childhood disability redeterminations in  
missed cases.

Sec. 9102. Repeal of maintenance of effort requirements applicable to optional  
State programs for supplementation of SSI benefits.

Sec. 9103. Fees for Federal administration of State supplementary payments.

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Subtitle C—Child Support Enforcement

Sec. 9201. Clarification of authority to permit certain redisclosures of wage and claim information.

Subtitle D—Restricting Welfare and Public Benefits for Aliens

Sec. 9301. Extension of eligibility period for refugees and certain other qualified aliens from 5 to 7 years for SSI and medicaid.

Sec. 9302. SSI eligibility for aliens receiving SSI on August 22, 1996.

Sec. 9303. SSI eligibility for permanent resident aliens who are members of an Indian tribe.

Sec. 9304. Verification of eligibility for State and local public benefits.

Sec. 9305. Derivative eligibility for benefits.

Sec. 9306. Effective date.

Subtitle E—Unemployment Compensation

Sec. 9401. Clarifying provision relating to base periods.

Sec. 9402. Increase in Federal unemployment account ceiling.

Sec. 9403. Special distribution to States from Unemployment Trust Fund.

Sec. 9404. Interest-free advances to State accounts in Unemployment Trust Fund restricted to States which meet funding goals.

Sec. 9405. Exemption of service performed by election workers from the Federal unemployment tax.

Sec. 9406. Treatment of certain services performed by inmates.

Sec. 9407. Exemption of service performed for an elementary or secondary school operated primarily for religious purposes from the Federal unemployment tax.

Sec. 9408. State program integrity activities for unemployment compensation.

Subtitle F—Increase in Public Debt Limit

Sec. 9501. Increase in public debt limit.

1       **Subtitle A—TANF Block Grant**

2       **SEC. 9001. WELFARE-TO-WORK GRANTS.**

3           (a) GRANTS TO STATES.—

4               (1) IN GENERAL.—Section 403(a) of the Social  
5       Security Act (42 U.S.C. 603(a)) is amended by add-  
6       ing at the end the following:

7               “(5) WELFARE-TO-WORK GRANTS.—

8               “(A) NONCOMPETITIVE GRANTS.—

9               “(i) ENTITLEMENT.—A State shall be  
10       entitled to receive from the Secretary a

[HVAC Reconciliation]

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1 grant for each fiscal year specified in sub-  
2 paragraph (H) of this paragraph for which  
3 the State is a welfare-to-work State, in an  
4 amount that does not exceed the lesser  
5 of—

6 “(I) 2 times the total of the ex-  
7 penditures by the State (excluding  
8 qualified State expenditures (as de-  
9 fined in section 409(a)(7)(B)(i)) and  
10 any expenditure described in sub-  
11 clause (I), (II), or (IV) of section  
12 409(a)(7)(B)(iv)) during the fiscal  
13 year for activities described in sub-  
14 paragraph (C)(i) of this paragraph; or

15 “(II) the allotment of the State  
16 under clause (iii) of this subparagraph  
17 for the fiscal year.

18 “(ii) WELFARE-TO-WORK STATE.—A  
19 State shall be considered a welfare-to-work  
20 State for a fiscal year for purposes of this  
21 subparagraph if the Secretary, after con-  
22 sultation (and the sharing of any plan or  
23 amendment thereto submitted under this  
24 clause) with the Secretary of Health and  
25 Human Services and the Secretary of



[HVAC Reconciliation]

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1 Housing and Urban Development, deter-  
2 mines that the State meets the following  
3 requirements:

4 “(I) The State has submitted to  
5 the Secretary (in the form of an ad-  
6 dendum to the State plan submitted  
7 under section 402) a plan which—

8 “(aa) describes how, consist-  
9 ent with this subparagraph, the  
10 State will use any funds provided  
11 under this subparagraph during  
12 the fiscal year;

13 “(bb) specifies the formula  
14 to be used pursuant to clause (vi)  
15 to distribute funds in the State,  
16 and describes the process by  
17 which the formula was developed;

18 “(cc) contains evidence that  
19 the plan was developed in con-  
20 sultation and coordination with  
21 sub-State areas; and

22 “(dd) is approved by the  
23 agency administering the State  
24 program funded under this part.

**[HVAC Reconciliation]**

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1           “(II) The State has provided the  
2           Secretary with an estimate of the  
3           amount that the State intends to ex-  
4           pend during the fiscal year (excluding  
5           expenditures described in section  
6           409(a)(7)(B)(iv)) for activities de-  
7           scribed in subparagraph (C)(i) of this  
8           paragraph.

9           “(III) The State has agreed to  
10          negotiate in good faith with the Sec-  
11          retary of Health and Human Services  
12          with respect to the substance of any  
13          evaluation under section 413(j), and  
14          to cooperate with the conduct of any  
15          such evaluation.

16          “(IV) The State is an eligible  
17          State for the fiscal year.

18          “(V) Qualified State expenditures  
19          (within the meaning of section  
20          409(a)(7)) are at least 80 percent of  
21          historic State expenditures (within the  
22          meaning of such section), with respect  
23          to the fiscal year or the immediately  
24          preceding fiscal year.

[HVAC Reconciliation]

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1           “(iii) ALLOTMENTS TO WELFARE-TO-  
2 WORK STATES.—The allotment of a wel-  
3 fare-to-work State for a fiscal year shall be  
4 the available amount for the fiscal year  
5 multiplied by the State percentage for the  
6 fiscal year.

7           “(iv) AVAILABLE AMOUNT.—As used  
8 in this subparagraph, the term ‘available  
9 amount’ means, for a fiscal year, the sum  
10 of—

11                   “(I) 50 percent of the sum of—

12                           “(aa) the amount specified  
13 in subparagraph (H) for the fis-  
14 cal year, minus the total of the  
15 amounts reserved pursuant to  
16 subparagraphs (F) and (G) for  
17 the fiscal year; and

18                           “(bb) any amount reserved  
19 pursuant to subparagraph (F)  
20 for the immediately preceding fis-  
21 cal year that has not been obli-  
22 gated; and

23                   “(II) any available amount for  
24 the immediately preceding fiscal year

1 that has not been obligated by a State  
2 or sub-State entity.

3 “(v) STATE PERCENTAGE.—As  
4 used in clause (iii), the term ‘State  
5 percentage’ means, with respect to a  
6 fiscal year,  $\frac{1}{3}$  of the sum of—

7 “(aa) the percentage rep-  
8 resented by the number of indi-  
9 viduals in the State whose in-  
10 come is less than the poverty line  
11 divided by the number of such in-  
12 dividuals in the United States;

13 “(bb) the percentage rep-  
14 resented by the number of unem-  
15 ployed individuals in the State di-  
16 vided by the number of such indi-  
17 viduals in the United States; and

18 “(cc) the percentage rep-  
19 resented by the number of indi-  
20 viduals who are adult recipients  
21 of assistance under the State  
22 program funded under this part  
23 divided by the number of individ-  
24 uals in the United States who are  
25 adult recipients of assistance

**[HVAC Reconciliation]**

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1 under any State program funded  
2 under this part.

3 “(vi) DISTRIBUTION OF FUNDS WITH-  
4 IN STATES.—

5 “(I) IN GENERAL.—A State to  
6 which a grant is made under this sub-  
7 paragraph shall distribute not less  
8 than 85 percent of the grant funds  
9 among the service delivery areas in  
10 the State, in accordance with a for-  
11 mula which—

12 “(aa) determines the  
13 amount to be distributed for the  
14 benefit of a service delivery area  
15 in proportion to the number (if  
16 any) by which the number of in-  
17 dividuals residing in the service  
18 delivery area with an income that  
19 is less than the poverty line ex-  
20 ceeds 5 percent of the population  
21 of the service delivery area, rel-  
22 ative to such number for the  
23 other service delivery areas in the  
24 State, and accords a weight of

**[HVAC Reconciliation]**

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1 not less than 50 percent to this  
2 factor;

3 “(bb) may determine the  
4 amount to be distributed for the  
5 benefit of a service delivery area  
6 in proportion to the number of  
7 adults residing in the service de-  
8 livery area who are recipients of  
9 assistance under the State pro-  
10 gram funded under this part  
11 (whether in effect before or after  
12 the amendments made by section  
13 103(a) of the Personal Respon-  
14 sibility and Work Opportunity  
15 Reconciliation Act first applied to  
16 the State) for at least 30 months  
17 (whether or not consecutive) rel-  
18 ative to the number of such  
19 adults residing in the other serv-  
20 ice delivery areas in the State;  
21 and

22 “(cc) may determine the  
23 amount to be distributed for the  
24 benefit of a service delivery area  
25 in proportion to the number of

**[HVAC Reconciliation]**

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1 unemployed individuals residing  
2 in the service delivery area rel-  
3 ative to the number of such indi-  
4 viduals residing in the other serv-  
5 ice delivery areas in the State.

6 “(II) SPECIAL RULE.—Notwith-  
7 standing subclause (I), if the formula  
8 used pursuant to subclause (I) would  
9 result in the distribution of less than  
10 \$100,000 during a fiscal year for the  
11 benefit of a service delivery area, then  
12 in lieu of distributing such sum in ac-  
13 cordance with the formula, such sum  
14 shall be available for distribution  
15 under subclause (III) during the fiscal  
16 year.

17 “(III) PROJECTS TO HELP LONG-  
18 TERM RECIPIENTS OF ASSISTANCE  
19 INTO THE WORK FORCE.—The Gov-  
20 ernor of a State to which a grant is  
21 made under this subparagraph may  
22 distribute not more than 15 percent of  
23 the grant funds (plus any amount re-  
24 quired to be distributed under this  
25 subclause by reason of subclause (II))

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1 to projects that appear likely to help  
2 long-term recipients of assistance  
3 under the State program funded  
4 under this part (whether in effect be-  
5 fore or after the amendments made by  
6 section 103(a) of the Personal Re-  
7 sponsibility and Work Opportunity  
8 Reconciliation Act first applied to the  
9 State) enter the work force.

10 “(vii) ADMINISTRATION.—

11 “(I) IN GENERAL.—A grant  
12 made under this subparagraph to a  
13 State shall be administered by the  
14 State agency that is administering, or  
15 supervising the administration of, the  
16 State program funded under this part,  
17 or by another State agency designated  
18 by the Governor of the State.

19 “(II) SPENDING BY PRIVATE IN-  
20 DUSTRY COUNCILS.—The private in-  
21 dustry council for a service delivery  
22 area shall have sole authority to ex-  
23 pend the amounts provided for the  
24 benefit of a service delivery area  
25 under subparagraph (vi)(I), pursuant



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1 to an agreement with the agency that  
2 is administering the State program  
3 funded under this part in the service  
4 delivery area.

5 “(B) COMPETITIVE GRANTS.—

6 “(i) IN GENERAL.—The Secretary, in  
7 consultation with the Secretary of Health  
8 and Human Services and the Secretary of  
9 Housing and Urban Development, shall  
10 award grants in accordance with this sub-  
11 paragraph, in fiscal years 1998 and 2000,  
12 for projects proposed by eligible applicants,  
13 based on the following:

14 “(I) The effectiveness of the pro-  
15 posal in—

16 “(aa) expanding the base of  
17 knowledge about programs aimed  
18 at moving recipients of assistance  
19 under State programs funded  
20 under this part who are least job  
21 ready into the work force.

22 “(bb) moving recipients of  
23 assistance under State programs  
24 funded under this part who are

**[HVAC Reconciliation]**

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1 least job ready into the work  
2 force; and

3 “(cc) moving recipients of  
4 assistance under State programs  
5 funded under this part who are  
6 least job ready into the work  
7 force, even in labor markets that  
8 have a shortage of low-skill jobs.

9 “(II) At the discretion of the  
10 Secretary, any of the following:

11 “(aa) The history of success  
12 of the applicant in moving indi-  
13 viduals with multiple barriers  
14 into work.

15 “(bb) Evidence of the appli-  
16 cant’s ability to leverage private,  
17 State, and local resources.

18 “(cc) Use by the applicant  
19 of State and local resources be-  
20 yond those required by subpara-  
21 graph (A).

22 “(dd) Plans of the applicant  
23 to coordiate with other organiza-  
24 tions at the local and State level.

[HVAC Reconciliation]

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1                   “(ee) Use by the applicant  
2                   of current or former recipients of  
3                   assistance under a State program  
4                   funded under this part as men-  
5                   tors, case managers, or service  
6                   providers.

7                   “(ii) ELIGIBLE APPLICANTS.—As used  
8                   in clause (i), the term ‘eligible applicant’  
9                   means a private industry council or a polit-  
10                  ical subdivision of a State that submits a  
11                  proposal that is approved by the agency  
12                  administering the State program funded  
13                  under this part.

14                  “(iii) DETERMINATION OF GRANT  
15                  AMOUNT.—In determining the amount of a  
16                  grant to be made under this subparagraph  
17                  for a project proposed by an applicant, the  
18                  Secretary shall provide the applicant with  
19                  an amount sufficient to ensure that the  
20                  project has a reasonable opportunity to be  
21                  successful, taking into account the number  
22                  of long-term recipients of assistance under  
23                  a State program funded under this part,  
24                  the level of unemployment, the job oppor-  
25                  tunities and job growth, the poverty rate,

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1 and such other factors as the Secretary  
2 deems appropriate, in the area to be served  
3 by the project.

4 “(iv) TARGETING OF FUNDS TO CER-  
5 TAIN AREAS.—

6 “(I) CITIES WITH GREATEST  
7 NUMBER OF PERSONS WITH INCOME  
8 LESS THAN THE POVERTY LINE.—The  
9 Secretary shall use not less than 65  
10 percent of the funds available for  
11 grants under this subparagraph for a  
12 fiscal year to award grants for ex-  
13 penditures in cities that are among  
14 the 100 cities in the United States  
15 with the highest number of residents  
16 with an income that is less than the  
17 poverty line.

18 “(II) RURAL AREAS.—

19 “(aa) IN GENERAL.—The  
20 Secretary shall use not less than  
21 25 percent of the funds available  
22 for grants under this subpara-  
23 graph for a fiscal year to award  
24 grants for expenditures in rural  
25 areas.

[HVAC Reconciliation]

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1                   “(bb) RURAL AREA DE-  
2                   FINED.—As used in item (aa),  
3                   the term ‘rural area’ means a  
4                   city, town, or unincorporated  
5                   area that has a population of  
6                   50,000 or fewer inhabitants and  
7                   that is not an urbanized area im-  
8                   mediately adjacent to a city,  
9                   town, or unincorporated area  
10                  that has a population of more  
11                  than 50,000 inhabitants.

12                  “(v) FUNDING.—For grants under  
13                  this subparagraph for each fiscal year  
14                  specified in subparagraph (H), there shall  
15                  be available to the Secretary an amount  
16                  equal to the sum of—

17                         “(I) 50 percent of the sum of—

18                                 “(aa) the amount specified  
19                                 in subparagraph (H) for the fis-  
20                                 cal year, minus the total of the  
21                                 amounts reserved pursuant to  
22                                 subparagraphs (F) and (G) for  
23                                 the fiscal year; and

24                                 “(bb) any amount reserved  
25                                 pursuant to subparagraph (F)

**[HVAC Reconciliation]**

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1 for the immediately preceding fis-  
2 cal year that has not been obli-  
3 gated; and

4 “(II) any amount available for  
5 grants under this subparagraph for  
6 the immediately preceding fiscal year  
7 that has not been obligated.

8 “(C) LIMITATIONS ON USE OF FUNDS.—

9 “(i) ALLOWABLE ACTIVITIES.—An en-  
10 tity to which funds are provided under this  
11 paragraph may use the funds to move into  
12 the work force recipients of assistance  
13 under the program funded under this part  
14 of the State in which the entity is located  
15 and the noncustodial parent of any minor  
16 who is such a recipient, by means of any  
17 of the following:

18 “(I) Job creation through public  
19 or private sector employment wage  
20 subsidies.

21 “(II) On-the-job training.

22 “(III) Contracts with public or  
23 private providers of readiness, place-  
24 ment, and post-employment services.

**[HVAC Reconciliation]**

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1                   “(IV) Job vouchers for place-  
2                   ment, readiness, and postemployment  
3                   services.

4                   “(V) Job support services (ex-  
5                   cluding child care services) if such  
6                   services are not otherwise available.

7                   “(ii) REQUIRED BENEFICIARIES.—An  
8                   entity that operates a project with funds  
9                   provided under this paragraph shall expend  
10                  at least 90 percent of all funds provided to  
11                  the project for the benefit of recipients of  
12                  assistance under the program funded  
13                  under this part of the State in which the  
14                  entity is located who meet the require-  
15                  ments of each of the following subclauses:

16                  “(I) At least 2 of the following  
17                  apply to the recipient:

18                         “(aa) The individual has not  
19                         completed secondary school or  
20                         obtained a certificate of general  
21                         equivalency, and has low skills in  
22                         reading and mathematics.

23                         “(bb) The individual re-  
24                         quires substance abuse treatment  
25                         for employment.

**[HVAC Reconciliation]**

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1                   “(cc) The individual has a  
2                   poor work history.

3                   The Secretary shall prescribe such  
4                   regulations as may be necessary to in-  
5                   terpret this subclause.

6                   “(II) The individual—

7                   “(aa) has received assistance  
8                   under the State program funded  
9                   under this part (whether in effect  
10                  before or after the amendments  
11                  made by section 103 of the Per-  
12                  sonal Responsibility and Work  
13                  Opportunity Reconciliation Act of  
14                  1996 first apply to the State) for  
15                  at least 30 months (whether or  
16                  not consecutive); or

17                  “(bb) within 12 months, will  
18                  become ineligible for assistance  
19                  under the State program funded  
20                  under this part by reason of a  
21                  durational limit on such assist-  
22                  ance, without regard to any ex-  
23                  emption provided pursuant to  
24                  section 408(a)(7)(C) that may  
25                  apply to the individual.



**[HVAC Reconciliation]**

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1           “(iii) LIMITATION ON APPLICABILITY  
2 OF SECTION 404.—The rules of section  
3 404, other than subsections (b), (f), and  
4 (h) of section 404, shall not apply to a  
5 grant made under this paragraph.

6           “(iv) LIMITATIONS RELATING TO PRI-  
7 VATE INDUSTRY COUNCILS.—

8                   “(I) NO DIRECT PROVISION OF  
9 SERVICES.—A private industry council  
10 may not directly provide services  
11 using funds provided under this para-  
12 graph.

13                   “(II) COOPERATION WITH TANF  
14 AGENCY.—On a determination by the  
15 Secretary, in consultation with the  
16 Secretary of Health and Human Serv-  
17 ices and the Secretary of Housing and  
18 Urban Development, that the private  
19 industry council for a service delivery  
20 area in a State for which funds are  
21 provided under this paragraph and  
22 the agency administering the State  
23 program funded under this part are  
24 not adhering to the agreement re-  
25 ferred to in subparagraph (A)(vii)(II)

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1 to implement any plan or project for  
2 which the funds are provided, the re-  
3 cipient of the funds shall remit the  
4 funds to the Secretary.

5 “(v) PROHIBITION AGAINST USE OF  
6 GRANT FUNDS FOR ANY OTHER FUND  
7 MATCHING REQUIREMENT.—An entity to  
8 which funds are provided under this para-  
9 graph shall not use any part of the funds  
10 to fulfill any obligation of any State, politi-  
11 cal subdivision, or private industry council  
12 to contribute funds under other Federal  
13 law.

14 “(vi) DEADLINE FOR EXPENDI-  
15 TURE.—An entity to which funds are pro-  
16 vided under this paragraph shall remit to  
17 the Secretary any part of the funds that  
18 are not expended within 3 years after the  
19 date the funds are so provided.

20 “(D) INDIVIDUALS WITH INCOME LESS  
21 THAN THE POVERTY LINE.—For purposes of  
22 this paragraph, the number of individuals with  
23 an income that is less than the poverty line  
24 shall be determined based on the methodology  
25 used by the Bureau of the Census to produce

1 and publish intercensal poverty data for 1993  
2 for States and counties.

3 “(E) DEFINITIONS.—As used in this para-  
4 graph:

5 “(i) PRIVATE INDUSTRY COUNCIL.—  
6 The term ‘private industry council’ means,  
7 with respect to a service delivery area, the  
8 private industry council (or successor en-  
9 tity) established for the service delivery  
10 area pursuant to the Job Training Part-  
11 nership Act.

12 “(ii) SECRETARY.—The term ‘Sec-  
13 retary’ means the Secretary of Labor, ex-  
14 cept as otherwise expressly provided.

15 “(iii) SERVICE DELIVERY AREA.—The  
16 term ‘service delivery area’ shall have the  
17 meaning given such term for purposes of  
18 the Job Training Partnership Act.

19 “(F) SET-ASIDE FOR INDIAN TRIBES.—1  
20 percent of the amount specified in subpara-  
21 graph (H) for each fiscal year shall be reserved  
22 for grants to Indian tribes under section  
23 412(a)(3).

24 “(G) SET-ASIDE FOR EVALUATIONS.—0.5  
25 percent of the amount specified in subpara-

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1 graph (H) for each fiscal year shall be reserved  
2 for use by the Secretary of Health and Human  
3 Services to carry out section 413(j).

4 “(H) FUNDING.—The amount specified in  
5 this subparagraph is—

6 “(i) \$750,000,000 for fiscal year  
7 1998;

8 “(ii) \$1,250,000,000 for fiscal year  
9 1999; and

10 “(iii) \$1,000,000,000 for fiscal year  
11 2000.

12 “(I) AVAILABILITY OF FUNDS.—Amounts  
13 appropriated pursuant to this paragraph shall  
14 remain available through fiscal year 2002.

15 “(J) BUDGET SCORING.—Notwithstanding  
16 section 457(b)(2) of the Balanced Budget and  
17 Emergency Deficit Control Act of 1985, the  
18 baseline shall assume that no grant shall be  
19 awarded under this paragraph or under section  
20 412(a)(3) after fiscal year 2000.

21 “(K) WORKER PROTECTIONS.—

22 “(i) LABOR STANDARDS.—

23 “(I) DISPLACEMENT.—

24 “(aa) PROHIBITION.—A  
25 participant in an activity under

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1 this paragraph shall not displace  
2 (including a partial displacement,  
3 such as a reduction in the hours  
4 of nonovertime work, wages, or  
5 employment benefits) any cur-  
6 rently employed employee (as of  
7 the date of the participation).

8 “(bb) PROHIBITION ON IM-  
9 PAIRMENT OF CONTRACTS.—An  
10 activity under this paragraph  
11 shall not impair an existing con-  
12 tract for services or collective  
13 bargaining agreement, and no  
14 such activity that would be incon-  
15 sistent with the terms of a collec-  
16 tive bargaining agreement shall  
17 be undertaken without the writ-  
18 ten concurrence of the labor or-  
19 ganization and employer con-  
20 cerned.

21 “(II) OTHER PROHIBITIONS.—A  
22 participant in an activity under this  
23 paragraph shall not be employed in a  
24 job—

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1                   “(aa) when any other indi-  
2                   vidual is on layoff from the same  
3                   or any substantially equivalent  
4                   job;

5                   “(bb) when the employer has  
6                   terminated the employment of  
7                   any regular employee or other-  
8                   wise reduced the workforce of the  
9                   employer with the intention of  
10                  filling the vacancy so created  
11                  with the participant; or

12                  “(cc) which is created in a  
13                  promotional line that will infringe  
14                  in any way upon the promotional  
15                  opportunities of currently em-  
16                  ployed individuals.

17                  “(III) HEALTH AND SAFETY.—  
18                  Health and safety standards estab-  
19                  lished under Federal and State law  
20                  otherwise applicable to working condi-  
21                  tions of employees shall be equally ap-  
22                  plicable to working conditions of par-  
23                  ticipants engaged in activities under  
24                  this paragraph. To the extent that a  
25                  State workers’ compensation law ap-

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1           plies, workers' compensation shall be  
2           provided to participants on the same  
3           basis as the compensation is provided  
4           to other individuals in the State in  
5           similar employment.

6                   “(IV) EMPLOYMENT CONDI-  
7                   TIONS.—Individuals in on-the-job  
8                   training or individuals employed in ac-  
9                   tivities under this paragraph shall be  
10                  provided benefits and working condi-  
11                  tions at the same level and to the  
12                  same extent as other trainees or em-  
13                  ployees working a similar length of  
14                  time and doing the same type of work.

15                   “(V) OPPORTUNITY TO SUBMIT  
16                   COMMENTS.—Interested parties shall  
17                   be provided an opportunity to submit  
18                   comments with respect to training  
19                   programs proposed to be funded  
20                   under this paragraph.

21                   “(ii) GRIEVANCE PROCEDURE.—

22                   “(I) IN GENERAL.—A State to  
23                   which funds are provided under this  
24                   paragraph shall establish and main-  
25                   tain a procedure for addressing griev-

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1           ances or complaints alleging violations  
2           of this paragraph from participants  
3           and other interested or affected par-  
4           ties. The procedure shall include an  
5           opportunity for a hearing and be com-  
6           pleted within 60 days of filing the  
7           grievance or complaint.

8                           “(II) INVESTIGATION.—

9                                   “(aa) IN GENERAL.—The  
10                                   Secretary shall investigate an al-  
11                                   legation of a violation of this  
12                                   paragraph if a decision relating  
13                                   to the allegation is made within  
14                                   60 days after the date of the fil-  
15                                   ing of the grievance or complaint  
16                                   and either party appeals to the  
17                                   Secretary, or if a decision relat-  
18                                   ing to the allegation is made  
19                                   within the 60-day period and the  
20                                   party to which the decision is ad-  
21                                   verse appeals the decision to the  
22                                   Secretary.

23                                   “(bb) ADDITIONAL RE-  
24                                   QUIREMENT.—The Secretary  
25                                   shall make a final determination



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1 relating to an appeal made under  
2 item (aa) no later than 120 days  
3 after receiving the appeal.

4 “(III) REMEDIES.—Remedies  
5 shall be limited to—

6 “(aa) suspension or termi-  
7 nation of payments under this  
8 paragraph;

9 “(bb) prohibition of place-  
10 ment of a participant with an  
11 employer who has violated this  
12 subparagraph;

13 “(cc) where applicable, rein-  
14 statement of an employee, pay-  
15 ment of lost wages and benefits,  
16 and reestablishment of other rel-  
17 evant terms, conditions and privi-  
18 leges of employment; and

19 “(dd) where appropriate,  
20 other equitable relief.”.

21 (2) CONFORMING AMENDMENT.—Section  
22 409(a)(7)(B)(iv) of such Act (42 U.S.C.  
23 609(a)(7)(B)(iv)) is amended to read as follows:

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1           “(iv) EXPENDITURES BY THE  
2 STATE.—The term ‘expenditures by the  
3 State’ does not include—

4                   “(I) any expenditure from  
5 amounts made available by the Fed-  
6 eral Government;

7                   “(II) any State funds expended  
8 for the medicaid program under title  
9 XIX;

10                   “(III) any State funds which are  
11 used to match Federal funds provided  
12 under section 403(a)(5); or

13                   “(IV) any State funds which are  
14 expended as a condition of receiving  
15 Federal funds other than under this  
16 part.

17           Notwithstanding subclause (IV) of the pre-  
18 ceding sentence, such term includes ex-  
19 penditures by a State for child care in a  
20 fiscal year to the extent that the total  
21 amount of the expenditures does not ex-  
22 ceed the amount of State expenditures in  
23 fiscal year 1994 or 1995 (whichever is the  
24 greater) that equal the non-Federal share

1 for the programs described in section  
2 418(a)(1)(A).”.

3 (b) GRANTS TO OUTLYING AREAS.—Section 1108(a)  
4 of such Act (42 U.S.C. 1308(a)) is amended by inserting  
5 “(except section 403(a)(5))” after “title IV”.

6 (c) GRANTS TO INDIAN TRIBES.—Section 412(a) of  
7 such Act (42 U.S.C. 612(a)) is amended by adding at the  
8 end the following:

9 “(3) WELFARE-TO-WORK GRANTS.—

10 “(A) IN GENERAL.—The Secretary shall  
11 award a grant in accordance with this para-  
12 graph to an Indian tribe for each fiscal year  
13 specified in section 403(a)(5)(H) for which the  
14 Indian tribe is a welfare-to-work tribe, in such  
15 amount as the Secretary deems appropriate,  
16 subject to subparagraph (B) of this paragraph.

17 “(B) WELFARE-TO-WORK TRIBE.—An In-  
18 dian tribe shall be considered a welfare-to-work  
19 tribe for a fiscal year for purposes of this para-  
20 graph if the Indian tribe meets the following re-  
21 quirements:

22 “(i) The Indian tribe has submitted to  
23 the Secretary (in the form of an addendum  
24 to the tribal family assistance plan, if any,  
25 of the Indian tribe) a plan which describes

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1           how, consistent with section 403(a)(5), the  
2           Indian tribe will use any funds provided  
3           under this paragraph during the fiscal  
4           year.

5           “(ii) The Indian tribe has provided  
6           the Secretary with an estimate of the  
7           amount that the Indian tribe intends to ex-  
8           pend during the fiscal year (excluding trib-  
9           al expenditures described in section  
10          409(a)(7)(B)(iv)) for activities described in  
11          section 403(a)(5)(C)(i).

12          “(iii) The Indian tribe has agreed to  
13          negotiate in good faith with the Secretary  
14          of Health and Human Services with re-  
15          spect to the substance of any evaluation  
16          under section 413(j), and to cooperate with  
17          the conduct of any such evaluation.

18          “(C) LIMITATIONS ON USE OF FUNDS.—  
19          Section 403(a)(5)(C) shall apply to funds pro-  
20          vided to Indian tribes under this paragraph in  
21          the same manner in which such section applies  
22          to funds provided under section 403(a)(5).”.

23          (d) FUNDS RECEIVED FROM GRANTS TO BE DIS-  
24          REGARDED IN APPLYING DURATIONAL LIMIT ON ASSIST-

1 ANCE.—Section 408(a)(7) of such Act (42 U.S.C.  
2 608(a)(7)) is amended by adding at the end the following:

3 “(G) INAPPLICABILITY TO WELFARE-TO-  
4 WORK GRANTS AND ASSISTANCE.—For purposes  
5 of subparagraph (A) of this paragraph, a grant  
6 made under section 403(a)(5) shall not be con-  
7 sidered a grant made under section 403, and  
8 assistance from funds provided under section  
9 403(a)(5) shall not be considered assistance.”.

10 (e) EVALUATIONS.—Section 413 of such Act (42  
11 U.S.C. 613) is amended by adding at the end the follow-  
12 ing:

13 “(j) EVALUATION OF WELFARE-TO-WORK PRO-  
14 GRAMS.—

15 “(1) EVALUATION.—The Secretary—

16 “(A) shall, in consultation with the Sec-  
17 retary of Labor, develop a plan to evaluate how  
18 grants made under sections 403(a)(5) and  
19 412(a)(3) have been used;

20 “(B) may evaluate the use of such grants  
21 by such grantees as the Secretary deems appro-  
22 priate, in accordance with an agreement entered  
23 into with the grantees after good-faith negotia-  
24 tions; and

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1           “(C) is urged to include the following out-  
2 come measures in the plan developed under  
3 subparagraph (A):

4           “(i) Placements in the labor force and  
5 placements in the labor force that last for  
6 at least 6 months.

7           “(ii) Placements in the private and  
8 public sectors.

9           “(iii) Earnings of individuals who ob-  
10 tain employment.

11           “(iv) Average expenditures per place-  
12 ment.

13           “(2) REPORTS TO THE CONGRESS.—

14           “(A) IN GENERAL.—Subject to subpara-  
15 graphs (B) and (C), the Secretary, in consulta-  
16 tion with the Secretary of Labor and the Sec-  
17 retary of Housing and Urban Development,  
18 shall submit to the Congress reports on the  
19 projects funded under section 403(a)(5) and  
20 412(a)(3) and on the evaluations of the  
21 projects.

22           “(B) INTERIM REPORT.—Not later than  
23 January 1, 1999, the Secretary shall submit an  
24 interim report on the matter described in sub-  
25 paragraph (A).

1           “(C) FINAL REPORT.—Not later than Jan-  
2           uary 1, 2001, (or at a later date, if the Sec-  
3           retary informs the Committees of the Congress  
4           with jurisdiction over the subject matter of the  
5           report) the Secretary shall submit a final report  
6           on the matter described in subparagraph (A).”.

7 **SEC. 9002. LIMITATION ON AMOUNT OF FEDERAL FUNDS**  
8           **TRANSFERABLE TO TITLE XX PROGRAMS.**

9           (a) IN GENERAL.—Section 404(d) of the Social Secu-  
10          rity Act (42 U.S.C. 604(d)) is amended—

11           (1) in paragraph (1), by striking “A State  
12          may” and inserting “Subject to paragraph (2), a  
13          State may”; and

14           (2) by amending paragraph (2) to read as fol-  
15          lows:

16           “(2) LIMITATION ON AMOUNT TRANSFERABLE  
17          TO TITLE XX PROGRAMS.—A State may use not  
18          more than 10 percent of the amount of any grant  
19          made to the State under section 403(a) for a fiscal  
20          year to carry out State programs pursuant to title  
21          XX.”.

22           (b) RETROACTIVITY.—The amendments made by  
23          subsection (a) of this section shall take effect as if in-  
24          cluded in the enactment of section 103(a) of the Personal

1 Responsibility and Work Opportunity Reconciliation Act  
2 of 1996.

3 **SEC. 9003. CLARIFICATION OF LIMITATION ON NUMBER OF**  
4 **PERSONS WHO MAY BE TREATED AS EN-**  
5 **GAGED IN WORK BY REASON OF PARTICIPA-**  
6 **TION IN VOCATIONAL EDUCATIONAL TRAIN-**  
7 **ING.**

8 (a) IN GENERAL.—Section 407(c)(2)(D) of the Social  
9 Security Act (42 U.S.C. 607(c)(2)(D)) is amended to read  
10 as follows:

11 “(D) LIMITATION ON NUMBER OF PER-  
12 SONS WHO MAY BE TREATED AS ENGAGED IN  
13 WORK BY REASON OF PARTICIPATION IN VOCA-  
14 TIONAL EDUCATIONAL TRAINING.—For pur-  
15 poses of determining monthly participation  
16 rates under paragraphs (1)(B)(i) and (2)(B) of  
17 subsection (b), not more than 30 percent of the  
18 number of individuals in all families and in 2-  
19 parent families, respectively, in a State who are  
20 treated as engaged in work for a month may  
21 consist of individuals who are determined to be  
22 engaged in work for the month by reason of  
23 participation in vocational educational train-  
24 ing.”.



1 (b) RETROACTIVITY.—The amendment made by sub-  
2 section (a) of this section shall take effect as if included  
3 in the enactment of section 103(a) of the Personal Re-  
4 sponsibility and Work Opportunity Reconciliation Act of  
5 1996.

6 **SEC. 9004. REQUIRED HOURS OF WORK; HEALTH AND SAFE-**  
7 **TY.**

8 (a) IN GENERAL.—Section 407 of the Social Security  
9 Act (42 U.S.C. 607) is amended by adding at the end the  
10 following:

11 “(j) LIMITATION ON NUMBER OF HOURS PER  
12 MONTH THAT A RECIPIENT OF ASSISTANCE MAY BE RE-  
13 QUIRED TO WORK FOR A PUBLIC AGENCY OR NONPROFIT  
14 ORGANIZATION.—

15 “(1) IN GENERAL.—A State to which a grant  
16 is made under section 403 may not require a recipi-  
17 ent of assistance under the State program funded  
18 under this part to be assigned to a work experience,  
19 on-the-job training, or community service position  
20 with a public agency or nonprofit organization dur-  
21 ing a month for more than the allowable number of  
22 hours determined for the month under paragraph  
23 (2).

24 “(2) ALLOWABLE NUMBER OF HOURS.—

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1           “(A) GENERAL METHOD.—Subject to this  
2 paragraph, the allowable number of hours de-  
3 termined for a month under this paragraph—

4           “(i) for a recipient to whom the bene-  
5 fit described in paragraph (3)(A) is pro-  
6 vided during the month is—

7           “(I) the average value of the ben-  
8 efit provided by the State during the  
9 month to families that the State de-  
10 termines are similarly situated to the  
11 family of the recipient, or (at the op-  
12 tion of the State) the value of the  
13 benefit provided by the State to the  
14 recipient during the month; divided by

15           “(II) the minimum wage rate in  
16 effect during the month under section  
17 6 of the Fair Labor Standards Act of  
18 1938;

19           “(ii) for a recipient to whom the bene-  
20 fits described in subparagraphs (A) and  
21 (B) of paragraph (3) are provided during  
22 the month is—

23           “(I) the average value of such  
24 benefits provided by the State during  
25 the month to families that the State

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1 determines are similarly situated to  
2 the family of the recipient, or (at the  
3 option of the State) the value of such  
4 benefits provided by the State to the  
5 recipient during the month; divided by

6 “(II) the minimum wage rate in  
7 effect during the month under section  
8 6 of the Fair Labor Standards Act of  
9 1938;

10 “(iii) for a recipient to whom the ben-  
11 efits described in subparagraphs (A), (B),  
12 and (C) of paragraph (3) are provided dur-  
13 ing the month is—

14 “(I) the average value of such  
15 benefits provided by the State during  
16 the month to families that the State  
17 determines are similarly situated to  
18 the family of the recipient, or (at the  
19 option of the State) the value of such  
20 benefits provided by the State to the  
21 recipient during the month; divided by

22 “(II) the minimum wage rate in  
23 effect during the month under section  
24 6 of the Fair Labor Standards Act of  
25 1938;

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1 “(iv) for a recipient to whom the ben-  
2 efits described in subparagraphs (A), (B),  
3 (C), and (D) of paragraph (3) are provided  
4 during the month is—

5 “(I) the average value of such  
6 benefits provided by the State during  
7 the month to families that the State  
8 determines are similarly situated to  
9 the family of the recipient, or (at the  
10 option of the State) the value of such  
11 benefits provided by the State to the  
12 recipient during the month; divided by

13 “(II) the minimum wage rate in  
14 effect during the month under section  
15 6 of the Fair Labor Standards Act of  
16 1938; and

17 “(v) for a recipient to whom the bene-  
18 fits described in subparagraphs (A), (B),  
19 (C), (D), and (E) of paragraph (3) are  
20 provided during the month is—

21 “(I) the average value of such  
22 benefits provided by the State during  
23 the month to families that the State  
24 determines are similarly situated to  
25 the family of the recipient, or (at the

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1 option of the State) the value of such  
2 benefits provided by the State to the  
3 recipient during the month; divided by

4 “(II) the minimum wage rate in  
5 effect during the month under section  
6 of the Fair Labor Standards Act of  
7 1938.

8 “(B) STATE OPTION TO TAKE ACCOUNT OF  
9 CERTAIN WORK ACTIVITIES.—

10 “(i) IN GENERAL.—In determining  
11 the number of hours for a month for which  
12 a sufficiently employed recipient may be  
13 determined to be engaged in work under  
14 subsection (c)(1), the State may, notwith-  
15 standing subsection (c)(2), count the num-  
16 ber of hours during the month for which  
17 the recipient participates in a work activity  
18 described in paragraph (6), (8), (9), (10),  
19 or (11) of subsection (d).

20 “(ii) SUFFICIENTLY EMPLOYED RE-  
21 CIPIENT.—As used in clause (i), the term  
22 ‘sufficiently employed recipient’ means,  
23 with respect to a month, a recipient who is  
24 in a position described in paragraph (1)

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1 during the month for a number of hours  
2 that is not less than—

3 “(I) the sum of the dollar value  
4 of any assistance provided to the re-  
5 cipient during the month under the  
6 State program funded under this part,  
7 and the dollar value equivalent of any  
8 benefits provided to the recipient dur-  
9 ing the month under the food stamp  
10 program under the Food Stamp Act  
11 of 1977; divided by

12 “(II) the minimum wage rate in  
13 effect during the month under section  
14 6 of the Fair Labor Standards Act of  
15 1938.

16 “(3) BENEFITS.—As used in paragraph (2)(A),  
17 the term ‘value of the benefits’ means—

18 “(A) in the case of assistance under the  
19 State program funded under this part, the dol-  
20 lar value of such assistance;

21 “(B) in the case of food stamp benefits  
22 under the food stamp program under the Food  
23 Stamp Act of 1977, the dollar value equivalent  
24 of such benefits;

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1           “(C) at the option of the State, in the case  
2 of medical assistance benefits provided under  
3 the State plan approved under title XIX, the  
4 dollar value of such benefits, as determined in  
5 accordance with paragraph (4);

6           “(D) at the option of the State, in the case  
7 of child care assistance, the dollar value of such  
8 assistance; and

9           “(E) at the option of the State, in the case  
10 of housing benefits, the dollar value of such  
11 benefits.

12           “(4) VALUATION OF MEDICAID BENEFITS.—An-  
13 nually, the Secretary shall publish a table that speci-  
14 fies the dollar value of the insurance coverage pro-  
15 vided under title XIX to a family of each size, which  
16 may take account of geographical variations or other  
17 factors identified by the Secretary.

18           “(5) TREATMENT OF RECIPIENTS ASSIGNED TO  
19 CERTAIN POSITIONS WITH A PUBLIC AGENCY OR  
20 NONPROFIT ORGANIZATION.—A recipient of assist-  
21 ance under a State program funded under this part  
22 who is engaged in work experience or community  
23 service with a public agency or nonprofit organiza-  
24 tion shall not be considered an employee of the pub-  
25 lic agency or the nonprofit organization.

1       “(k) HEALTH AND SAFETY.—Health and safety  
2 standards established under Federal and State law other-  
3 wise applicable to working conditions of employees shall  
4 be equally applicable to working conditions of participants  
5 engaged in a work activity. To the extent that a State  
6 workers’ compensation law applies, workers’ compensation  
7 shall be provided to participants on the same basis as the  
8 compensation is provided to other individuals in the State  
9 in similar employment.”.

10       (b) RETROACTIVITY.—The amendment made by sub-  
11 section (a) of this section shall take effect as if included  
12 in the enactment of section 103(a) of the Personal Re-  
13 sponsibility and Work Opportunity Reconciliation Act of  
14 1996.

15 **SEC. 9005. PENALTY FOR FAILURE OF STATE TO REDUCE**  
16 **ASSISTANCE FOR RECIPIENTS REFUSING**  
17 **WITHOUT GOOD CAUSE TO WORK.**

18       (a) IN GENERAL.—Section 409(a) of the Social Secu-  
19 rity Act (42 U.S.C. 609(a)) is amended by adding at the  
20 end the following:

21               “(13) PENALTY FOR FAILURE TO REDUCE AS-  
22               SISTANCE FOR RECIPIENTS REFUSING WITHOUT  
23               GOOD CAUSE TO WORK.—

24                       “(A) IN GENERAL.—If the Secretary deter-  
25                       mines that a State to which a grant is made



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1 under section 403 in a fiscal year has violated  
2 section 407(e) during the fiscal year, the Sec-  
3 retary shall reduce the grant payable to the  
4 State under section 403(a)(1) for the imme-  
5 diately succeeding fiscal year by an amount  
6 equal to not less than 1 percent and not more  
7 than 5 percent of the State family assistance  
8 grant.

9 “(B) PENALTY BASED ON SEVERITY OF  
10 FAILURE.—The Secretary shall impose reduc-  
11 tions under subparagraph (A) with respect to a  
12 fiscal year based on the degree of noncompli-  
13 ance.”.

14 (b) RETROACTIVITY.—The amendment made by sub-  
15 section (a) of this section shall take effect as if included  
16 in the enactment of section 103(a) of the Personal Re-  
17 sponsibility and Work Opportunity Reconciliation Act of  
18 1996.

1 **Subtitle B—Supplemental Security**  
2 **Income**

3 **SEC. 9101. REQUIREMENT TO PERFORM CHILDHOOD DIS-**  
4 **ABILITY REDETERMINATIONS IN MISSED**  
5 **CASES.**

6 Section 211(d)(2) of the Personal Responsibility and  
7 Work Opportunity Reconciliation Act of 1996 (110 Stat.  
8 2190) is amended—

9 (1) in subparagraph (A)—

10 (A) in the 1st sentence, by striking “1  
11 year” and inserting “18 months”; and

12 (B) by inserting after the 1st sentence the  
13 following: “Any redetermination required by the  
14 preceding sentence that is not performed before  
15 the end of the period described in the preceding  
16 sentence shall be performed as soon as is prac-  
17 ticable thereafter.”; and

18 (2) in subparagraph (C), by adding at the end  
19 the following: “Before commencing a redetermina-  
20 tion under the 2nd sentence of subparagraph (A), in  
21 any case in which the individual involved has not al-  
22 ready been notified of the provisions of this para-  
23 graph, the Commissioner of Social Security shall no-  
24 tify the individual involved of the provisions of this  
25 paragraph.”.

1 **SEC. 9102. REPEAL OF MAINTENANCE OF EFFORT RE-**  
2 **QUIREMENTS APPLICABLE TO OPTIONAL**  
3 **STATE PROGRAMS FOR SUPPLEMENTATION**  
4 **OF SSI BENEFITS.**

5 Section 1618 of the Social Security Act (42 U.S.C.  
6 1382g) is repealed.

7 **SEC. 9103. FEES FOR FEDERAL ADMINISTRATION OF STATE**  
8 **SUPPLEMENTARY PAYMENTS.**

9 (a) FEE SCHEDULE.—

10 (1) OPTIONAL STATE SUPPLEMENTARY PAY-  
11 MENTS.—

12 (A) IN GENERAL.—Section 1616(d)(2)(B)  
13 of the Social Security Act (42 U.S.C.  
14 1382e(d)(2)(B)) is amended—

15 (i) by striking “and” at the end of  
16 clause (iii); and

17 (ii) by striking clause (iv) and insert-  
18 ing the following:

19 “(iv) for fiscal year 1997, \$5.00;

20 “(v) for fiscal year 1998, \$6.20;

21 “(vi) for fiscal year 1999, \$7.60;

22 “(vii) for fiscal year 2000, \$7.80;

23 “(viii) for fiscal year 2001, \$8.10;

24 “(ix) for fiscal year 2002, \$8.50; and

25 “(x) for fiscal year 2003 and each succeeding  
26 fiscal year—

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1           “(I) the applicable rate in the preceding  
2           fiscal year, increased by the percentage, if any,  
3           by which the Consumer Price Index for the  
4           month of June of the calendar year of the in-  
5           crease exceeds the Consumer Price Index for  
6           the month of June of the calendar year preced-  
7           ing the calendar year of the increase, and  
8           rounded to the nearest whole cent; or

9           “(II) such different rate as the Commis-  
10          sioner determines is appropriate for the State.”.

11          (B) CONFORMING AMENDMENT.—Section  
12          1616(d)(2)(C) of such Act (42 U.S.C.  
13          1382e(d)(2)(C)) is amended by striking  
14          “(B)(iv)” and inserting “(B)(x)(II)”.

15          (2) MANDATORY STATE SUPPLEMENTARY PAY-  
16          MENTS.—

17                 (A)           IN           GENERAL.—Section  
18                 212(b)(3)(B)(ii) of Public Law 93–66 (42  
19                 U.S.C. 1382 note) is amended—

20                         (i) by striking “and” at the end of  
21                         subclause (III); and

22                         (ii) by striking subclause (IV) and in-  
23                         serting the following:

24                         “(IV) for fiscal year 1997, \$5.00;

25                         “(V) for fiscal year 1998, \$6.20;

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1 “(VI) for fiscal year 1999, \$7.60;  
2 “(VII) for fiscal year 2000, \$7.80;  
3 “(VIII) for fiscal year 2001, \$8.10;  
4 “(IX) for fiscal year 2002, \$8.50; and  
5 “(X) for fiscal year 2003 and each succeeding  
6 fiscal year—

7 “(aa) the applicable rate in the preceding  
8 fiscal year, increased by the percentage, if any,  
9 by which the Consumer Price Index for the  
10 month of June of the calendar year of the in-  
11 crease exceeds the Consumer Price Index for  
12 the month of June of the calendar year preced-  
13 ing the calendar year of the increase, and  
14 rounded to the nearest whole cent; or

15 “(bb) such different rate as the Commis-  
16 sioner determines is appropriate for the State.”.

17 (B) CONFORMING AMENDMENT.—Section  
18 212(b)(3)(B)(iii) of such Act (42 U.S.C. 1382  
19 note) is amended by striking “(ii)(IV)” and in-  
20 serting “(ii)(X)(bb)”.

21 (b) USE OF NEW FEES TO DEFRAY THE SOCIAL SE-  
22 CURITY ADMINISTRATION’S ADMINISTRATIVE EX-  
23 PENSES.—

24 (1) CREDIT TO SPECIAL FUND FOR FISCAL  
25 YEAR 1998 AND SUBSEQUENT YEARS.—

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1 (A) OPTIONAL STATE SUPPLEMENTARY  
2 PAYMENT FEES.—Section 1616(d)(4) of the So-  
3 cial Security Act (42 U.S.C. 1382e(d)(4)) is  
4 amended to read as follows:

5 “(4)(A) The first \$5 of each administration fee as-  
6 sessed pursuant to paragraph (2), upon collection, shall  
7 be deposited in the general fund of the Treasury of the  
8 United States as miscellaneous receipts.

9 “(B) That portion of each administration fee in ex-  
10 cess of \$5, and 100 percent of each additional services  
11 fee charged pursuant to paragraph (3), upon collection for  
12 fiscal year 1998 and each subsequent fiscal year, shall be  
13 credited to a special fund established in the Treasury of  
14 the United States for State supplementary payment fees.  
15 The amounts so credited, to the extent and in the amounts  
16 provided in advance in appropriations Acts, shall be avail-  
17 able to defray expenses incurred in carrying out this title  
18 and related laws.”.

19 (B) MANDATORY STATE SUPPLEMENTARY  
20 PAYMENT FEES.—Section 212(b)(3)(D) of Pub-  
21 lic Law 93–66 (42 U.S.C. 1382 note) is amend-  
22 ed to read as follows:

23 “(D)(i) The first \$5 of each administration fee as-  
24 sessed pursuant to subparagraph (B), upon collection,

1 shall be deposited in the general fund of the Treasury of  
2 the United States as miscellaneous receipts.

3 “(ii) The portion of each administration fee in excess  
4 of \$5, and 100 percent of each additional services fee  
5 charged pursuant to subparagraph (C), upon collection for  
6 fiscal year 1998 and each subsequent fiscal year, shall be  
7 credited to a special fund established in the Treasury of  
8 the United States for State supplementary payment fees.  
9 The amounts so credited, to the extent and in the amounts  
10 provided in advance in appropriations Acts, shall be avail-  
11 able to defray expenses incurred in carrying out this sec-  
12 tion and title XVI of the Social Security Act and related  
13 laws.”.

14 (2) LIMITATIONS ON AUTHORIZATION OF AP-  
15 PROPRIATIONS.—From amounts credited pursuant  
16 to section 1616(d)(4)(B) of the Social Security Act  
17 and section 212(b)(3)(D)(ii) of Public Law 93–66 to  
18 the special fund established in the Treasury of the  
19 United States for State supplementary payment  
20 fees, there is authorized to be appropriated an  
21 amount not to exceed \$35,000,000 for fiscal year  
22 1998, and such sums as may be necessary for each  
23 fiscal year thereafter.

1                   **Subtitle C—Child Support**  
2                   **Enforcement**

3 **SEC. 9201. CLARIFICATION OF AUTHORITY TO PERMIT CER-**  
4                   **TAIN REDISCLOSURES OF WAGE AND CLAIM**  
5                   **INFORMATION.**

6           Section 303(h)(1)(C) of the Social Security Act (42  
7 U.S.C. 503(h)(1)(C)) is amended by striking “section  
8 453(i)(1) in carrying out the child support enforcement  
9 program under title IV” and inserting “subsections (i)(1),  
10 (i)(3), and (j) of section 453”.

11                   **Subtitle D—Restricting Welfare**  
12                   **and Public Benefits for Aliens**

13 **SEC. 9301. EXTENSION OF ELIGIBILITY PERIOD FOR REFU-**  
14                   **GEES AND CERTAIN OTHER QUALIFIED**  
15                   **ALIENS FROM 5 TO 7 YEARS FOR SSI AND**  
16                   **MEDICAID.**

17           (a) SSI.—Section 402(a)(2)(A) of the Personal Re-  
18 sponsibility and Work Opportunity Reconciliation Act of  
19 1996 (8 U.S.C. 1612(a)(2)(A)) is amended to read as fol-  
20 lows:

21                   “(A) TIME-LIMITED EXCEPTION FOR REF-

22                   UGEEES AND ASYLEES.—

23                   “(i) SSI.—With respect to the speci-

24                   fied Federal program described in para-



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1 graph (3)(A) paragraph 1 shall not apply  
2 to an alien until 7 years after the date—

3 “(I) an alien is admitted to the  
4 United States as a refugee under sec-  
5 tion 207 of the Immigration and Na-  
6 tionality Act;

7 “(II) an alien is granted asylum  
8 under section 208 of such Act; or

9 “(III) an alien’s deportation is  
10 withheld under section 243(h) of such  
11 Act.

12 “(ii) FOOD STAMPS.—With respect to  
13 the specified Federal program described in  
14 paragraph (3)(B), paragraph 1 shall not  
15 apply to an alien until 5 years after the  
16 date—

17 “(I) an alien is admitted to the  
18 United States as a refugee under sec-  
19 tion 207 of the Immigration and Na-  
20 tionality Act;

21 “(II) an alien is granted asylum  
22 under section 208 of such Act; or

23 “(III) an alien’s deportation is  
24 withheld under section 243(h) of such  
25 Act.”.

1 (b) MEDICAID.—Section 402(b)(2)(A) of the Per-  
2 sonal Responsibility and Work Opportunity Reconciliation  
3 Act of 1996 (8 U.S.C. 1612(b)(2)(A)) is amended to read  
4 as follows:

5 “(A) TIME-LIMITED EXCEPTION FOR REF-  
6 UGEEES AND ASYLEES.—

7 “(i) MEDICAID.—With respect to the  
8 designated Federal program described in  
9 paragraph (3)(C), paragraph 1 shall not  
10 apply to an alien until 7 years after the  
11 date—

12 “(I) an alien is admitted to the  
13 United States as a refugee under sec-  
14 tion 207 of the Immigration and Na-  
15 tionality Act;

16 “(II) an alien is granted asylum  
17 under section 208 of such Act; or

18 “(III) an alien’s deportation is  
19 withheld under section 243(h) of such  
20 Act.

21 “(ii) OTHER DESIGNATED FEDERAL  
22 PROGRAMS.—With respect to the des-  
23 ignated Federal programs under paragraph  
24 (3) (other than subparagraph (C)), para-

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1 graph 1 shall not apply to an alien until 5  
2 years after the date—

3 “(I) an alien is admitted to the  
4 United States as a refugee under sec-  
5 tion 207 of the Immigration and Na-  
6 tionality Act;

7 “(II) an alien is granted asylum  
8 under section 208 of such Act; or

9 “(III) an alien’s deportation is  
10 withheld under section 243(h) of such  
11 Act.”.

12 **SEC. 9302. SSI ELIGIBILITY FOR ALIENS RECEIVING SSI ON**  
13 **AUGUST 22, 1996.**

14 (a) IN GENERAL.—Section 402(a)(2) of the Personal  
15 Responsibility and Work Opportunity Reconciliation Act  
16 of 1996 (8 U.S.C. 1612(a)(2)) is amended by adding after  
17 subparagraph (D) the following new subparagraph:

18 “(E) ALIENS RECEIVING SSI ON AUGUST  
19 22, 1996.—With respect to eligibility for bene-  
20 fits for the program defined in paragraph  
21 (3)(A) (relating to the supplemental security in-  
22 come program), paragraph (1) shall not apply  
23 to an alien who was receiving such benefits on  
24 August 22, 1996.”.

1 (b) STATUS OF CUBAN AND HAITIAN ENTRANTS AND  
2 AMERASIAN PERMANENT RESIDENT ALIENS.—For pur-  
3 poses of section 402(a)(2)(E) of the Personal Responsibil-  
4 ity and Work Opportunity Reconciliation Act of 1996, the  
5 following aliens shall be considered qualified aliens:

6 (1) An alien who is a Cuban and Haitian en-  
7 trant as defined in section 501(e) of the Refugee  
8 Education Assistance Act of 1980.

9 (2) An alien admitted to the United States as  
10 an Amerasian immigrant pursuant to section 584 of  
11 the Foreign Operations, Export Financing, and Re-  
12 lated Programs Appropriations Act, 1988, as con-  
13 tained in section 101(e) of Public Law 100-202,  
14 (other than an alien admitted pursuant to section  
15 584(b)(1)(C)).

16 (c) CONFORMING AMENDMENTS.—Section  
17 402(a)(2)(D) of the Personal Responsibility and Work Op-  
18 portunity Reconciliation Act of 1996 (8 U.S.C.  
19 1612(a)(D)) is amended—

20 (1) by striking clause (i);

21 (2) in the subparagraph heading by striking  
22 “BENEFITS” and inserting “FOOD STAMPS”;

23 (3) by striking “(ii) FOOD STAMPS’.—”;

24 (3) by redesignating subclauses (I), (II), and  
25 (III) as clauses (i), (ii), and (iii).

1 **SEC. 9303. SSI ELIGIBILITY FOR PERMANENT RESIDENT**  
2 **ALIENS WHO ARE MEMBERS OF AN INDIAN**  
3 **TRIBE.**

4 Section 402(a)(2) of the Personal Responsibility and  
5 Work Opportunity Reconciliation Act of 1996 (8 U.S.C.  
6 1612(a)(2)) (as amended by section 9302) is amended by  
7 adding after subparagraph (E) the following new subpara-  
8 graph:

9 “(F) PERMANENT RESIDENT ALIENS WHO  
10 ARE MEMBERS OF AN INDIAN TRIBE.—With re-  
11 spect to eligibility for benefits for the program  
12 defined in paragraph (3)(A) (relating to the  
13 supplemental security income program), para-  
14 graph (1) shall not apply to an alien who—

15 “(i) is lawfully admitted for perma-  
16 nent residence under the Immigration and  
17 Nationality Act; and

18 “(ii) is a member of an Indian tribe  
19 (as defined in section 4(e) of the Indian  
20 Self-Determination and Education Assist-  
21 ance Act).”.

22 **SEC. 9304. VERIFICATION OF ELIGIBILITY FOR STATE AND**  
23 **LOCAL PUBLIC BENEFITS.**

24 (a) IN GENERAL.—The Personal Responsibility and  
25 Work Opportunity Reconciliation Act of 1996 is amended  
26 by adding after section 412 the following new section:

1 **“SEC. 413. AUTHORIZATION FOR VERIFICATION OF ELIGI-**  
2 **BILITY FOR STATE AND LOCAL PUBLIC BENE-**  
3 **FITS.**

4 “A State or political subdivision of a State is author-  
5 ized to require an applicant for State and local public ben-  
6 efits (as defined in section 411(c)) to provide proof of eli-  
7 gibility.”.

8 (b) CLERICAL AMENDMENT.—Section 2 of the Per-  
9 sonal Responsibility and Work Opportunity Reconciliation  
10 Act of 1996 is amended by adding after the item related  
11 to section 412 the following:

“Sec. 413. Authorization for verification of eligibility for state and local public  
benefits.”.

12 **SEC. 9305. DERIVATIVE ELIGIBILITY FOR BENEFITS.**

13 (a) IN GENERAL.—The Personal Responsibility and  
14 Work Opportunity Reconciliation Act of 1996 is amended  
15 by adding after section 435 the following new section:

16 **“SEC. 436. DERIVATIVE ELIGIBILITY FOR BENEFITS.**

17 “(a) FOOD STAMPS.—Notwithstanding any other  
18 provision of law, an alien who under the provisions of this  
19 title is ineligible for benefits under the food stamp pro-  
20 gram (as defined in section 402(a)(3)(A)) shall not be eli-  
21 gible for such benefits because the alien receives benefits  
22 under the supplemental security income program (as de-  
23 fined in section 402(a)(3)(B)).

1 “(b) MEDICAID.—Notwithstanding any other provi-  
2 sion of this title, an alien who under the provisions of this  
3 title is ineligible for benefits under the medicaid program  
4 (as defined in section 402(b)(3)(C)) shall be eligible for  
5 such benefits if the alien is receiving benefits under the  
6 supplemental security income program and title XIX of  
7 the Social Security Act provides for such derivative eligi-  
8 bility.”.

9 (b) CLERICAL AMENDMENT.—Section 2 of the Per-  
10 sonal Responsibility and Work Opportunity Reconciliation  
11 Act of 1996 is amended by adding after the item related  
12 to section 435 the following:

“Sec. 436. Derivative eligibility for benefits.”.

13 **SEC. 9306. EFFECTIVE DATE.**

14 Except as otherwise provided, the amendments made  
15 by this subtitle shall be effective as if included in the en-  
16 actment of title IV of the Personal Responsibility and  
17 Work Opportunity Reconciliation Act of 1996.

18 **Subtitle E—Unemployment**  
19 **Compensation**

20 **SEC. 9401. CLARIFYING PROVISION RELATING TO BASE PE-**  
21 **RIODS.**

22 (a) IN GENERAL.—No provision of a State law under  
23 which the base period for such State is defined or other-  
24 wise determined shall, for purposes of section 303(a)(1)

1 of the Social Security Act (42 U.S.C. 503(a)(1)), be con-  
2 sidered a provision for a method of administration.

3 (b) DEFINITIONS.—For purposes of this section, the  
4 terms “State law”, “base period”, and “State” shall have  
5 the meanings given them under section 205 of the Fed-  
6 eral-State Extended Unemployment Compensation Act of  
7 1970 (26 U.S.C. 3304 note).

8 (c) EFFECTIVE DATE.—This section shall apply for  
9 purposes of any period beginning before, on, or after the  
10 date of the enactment of this Act.

11 **SEC. 9402. INCREASE IN FEDERAL UNEMPLOYMENT AC-**  
12 **COUNT CEILING.**

13 (a) IN GENERAL.—Section 902(a)(2) of the Social  
14 Security Act (42 U.S.C. 1102(a)(2)) is amended by strik-  
15 ing “0.25 percent” and inserting “0.5 percent”.

16 (b) EFFECTIVE DATE.—This section and the amend-  
17 ment made by this section—

18 (1) shall take effect on October 1, 2001, and

19 (2) shall apply to fiscal years beginning on or  
20 after that date.

21 **SEC. 9403. SPECIAL DISTRIBUTION TO STATES FROM UNEM-**  
22 **PLOYMENT TRUST FUND.**

23 (a) IN GENERAL.—Subsection (a) of section 903 of  
24 the Social Security Act (42 U.S.C. 1103(a)) is amended  
25 by adding at the end the following new paragraph:



1       “(3)(A) Notwithstanding any other provision of this  
2 section, for purposes of carrying out this subsection with  
3 respect to any excess amount (referred to in paragraph  
4 (1)) remaining in the employment security administration  
5 account as of the close of fiscal year 1999, 2000, or 2001,  
6 such amount shall—

7               “(i) to the extent of any amounts not in excess  
8 of \$100,000,000, be subject to subparagraph (B),  
9 and

10              “(ii) to the extent of any amounts in excess of  
11 \$100,000,000, be subject to subparagraph (C).

12       “(B) Paragraphs (1) and (2) shall apply with respect  
13 to any amounts described in subparagraph (A)(i), except  
14 that—

15              “(i) in carrying out the provisions of paragraph  
16 (2)(B) with respect to such amounts (to determine  
17 the portion of such amounts which is to be allocated  
18 to a State for a succeeding fiscal year), the ratio to  
19 be applied under such provisions shall be the same  
20 as the ratio that—

21                      “(I) the amount of funds to be allocated to  
22 such State for such fiscal year pursuant to title  
23 III, bears to

1           “(II) the total amount of funds to be allo-  
2           cated to all States for such fiscal year pursuant  
3           to title III,

4           as determined by the Secretary of Labor, and

5           “(ii) the amounts allocated to a State pursuant  
6           to this subparagraph shall be available to such  
7           State, subject to the last sentence of subsection  
8           (c)(2).

9           Nothing in this paragraph shall preclude the application  
10          of subsection (b) with respect to any allocation determined  
11          under this subparagraph.

12          “(C) Any amounts described in clause (ii) of subpara-  
13          graph (A) (remaining in the employment security adminis-  
14          tration account as of the close of any fiscal year specified  
15          in such subparagraph) shall, as of the beginning of the  
16          succeeding fiscal year, accrue to the Federal unemploy-  
17          ment account, without regard to the limit provided in sec-  
18          tion 902(a).”

19          (b) CONFORMING AMENDMENT.—Paragraph (2) of  
20          section 903(c) of the Social Security Act is amended by  
21          adding at the end, as a flush left sentence, the following:  
22          “Any amount allocated to a State under this section for  
23          fiscal year 2000, 2001, or 2002 may be used by such State  
24          only to pay expenses incurred by it for the administration  
25          of its unemployment compensation law, and may be so

1 used by it without regard to any of the conditions pre-  
2 scribed in any of the preceding provisions of this para-  
3 graph.”

4 **SEC. 9404. INTEREST-FREE ADVANCES TO STATE AC-**  
5 **COUNTS IN UNEMPLOYMENT TRUST FUND**  
6 **RESTRICTED TO STATES WHICH MEET FUND-**  
7 **ING GOALS.**

8 (a) IN GENERAL.—Paragraph (2) of section 1202(b)  
9 of the Social Security Act (42 U.S.C. 1322(b)) is amend-  
10 ed—

11 (1) by striking “and” at the end of subpara-  
12 graph (A),

13 (2) by striking the period at the end of sub-  
14 paragraph (B) and inserting “, and”, and

15 (3) by adding at the end the following new sub-  
16 paragraph:

17 “(C) the average daily balance in the account of  
18 such State in the Unemployment Trust Fund for  
19 each of 4 of the 5 calendar quarters preceding the  
20 calendar quarter in which such advances were made  
21 exceeds the funding goal of such State (as defined  
22 in subsection (d)).”

23 (b) FUNDING GOAL DEFINED.—Section 1202 of the  
24 Social Security Act is amended by adding at the end the  
25 following new subsection:

1 “(d) For purposes of subsection (b)(2)(C), the term  
2 ‘funding goal’ means, for any State for any calendar quar-  
3 ter, the average of the unemployment insurance benefits  
4 paid by such State during each of the 3 years, in the 20-  
5 year period ending with the calendar year containing such  
6 calendar quarter, during which the State paid the greatest  
7 amount of unemployment benefits.”

8 (c) EFFECTIVE DATE.—The amendments made by  
9 this section shall apply to calendar years beginning after  
10 the date of the enactment of this Act.

11 **SEC. 9405. EXEMPTION OF SERVICE PERFORMED BY ELEC-**  
12 **TION WORKERS FROM THE FEDERAL UNEM-**  
13 **PLOYMENT TAX.**

14 (a) IN GENERAL.—Paragraph (3) of section 3309(b)  
15 of the Internal Revenue Code of 1986 (relating to exemp-  
16 tion for certain services) is amended—

17 (1) by striking “or” at the end of subparagraph  
18 (D),

19 (2) by adding “or” at the end of subparagraph  
20 (E), and

21 (3) by inserting after subparagraph (E) the fol-  
22 lowing new subparagraph:

23 “(F) as an election official or election  
24 worker if the amount of remuneration received  
25 by the individual during the calendar year for

1 services as an election official or election worker  
2 is less than \$1,000;”.

3 (b) EFFECTIVE DATE.—The amendments made by  
4 this section shall apply with respect to service performed  
5 after the date of the enactment of this Act.

6 **SEC. 9406. TREATMENT OF CERTAIN SERVICES PER-**  
7 **FORMED BY INMATES.**

8 (a) IN GENERAL.—Subsection (c) of section 3306 of  
9 the Internal Revenue Code of 1986 (defining employment)  
10 is amended—

11 (1) by striking “or” at the end of paragraph  
12 (19),

13 (2) by striking the period at the end of para-  
14 graph (20) and inserting “; or”, and

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

17 “(21) service performed by a person committed  
18 to a penal institution.”

19 (b) EFFECTIVE DATE.—The amendments made by  
20 this section shall apply with respect to service performed  
21 after March 26, 1996.

1 **SEC. 9407. EXEMPTION OF SERVICE PERFORMED FOR AN**  
2 **ELEMENTARY OR SECONDARY SCHOOL OPER-**  
3 **ATED PRIMARILY FOR RELIGIOUS PURPOSES**  
4 **FROM THE FEDERAL UNEMPLOYMENT TAX.**

5 (a) IN GENERAL.—Paragraph (1) of section 3309(b)  
6 of the Internal Revenue Code of 1986 (relating to exemp-  
7 tion for certain services) is amended—

8 (1) by striking “or” at the end of subparagraph  
9 (A), and

10 (2) by inserting before the semicolon at the end  
11 the following: “, or (C) an elementary or secondary  
12 school which is operated primarily for religious pur-  
13 poses, which is described in section 501(c)(3), and  
14 which is exempt from tax under section 501(a)”.

15 (b) EFFECTIVE DATE.—The amendments made by  
16 this section shall apply with respect to service performed  
17 after the date of the enactment of this Act.

18 **SEC. 9408. STATE PROGRAM INTEGRITY ACTIVITIES FOR**  
19 **UNEMPLOYMENT COMPENSATION.**

20 Section 901(c) of the Social Security Act (42 U.S.C.  
21 1101(c)) is amended by adding at the end the following  
22 new paragraph:

23 “(5)(A) There are authorized to be appropriated out  
24 of the employment security administration account to  
25 carry out program integrity activities, in addition to any  
26 amounts available under paragraph (1)(A)(i)—

- 1           “(i) \$89,000,000 for fiscal year 1998;
- 2           “(ii) \$91,000,000 for fiscal year 1999;
- 3           “(iii) \$93,000,000 fiscal year 2000;
- 4           “(iv) \$96,000,000 for fiscal year 2001; and
- 5           “(v) \$98,000,000 for fiscal year 2002.

6           “(B) In any fiscal year in which a State receives

7 funds appropriated pursuant to this paragraph, the State

8 shall expend a proportion of the funds appropriated pursu-

9 ant to paragraph (1)(A)(i) to carry out program integrity

10 activities that is not less than the proportion of the funds

11 appropriated under such paragraph that was expended by

12 the State to carry out program integrity activities in fiscal

13 year 1997.

14           “(C) For purposes of this paragraph, the term ‘pro-

15 gram integrity activities’ means initial claims review ac-

16 tivities, eligibility review activities, benefit payments con-

17 trol activities, and employer liability auditing activities.”.

18 **Subtitle F—Increase in Public Debt**

19 **Limit**

20 **SEC. 9501. INCREASE IN PUBLIC DEBT LIMIT.**

21           Subsection (b) of section 3101 of title 31, United

22 States Code, is amended by striking the dollar amount

23 contained therein and inserting “\$5,950,000,000,000”.

1 **TITLE X—COMMITTEE ON WAYS**  
2 **AND MEANS—MEDICARE**

3 **SEC. 10000. AMENDMENTS TO SOCIAL SECURITY ACT AND**  
4 **REFERENCES TO OBRA; TABLE OF CONTENTS**  
5 **OF TITLE.**

6 (a) AMENDMENTS TO SOCIAL SECURITY ACT.—Ex-  
7 cept as otherwise specifically provided, whenever in this  
8 title an amendment is expressed in terms of an amend-  
9 ment to or repeal of a section or other provision, the ref-  
10 erence shall be considered to be made to that section or  
11 other provision of the Social Security Act.

12 (b) REFERENCES TO OBRA.—In this title, the terms  
13 “OBRA–1986”, “OBRA–1987”, “OBRA–1989”,  
14 “OBRA–1990”, and “OBRA–1993” refer to the Omnibus  
15 Budget Reconciliation Act of 1986 (Public Law 99–509),  
16 the Omnibus Budget Reconciliation Act of 1987 (Public  
17 Law 100–203), the Omnibus Budget Reconciliation Act  
18 of 1989 (Public Law 101–239), the Omnibus Budget Rec-  
19 onciliation Act of 1990 (Public Law 101–508), and the  
20 Omnibus Budget Reconciliation Act of 1993 (Public Law  
21 103–66), respectively.

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

Sec. 10000. Amendments to Social Security Act and references to OBRA; table  
of contents of title.

Subtitle A—MedicarePlus Program



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### CHAPTER 1—MEDICAREPLUS PROGRAM

#### SUBCHAPTER A—MEDICAREPLUS PROGRAM

Sec. 10001. Establishment of MedicarePlus program.

#### “PART C—MEDICAREPLUS PROGRAM

“Sec. 1851. Eligibility, election, and enrollment.

“Sec. 1852. Benefits and beneficiary protections.

“Sec. 1853. Payments to MedicarePlus organizations.

“Sec. 1854. Premiums.

“Sec. 1855. Organizational and financial requirements for MedicarePlus organizations; provider-sponsored organizations.

“Sec. 1856. Establishment of standards.

“Sec. 1857. Contracts with MedicarePlus organizations.

“Sec. 1859. Definitions; miscellaneous provisions.

Sec. 10002. Transitional rules for current medicare HMO program.

Sec. 10003. Conforming changes in medigap program.

#### SUBCHAPTER B—SPECIAL RULES FOR MEDICAREPLUS MEDICAL SAVINGS ACCOUNTS

Sec. 10006. MedicarePlus MSA.

### CHAPTER 2—INTEGRATED LONG-TERM CARE PROGRAMS

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

Sec. 10011. Coverage of PACE under the medicare program.

Sec. 10012. Establishment of PACE program as medicaid State option.

Sec. 10013. Effective date; transition.

Sec. 10014. Study and reports.

#### SUBCHAPTER B—SOCIAL HEALTH MAINTENANCE ORGANIZATIONS

Sec. 10015. Social health maintenance organizations (SHMOs).

#### SUBCHAPTER C—OTHER PROGRAMS

Sec. 10018. Orderly transition of municipal health service demonstration projects.

Sec. 10019. Extension of certain medicare community nursing organization demonstration projects.

### CHAPTER 3—MEDICARE PAYMENT ADVISORY COMMISSION

Sec. 10021. Medicare Payment Advisory Commission.

### CHAPTER 4—MEDIGAP PROTECTIONS

Sec. 10031. Medigap protections.

Sec. 10032. Medicare prepaid competitive pricing demonstration project.

### CHAPTER 5—TAX TREATMENT OF HOSPITALS PARTICIPATING IN PROVIDER-SPONSORED ORGANIZATIONS

Sec. 10041. Tax treatment of hospitals which participate in provider-sponsored organizations.

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### Subtitle B—Prevention Initiatives

- Sec. 10101. Screening mammography.
- Sec. 10102. Screening pap smear and pelvic exams.
- Sec. 10103. Prostate cancer screening tests.
- Sec. 10104. Coverage of colorectal screening.
- Sec. 10105. Diabetes screening tests.
- Sec. 10106. Standardization of medicare coverage of bone mass measurements.
- Sec. 10107. Vaccines outreach expansion.
- Sec. 10108. Study on preventive benefits.

### Subtitle C—Rural Initiatives

- Sec. 10201. Rural primary care hospital program.
- Sec. 10202. Prohibiting denial of request by rural referral centers for reclassification on basis of comparability of wages.
- Sec. 10203. Hospital geographic reclassification permitted for purposes of disproportionate share payment adjustments.
- Sec. 10204. Medicare-dependent, small rural hospital payment extension.
- Sec. 10205. Geographic reclassification for certain disproportionately large hospitals.
- Sec. 10206. Floor on area wage index.
- Sec. 10207. Informatics, telemedicine, and education demonstration project.

### Subtitle D—Anti-Fraud and Abuse Provisions

- Sec. 10301. Permanent exclusion for those convicted of 3 health care related crimes.
- Sec. 10302. Authority to refuse to enter into medicare agreements with individuals or entities convicted of felonies.
- Sec. 10303. Inclusion of toll-free number to report medicare waste, fraud, and abuse in explanation of benefits forms.
- Sec. 10304. Liability of medicare carriers and fiscal intermediaries for claims submitted by excluded providers.
- Sec. 10305. Exclusion of entity controlled by family member of a sanctioned individual.
- Sec. 10306. Imposition of civil money penalties.
- Sec. 10307. Disclosure of information and surety bonds.
- Sec. 10308. Provision of certain identification numbers.
- Sec. 10309. Advisory opinions regarding certain physician self-referral provisions.
- Sec. 10310. Other fraud and abuse related provisions.

### Subtitle E—Prospective Payment Systems

#### CHAPTER 1—PAYMENT UNDER PART A

- Sec. 10401. Prospective payment for skilled nursing facility services.
- Sec. 10402. Prospective payment for inpatient rehabilitation hospital services.

#### CHAPTER 2—PAYMENT UNDER PART B

##### SUBCHAPTER A—PAYMENT FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES

- Sec. 10411. Elimination of formula-driven overpayments (FDO) for certain outpatient hospital services.

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- Sec. 10412. Extension of reductions in payments for costs of hospital outpatient services.
- Sec. 10413. Prospective payment system for hospital outpatient department services.

### SUBCHAPTER B—REHABILITATION SERVICES

- Sec. 10421. Rehabilitation agencies and services.
- Sec. 10422. Comprehensive outpatient rehabilitation facilities (corf).

### SUBCHAPTER C—AMBULANCE SERVICES

- Sec. 10431. Payments for ambulance services.
- Sec. 10432. Demonstration of coverage of ambulance services under medicare through contracts with units of local government.

## CHAPTER 3—PAYMENT UNDER PARTS A AND B

- Sec. 10441. Prospective payment for home health services.

### Subtitle F—Provisions Relating to Part A

#### CHAPTER 1—PAYMENT OF PPS HOSPITALS

- Sec. 10501. PPS hospital payment update.
- Sec. 10502. Capital payments for PPS hospitals.
- Sec. 10503. Freeze in disproportionate share.
- Sec. 10504. Medicare capital asset sales price equal to book value.
- Sec. 10505. Elimination of IME and DSH payments attributable to outlier payments.
- Sec. 10506. Reduction in adjustment for indirect medical education.
- Sec. 10507. Treatment of transfer cases.
- Sec. 10508. Increase base payment rate to Puerto Rico hospitals.

#### CHAPTER 2—PAYMENT OF PPS EXEMPT HOSPITALS

- Sec. 10511. Payment update.
- Sec. 10512. Reductions to capital payments for certain PPS-exempt hospitals and units.
- Sec. 10513. Cap on TEFRA limits.
- Sec. 10514. Change in bonus and relief payments.
- Sec. 10515. Change in payment and target amount for new providers.
- Sec. 10516. Rebasing.
- Sec. 10517. Treatment of certain long-term care hospitals.
- Sec. 10518. Elimination of exemptions; report on exceptions and adjustments.

#### CHAPTER 3—PROVISIONS RELATED TO HOSPICE SERVICES

- Sec. 10521. Payments for hospice services.
- Sec. 10522. Payment for home hospice care based on location where care is furnished.
- Sec. 10523. Hospice care benefits periods.
- Sec. 10524. Other items and services included in hospice care.
- Sec. 10525. Contracting with independent physicians or physician groups for hospice care services permitted.
- Sec. 10526. Waiver of certain staffing requirements for hospice care programs in non-urbanized areas.

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- Sec. 10527. Limitation on liability of beneficiaries for certain hospice coverage denials.
- Sec. 10528. Extending the period for physician certification of an individual's terminal illness.
- Sec. 10529. Effective date.

### CHAPTER 4—MODIFICATION OF PART A HOME HEALTH BENEFIT

- Sec. 10531. Modification of part A home health benefit for individuals enrolled under part B.

### CHAPTER 5—OTHER PAYMENT PROVISIONS

- Sec. 10541. Reductions in payments for enrollee bad debt.
- Sec. 10542. Permanent extension of hemophilia pass-through.
- Sec. 10543. Reduction in part A medicare premium for certain public retirees.

### Subtitle G—Provisions Relating to Part B Only

#### CHAPTER 1—PHYSICIANS' SERVICES

- Sec. 10601. Establishment of single conversion factor for 1998.
- Sec. 10602. Establishing update to conversion factor to match spending under sustainable growth rate.
- Sec. 10603. Replacement of volume performance standard with sustainable growth rate.
- Sec. 10604. Payment rules for anesthesia services.
- Sec. 10605. Implementation of resource-based physician practice expense.
- Sec. 10606. Dissemination of information on high per discharge relative values for in-hospital physicians' services.
- Sec. 10607. No X-ray required for chiropractic services.
- Sec. 10608. Temporary coverage restoration for portable electrocardiogram transportation.

#### CHAPTER 2—OTHER PAYMENT PROVISIONS

- Sec. 10611. Payments for durable medical equipment.
- Sec. 10612. Oxygen and oxygen equipment.
- Sec. 10613. Reduction in updates to payment amounts for clinical diagnostic laboratory tests.
- Sec. 10614. Simplification in administration of laboratory tests.
- Sec. 10615. Updates for ambulatory surgical services.
- Sec. 10616. Reimbursement for drugs and biologicals.
- Sec. 10617. Coverage of oral anti-nausea drugs under chemotherapeutic regimen.
- Sec. 10618. Rural health clinic services.
- Sec. 10619. Increased medicare reimbursement for nurse practitioners and clinical nurse specialists.
- Sec. 10620. Increased medicare reimbursement for physician assistants.
- Sec. 10621. Renal dialysis-related services.

#### CHAPTER 3—PART B PREMIUM

- Sec. 10631. Part B premium.

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

#### CHAPTER 1—PROVISIONS RELATING TO MEDICARE SECONDARY PAYER

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- Sec. 10701. Permanent extension and revision of certain secondary payer provisions.
- Sec. 10702. Clarification of time and filing limitations.
- Sec. 10703. Permitting recovery against third party administrators.

### CHAPTER 2—HOME HEALTH SERVICES

- Sec. 10711. Recapturing savings resulting from temporary freeze on payment increases for home health services.
- Sec. 10712. Interim payments for home health services.
- Sec. 10713. Clarification of part-time or intermittent nursing care.
- Sec. 10714. Study of definition of homebound.
- Sec. 10715. Payment based on location where home health service is furnished.
- Sec. 10716. Normative standards for home health claims denials.
- Sec. 10717. No home health benefits based solely on drawing blood.

### CHAPTER 3—BABY BOOM GENERATION MEDICARE COMMISSION

- Sec. 10721. Bipartisan Commission on the Effect of the Baby Boom Generation on the Medicare Program.

### CHAPTER 4—PROVISIONS RELATING TO DIRECT GRADUATE MEDICAL EDUCATION

- Sec. 10731. Limitation on payment based on number of residents and implementation of rolling average FTE count.
- Sec. 10732. Phased-in limitation on hospital overhead and supervisory physician component of direct medical education costs.
- Sec. 10733. Permitting payment to non-hospital providers.
- Sec. 10734. Incentive payments under plans for voluntary reduction in number of residents.
- Sec. 10735. Demonstration project on use of consortia.
- Sec. 10736. Recommendations on long-term payment policies regarding financing teaching hospitals and graduate medical education.
- Sec. 10737. Medicare special reimbursement rule for certain combined residency programs.

### CHAPTER 5—OTHER PROVISIONS

- Sec. 10741. Centers of excellence.
- Sec. 10742. Medicare part B special enrollment period and waiver of part B late enrollment penalty and medigap special open enrollment period for certain military retirees and dependents.
- Sec. 10743. Protections under the medicare program for disabled workers who lose benefits under a group health plan.
- Sec. 10744. Placement of advance directive in medical record.

### Subtitle I—Medical Liability Reform

#### CHAPTER 1—GENERAL PROVISIONS

- Sec. 10801. Federal reform of health care liability actions.
- Sec. 10802. Definitions.
- Sec. 10803. Effective date.

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

- Sec. 10811. Statute of limitations.

Sec. 10812. Calculation and payment of damages.

Sec. 10813. Alternative dispute resolution.

1 **Subtitle A—MedicarePlus Program**

2 **CHAPTER 1—MEDICAREPLUS PROGRAM**

3 **Subchapter A—MedicarePlus Program**

4 **SEC. 10001. ESTABLISHMENT OF MEDICAREPLUS PRO-**  
5 **GRAM.**

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

9 “PART C—MEDICAREPLUS PROGRAM

10 “ELIGIBILITY, ELECTION, AND ENROLLMENT

11 “SEC. 1851. (a) CHOICE OF MEDICARE BENEFITS  
12 THROUGH MEDICAREPLUS PLANS.—

13 “(1) IN GENERAL.—Subject to the provisions of  
14 this section, each MedicarePlus eligible individual  
15 (as defined in paragraph (3)) is entitled to elect to  
16 receive benefits under this title—

17 “(A) through the medicare fee-for-service  
18 program under parts A and B, or

19 “(B) through enrollment in a MedicarePlus  
20 plan under this part.

21 “(2) TYPES OF MEDICAREPLUS PLANS THAT  
22 MAY BE AVAILABLE.—A MedicarePlus plan may be  
23 any of the following types of plans of health insur-  
24 ance:

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1           “(A) COORDINATED CARE PLANS.—Coordi-  
2           nated care plans which provide health care serv-  
3           ices, including health maintenance organization  
4           plans and preferred provider organization plans.

5           “(B) PLANS OFFERED BY PROVIDER-SPON-  
6           SORED ORGANIZATION.—A MedicarePlus plan  
7           offered by a provider-sponsored organization, as  
8           defined in section 1855(e).

9           “(C) COMBINATION OF MSA PLAN AND  
10          CONTRIBUTIONS TO MEDICAREPLUS MSA.—An  
11          MSA plan, as defined in section 1859(b)(2),  
12          and a contribution into a MedicarePlus medical  
13          savings account (MSA).

14          “(3) MEDICAREPLUS ELIGIBLE INDIVIDUAL.—

15                 “(A) IN GENERAL.—In this title, subject to  
16                 subparagraph (B), the term ‘MedicarePlus eligi-  
17                 ble individual’ means an individual who is enti-  
18                 tled to benefits under part A and enrolled under  
19                 part B.

20                 “(B) SPECIAL RULE FOR END-STAGE  
21                 RENAL DISEASE.—Such term shall not include  
22                 an individual medically determined to have end-  
23                 stage renal disease, except that an individual  
24                 who develops end-stage renal disease while en-

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1 rolled in a MedicarePlus plan may continue to  
2 be enrolled in that plan.

3 “(b) SPECIAL RULES.—

4 “(1) RESIDENCE REQUIREMENT.—

5 “(A) IN GENERAL.—Except as the Sec-  
6 retary may otherwise provide, an individual is  
7 eligible to elect a MedicarePlus plan offered by  
8 a MedicarePlus organization only if the organi-  
9 zation serves the geographic area in which the  
10 individual resides.

11 “(B) CONTINUATION OF ENROLLMENT  
12 PERMITTED.—Pursuant to rules specified by  
13 the Secretary, the Secretary shall provide that  
14 an individual may continue enrollment in a  
15 plan, notwithstanding that the individual no  
16 longer resides in the service area of the plan, so  
17 long as the plan provides benefits for enrollees  
18 located in the area in which the individual re-  
19 sides.

20 “(2) SPECIAL RULE FOR CERTAIN INDIVIDUALS  
21 COVERED UNDER FEHBP OR ELIGIBLE FOR VETER-  
22 ANS OR MILITARY HEALTH BENEFITS, VETERANS .—

23 “(A) FEHBP.—An individual who is en-  
24 rolled in a health benefit plan under chapter 89  
25 of title 5, United States Code, is not eligible to



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1 enroll in an MSA plan until such time as the  
2 Director of the Office of Management and  
3 Budget certifies to the Secretary that the Office  
4 of Personnel Management has adopted policies  
5 which will ensure that the enrollment of such  
6 individuals in such plans will not result in in-  
7 creased expenditures for the Federal Govern-  
8 ment for health benefit plans under such chap-  
9 ter.

10 “(B) VA AND DOD.—The Secretary may  
11 apply rules similar to the rules described in  
12 subparagraph (A) in the case of individuals who  
13 are eligible for health care benefits under chap-  
14 ter 55 of title 10, United States Code, or under  
15 chapter 17 of title 38 of such Code.

16 “(3) LIMITATION ON ELIGIBILITY OF QUALI-  
17 FIED MEDICARE BENEFICIARIES AND OTHER MEDIC-  
18 AID BENEFICIARIES TO ENROLL IN AN MSA  
19 PLAN.—An individual who is a qualified medicare  
20 beneficiary (as defined in section 1905(p)(1)), a  
21 qualified disabled and working individual (described  
22 in section 1905(s)), an individual described in sec-  
23 tion 1902(a)(10)(E)(iii), or otherwise entitled to  
24 medicare cost-sharing under a State plan under title  
25 XIX is not eligible to enroll in an MSA plan.

1           “(4) COVERAGE UNDER MSA PLANS ON A DEM-  
2           ONSTRATION BASIS.—

3           “(A) IN GENERAL.—An individual is not  
4           eligible to enroll in an MSA plan under this  
5           part—

6                   “(i) on or after January 1, 2003, un-  
7                   less the enrollment is the continuation of  
8                   such an enrollment in effect as of such  
9                   date; or

10                   “(ii) as of any date if the number of  
11                   such individuals so enrolled as of such date  
12                   has reached 500,000.

13           Under rules established by the Secretary, an in-  
14           dividual is not eligible to enroll (or continue en-  
15           rollment) in an MSA plan for a year unless the  
16           individual provides assurances satisfactory to  
17           the Secretary that the individual will reside in  
18           the United States for at least 183 days during  
19           the year.

20           “(B) EVALUATION.—The Secretary shall  
21           regularly evaluate the impact of permitting en-  
22           rollment in MSA plans under this part on selec-  
23           tion (including adverse selection), use of preven-  
24           tive care, access to care, and the financial sta-  
25           tus of the Trust Funds under this title.

1           “(C) REPORTS.—The Secretary shall sub-  
2           mit to Congress periodic reports on the num-  
3           bers of individuals enrolled in such plans and  
4           on the evaluation being conducted under sub-  
5           paragraph (B). The Secretary shall submit such  
6           a report, by not later than March 1, 2002, on  
7           whether the time limitation under subparagraph  
8           (A)(i) should be extended or removed and  
9           whether to change the numerical limitation  
10          under subparagraph (A)(ii).

11          “(c) PROCESS FOR EXERCISING CHOICE.—

12           “(1) IN GENERAL.—The Secretary shall estab-  
13          lish a process through which elections described in  
14          subsection (a) are made and changed, including the  
15          form and manner in which such elections are made  
16          and changed. Such elections shall be made or  
17          changed only during coverage election periods speci-  
18          fied under subsection (e) and shall become effective  
19          as provided in subsection (f).

20           “(2) COORDINATION THROUGH MEDICAREPLUS  
21          ORGANIZATIONS.—

22           “(A) ENROLLMENT.—Such process shall  
23          permit an individual who wishes to elect a  
24          MedicarePlus plan offered by a MedicarePlus  
25          organization to make such election through the

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1 filing of an appropriate election form with the  
2 organization.

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

10 “(3) DEFAULT.—

11 “(A) INITIAL ELECTION.—

12 “(i) IN GENERAL.—Subject to clause  
13 (ii), an individual who fails to make an  
14 election during an initial election period  
15 under subsection (e)(1) is deemed to have  
16 chosen the medicare fee-for-service pro-  
17 gram option.

18 “(ii) SEAMLESS CONTINUATION OF  
19 COVERAGE.—The Secretary may establish  
20 procedures under which an individual who  
21 is enrolled in a health plan (other than  
22 MedicarePlus plan) offered by a  
23 MedicarePlus organization at the time of  
24 the initial election period and who fails to  
25 elect to receive coverage other than

1 through the organization is deemed to have  
2 elected the MedicarePlus plan offered by  
3 the organization (or, if the organization of-  
4 fers more than one such plan, such plan or  
5 plans as the Secretary identifies under  
6 such procedures).

7 “(B) CONTINUING PERIODS.—An individ-  
8 ual who has made (or is deemed to have made)  
9 an election under this section is considered to  
10 have continued to make such election until such  
11 time as—

12 “(i) the individual changes the elec-  
13 tion under this section, or

14 “(ii) a MedicarePlus plan is discon-  
15 tinued, if the individual had elected such  
16 plan at the time of the discontinuation.

17 “(d) PROVIDING INFORMATION TO PROMOTE IN-  
18 FORMED CHOICE.—

19 “(1) IN GENERAL.—The Secretary shall provide  
20 for activities under this subsection to broadly dis-  
21 seminate information to medicare beneficiaries (and  
22 prospective medicare beneficiaries) on the coverage  
23 options provided under this section in order to pro-  
24 mote an active, informed selection among such op-  
25 tions.

1 “(2) PROVISION OF NOTICE.—

2 “(A) OPEN SEASON NOTIFICATION.—At  
3 least 30 days before the beginning of each an-  
4 nual, coordinated election period (as defined in  
5 subsection (e)(3)(B)), the Secretary shall mail  
6 to each MedicarePlus eligible individual residing  
7 in an area the following:

8 “(i) GENERAL INFORMATION.—The  
9 general information described in paragraph  
10 (3).

11 “(ii) LIST OF PLANS AND COMPARI-  
12 SON OF PLAN OPTIONS.—A list identifying  
13 the MedicarePlus plans that are (or will  
14 be) available to residents of the area and  
15 information described in paragraph (4)  
16 concerning such plans. Such information  
17 shall be presented in a comparative form.

18 “(iii) MEDICAREPLUS MONTHLY CAPI-  
19 TATION RATE.—The amount of the month-  
20 ly MedicarePlus capitation rate for the  
21 area.

22 “(iv) ADDITIONAL INFORMATION.—  
23 Any other information that the Secretary  
24 determines will assist the individual in  
25 making the election under this section.

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1 The mailing of such information shall be coordi-  
2 nated with the mailing of any annual notice  
3 under section 1804.

4 “(B) NOTIFICATION TO NEWLY  
5 MEDICAREPLUS ELIGIBLE INDIVIDUALS.—To  
6 the extent practicable, the Secretary shall, not  
7 later than 2 months before the beginning of the  
8 initial MedicarePlus enrollment period for an  
9 individual described in subsection (e)(1), mail  
10 to the individual the information described in  
11 subparagraph (A).

12 “(C) FORM.—The information dissemi-  
13 nated under this paragraph shall be written and  
14 formatted using language that is easily under-  
15 standable by medicare beneficiaries.

16 “(D) PERIODIC UPDATING.—The informa-  
17 tion described in subparagraph (A) shall be up-  
18 dated on at least an annual basis to reflect  
19 changes in the availability of MedicarePlus  
20 plans and the benefits and monthly premiums  
21 (and net monthly premiums) for such plans.

22 “(3) GENERAL INFORMATION.—General infor-  
23 mation under this paragraph, with respect to cov-  
24 erage under this part during a year, shall include  
25 the following:

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1           “(A) BENEFITS UNDER FEE-FOR-SERVICE  
2 PROGRAM OPTION.—A general description of  
3 the benefits covered (and not covered) under  
4 the medicare fee-for-service program under  
5 parts A and B, including—

6                   “(i) covered items and services,

7                   “(ii) beneficiary cost sharing, such as  
8 deductibles, coinsurance, and copayment  
9 amounts, and

10                   “(iii) any beneficiary liability for bal-  
11 ance billing.

12           “(B) PART B PREMIUM.—The part B pre-  
13 mium rates that will be charged for part B cov-  
14 erage.

15           “(C) ELECTION PROCEDURES.—Informa-  
16 tion and instructions on how to exercise election  
17 options under this section.

18           “(D) RIGHTS.—The general description of  
19 procedural rights (including grievance and ap-  
20 peals procedures) of beneficiaries under the  
21 medicare fee-for-service program and the  
22 MedicarePlus program and right to be pro-  
23 tected against discrimination based on health  
24 status-related factors under section 1852(b).



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1           “(E) INFORMATION ON MEDIGAP AND  
2           MEDICARE SELECT.—A general description of  
3           the benefits, enrollment rights, and other re-  
4           quirements applicable to medicare supplemental  
5           policies under section 1882 and provisions relat-  
6           ing to medicare select policies described in sec-  
7           tion 1882(t).

8           “(F) POTENTIAL FOR CONTRACT TERMI-  
9           NATION.—The fact that a MedicarePlus organi-  
10          zation may terminate or refuse to renew its  
11          contract under this part and the effect the ter-  
12          mination or nonrenewal of its contract may  
13          have on individuals enrolled with the  
14          MedicarePlus plan under this part.

15          “(4) INFORMATION COMPARING PLAN OP-  
16          TIONS.—Information under this paragraph, with re-  
17          spect to a MedicarePlus plan for a year, shall in-  
18          clude the following:

19                 “(A) BENEFITS.—The benefits covered  
20                 (and not covered) under the plan, including—

21                         “(i) covered items and services beyond  
22                         those provided under the medicare fee-for-  
23                         service program,

24                         “(ii) any beneficiary cost sharing,

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1           “(iii) any maximum limitations on  
2           out-of-pocket expenses, and

3           “(iv) in the case of an MSA plan, dif-  
4           ferences in cost sharing and balance billing  
5           under such a plan compared to under  
6           other MedicarePlus plans.

7           “(B) PREMIUMS.—The monthly premium  
8           (and net monthly premium), if any, for the  
9           plan.

10          “(C) SERVICE AREA.—The service area of  
11          the plan.

12          “(D) QUALITY AND PERFORMANCE.—To  
13          the extent available, plan quality and perform-  
14          ance indicators for the benefits under the plan  
15          (and how they compare to such indicators  
16          under the medicare fee-for-service program  
17          under parts A and B in the area involved), in-  
18          cluding—

19               “(i) disenrollment rates for medicare  
20               enrollees electing to receive benefits  
21               through the plan for the previous 2 years  
22               (excluding disenrollment due to death or  
23               moving outside the plan’s service area),

24               “(ii) information on medicare enrollee  
25               satisfaction,

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1                   “(iii) information on health outcomes,  
2                   and

3                   “(iv) the recent record regarding com-  
4                   pliance of the plan with requirements of  
5                   this part (as determined by the Secretary).

6                   “(E) SUPPLEMENTAL BENEFITS OP-  
7                   TIONS.—Whether the organization offering the  
8                   plan offers optional supplemental benefits and  
9                   the terms and conditions (including premiums)  
10                  for such coverage.

11                  “(5) MAINTAINING A TOLL-FREE NUMBER AND  
12                  INTERNET SITE.—The Secretary shall maintain a  
13                  toll-free number for inquiries regarding  
14                  MedicarePlus options and the operation of this part  
15                  in all areas in which MedicarePlus plans are offered  
16                  and an Internet site through which individuals may  
17                  electronically obtain information on such options and  
18                  MedicarePlus plans.

19                  “(6) USE OF NONFEDERAL ENTITIES.—The  
20                  Secretary may enter into contracts with non-Federal  
21                  entities to carry out activities under this subsection.

22                  “(7) PROVISION OF INFORMATION.—A  
23                  MedicarePlus organization shall provide the Sec-  
24                  retary with such information on the organization  
25                  and each MedicarePlus plan it offers as may be re-

1 required for the preparation of the information re-  
2 ferred to in paragraph (2)(A).

3 “(e) COVERAGE ELECTION PERIODS.—

4 “(1) INITIAL CHOICE UPON ELIGIBILITY TO  
5 MAKE ELECTION IF MEDICAREPLUS PLANS AVAIL-  
6 ABLE TO INDIVIDUAL.—If, at the time an individual  
7 first becomes entitled to benefits under part A and  
8 enrolled under part B, there is one or more  
9 MedicarePlus plans offered in the area in which the  
10 individual resides, the individual shall make the elec-  
11 tion under this section during a period (of a dura-  
12 tion and beginning at a time specified by the Sec-  
13 retary) at such time. Such period shall be specified  
14 in a manner so that, in the case of an individual who  
15 elects a MedicarePlus plan during the period, cov-  
16 erage under the plan becomes effective as of the first  
17 date on which the individual may receive such cov-  
18 erage.

19 “(2) OPEN ENROLLMENT AND DISENROLLMENT  
20 OPPORTUNITIES.—Subject to paragraph (5)—

21 “(A) CONTINUOUS OPEN ENROLLMENT  
22 AND DISENROLLMENT THROUGH 2000.—At any  
23 time during 1998, 1999, and 2000, a  
24 MedicarePlus eligible individual may change the  
25 election under subsection (a)(1).

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1           “(B) CONTINUOUS OPEN ENROLLMENT  
2           AND DISENROLLMENT FOR FIRST 6 MONTHS  
3           DURING 2001.—

4                   “(i) IN GENERAL.—Subject to clause  
5                   (ii), at any time during the first 6 months  
6                   of 2001, or, if the individual first becomes  
7                   a MedicarePlus eligible individual during  
8                   2001, during the first 6 months during  
9                   2001 in which the individual is a  
10                  MedicarePlus eligible individual, a  
11                  MedicarePlus eligible individual may  
12                  change the election under subsection  
13                  (a)(1).

14                   “(ii) LIMITATION OF ONE CHANGE  
15                   PER YEAR.—An individual may exercise  
16                   the right under clause (i) only once during  
17                   2001. The limitation under this clause  
18                   shall not apply to changes in elections ef-  
19                   fected during an annual, coordinated elec-  
20                   tion period under paragraph (3) or during  
21                   a special enrollment period under para-  
22                   graph (4).

23           “(C) CONTINUOUS OPEN ENROLLMENT  
24           AND DISENROLLMENT FOR FIRST 3 MONTHS IN  
25           SUBSEQUENT YEARS.—

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1           “(i) IN GENERAL.—Subject to clause  
2           (ii), at any time during the first 3 months  
3           of a year after 2001, or, if the individual  
4           first becomes a MedicarePlus eligible indi-  
5           vidual during a year after 2001, during the  
6           first 3 months of such year in which the  
7           individual is a MedicarePlus eligible indi-  
8           vidual, a MedicarePlus eligible individual  
9           may change the election under subsection  
10          (a)(1).

11           “(ii) LIMITATION OF ONE CHANGE  
12          PER YEAR.—An individual may exercise  
13          the right under clause (i) only once a year.  
14          The limitation under this clause shall not  
15          apply to changes in elections effected dur-  
16          ing an annual, coordinated election period  
17          under paragraph (3) or during a special  
18          enrollment period under paragraph (4).

19           “(3) ANNUAL, COORDINATED ELECTION PE-  
20          RIOD.—

21           “(A) IN GENERAL.—Subject to paragraph  
22          (5), each individual who is eligible to make an  
23          election under this section may change such  
24          election during an annual, coordinated election  
25          period.

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1           “(B) ANNUAL, COORDINATED ELECTION  
2 PERIOD.—For purposes of this section, the  
3 term ‘annual, coordinated election period’  
4 means, with respect to a calendar year (begin-  
5 ning with 2001), the month of October before  
6 such year.

7           “(C) MEDICAREPLUS HEALTH FAIRS.—In  
8 the month of October of each year (beginning  
9 with 1998), the Secretary shall provide for a  
10 nationally coordinated educational and publicity  
11 campaign to inform MedicarePlus eligible indi-  
12 viduals about MedicarePlus plans and the elec-  
13 tion process provided under this section.

14           “(4) SPECIAL ELECTION PERIODS.—Effective  
15 as of January 1, 2001, an individual may dis-  
16 continue an election of a MedicarePlus plan offered  
17 by a MedicarePlus organization other than during  
18 an annual, coordinated election period and make a  
19 new election under this section if—

20           “(A) the organization’s or plan’s certifi-  
21 cation under this part has been terminated or  
22 the organization has terminated or otherwise  
23 discontinued providing the plan;

24           “(B) the individual is no longer eligible to  
25 elect the plan because of a change in the indi-

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1 individual's place of residence or other change in  
2 circumstances (specified by the Secretary, but  
3 not including termination of the individual's en-  
4 rollment on the basis described in clause (i) or  
5 (ii) of subsection (g)(3)(B));

6 “(C) the individual demonstrates (in ac-  
7 cordance with guidelines established by the Sec-  
8 retary) that—

9 “(i) the organization offering the plan  
10 substantially violated a material provision  
11 of the organization's contract under this  
12 part in relation to the individual (including  
13 the failure to provide an enrollee on a  
14 timely basis medically necessary care for  
15 which benefits are available under the plan  
16 or the failure to provide such covered care  
17 in accordance with applicable quality  
18 standards); or

19 “(ii) the organization (or an agent or  
20 other entity acting on the organization's  
21 behalf) materially misrepresented the  
22 plan's provisions in marketing the plan to  
23 the individual; or



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1           “(D) the individual meets such other ex-  
2           ceptional conditions as the Secretary may pro-  
3           vide.

4           “(5) SPECIAL RULES FOR MSA PLANS.—Not-  
5           withstanding the preceding provisions of this sub-  
6           section, an individual—

7           “(A) may elect an MSA plan only during—

8                   “(i) an initial open enrollment period  
9                   described in paragraph (1),

10                   “(ii) an annual, coordinated election  
11                   period described in paragraph (3)(B), or

12                   “(iii) the months of October 1998 and  
13                   October 1999; and

14           “(B) may not discontinue an election of an  
15           MSA plan except during the periods described  
16           in clause (ii) or (iii) of subparagraph (A) and  
17           under paragraph (4).

18           “(f) EFFECTIVENESS OF ELECTIONS AND CHANGES  
19           OF ELECTIONS.—

20           “(1) DURING INITIAL COVERAGE ELECTION PE-  
21           RIOD.—An election of coverage made during the ini-  
22           tial coverage election period under subsection (e)(1)  
23           shall take effect upon the date the individual be-  
24           comes entitled to benefits under part A and enrolled  
25           under part B, except as the Secretary may provide

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

3 “(2) DURING CONTINUOUS OPEN ENROLLMENT  
4 PERIODS.—An election or change of coverage made  
5 under subsection (e)(2) shall take effect with the  
6 first day of the first calendar month following the  
7 date on which the election is made.

8 “(3) ANNUAL, COORDINATED ELECTION PE-  
9 RIOD.—An election or change of coverage made dur-  
10 ing an annual, coordinated election period (as de-  
11 fined in subsection (e)(3)(B)) in a year shall take ef-  
12 fect as of the first day of the following year.

13 “(4) OTHER PERIODS.—An election or change  
14 of coverage made during any other period under  
15 subsection (e)(4) shall take effect in such manner as  
16 the Secretary provides in a manner consistent (to  
17 the extent practicable) with protecting continuity of  
18 health benefit coverage.

19 “(g) GUARANTEED ISSUE AND RENEWAL.—

20 “(1) IN GENERAL.—Except as provided in this  
21 subsection, a MedicarePlus organization shall pro-  
22 vide that at any time during which elections are ac-  
23 cepted under this section with respect to a  
24 MedicarePlus plan offered by the organization, the

1 organization will accept without restrictions individ-  
2 uals who are eligible to make such election.

3 “(2) PRIORITY.—If the Secretary determines  
4 that a MedicarePlus organization, in relation to a  
5 MedicarePlus plan it offers, has a capacity limit and  
6 the number of MedicarePlus eligible individuals who  
7 elect the plan under this section exceeds the capacity  
8 limit, the organization may limit the election of indi-  
9 viduals of the plan under this section but only if pri-  
10 ority in election is provided—

11 “(A) first to such individuals as have elect-  
12 ed the plan at the time of the determination,  
13 and

14 “(B) then to other such individuals in such  
15 a manner that does not discriminate, on a basis  
16 described in section 1852(b), among the individ-  
17 uals (who seek to elect the plan).

18 The preceding sentence shall not apply if it would  
19 result in the enrollment of enrollees substantially  
20 nonrepresentative, as determined in accordance with  
21 regulations of the Secretary, of the medicare popu-  
22 lation in the service area of the plan.

23 “(3) LIMITATION ON TERMINATION OF ELEC-  
24 TION.—

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1           “(A) IN GENERAL.—Subject to subpara-  
2 graph (B), a MedicarePlus organization may  
3 not for any reason terminate the election of any  
4 individual under this section for a MedicarePlus  
5 plan it offers.

6           “(B) BASIS FOR TERMINATION OF ELEC-  
7 TION.—A MedicarePlus organization may ter-  
8minate an individual’s election under this sec-  
9tion with respect to a MedicarePlus plan it of-  
10fers if—

11           “(i) any net monthly premiums re-  
12quired with respect to such plan are not  
13paid on a timely basis (consistent with  
14standards under section 1856 that provide  
15for a grace period for late payment of net  
16monthly premiums),

17           “(ii) the individual has engaged in  
18disruptive behavior (as specified in such  
19standards), or

20           “(iii) the plan is terminated with re-  
21spect to all individuals under this part in  
22the area in which the individual resides.

23           “(C) CONSEQUENCE OF TERMINATION.—

24           “(i) TERMINATIONS FOR CAUSE.—  
25 Any individual whose election is terminated

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1 under clause (i) or (ii) of subparagraph  
2 (B) is deemed to have elected the medicare  
3 fee-for-service program option described in  
4 subsection (a)(1)(A).

5 “(ii) TERMINATION BASED ON PLAN  
6 TERMINATION OR SERVICE AREA REDUC-  
7 TION.—Any individual whose election is  
8 terminated under subparagraph (B)(iii)  
9 shall have a special election period under  
10 subsection (e)(4)(A) in which to change  
11 coverage to coverage under another  
12 MedicarePlus plan. Such an individual who  
13 fails to make an election during such pe-  
14 riod is deemed to have chosen to change  
15 coverage to the medicare fee-for-service  
16 program option described in subsection  
17 (a)(1)(A).

18 “(D) ORGANIZATION OBLIGATION WITH  
19 RESPECT TO ELECTION FORMS.—Pursuant to a  
20 contract under section 1857, each MedicarePlus  
21 organization receiving an election form under  
22 subsection (c)(2) shall transmit to the Secretary  
23 (at such time and in such manner as the Sec-  
24 retary may specify) a copy of such form or such

1 other information respecting the election as the  
2 Secretary may specify.

3 “(h) APPROVAL OF MARKETING MATERIAL AND AP-  
4 PPLICATION FORMS.—

5 “(1) SUBMISSION.—No marketing material or  
6 application form may be distributed by a  
7 MedicarePlus organization to (or for the use of)  
8 MedicarePlus eligible individuals unless—

9 “(A) at least 45 days before the date of  
10 distribution the organization has submitted the  
11 material or form to the Secretary for review,  
12 and

13 “(B) the Secretary has not disapproved the  
14 distribution of such material or form.

15 “(2) REVIEW.—The standards established  
16 under section 1856 shall include guidelines for the  
17 review of all such material or form submitted and  
18 under such guidelines the Secretary shall disapprove  
19 (or later require the correction of) such material or  
20 form if the material or form is materially inaccurate  
21 or misleading or otherwise makes a material mis-  
22 representation.

23 “(3) DEEMED APPROVAL (1-STOP SHOPPING).—  
24 In the case of material or form that is submitted  
25 under paragraph (1)(A) to the Secretary or a re-

1 regional office of the Department of Health and  
2 Human Services and the Secretary or the office has  
3 not disapproved the distribution of marketing mate-  
4 rial or form under paragraph (1)(B) with respect to  
5 a MedicarePlus plan in an area, the Secretary is  
6 deemed not to have disapproved such distribution in  
7 all other areas covered by the plan and organization  
8 except to the extent that such material or form is  
9 specific only to an area involved.

10 “(4) PROHIBITION OF CERTAIN MARKETING  
11 PRACTICES.—Each MedicarePlus organization shall  
12 conform to fair marketing standards, in relation to  
13 MedicarePlus plans offered under this part, included  
14 in the standards established under section 1856.  
15 Such standards shall include a prohibition against a  
16 MedicarePlus organization (or agent of such an or-  
17 ganization) completing any portion of any election  
18 form used to carry out elections under this section  
19 on behalf of any individual.

20 “(i) EFFECT OF ELECTION OF MEDICAREPLUS PLAN  
21 OPTION.—Subject to sections 1852(a)(5), 1857(f)(2), and  
22 1857(g)—

23 “(1) payments under a contract with a  
24 MedicarePlus organization under section 1853(a)  
25 with respect to an individual electing a MedicarePlus

1 plan offered by the organization shall be instead of  
2 the amounts which (in the absence of the contract)  
3 would otherwise be payable under parts A and B for  
4 items and services furnished to the individual, and

5 “(2) subject to subsections (e) and (f) of section  
6 1853, only the MedicarePlus organization shall be  
7 entitled to receive payments from the Secretary  
8 under this title for services furnished to the individ-  
9 ual.

10 “BENEFITS AND BENEFICIARY PROTECTIONS

11 “SEC. 1852. (a) BASIC BENEFITS.—

12 “(1) IN GENERAL.—Except as provided in sec-  
13 tion 1859(b)(2) for MSA plans, each MedicarePlus  
14 plan shall provide to members enrolled under this  
15 part, through providers and other persons that meet  
16 the applicable requirements of this title and part A  
17 of title XI—

18 “(A) those items and services for which  
19 benefits are available under parts A and B to  
20 individuals residing in the area served by the  
21 plan, and

22 “(B) additional benefits required under  
23 section 1854(f)(1)(A).

24 “(2) SATISFACTION OF REQUIREMENT.—A  
25 MedicarePlus plan (other than an MSA plan) offered  
26 by a MedicarePlus organization satisfies paragraph



1 (1)(A), with respect to benefits for items and serv-  
2 ices furnished other than through a provider that  
3 has a contract with the organization offering the  
4 plan, if the plan provides (in addition to any cost  
5 sharing provided for under the plan) for at least the  
6 total dollar amount of payment for such items and  
7 services as would otherwise be authorized under  
8 parts A and B (including any balance billing per-  
9 mitted under such parts).

10 “(3) SUPPLEMENTAL BENEFITS.—

11 “(A) BENEFITS INCLUDED SUBJECT TO  
12 SECRETARY’S APPROVAL.—Each MedicarePlus  
13 organization may provide to individuals enrolled  
14 under this part, other than under an MSA plan,  
15 (without affording those individuals an option  
16 to decline the coverage) supplemental health  
17 care benefits that the Secretary may approve.  
18 The Secretary shall approve any such supple-  
19 mental benefits unless the Secretary determines  
20 that including such supplemental benefits would  
21 substantially discourage enrollment by  
22 MedicarePlus eligible individuals with the orga-  
23 nization.

24 “(B) AT ENROLLEES’ OPTION.—A  
25 MedicarePlus organization may provide to indi-

1 individuals enrolled under this part, other than  
2 under an MSA plan, supplemental health care  
3 benefits that the individuals may elect, at their  
4 option, to have covered.

5 “(4) ORGANIZATION AS SECONDARY PAYER.—  
6 Notwithstanding any other provision of law, a  
7 MedicarePlus organization may (in the case of the  
8 provision of items and services to an individual  
9 under a MedicarePlus plan under circumstances in  
10 which payment under this title is made secondary  
11 pursuant to section 1862(b)(2)) charge or authorize  
12 the provider of such services to charge, in accord-  
13 ance with the charges allowed under such a law,  
14 plan, or policy—

15 “(A) the insurance carrier, employer, or  
16 other entity which under such law, plan, or pol-  
17 icy is to pay for the provision of such services,  
18 or

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

22 “(5) NATIONAL COVERAGE DETERMINATIONS.—  
23 If there is a national coverage determination made  
24 in the period beginning on the date of an announce-  
25 ment under section 1853(b) and ending on the date

1 of the next announcement under such section and  
2 the Secretary projects that the determination will re-  
3 sult in a significant change in the costs to a  
4 MedicarePlus organization of providing the benefits  
5 that are the subject of such national coverage deter-  
6 mination and that such change in costs was not in-  
7 corporated in the determination of the annual  
8 MedicarePlus capitation rate under section 1853 in-  
9 cluded in the announcement made at the beginning  
10 of such period—

11 “(A) such determination shall not apply to  
12 contracts under this part until the first contract  
13 year that begins after the end of such period,  
14 and

15 “(B) if such coverage determination pro-  
16 vides for coverage of additional benefits or cov-  
17 erage under additional circumstances, section  
18 1851(i) shall not apply to payment for such ad-  
19 ditional benefits or benefits provided under such  
20 additional circumstances until the first contract  
21 year that begins after the end of such period,  
22 unless otherwise required by law.

23 “(b) ANTIDISCRIMINATION.—

24 “(1) IN GENERAL.—A MedicarePlus organiza-  
25 tion may not deny, limit, or condition the coverage

1 or provision of benefits under this part, for individ-  
2 uals permitted to be enrolled with the organization  
3 under this part, based on any health status-related  
4 factor described in section 2702(a)(1) of the Public  
5 Health Service Act.

6 “(2) CONSTRUCTION.—Paragraph (1) shall not  
7 be construed as requiring a MedicarePlus organiza-  
8 tion to enroll individuals who are determined to have  
9 end-stage renal disease, except as provided under  
10 section 1851(a)(3)(B).

11 “(c) DETAILED DESCRIPTION OF PLAN PROVI-  
12 SIONS.—A MedicarePlus organization shall disclose, in  
13 clear, accurate, and standardized form to each enrollee  
14 with a MedicarePlus plan offered by the organization  
15 under this part at the time of enrollment and at least an-  
16 nually thereafter, the following information regarding such  
17 plan:

18 “(1) SERVICE AREA.—The plan’s service area.

19 “(2) BENEFITS.—Benefits offered (and not of-  
20 fered) under the plan offered, including information  
21 described in section 1851(d)(3)(A) and exclusions  
22 from coverage and, if it is an MSA plan, a compari-  
23 son of benefits under such a plan with benefits  
24 under other MedicarePlus plans.

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1           “(3) ACCESS.—The number, mix, and distribu-  
2           tion of plan providers.

3           “(4) OUT-OF-AREA COVERAGE.—Out-of-area  
4           coverage provided by the plan.

5           “(5) EMERGENCY COVERAGE.—Coverage of  
6           emergency services and urgently needed care, includ-  
7           ing—

8                   “(A) the appropriate use of emergency  
9                   services, including use of the 911 telephone sys-  
10                  tem or its local equivalent in emergency situa-  
11                  tions and an explanation of what constitutes an  
12                  emergency situation;

13                  “(B) the process and procedures of the  
14                  plan for obtaining emergency services; and

15                  “(C) the locations of (i) emergency depart-  
16                  ments, and (ii) other settings, in which plan  
17                  physicians and hospitals provide emergency  
18                  services and post-stabilization care.

19           “(6) SUPPLEMENTAL BENEFITS.—Supple-  
20           mental benefits available from the organization of-  
21           fering the plan, including—

22                   “(A) whether the supplemental benefits are  
23                   optional,

24                   “(B) the supplemental benefits covered,  
25                   and

1           “(C) the premium price for the supple-  
2           mental benefits.

3           “(7) PRIOR AUTHORIZATION RULES.—Rules re-  
4           garding prior authorization or other review require-  
5           ments that could result in nonpayment.

6           “(8) PLAN GRIEVANCE AND APPEALS PROCE-  
7           DURES.—Any appeal or grievance rights and proce-  
8           dures.

9           “(9) QUALITY ASSURANCE PROGRAM.—A de-  
10          scription of the organization’s quality assurance pro-  
11          gram under subsection (e).

12          “(d) ACCESS TO SERVICES.—

13           “(1) IN GENERAL.—A MedicarePlus organiza-  
14          tion offering a MedicarePlus plan may select the  
15          providers from whom the benefits under the plan are  
16          provided so long as—

17           “(A) the organization makes such benefits  
18          available and accessible to each individual elect-  
19          ing the plan within the plan service area with  
20          reasonable promptness and in a manner which  
21          assures continuity in the provision of benefits;

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

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1           “(C) the plan provides for reimbursement  
2 with respect to services which are covered under  
3 subparagraphs (A) and (B) and which are pro-  
4 vided to such an individual other than through  
5 the organization, if—

6                   “(i) the services were medically nec-  
7 essary and immediately required because of  
8 an unforeseen illness, injury, or condition,  
9 and it was not reasonable given the cir-  
10 cumstances to obtain the services through  
11 the organization,

12                   “(ii) the services were renal dialysis  
13 services and were provided other than  
14 through the organization because the indi-  
15 vidual was temporarily out of the plan’s  
16 service area, or

17                   “(iii) the services are maintenance  
18 care or post-stabilization care covered  
19 under the guidelines established under  
20 paragraph (2);

21           “(D) the organization provides access to  
22 appropriate providers, including credentialed  
23 specialists, for medically necessary treatment  
24 and services; and

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1           “(E) coverage is provided for emergency  
2 services (as defined in paragraph (3)) without  
3 regard to prior authorization or the emergency  
4 care provider’s contractual relationship with the  
5 organization.

6           “(2) GUIDELINES RESPECTING COORDINATION  
7 OF POST-STABILIZATION CARE.—A MedicarePlus  
8 plan shall comply with such guidelines as the Sec-  
9 retary may prescribe relating to promoting efficient  
10 and timely coordination of appropriate maintenance  
11 and post-stabilization care of an enrollee after the  
12 enrollee has been determined to be stable under sec-  
13 tion 1867.

14           “(3) DEFINITION OF EMERGENCY SERVICES.—  
15 In this subsection—

16           “(A) IN GENERAL.—The term ‘emergency  
17 services’ means, with respect to an individual  
18 enrolled with an organization, covered inpatient  
19 and outpatient services that—

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

23                   “(ii) are needed to evaluate or sta-  
24 bilize an emergency medical condition (as  
25 defined in subparagraph (B)).



1           “(B) EMERGENCY MEDICAL CONDITION  
2           BASED ON PRUDENT LAYPERSON.—The term  
3           ‘emergency medical condition’ means a medical  
4           condition manifesting itself by acute symptoms  
5           of sufficient severity such that a prudent  
6           layperson, who possesses an average knowledge  
7           of health and medicine, could reasonably expect  
8           the absence of immediate medical attention to  
9           result in—

10                   “(i) placing the health of the individ-  
11                   ual (or, with respect to a pregnant woman,  
12                   the health of the woman or her unborn  
13                   child) in serious jeopardy,

14                   “(ii) serious impairment to bodily  
15                   functions, or

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

18           “(e) QUALITY ASSURANCE PROGRAM.—

19                   “(1) IN GENERAL.—Each MedicarePlus organi-  
20                   zation must have arrangements, consistent with any  
21                   regulation, for an ongoing quality assurance pro-  
22                   gram for health care services it provides to individ-  
23                   uals enrolled with MedicarePlus plans of the organi-  
24                   zation.

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

3                   “(A) stress health outcomes and provide  
4                   for the collection, analysis, and reporting of  
5                   data (in accordance with a quality measurement  
6                   system that the Secretary recognizes) that will  
7                   permit measurement of outcomes and other in-  
8                   dices of the quality of MedicarePlus plans and  
9                   organizations;

10                   “(B) provide for the establishment of writ-  
11                   ten protocols for utilization review, based on  
12                   current standards of medical practice;

13                   “(C) provide review by physicians and  
14                   other health care professionals of the process  
15                   followed in the provision of such health care  
16                   services;

17                   “(D) monitor and evaluate high volume  
18                   and high risk services and the care of acute and  
19                   chronic conditions;

20                   “(E) evaluate the continuity and coordina-  
21                   tion of care that enrollees receive;

22                   “(F) have mechanisms to detect both un-  
23                   derutilization and overutilization of services;

24                   “(G) after identifying areas for improve-  
25                   ment, establish or alter practice parameters;

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1           “(H) take action to improve quality and  
2           assesses the effectiveness of such action  
3           through systematic followup;

4           “(I) make available information on quality  
5           and outcomes measures to facilitate beneficiary  
6           comparison and choice of health coverage op-  
7           tions (in such form and on such quality and  
8           outcomes measures as the Secretary determines  
9           to be appropriate);

10           “(J) be evaluated on an ongoing basis as  
11           to its effectiveness;

12           “(K) include measures of consumer satis-  
13           faction; and

14           “(L) provide the Secretary with such ac-  
15           cess to information collected as may be appro-  
16           priate to monitor and ensure the quality of care  
17           provided under this part.

18           “(3) EXTERNAL REVIEW.—Each MedicarePlus  
19           organization shall, for each MedicarePlus plan it op-  
20           erates, have an agreement with an independent qual-  
21           ity review and improvement organization approved  
22           by the Secretary to perform functions of the type de-  
23           scribed in sections 1154(a)(4)(B) and 1154(a)(14)  
24           with respect to services furnished by MedicarePlus  
25           plans for which payment is made under this title.

1           “(4) TREATMENT OF ACCREDITATION.—The  
2 Secretary shall provide that a MedicarePlus organi-  
3 zation is deemed to meet requirements of para-  
4 graphs (1) through (3) of this subsection and sub-  
5 section (h) (relating to confidentiality and accuracy  
6 of enrollee records) if the organization is accredited  
7 (and periodically reaccredited) by a private organiza-  
8 tion under a process that the Secretary has deter-  
9 mined assures that the organization, as a condition  
10 of accreditation, applies and enforces standards with  
11 respect to the requirements involved that are no less  
12 stringent than the standards established under sec-  
13 tion 1856 to carry out the respective requirements.

14           “(f) COVERAGE DETERMINATIONS.—

15           “(1) DECISIONS ON NONEMERGENCY CARE.—A  
16 MedicarePlus organization shall make determina-  
17 tions regarding authorization requests for non-  
18 emergency care on a timely basis, depending on the  
19 urgency of the situation.

20           “(2) RECONSIDERATIONS.—

21           “(A) IN GENERAL.—Subject to subsection  
22 (g)(4), a reconsideration of a determination of  
23 an organization denying coverage shall be made  
24 within 30 days of the date of receipt of medical

1 information, but not later than 60 days after  
2 the date of the determination.

3 “(B) PHYSICIAN DECISION ON CERTAIN  
4 RECONSIDERATIONS.—A reconsideration relat-  
5 ing to a determination to deny coverage based  
6 on a lack of medical necessity shall be made  
7 only by a physician other than a physician in-  
8 volved in the initial determination.

9 “(g) GRIEVANCES AND APPEALS.—

10 “(1) GRIEVANCE MECHANISM.—Each  
11 MedicarePlus organization must provide meaningful  
12 procedures for hearing and resolving grievances be-  
13 tween the organization (including any entity or indi-  
14 vidual through which the organization provides  
15 health care services) and enrollees with  
16 MedicarePlus plans of the organization under this  
17 part.

18 “(2) APPEALS.—An enrollee with a  
19 MedicarePlus plan of a MedicarePlus organization  
20 under this part who is dissatisfied by reason of the  
21 enrollee’s failure to receive any health service to  
22 which the enrollee believes the enrollee is entitled  
23 and at no greater charge than the enrollee believes  
24 the enrollee is required to pay is entitled, if the  
25 amount in controversy is \$100 or more, to a hearing

1 before the Secretary to the same extent as is pro-  
2 vided in section 205(b), and in any such hearing the  
3 Secretary shall make the organization a party. If the  
4 amount in controversy is \$1,000 or more, the indi-  
5 vidual or organization shall, upon notifying the other  
6 party, be entitled to judicial review of the Sec-  
7 retary's final decision as provided in section 205(g),  
8 and both the individual and the organization shall be  
9 entitled to be parties to that judicial review. In ap-  
10 plying sections 205(b) and 205(g) as provided in  
11 this paragraph, and in applying section 205(l) there-  
12 to, any reference therein to the Commissioner of So-  
13 cial Security or the Social Security Administration  
14 shall be considered a reference to the Secretary or  
15 the Department of Health and Human Services, re-  
16 spectively.

17 “(3) INDEPENDENT REVIEW OF CERTAIN COV-  
18 ERAGE DENIALS.—The Secretary shall contract with  
19 an independent, outside entity to review and resolve  
20 reconsiderations that affirm denial of coverage.

21 “(4) EXPEDITED DETERMINATIONS AND RE-  
22 CONSIDERATIONS.—

23 “(A) RECEIPT OF REQUESTS.—An enrollee  
24 in a MedicarePlus plan may request, either in  
25 writing or orally, an expedited determination or

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1 reconsideration by the MedicarePlus organiza-  
2 tion regarding a matter described in paragraph  
3 (2). The organization shall also permit the ac-  
4 ceptance of such requests by physicians.

5 “(B) ORGANIZATION PROCEDURES.—

6 “(i) IN GENERAL.—The MedicarePlus  
7 organization shall maintain procedures for  
8 expediting organization determinations and  
9 reconsiderations when, upon request of an  
10 enrollee, the organization determines that  
11 the application of normal time frames for  
12 making a determination (or a reconsider-  
13 ation involving a determination) could seri-  
14 ously jeopardize the life or health of the  
15 enrollee or the enrollee’s ability to regain  
16 maximum function.

17 “(ii) TIMELY RESPONSE.—In an ur-  
18 gent case described in clause (i), the orga-  
19 nization shall notify the enrollee (and the  
20 physician involved, as appropriate) of the  
21 determination (or determination on the re-  
22 consideration) as expeditiously as the en-  
23 rollee’s health condition requires, but not  
24 later than 72 hours (or 24 hours in the  
25 case of a reconsideration) of the time of re-

1 receipt of the request for the determination  
2 or reconsideration (or receipt of the infor-  
3 mation necessary to make the determina-  
4 tion or reconsideration), or such longer pe-  
5 riod as the Secretary may permit in speci-  
6 fied cases.

7 “(h) CONFIDENTIALITY AND ACCURACY OF EN-  
8 ROLLEE RECORDS.—Each MedicarePlus organization  
9 shall establish procedures—

10 “(1) to safeguard the privacy of individually  
11 identifiable enrollee information,

12 “(2) to maintain accurate and timely medical  
13 records and other health information for enrollees,  
14 and

15 “(3) to assure timely access of enrollees to their  
16 medical information.

17 “(i) INFORMATION ON ADVANCE DIRECTIVES.—Each  
18 MedicarePlus organization shall meet the requirement of  
19 section 1866(f) (relating to maintaining written policies  
20 and procedures respecting advance directives).

21 “(j) RULES REGARDING PHYSICIAN PARTICIPA-  
22 TION.—

23 “(1) PROCEDURES.—Each MedicarePlus orga-  
24 nization shall establish reasonable procedures relat-  
25 ing to the participation (under an agreement be-



1       tween a physician and the organization) of physi-  
2       cians under MedicarePlus plans offered by the orga-  
3       nization under this part. Such procedures shall in-  
4       clude—

5               “(A) providing notice of the rules regard-  
6               ing participation,

7               “(B) providing written notice of participa-  
8               tion decisions that are adverse to physicians,  
9               and

10              “(C) providing a process within the organi-  
11              zation for appealing such adverse decisions, in-  
12              cluding the presentation of information and  
13              views of the physician regarding such decision.

14              “(2) CONSULTATION IN MEDICAL POLICIES.—A  
15              MedicarePlus organization shall consult with physi-  
16              cians who have entered into participation agree-  
17              ments with the organization regarding the organiza-  
18              tion’s medical policy, quality, and medical manage-  
19              ment procedures.

20              “(3) PROHIBITING INTERFERENCE WITH PRO-  
21              VIDER ADVICE TO ENROLLEES.—

22              “(A) IN GENERAL.—Subject to subpara-  
23              graphs (B) and (C), a MedicarePlus organiza-  
24              tion (in relation to an individual enrolled under  
25              a MedicarePlus plan offered by the organization

1 under this part) shall not prohibit or otherwise  
2 restrict a covered health care professional (as  
3 defined in subparagraph (D)) from advising  
4 such an individual who is a patient of the pro-  
5 fessional about the health status of the individ-  
6 ual or medical care or treatment for the individ-  
7 ual’s condition or disease, regardless of whether  
8 benefits for such care or treatment are provided  
9 under the plan, if the professional is acting  
10 within the lawful scope of practice.

11 “(B) CONSCIENCE PROTECTION.—Sub-  
12 paragraph (A) shall not be construed as requir-  
13 ing a MedicarePlus plan to provide, reimburse  
14 for, or provide coverage of a counseling or re-  
15 ferral service if the MedicarePlus organization  
16 offering the plan—

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

19 “(ii) in the manner and through the  
20 written instrumentalities such  
21 MedicarePlus organization deems appro-  
22 priate, makes available information on its  
23 policies regarding such service to prospec-  
24 tive enrollees before or during enrollment  
25 and to enrollees within 90 days after the

1 date that the organization or plan adopts  
2 a change in policy regarding such a coun-  
3 seling or referral service.

4 “(C) CONSTRUCTION.—Nothing in sub-  
5 paragraph (B) shall be construed to affect dis-  
6 closure requirements under State law or under  
7 the Employee Retirement Income Security Act  
8 of 1974.

9 “(D) HEALTH CARE PROFESSIONAL DE-  
10 FINED.—For purposes of this paragraph, the  
11 term ‘health care professional’ means a physi-  
12 cian (as defined in section 1861(r)) or other  
13 health care professional if coverage for the pro-  
14 fessional’s services is provided under the  
15 MedicarePlus plan for the services of the pro-  
16 fessional. Such term includes a podiatrist, op-  
17 tometrist, chiropractor, psychologist, dentist,  
18 physician assistant, physical or occupational  
19 therapist and therapy assistant, speech-lan-  
20 guage pathologist, audiologist, registered or li-  
21 censed practical nurse (including nurse practi-  
22 tioner, clinical nurse specialist, certified reg-  
23 istered nurse anesthetist, and certified nurse-  
24 midwife), licensed certified social worker, reg-

1           istered respiratory therapist, and certified res-  
2           piratory therapy technician.

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

5                   “(A) IN GENERAL.—No MedicarePlus or-  
6                   ganization may operate any physician incentive  
7                   plan (as defined in subparagraph (B)) unless  
8                   the following requirements are met:

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

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

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

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

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

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

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

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

4           “(5) LIMITATION ON PROVIDER INDEMNIFICA-  
5           TION.—A MedicarePlus organization may not pro-  
6           vide (directly or indirectly) for a provider (or group  
7           of providers) to indemnify the organization against  
8           any liability resulting from a civil action brought for  
9           any damage caused to an enrollee with a  
10          MedicarePlus plan of the organization under this  
11          part by the organization’s denial of medically nec-  
12          essary care.

13          “(k) TREATMENT OF SERVICES FURNISHED BY CER-  
14          TAIN PROVIDERS.—A physician or other entity (other  
15          than a provider of services) that does not have a contract  
16          establishing payment amounts for services furnished to an  
17          individual enrolled under this part with a MedicarePlus  
18          organization (other than under an MSA plan) shall accept  
19          as payment in full for covered services under this title that  
20          are furnished to such an individual the amounts that the  
21          physician or other entity could collect if the individual  
22          were not so enrolled. Any penalty or other provision of  
23          law that applies to such a payment with respect to an indi-  
24          vidual entitled to benefits under this title (but not enrolled

1 with a MedicarePlus organization under this part) also ap-  
2 plies with respect to an individual so enrolled.

3 “(l) DISCLOSURE OF USE OF DSH AND TEACHING  
4 HOSPITALS.—Each MedicarePlus organization shall pro-  
5 vide the Secretary with information on—

6 “(1) the extent to which the organization pro-  
7 vides inpatient and outpatient hospital benefits  
8 under this part—

9 “(A) through the use of hospitals that are  
10 eligible for additional payments under section  
11 1886(d)(5)(F)(i) (relating to so-called DSH  
12 hospitals), or

13 “(B) through the use of teaching hospitals  
14 that receive payments under section 1886(h);  
15 and

16 “(2) the extent to which differences between  
17 payment rates to different hospitals reflect the dis-  
18 proportionate share percentage of low-income pa-  
19 tients and the presence of medical residency training  
20 programs in those hospitals.

21 “PAYMENTS TO MEDICAREPLUS ORGANIZATIONS

22 “SEC. 1853. (a) PAYMENTS TO ORGANIZATIONS.—

23 “(1) MONTHLY PAYMENTS.—

24 “(A) IN GENERAL.—Under a contract  
25 under section 1857 and subject to subsections  
26 (e) and (f), the Secretary shall make monthly

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1 payments under this section in advance to each  
2 MedicarePlus organization, with respect to cov-  
3 erage of an individual under this part in a  
4 MedicarePlus payment area for a month, in an  
5 amount equal to  $\frac{1}{12}$  of the annual  
6 MedicarePlus capitation rate (as calculated  
7 under subsection (c)) with respect to that indi-  
8 vidual for that area, adjusted for such risk fac-  
9 tors as age, disability status, gender, institu-  
10 tional status, and such other factors as the Sec-  
11 retary determines to be appropriate, so as to  
12 ensure actuarial equivalence. The Secretary  
13 may add to, modify, or substitute for such fac-  
14 tors, if such changes will improve the deter-  
15 mination of actuarial equivalence.

16 “(B) SPECIAL RULE FOR END-STAGE  
17 RENAL DISEASE.—The Secretary shall establish  
18 separate rates of payment to a MedicarePlus  
19 organization with respect to classes of individ-  
20 uals determined to have end-stage renal disease  
21 and enrolled in a MedicarePlus plan of the or-  
22 ganization. Such rates of payment shall be ac-  
23 tuarially equivalent to rates paid to other en-  
24 rollees in the MedicarePlus payment area (or  
25 such other area as specified by the Secretary).



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1 In accordance with regulations, the Secretary  
2 shall provide for the application of the seventh  
3 sentence of section 1881(b)(7) to payments  
4 under this section covering the provision of  
5 renal dialysis treatment in the same manner as  
6 such sentence applies to composite rate pay-  
7 ments described in such sentence.

8 “(2) ADJUSTMENT TO REFLECT NUMBER OF  
9 ENROLLEES.—

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

18 “(B) SPECIAL RULE FOR CERTAIN EN-  
19 ROLLEES.—

20 “(i) IN GENERAL.—Subject to clause  
21 (ii), the Secretary may make retroactive  
22 adjustments under subparagraph (A) to  
23 take into account individuals enrolled dur-  
24 ing the period beginning on the date on  
25 which the individual enrolls with a

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1 MedicarePlus organization under a plan  
2 operated, sponsored, or contributed to by  
3 the individual's employer or former em-  
4 ployer (or the employer or former employer  
5 of the individual's spouse) and ending on  
6 the date on which the individual is enrolled  
7 in the organization under this part, except  
8 that for purposes of making such retro-  
9 active adjustments under this subpara-  
10 graph, such period may not exceed 90  
11 days.

12 “(ii) EXCEPTION.—No adjustment  
13 may be made under clause (i) with respect  
14 to any individual who does not certify that  
15 the organization provided the individual  
16 with the information required to be dis-  
17 closed under section 1852(c) at the time  
18 the individual enrolled with the organiza-  
19 tion.

20 “(3) ESTABLISHMENT OF RISK ADJUSTMENT  
21 FACTORS.—

22 “(A) REPORT.—The Secretary shall de-  
23 velop, and submit to Congress by not later than  
24 October 1, 1999, a report on a method of risk  
25 adjustment of payment rates under this section

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1 that accounts for variations in per capita costs  
2 based on health status. Such report shall in-  
3 clude an evaluation of such method by an out-  
4 side, independent actuary of the actuarial  
5 soundness of the proposal.

6 “(B) DATA COLLECTION.—In order to  
7 carry out this paragraph, the Secretary shall re-  
8 quire MedicarePlus organizations (and eligible  
9 organizations with risk-sharing contracts under  
10 section 1876) to submit, for periods beginning  
11 on or after January 1, 1998, data regarding in-  
12 patient hospital services and other services and  
13 other information the Secretary deems nec-  
14 essary.

15 “(C) INITIAL IMPLEMENTATION.—The  
16 Secretary shall first provide for implementation  
17 of a risk adjustment methodology that accounts  
18 for variations in per capita costs based on  
19 health status and other demographic factors for  
20 payments by no later than January 1, 2000.

21 “(b) ANNUAL ANNOUNCEMENT OF PAYMENT  
22 RATES.—

23 “(1) ANNUAL ANNOUNCEMENT.—The Secretary  
24 shall annually determine, and shall announce (in a  
25 manner intended to provide notice to interested par-

1 ties) not later than August 1 before the calendar  
2 year concerned—

3 “(A) the annual MedicarePlus capitation  
4 rate for each MedicarePlus payment area for  
5 the year, and

6 “(B) the risk and other factors to be used  
7 in adjusting such rates under subsection  
8 (a)(1)(A) for payments for months in that year.

9 “(2) ADVANCE NOTICE OF METHODOLOGICAL  
10 CHANGES.—At least 45 days before making the an-  
11 nouncement under paragraph (1) for a year, the  
12 Secretary shall provide for notice to MedicarePlus  
13 organizations of proposed changes to be made in the  
14 methodology from the methodology and assumptions  
15 used in the previous announcement and shall provide  
16 such organizations an opportunity to comment on  
17 such proposed changes.

18 “(3) EXPLANATION OF ASSUMPTIONS.—In each  
19 announcement made under paragraph (1), the Sec-  
20 retary shall include an explanation of the assump-  
21 tions and changes in methodology used in the an-  
22 nouncement in sufficient detail so that MedicarePlus  
23 organizations can compute monthly adjusted  
24 MedicarePlus capitation rates for individuals in each

1 MedicarePlus payment area which is in whole or in  
2 part within the service area of such an organization.

3 “(c) CALCULATION OF ANNUAL MEDICAREPLUS  
4 CAPITATION RATES.—

5 “(1) IN GENERAL.—For purposes of this part,  
6 each annual MedicarePlus capitation rate, for a  
7 MedicarePlus payment area for a contract year con-  
8 sisting of a calendar year, is equal to the largest of  
9 the amounts specified in the following subpara-  
10 graphs (A), (B), or (C):

11 “(A) BLENDED CAPITATION RATE.—The  
12 sum of—

13 “(i) area-specific percentage for the  
14 year (as specified under paragraph (2) for  
15 the year) of the annual area-specific  
16 MedicarePlus capitation rate for the year  
17 for the MedicarePlus payment area, as de-  
18 termined under paragraph (3), and

19 “(ii) national percentage (as specified  
20 under paragraph (2) for the year) of the  
21 input-price-adjusted annual national  
22 MedicarePlus capitation rate for the year,  
23 as determined under paragraph (4),

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1 multiplied by the payment adjustment factors  
2 described in subparagraphs (A) and (B) of  
3 paragraph (5).

4 “(B) MINIMUM AMOUNT.—12 multiplied  
5 by the following amount:

6 “(i) For 1998, \$350 (but not to ex-  
7 ceed, in the case of an area outside the 50  
8 States and the District of Columbia, 150  
9 percent of the annual per capita rate of  
10 payment for 1997 determined under sec-  
11 tion 1876(a)(1)(C) for the area).

12 “(ii) For a succeeding year, the mini-  
13 mum amount specified in this clause (or  
14 clause (i)) for the preceding year increased  
15 by the national per capita MedicarePlus  
16 growth percentage, specified under para-  
17 graph (6) for that succeeding year.

18 “(C) MINIMUM PERCENTAGE INCREASE.—

19 “(i) For 1998, 102 percent of the an-  
20 nual per capita rate of payment for 1997  
21 determined under section 1876(a)(1)(C)  
22 for the MedicarePlus payment area.

23 “(ii) For a subsequent year, 102 per-  
24 cent of the annual MedicarePlus capitation

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1 rate under this paragraph for the area for  
2 the previous year.

3 “(2) AREA-SPECIFIC AND NATIONAL PERCENT-  
4 AGES.—For purposes of paragraph (1)(A)—

5 “(A) for 1998, the ‘area-specific percent-  
6 age’ is 90 percent and the ‘national percentage’  
7 is 10 percent,

8 “(B) for 1999, the ‘area-specific percent-  
9 age’ is 80 percent and the ‘national percentage’  
10 is 20 percent,

11 “(C) for 2000, the ‘area-specific percent-  
12 age’ is 70 percent and the ‘national percentage’  
13 is 30 percent,

14 “(D) for 2001, the ‘area-specific percent-  
15 age’ is 60 percent and the ‘national percentage’  
16 is 40 percent, and

17 “(E) for a year after 2001, the ‘area-spe-  
18 cific percentage’ is 50 percent and the ‘national  
19 percentage’ is 50 percent.

20 “(3) ANNUAL AREA-SPECIFIC MEDICAREPLUS  
21 CAPITATION RATE.—For purposes of paragraph  
22 (1)(A), the annual area-specific MedicarePlus capita-  
23 tion rate for a MedicarePlus payment area—

24 “(A) for 1998 is the annual per capita rate  
25 of payment for 1997 determined under section

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1 1876(a)(1)(C) for the area, increased by the  
2 national per capita MedicarePlus growth per-  
3 centage for 1998 (as defined in paragraph (6));  
4 or

5 “(B) for a subsequent year is the annual  
6 area-specific MedicarePlus capitation rate for  
7 the previous year determined under this para-  
8 graph for the area, increased by the national  
9 per capita MedicarePlus growth percentage for  
10 such subsequent year.

11 “(4) INPUT-PRICE-ADJUSTED ANNUAL NA-  
12 TIONAL MEDICAREPLUS CAPITATION RATE.—

13 “(A) IN GENERAL.—For purposes of para-  
14 graph (1)(A), the input-price-adjusted annual  
15 national MedicarePlus capitation rate for a  
16 MedicarePlus payment area for a year is equal  
17 to the sum, for all the types of medicare serv-  
18 ices (as classified by the Secretary), of the  
19 product (for each such type of service) of—

20 “(i) the national standardized annual  
21 MedicarePlus capitation rate (determined  
22 under subparagraph (B)) for the year,

23 “(ii) the proportion of such rate for  
24 the year which is attributable to such type  
25 of services, and



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1 “(iii) an index that reflects (for that  
2 year and that type of services) the relative  
3 input price of such services in the area  
4 compared to the national average input  
5 price of such services.

6 In applying clause (iii), the Secretary shall, sub-  
7 ject to subparagraph (C), apply those indices  
8 under this title that are used in applying (or  
9 updating) national payment rates for specific  
10 areas and localities.

11 “(B) NATIONAL STANDARDIZED ANNUAL  
12 MEDICAREPLUS CAPITATION RATE.—In sub-  
13 paragraph (A)(i), the ‘national standardized an-  
14 nual MedicarePlus capitation rate’ for a year is  
15 equal to—

16 “(i) the sum (for all MedicarePlus  
17 payment areas) of the product of—

18 “(I) the annual area-specific  
19 MedicarePlus capitation rate for that  
20 year for the area under paragraph  
21 (3), and

22 “(II) the average number of med-  
23 icare beneficiaries residing in that  
24 area in the year, multiplied by the av-  
25 erage of the risk factor weights used

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1 to adjust payments under subsection  
2 (a)(1)(A) for such beneficiaries in  
3 such area; divided by

4 “(ii) the sum of the products de-  
5 scribed in clause (i)(II) for all areas for  
6 that year.

7 “(C) SPECIAL RULES FOR 1998.—In apply-  
8 ing this paragraph for 1998—

9 “(i) medicare services shall be divided  
10 into 2 types of services: part A services  
11 and part B services;

12 “(ii) the proportions described in sub-  
13 paragraph (A)(ii)—

14 “(I) for part A services shall be  
15 the ratio (expressed as a percentage)  
16 of the national average annual per  
17 capita rate of payment for part A for  
18 1997 to the total national average an-  
19 nual per capita rate of payment for  
20 parts A and B for 1997, and

21 “(II) for part B services shall be  
22 100 percent minus the ratio described  
23 in subclause (I);

24 “(iii) for part A services, 70 percent  
25 of payments attributable to such services

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1 shall be adjusted by the index used under  
2 section 1886(d)(3)(E) to adjust payment  
3 rates for relative hospital wage levels for  
4 hospitals located in the payment area in-  
5 volved;

6 “(iv) for part B services—

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

14 “(II) of the remaining 34 percent  
15 of the amount of such payments, 40  
16 percent shall be adjusted by the index  
17 described in clause (iii); and

18 “(v) the index values shall be com-  
19 puted based only on the beneficiary popu-  
20 lation who are 65 years of age or older and  
21 who are not determined to have end stage  
22 renal disease.

23 The Secretary may continue to apply the rules  
24 described in this subparagraph (or similar  
25 rules) for 1999.

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1           “(5) PAYMENT ADJUSTMENT BUDGET NEU-  
2           TRALITY FACTORS.—For purposes of paragraph  
3           (1)(A)—

4                   “(A) BLENDED RATE PAYMENT ADJUST-  
5                   MENT FACTOR.—For each year, the Secretary  
6                   shall compute a blended rate payment adjust-  
7                   ment factor such that, not taking into account  
8                   subparagraphs (B) and (C) of paragraph (1)  
9                   and the application of the payment adjustment  
10                  factor described in subparagraph (B), the ag-  
11                  gregate of the payments that would be made  
12                  under this part is equal to the aggregate pay-  
13                  ments that would have been made under this  
14                  part (not taking into account such subpara-  
15                  graphs and such other adjustment factor) if the  
16                  area-specific percentage under paragraph (1)  
17                  for the year had been 100 percent and the na-  
18                  tional percentage had been 0 percent.

19                   “(B) FLOOR-AND-MINIMUM-UPDATE PAY-  
20                   MENT ADJUSTMENT FACTOR.—For each year,  
21                   the Secretary shall compute a floor-and-mini-  
22                   mum-update payment adjustment factor so  
23                   that, taking into account the application of the  
24                   blended rate payment adjustment factor under  
25                   subparagraph (A) and subparagraphs (B) and

1 (C) of paragraph (1) and the application of the  
2 adjustment factor under this subparagraph, the  
3 aggregate of the payments under this part shall  
4 not exceed the aggregate payments that would  
5 have been made under this part if subpara-  
6 graphs (B) and (C) of paragraph (1) did not  
7 apply and if the floor-and-minimum-update pay-  
8 ment adjustment factor under this subpara-  
9 graph was 1.

10 “(6) NATIONAL PER CAPITA MEDICAREPLUS  
11 GROWTH PERCENTAGE DEFINED.—

12 “(A) IN GENERAL.—In this part, the ‘na-  
13 tional per capita MedicarePlus growth percent-  
14 age’ for a year is the percentage determined by  
15 the Secretary, by April 30th before the begin-  
16 ning of the year involved, to reflect the Sec-  
17 retary’s estimate of the projected per capita  
18 rate of growth in expenditures under this title  
19 for an individual entitled to benefits under part  
20 A and enrolled under part B, reduced by the  
21 number of percentage points specified in sub-  
22 paragraph (B) for the year. Separate deter-  
23 minations may be made for aged enrollees, dis-  
24 abled enrollees, and enrollees with end-stage  
25 renal disease. Such percentage shall include an

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1 adjustment for over or under projection in the  
2 growth percentage for previous years.

3 “(B) ADJUSTMENT.—The number of per-  
4 centage points specified in this subparagraph  
5 is—

6 “(i) for 1998, 0.5 percentage points,

7 “(ii) for 1999, 0.5 percentage points,

8 “(iii) for 2000, 0.5 percentage points,

9 “(iv) for 2001, 0.5 percentage points,

10 “(v) for 2002, 0.5 percentage points,

11 and

12 “(vi) for a year after 2002, 0 percent-  
13 age points.

14 “(d) MEDICAREPLUS PAYMENT AREA DEFINED.—

15 “(1) IN GENERAL.—In this part, except as pro-  
16 vided in paragraph (3), the term ‘MedicarePlus pay-  
17 ment area’ means a county, or equivalent area speci-  
18 fied by the Secretary.

19 “(2) RULE FOR ESRD BENEFICIARIES.—In the  
20 case of individuals who are determined to have end  
21 stage renal disease, the MedicarePlus payment area  
22 shall be a State or such other payment area as the  
23 Secretary specifies.

24 “(3) GEOGRAPHIC ADJUSTMENT.—

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1           “(A) IN GENERAL.—Upon written request  
2 of the chief executive officer of a State for a  
3 contract year (beginning after 1998) made at  
4 least 7 months before the beginning of the year,  
5 the Secretary shall make a geographic adjust-  
6 ment to a MedicarePlus payment area in the  
7 State otherwise determined under paragraph  
8 (1)—

9                   “(i) to a single statewide  
10 MedicarePlus payment area,

11                   “(ii) to the metropolitan based system  
12 described in subparagraph (C), or

13                   “(iii) to consolidating into a single  
14 MedicarePlus payment area noncontiguous  
15 counties (or equivalent areas described in  
16 paragraph (1)) within a State.

17 Such adjustment shall be effective for payments  
18 for months beginning with January of the year  
19 following the year in which the request is re-  
20 ceived.

21           “(B) BUDGET NEUTRALITY ADJUST-  
22 MENT.—In the case of a State requesting an  
23 adjustment under this paragraph, the Secretary  
24 shall adjust the payment rates otherwise estab-  
25 lished under this section for MedicarePlus pay-

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1           ment areas in the State in a manner so that the  
2           aggregate of the payments under this section in  
3           the State shall not exceed the aggregate pay-  
4           ments that would have been made under this  
5           section for MedicarePlus payment areas in the  
6           State in the absence of the adjustment under  
7           this paragraph.

8           “(C) METROPOLITAN BASED SYSTEM.—  
9           The metropolitan based system described in this  
10          subparagraph is one in which—

11                 “(i) all the portions of each metropoli-  
12                 tan statistical area in the State or in the  
13                 case of a consolidated metropolitan statis-  
14                 tical area, all of the portions of each pri-  
15                 mary metropolitan statistical area within  
16                 the consolidated area within the State, are  
17                 treated as a single MedicarePlus payment  
18                 area, and

19                 “(ii) all areas in the State that do not  
20                 fall within a metropolitan statistical area  
21                 are treated as a single MedicarePlus pay-  
22                 ment area.

23           “(D) AREAS.—In subparagraph (C), the  
24           terms ‘metropolitan statistical area’, ‘consoli-  
25           dated metropolitan statistical area’, and ‘pri-



1           mary metropolitan statistical area’ mean any  
2           area designated as such by the Secretary of  
3           Commerce.

4           “(e) SPECIAL RULES FOR INDIVIDUALS ELECTING  
5 MSA PLANS.—

6           “(1) IN GENERAL.—If the amount of the  
7           monthly premium for an MSA plan for a  
8           MedicarePlus payment area for a year is less than  
9            $\frac{1}{12}$  of the annual MedicarePlus capitation rate ap-  
10          plied under this section for the area and year in-  
11          volved, the Secretary shall deposit an amount equal  
12          to 100 percent of such difference in a MedicarePlus  
13          MSA established (and, if applicable, designated) by  
14          the individual under paragraph (2).

15          “(2) ESTABLISHMENT AND DESIGNATION OF  
16          MEDICAREPLUS MEDICAL SAVINGS ACCOUNT AS RE-  
17          QUIREMENT FOR PAYMENT OF CONTRIBUTION.—In  
18          the case of an individual who has elected coverage  
19          under an MSA plan, no payment shall be made  
20          under paragraph (1) on behalf of an individual for  
21          a month unless the individual—

22                  “(A) has established before the beginning  
23                  of the month (or by such other deadline as the  
24                  Secretary may specify) a MedicarePlus MSA

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1 (as defined in section 138(b)(2) of the Internal  
2 Revenue Code of 1986), and

3 “(B) if the individual has established more  
4 than one such MedicarePlus MSA, has des-  
5 ignated one of such accounts as the individual’s  
6 MedicarePlus MSA for purposes of this part.

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

10 “(3) LUMP SUM DEPOSIT OF MEDICAL SAVINGS  
11 ACCOUNT CONTRIBUTION.—In the case of an indi-  
12 vidual electing an MSA plan effective beginning with  
13 a month in a year, the amount of the contribution  
14 to the MedicarePlus MSA on behalf of the individual  
15 for that month and all successive months in the year  
16 shall be deposited during that first month. In the  
17 case of a termination of such an election as of a  
18 month before the end of a year, the Secretary shall  
19 provide for a procedure for the recovery of deposits  
20 attributable to the remaining months in the year.

21 “(f) PAYMENTS FROM TRUST FUND.—The payment  
22 to a MedicarePlus organization under this section for indi-  
23 viduals enrolled under this part with the organization and  
24 payments to a MedicarePlus MSA under subsection (e)(1)  
25 shall be made from the Federal Hospital Insurance Trust

1 Fund and the Federal Supplementary Medical Insurance  
2 Trust Fund in such proportion as the Secretary deter-  
3 mines reflects the relative weight that benefits under part  
4 A and under part B represents of the actuarial value of  
5 the total benefits under this title. Monthly payments oth-  
6 erwise payable under this section for October 2001 shall  
7 be paid on the last business day of September 2001.

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

13 “(1) election under this part of a MedicarePlus  
14 plan offered by a MedicarePlus organization—

15 “(A) payment for such services until the  
16 date of the individual’s discharge shall be made  
17 under this title through the MedicarePlus plan  
18 or the medicare fee-for-service program option  
19 described in section 1851(a)(1)(A) (as the case  
20 may be) elected before the election with such  
21 organization,

22 “(B) the elected organization shall not be  
23 financially responsible for payment for such  
24 services until the date after the date of the indi-  
25 vidual’s discharge, and

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1           “(C) the organization shall nonetheless be  
2           paid the full amount otherwise payable to the  
3           organization under this part; or

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

6           “(A) the organization shall be financially  
7           responsible for payment for such services after  
8           such date and until the date of the individual’s  
9           discharge,

10           “(B) payment for such services during the  
11           stay shall not be made under section 1886(d) or  
12           by any succeeding MedicarePlus organization,  
13           and

14           “(C) the terminated organization shall not  
15           receive any payment with respect to the individ-  
16           ual under this part during the period the indi-  
17           vidual is not enrolled.

18                           “PREMIUMS

19           “SEC. 1854. (a) SUBMISSION AND CHARGING OF  
20           PREMIUMS.—

21           “(1) IN GENERAL.—Subject to paragraph (3),  
22           each MedicarePlus organization shall file with the  
23           Secretary each year, in a form and manner and at  
24           a time specified by the Secretary—

25           “(A) the amount of the monthly premium  
26           for coverage for services under section 1852(a)

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1 under each MedicarePlus plan it offers under  
2 this part in each MedicarePlus payment area  
3 (as defined in section 1853(d)) in which the  
4 plan is being offered; and

5 “(B) the enrollment capacity in relation to  
6 the plan in each such area.

7 “(2) TERMINOLOGY.—In this part—

8 “(A) the term ‘monthly premium’ means,  
9 with respect to a MedicarePlus plan offered by  
10 a MedicarePlus organization, the monthly pre-  
11 mium filed under paragraph (1), not taking  
12 into account the amount of any payment made  
13 toward the premium under section 1853; and

14 “(B) the term ‘net monthly premium’  
15 means, with respect to such a plan and an indi-  
16 vidual enrolled with the plan, the premium (as  
17 defined in subparagraph (A)) for the plan re-  
18 duced by the amount of payment made toward  
19 such premium under section 1853.

20 “(b) MONTHLY PREMIUM CHARGED.—The monthly  
21 amount of the premium charged by a MedicarePlus orga-  
22 nization for a MedicarePlus plan offered in a  
23 MedicarePlus payment area to an individual under this  
24 part shall be equal to the net monthly premium plus any

1 monthly premium charged in accordance with subsection  
2 (e)(2) for supplemental benefits.

3 “(c) UNIFORM PREMIUM.—The monthly premium  
4 and monthly amount charged under subsection (b) of a  
5 MedicarePlus organization under this part may not vary  
6 among individuals who reside in the same MedicarePlus  
7 payment area.

8 “(d) TERMS AND CONDITIONS OF IMPOSING PRE-  
9 MIUMS.—Each MedicarePlus organization shall permit the  
10 payment of net monthly premiums on a monthly basis and  
11 may terminate election of individuals for a MedicarePlus  
12 plan for failure to make premium payments only in ac-  
13 cordance with section 1851(g)(3)(B)(i). A MedicarePlus  
14 organization is not authorized to provide for cash or other  
15 monetary rebates as an inducement for enrollment or oth-  
16 erwise.

17 “(e) LIMITATION ON ENROLLEE COST-SHARING.—

18 “(1) FOR BASIC AND ADDITIONAL BENEFITS.—  
19 Except as provided in paragraph (2), in no event  
20 may—

21 “(A) the net monthly premium (multiplied  
22 by 12) and the actuarial value of the  
23 deductibles, coinsurance, and copayments appli-  
24 cable on average to individuals enrolled under  
25 this part with a MedicarePlus plan of an orga-

1           nization with respect to required benefits de-  
2           scribed in section 1852(a)(1) and additional  
3           benefits (if any) required under subsection  
4           (f)(1) for a year, exceed

5           “(B) the actuarial value of the deductibles,  
6           coinsurance, and copayments that would be ap-  
7           plicable on average to individuals entitled to  
8           benefits under part A and enrolled under part  
9           B if they were not members of a MedicarePlus  
10          organization for the year.

11          “(2) FOR SUPPLEMENTAL BENEFITS.—If the  
12          MedicarePlus organization provides to its members  
13          enrolled under this part supplemental benefits de-  
14          scribed in section 1852(a)(3), the sum of the month-  
15          ly premium rate (multiplied by 12) charged for such  
16          supplemental benefits and the actuarial value of its  
17          deductibles, coinsurance, and copayments charged  
18          with respect to such benefits may not exceed the ad-  
19          justed community rate for such benefits (as defined  
20          in subsection (f)(4)).

21          “(3) EXCEPTION FOR MSA PLANS.—Paragraphs  
22          (1) and (2) do not apply to an MSA plan.

23          “(4) DETERMINATION ON OTHER BASIS.—If the  
24          Secretary determines that adequate data are not  
25          available to determine the actuarial value under

1 paragraph (1)(A) or (2), the Secretary may deter-  
2 mine such amount with respect to all individuals in  
3 the MedicarePlus payment area, the State, or in the  
4 United States, eligible to enroll in the MedicarePlus  
5 plan involved under this part or on the basis of other  
6 appropriate data.

7 “(f) REQUIREMENT FOR ADDITIONAL BENEFITS.—

8 “(1) REQUIREMENT.—

9 “(A) IN GENERAL.—Each MedicarePlus  
10 organization (in relation to a MedicarePlus plan  
11 it offers) shall provide that if there is an excess  
12 amount (as defined in subparagraph (B)) for  
13 the plan for a contract year, subject to the suc-  
14 ceeding provisions of this subsection, the orga-  
15 nization shall provide to individuals such addi-  
16 tional benefits (as the organization may specify)  
17 in a value which is at least equal to the ad-  
18 justed excess amount (as defined in subpara-  
19 graph (C)).

20 “(B) EXCESS AMOUNT.—For purposes of  
21 this paragraph, the ‘excess amount’, for an or-  
22 ganization for a plan, is the amount (if any) by  
23 which—

24 “(i) the average of the capitation pay-  
25 ments made to the organization under sec-



1           tion 1853 for the plan at the beginning of  
2           contract year, exceeds

3           “(ii) the actuarial value of the re-  
4           quired benefits described in section  
5           1852(a)(1) under the plan for individuals  
6           under this part, as determined based upon  
7           an adjusted community rate described in  
8           paragraph (4) (as reduced for the actuarial  
9           value of the coinsurance and deductibles  
10          under parts A and B).

11          “(C) ADJUSTED EXCESS AMOUNT.—For  
12          purposes of this paragraph, the ‘adjusted excess  
13          amount’, for an organization for a plan, is the  
14          excess amount reduced to reflect any amount  
15          withheld and reserved for the organization for  
16          the year under paragraph (2).

17          “(D) NO APPLICATION TO MSA PLANS.—  
18          Subparagraph (A) shall not apply to an MSA  
19          plan.

20          “(E) UNIFORM APPLICATION.—This para-  
21          graph shall be applied uniformly for all enroll-  
22          ees for a plan in a MedicarePlus payment area.

23          “(F) CONSTRUCTION.—Nothing in this  
24          subsection shall be construed as preventing a  
25          MedicarePlus organization from providing

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1 health care benefits that are in addition to the  
2 benefits otherwise required to be provided under  
3 this paragraph and from imposing a premium  
4 for such additional benefits.

5 “(2) STABILIZATION FUND.—A MedicarePlus  
6 organization may provide that a part of the value of  
7 an excess amount described in paragraph (1) be  
8 withheld and reserved in the Federal Hospital Insur-  
9 ance Trust Fund and in the Federal Supplementary  
10 Medical Insurance Trust Fund (in such proportions  
11 as the Secretary determines to be appropriate) by  
12 the Secretary for subsequent annual contract peri-  
13 ods, to the extent required to stabilize and prevent  
14 undue fluctuations in the additional benefits offered  
15 in those subsequent periods by the organization in  
16 accordance with such paragraph. Any of such value  
17 of the amount reserved which is not provided as ad-  
18 ditional benefits described in paragraph (1)(A) to in-  
19 dividuals electing the MedicarePlus plan of the orga-  
20 nization in accordance with such paragraph prior to  
21 the end of such periods, shall revert for the use of  
22 such trust funds.

23 “(3) DETERMINATION BASED ON INSUFFICIENT  
24 DATA.—For purposes of this subsection, if the Sec-  
25 retary finds that there is insufficient enrollment ex-

1 perience (including no enrollment experience in the  
2 case of a provider-sponsored organization) to deter-  
3 mine an average of the capitation payments to be  
4 made under this part at the beginning of a contract  
5 period, the Secretary may determine such an aver-  
6 age based on the enrollment experience of other con-  
7 tracts entered into under this part.

8 “(4) ADJUSTED COMMUNITY RATE.—

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

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

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

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

19               “(B) SPECIAL RULE FOR PROVIDER-SPON-  
20               SORED ORGANIZATIONS.—In the case of a  
21               MedicarePlus organization that is a provider-  
22               sponsored organization, the adjusted community  
23               rate under subparagraph (A) for a  
24               MedicarePlus plan of the organization may be  
25               computed (in a manner specified by the Sec-

1           retary) using data in the general commercial  
2           marketplace or (during a transition period)  
3           based on the costs incurred by the organization  
4           in providing such a plan.

5           “(g) PERIODIC AUDITING.—The Secretary shall pro-  
6           vide for the annual auditing of the financial records (in-  
7           cluding data relating to medicare utilization, costs, and  
8           computation of the adjusted community rate) of at least  
9           one-third of the MedicarePlus organizations offering  
10          MedicarePlus plans under this part. The Comptroller Gen-  
11          eral shall monitoring auditing activities conducted under  
12          this subsection.

13          “(h) PROHIBITION OF STATE IMPOSITION OF PRE-  
14          MIUM TAXES.—No State may impose a premium tax or  
15          similar tax with respect to premiums on MedicarePlus  
16          plans or the offering of such plans.

17          “ORGANIZATIONAL AND FINANCIAL REQUIREMENTS FOR  
18          MEDICAREPLUS ORGANIZATIONS; PROVIDER-SPON-  
19          SORED ORGANIZATIONS

20          “SEC. 1855. (a) ORGANIZED AND LICENSED UNDER  
21          STATE LAW.—

22                  “(1) IN GENERAL.—Subject to paragraphs (2)  
23                  and (3), a MedicarePlus organization shall be orga-  
24                  nized and licensed under State law as a risk-bearing  
25                  entity eligible to offer health insurance or health

1 benefits coverage in each State in which it offers a  
2 MedicarePlus plan.

3 “(2) SPECIAL EXCEPTION FOR PROVIDER-SPON-  
4 SORED ORGANIZATIONS.—

5 “(A) IN GENERAL.—In the case of a pro-  
6 vider-sponsored organization that seeks to offer  
7 a MedicarePlus plan in a State, the Secretary  
8 shall waive the requirement of paragraph (1)  
9 that the organization be licensed in that State  
10 if—

11 “(i) the organization files an applica-  
12 tion for such waiver with the Secretary,  
13 and

14 “(ii) the Secretary determines, based  
15 on the application and other evidence pre-  
16 sented to the Secretary, that any of the  
17 grounds for approval of the application de-  
18 scribed in subparagraph (B), (C), or (D)  
19 has been met.

20 “(B) FAILURE TO ACT ON LICENSURE AP-  
21 PPLICATION ON A TIMELY BASIS.—A ground for  
22 approval of such a waiver application is that the  
23 State has failed to complete action on a licens-  
24 ing application of the organization within 90  
25 days of the date of the State’s receipt of the

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1 completed application. No period before the  
2 date of the enactment of this section shall be  
3 included in determining such 90-day period.

4 “(C) DENIAL OF APPLICATION BASED ON  
5 DISCRIMINATORY TREATMENT.—A ground for  
6 approval of such a waiver application is that the  
7 State has denied such a licensing application  
8 and—

9 “(i) the State has imposed docu-  
10 mentation or information requirements not  
11 related to solvency requirements that are  
12 not generally applicable to other entities  
13 engaged in substantially similar business,  
14 or

15 “(ii) the standards or review process  
16 imposed by the State as a condition of ap-  
17 proval of the license imposes any material  
18 requirements, procedures, or standards  
19 (other than requirements and standards  
20 relating to solvency) to such organizations  
21 that are not generally applicable to other  
22 entities engaged in substantially similar  
23 business.

24 “(D) DENIAL OF APPLICATION BASED ON  
25 APPLICATION OF SOLVENCY REQUIREMENTS.—

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1 A ground for approval of such a waiver applica-  
2 tion is that the State has denied such a licens-  
3 ing application based (in whole or in part) on  
4 the organization’s failure to meet applicable sol-  
5 vency requirements and—

6 “(i) such requirements are not the  
7 same as the solvency standards established  
8 under section 1856(a); or

9 “(ii) the State has imposed as a con-  
10 dition of approval of the license any docu-  
11 mentation or information requirements re-  
12 lating to solvency or other material re-  
13 quirements, procedures, or standards relat-  
14 ing to solvency that are different from the  
15 requirements, procedures, and standards  
16 applied by the Secretary under subsection  
17 (d)(2).

18 For purposes of this subparagraph, the term  
19 ‘solvency requirements’ means requirements re-  
20 lating to solvency and other matters covered  
21 under the standards established under section  
22 1856(a).

23 “(E) TREATMENT OF WAIVER.—In the  
24 case of a waiver granted under this paragraph  
25 for a provider-sponsored organization—



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1           “(i) the waiver shall be effective for a  
2           36-month period, except it may be renewed  
3           based on a subsequent application filed  
4           during the last 6 months of such period,  
5           and

6           “(ii) any provisions of State law which  
7           relate to the licensing of the organization  
8           and which prohibit the organization from  
9           providing coverage pursuant to a contract  
10          under this part shall be superseded.

11          Nothing in this subparagraph shall be con-  
12          strued as limiting the number of times such a  
13          waiver may be renewed.

14          “(F) PROMPT ACTION ON APPLICATION.—  
15          The Secretary shall grant or deny such a waiver  
16          application within 60 days after the date the  
17          Secretary determines that a substantially com-  
18          plete application has been filed. Nothing in this  
19          section shall be construed as preventing an or-  
20          ganization which has had such a waiver applica-  
21          tion denied from submitting a subsequent waiv-  
22          er application.

23          “(3) EXCEPTION IF REQUIRED TO OFFER MORE  
24          THAN MEDICAREPLUS PLANS.—Paragraph (1) shall  
25          not apply to a MedicarePlus organization in a State

1 if the State requires the organization, as a condition  
2 of licensure, to offer any product or plan other than  
3 a MedicarePlus plan.

4 “(4) LICENSURE DOES NOT SUBSTITUTE FOR  
5 OR CONSTITUTE CERTIFICATION.—The fact that an  
6 organization is licensed in accordance with para-  
7 graph (1) does not deem the organization to meet  
8 other requirements imposed under this part.

9 “(b) PREPAID PAYMENT.—A MedicarePlus organiza-  
10 tion shall be compensated (except for premiums,  
11 deductibles, coinsurance, and copayments) for the provi-  
12 sion of health care services to enrolled members under the  
13 contract under this part by a payment which is paid on  
14 a periodic basis without regard to the date the health care  
15 services are provided and which is fixed without regard  
16 to the frequency, extent, or kind of health care service ac-  
17 tually provided to a member.

18 “(c) ASSUMPTION OF FULL FINANCIAL RISK.—The  
19 MedicarePlus organization shall assume full financial risk  
20 on a prospective basis for the provision of the health care  
21 services (except, at the election of the organization, hos-  
22 pice care) for which benefits are required to be provided  
23 under section 1852(a)(1), except that the organization—

24 “(1) may obtain insurance or make other ar-  
25 rangements for the cost of providing to any enrolled

1 member such services the aggregate value of which  
2 exceeds \$5,000 in any year,

3 “(2) may obtain insurance or make other ar-  
4 rangements for the cost of such services provided to  
5 its enrolled members other than through the organi-  
6 zation because medical necessity required their pro-  
7 vision before they could be secured through the orga-  
8 nization,

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

14 “(4) may make arrangements with physicians  
15 or other health professionals, health care institu-  
16 tions, or any combination of such individuals or in-  
17 stitutions to assume all or part of the financial risk  
18 on a prospective basis for the provision of basic  
19 health services by the physicians or other health pro-  
20 fessionals or through the institutions.

21 “(d) CERTIFICATION OF PROVISION AGAINST RISK  
22 OF INSOLVENCY FOR UNLICENSED PSOs.—

23 “(1) IN GENERAL.—Each MedicarePlus organi-  
24 zation that is a provider-sponsored organization,  
25 that is not licensed by a State under subsection (a),

1 and for which a waiver application has been ap-  
2 proved under subsection (a)(2), shall meet standards  
3 established under section 1856(a) relating to the fi-  
4 nancial solvency and capital adequacy of the organi-  
5 zation.

6 “(2) CERTIFICATION PROCESS FOR SOLVENCY  
7 STANDARDS FOR PSOS.—The Secretary shall estab-  
8 lish a process for the receipt and approval of appli-  
9 cations of a provider-sponsored organization de-  
10 scribed in paragraph (1) for certification (and peri-  
11 odic recertification) of the organization as meeting  
12 such solvency standards. Under such process, the  
13 Secretary shall act upon such an application not  
14 later than 60 days after the date the application has  
15 been received.

16 “(e) PROVIDER-SPONSORED ORGANIZATION DE-  
17 FINED.—

18 “(1) IN GENERAL.—In this part, the term ‘pro-  
19 vider-sponsored organization’ means a public or pri-  
20 vate entity—

21 “(A) that is established or organized by a  
22 health care provider, or group of affiliated  
23 health care providers,

24 “(B) that provides a substantial proportion  
25 (as defined by the Secretary in accordance with

1 paragraph (2)) of the health care items and  
2 services under the contract under this part di-  
3 rectly through the provider or affiliated group  
4 of providers, and

5 “(C) with respect to which those affiliated  
6 providers that share, directly or indirectly, sub-  
7 stantial financial risk with respect to the provi-  
8 sion of such items and services have at least a  
9 majority financial interest in the entity.

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

13 “(A) shall take into account (i) the need  
14 for such an organization to assume responsibil-  
15 ity for a substantial proportion of services in  
16 order to assure financial stability and (ii) the  
17 practical difficulties in such an organization in-  
18 tegrating a very wide range of service providers;  
19 and

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

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

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1           “(A) one provider, directly or indirectly,  
2           controls, is controlled by, or is under common  
3           control with the other,

4           “(B) both providers are part of a con-  
5           trolled group of corporations under section  
6           1563 of the Internal Revenue Code of 1986, or

7           “(C) both providers are part of an affili-  
8           ated service group under section 414 of such  
9           Code.

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

16          “(5) HEALTH CARE PROVIDER DEFINED.—In  
17          this subsection, the term ‘health care provider’  
18          means—

19                 “(A) any individual who is engaged in the  
20                 delivery of health care services in a State and  
21                 who is required by State law or regulation to be  
22                 licensed or certified by the State to engage in  
23                 the delivery of such services in the State, and

24                 “(B) any entity that is engaged in the de-  
25                 livery of health care services in a State and

1 that, if it is required by State law or regulation  
2 to be licensed or certified by the State to en-  
3 gage in the delivery of such services in the  
4 State, is so licensed.

5 “(6) REGULATIONS.—The Secretary shall issue  
6 regulations to carry out this subsection.

7 “ESTABLISHMENT OF STANDARDS

8 “SEC. 1856. (a) ESTABLISHMENT OF SOLVENCY  
9 STANDARDS FOR PROVIDER-SPONSORED ORGANIZA-  
10 TIONS.—

11 “(1) ESTABLISHMENT.—

12 “(A) IN GENERAL.—The Secretary shall  
13 establish, on an expedited basis and using a ne-  
14 gotiated rulemaking process under subchapter  
15 III of chapter 5 of title 5, United States Code,  
16 standards described in section 1855(d)(1) (re-  
17 lating to the financial solvency and capital ade-  
18 quacy of the organization) that entities must  
19 meet to qualify as provider-sponsored organiza-  
20 tions under this part.

21 “(B) FACTORS TO CONSIDER FOR SOL-  
22 VENCY STANDARDS.—In establishing solvency  
23 standards under subparagraph (A) for provider-  
24 sponsored organizations, the Secretary shall  
25 consult with interested parties and shall take  
26 into account—

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1 “(i) the delivery system assets of such  
2 an organization and ability of such an or-  
3 ganization to provide services directly to  
4 enrollees through affiliated providers, and

5 “(ii) alternative means of protecting  
6 against insolvency, including reinsurance,  
7 unrestricted surplus, letters of credit, guar-  
8 antees, organizational insurance coverage,  
9 partnerships with other licensed entities,  
10 and valuation attributable to the ability of  
11 such an organization to meet its service  
12 obligations through direct delivery of care.

13 “(C) ENROLLEE PROTECTION AGAINST IN-  
14 SOLVENCY.—Such standards shall include pro-  
15 visions to prevent enrollees from being held lia-  
16 ble to any person or entity for the MedicarePlus  
17 organization’s debts in the event of the organi-  
18 zation’s insolvency.

19 “(2) PUBLICATION OF NOTICE.—In carrying  
20 out the rulemaking process under this subsection,  
21 the Secretary, after consultation with the National  
22 Association of Insurance Commissioners, the Amer-  
23 ican Academy of Actuaries, organizations represent-  
24 ative of medicare beneficiaries, and other interested  
25 parties, shall publish the notice provided for under



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1 section 564(a) of title 5, United States Code, by not  
2 later than 45 days after the date of the enactment  
3 of this section.

4 “(3) TARGET DATE FOR PUBLICATION OF  
5 RULE.—As part of the notice under paragraph (2),  
6 and for purposes of this subsection, the ‘target date  
7 for publication’ (referred to in section 564(a)(5) of  
8 such title) shall be April 1, 1998.

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

13 “(5) APPOINTMENT OF NEGOTIATED RULE-  
14 MAKING COMMITTEE AND FACILITATOR.—The Sec-  
15 retary shall provide for—

16 “(A) the appointment of a negotiated rule-  
17 making committee under section 565(a) of such  
18 title by not later than 30 days after the end of  
19 the comment period provided for under section  
20 564(c) of such title (as shortened under para-  
21 graph (4)), and

22 “(B) the nomination of a facilitator under  
23 section 566(c) of such title by not later than 10  
24 days after the date of appointment of the com-  
25 mittee.

1           “(6) PRELIMINARY COMMITTEE REPORT.—The  
2 negotiated rulemaking committee appointed under  
3 paragraph (5) shall report to the Secretary, by not  
4 later than January 1, 1998, regarding the commit-  
5 tee’s progress on achieving a consensus with regard  
6 to the rulemaking proceeding and whether such con-  
7 sensus is likely to occur before one month before the  
8 target date for publication of the rule. If the com-  
9 mittee reports that the committee has failed to make  
10 significant progress towards such consensus or is  
11 unlikely to reach such consensus by the target date,  
12 the Secretary may terminate such process and pro-  
13 vide for the publication of a rule under this sub-  
14 section through such other methods as the Secretary  
15 may provide.

16           “(7) FINAL COMMITTEE REPORT.—If the com-  
17 mittee is not terminated under paragraph (6), the  
18 rulemaking committee shall submit a report contain-  
19 ing a proposed rule by not later than one month be-  
20 fore the target date of publication.

21           “(8) INTERIM, FINAL EFFECT.—The Secretary  
22 shall publish a rule under this subsection in the Fed-  
23 eral Register by not later than the target date of  
24 publication. Such rule shall be effective and final im-  
25 mediately on an interim basis, but is subject to

1 change and revision after public notice and oppor-  
2 tunity for a period (of not less than 60 days) for  
3 public comment. In connection with such rule, the  
4 Secretary shall specify the process for the timely re-  
5 view and approval of applications of entities to be  
6 certified as provider-sponsored organizations pursu-  
7 ant to such rules and consistent with this subsection.

8 “(9) PUBLICATION OF RULE AFTER PUBLIC  
9 COMMENT.—The Secretary shall provide for consid-  
10 eration of such comments and republication of such  
11 rule by not later than 1 year after the target date  
12 of publication.

13 “(b) ESTABLISHMENT OF OTHER STANDARDS.—

14 “(1) IN GENERAL.—The Secretary shall estab-  
15 lish by regulation other standards (not described in  
16 subsection (a)) for MedicarePlus organizations and  
17 plans consistent with, and to carry out, this part.

18 “(2) USE OF CURRENT STANDARDS.—Consist-  
19 ent with the requirements of this part, standards es-  
20 tablished under this subsection shall be based on  
21 standards established under section 1876 to carry  
22 out analogous provisions of such section.

23 “(3) USE OF INTERIM STANDARDS.—For the  
24 period in which this part is in effect and standards  
25 are being developed and established under the pre-

1 ceding provisions of this subsection, the Secretary  
2 shall provide by not later than June 1, 1998, for the  
3 application of such interim standards (without re-  
4 gard to any requirements for notice and public com-  
5 ment) as may be appropriate to provide for the expe-  
6 dited implementation of this part. Such interim  
7 standards shall not apply after the date standards  
8 are established under the preceding provisions of  
9 this subsection.

10 “(4) APPLICATION OF NEW STANDARDS TO EN-  
11 TITIES WITH A CONTRACT.—In the case of a  
12 MedicarePlus organization with a contract in effect  
13 under this part at the time standards applicable to  
14 the organization under this section are changed, the  
15 organization may elect not to have such changes  
16 apply to the organization until the end of the cur-  
17 rent contract year (or, if there is less than 6 months  
18 remaining in the contract year, until 1 year after the  
19 end of the current contract year).

20 “(5) RELATION TO STATE LAWS.—The stand-  
21 ards established under this subsection shall super-  
22 sede any State law or regulation with respect to  
23 MedicarePlus plans which are offered by  
24 MedicarePlus organizations under this part to the

1 extent such law or regulation is inconsistent with  
2 such standards.

3 “CONTRACTS WITH MEDICAREPLUS ORGANIZATIONS

4 “SEC. 1857. (a) IN GENERAL.—The Secretary shall  
5 not permit the election under section 1851 of a  
6 MedicarePlus plan offered by a MedicarePlus organization  
7 under this part, and no payment shall be made under sec-  
8 tion 1853 to an organization, unless the Secretary has en-  
9 tered into a contract under this section with the organiza-  
10 tion with respect to the offering of such plan. Such a con-  
11 tract with an organization may cover more than one  
12 MedicarePlus plan. Such contract shall provide that the  
13 organization agrees to comply with the applicable require-  
14 ments and standards of this part and the terms and condi-  
15 tions of payment as provided for in this part.

16 “(b) MINIMUM ENROLLMENT REQUIREMENTS.—

17 “(1) IN GENERAL.—Subject to paragraphs (2)  
18 and (3), the Secretary may not enter into a contract  
19 under this section with a MedicarePlus organization  
20 unless the organization has at least 5,000 individ-  
21 uals (or 1,500 individuals in the case of an organiza-  
22 tion that is a provider-sponsored organization) who  
23 are receiving health benefits through the organiza-  
24 tion, except that the standards under section 1856  
25 may permit the organization to have a lesser number  
26 of beneficiaries (but not less than 500 in the case

1 of an organization that is a provider-sponsored orga-  
2 nization) if the organization primarily serves individ-  
3 uals residing outside of urbanized areas.

4 “(2) EXCEPTION FOR MSA PLAN.—Paragraph  
5 (1) shall not apply with respect to a contract that  
6 relates only to an MSA plan.

7 “(3) ALLOWING TRANSITION.—The Secretary  
8 may waive the requirement of paragraph (1) during  
9 the first 3 contract years with respect to an organi-  
10 zation.

11 “(c) CONTRACT PERIOD AND EFFECTIVENESS.—

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

18 “(2) TERMINATION AUTHORITY.—In accord-  
19 ance with procedures established under subsection  
20 (h), the Secretary may at any time terminate any  
21 such contract if the Secretary determines that the  
22 organization—

23 “(A) has failed substantially to carry out  
24 the contract;

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1           “(B) is carrying out the contract in a man-  
2           ner inconsistent with the efficient and effective  
3           administration of this part; or

4           “(C) no longer substantially meets the ap-  
5           plicable conditions of this part.

6           “(3) EFFECTIVE DATE OF CONTRACTS.—The  
7           effective date of any contract executed pursuant to  
8           this section shall be specified in the contract, except  
9           that in no case shall a contract under this section  
10          which provides for coverage under an MSA plan be  
11          effective before January 1999 with respect to such  
12          coverage.

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

21          “(5) CONTRACTING AUTHORITY.—The author-  
22          ity vested in the Secretary by this part may be per-  
23          formed without regard to such provisions of law or  
24          regulations relating to the making, performance,  
25          amendment, or modification of contracts of the

1 United States as the Secretary may determine to be  
2 inconsistent with the furtherance of the purpose of  
3 this title.

4 “(d) PROTECTIONS AGAINST FRAUD AND BENE-  
5 FICIARY PROTECTIONS.—

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

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

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

23 “(2) ENROLLEE NOTICE AT TIME OF TERMI-  
24 NATION.—Each contract under this section shall re-  
25 quire the organization to provide (and pay for) writ-



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1 ten notice in advance of the contract’s termination,  
2 as well as a description of alternatives for obtaining  
3 benefits under this title, to each individual enrolled  
4 with the organization under this part.

5 “(3) DISCLOSURE.—

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

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

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

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

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

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

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

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

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

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

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

17                  “(I) is an officer or director;

18                  “(II) is a partner (if such entity  
19                  is organized as a partnership);

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

23                  “(IV) has a mortgage, deed of  
24                  trust, note, or other interest valuing

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1 more than 5 percent of the assets of  
2 such entity;

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

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

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

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

18 “(e) ADDITIONAL CONTRACT TERMS.—

19 “(1) IN GENERAL.—The contract shall contain  
20 such other terms and conditions not inconsistent  
21 with this part (including requiring the organization  
22 to provide the Secretary with such information) as  
23 the Secretary may find necessary and appropriate.

24 “(2) COST-SHARING IN ENROLLMENT-RELATED  
25 COSTS.—The contract with a MedicarePlus organiza-

1       tion shall require the payment to the Secretary for  
2       the organization's pro rata share (as determined by  
3       the Secretary) of the estimated costs to be incurred  
4       by the Secretary in carrying out section 1851 (relat-  
5       ing to enrollment and dissemination of information).  
6       Such payments are appropriated to defray the costs  
7       described in the preceding sentence, to remain avail-  
8       able until expended.

9       “(f) PROMPT PAYMENT BY MEDICAREPLUS ORGANI-  
10      ZATION.—

11           “(1) REQUIREMENT.—A contract under this  
12       part shall require a MedicarePlus organization to  
13       provide prompt payment (consistent with the provi-  
14       sions of sections 1816(c)(2) and 1842(c)(2)) of  
15       claims submitted for services and supplies furnished  
16       to individuals pursuant to the contract, if the serv-  
17       ices or supplies are not furnished under a contract  
18       between the organization and the provider or sup-  
19       plier.

20           “(2) SECRETARY'S OPTION TO BYPASS NON-  
21       COMPLYING ORGANIZATION.—In the case of a  
22       MedicarePlus eligible organization which the Sec-  
23       retary determines, after notice and opportunity for  
24       a hearing, has failed to make payments of amounts  
25       in compliance with paragraph (1), the Secretary may

1 provide for direct payment of the amounts owed to  
2 providers and suppliers for covered services and sup-  
3 plies furnished to individuals enrolled under this  
4 part under the contract. If the Secretary provides  
5 for the direct payments, the Secretary shall provide  
6 for an appropriate reduction in the amount of pay-  
7 ments otherwise made to the organization under this  
8 part to reflect the amount of the Secretary's pay-  
9 ments (and the Secretary's costs in making the pay-  
10 ments).

11 “(g) INTERMEDIATE SANCTIONS.—

12 “(1) IN GENERAL.—If the Secretary determines  
13 that a MedicarePlus organization with a contract  
14 under this section—

15 “(A) fails substantially to provide medi-  
16 cally necessary items and services that are re-  
17 quired (under law or under the contract) to be  
18 provided to an individual covered under the con-  
19 tract, if the failure has adversely affected (or  
20 has substantial likelihood of adversely affecting)  
21 the individual;

22 “(B) imposes net monthly premiums on in-  
23 dividuals enrolled under this part in excess of  
24 the net monthly premiums permitted;

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

4           “(D) engages in any practice that would  
5 reasonably be expected to have the effect of de-  
6 nying or discouraging enrollment (except as  
7 permitted by this part) by eligible individuals  
8 with the organization whose medical condition  
9 or history indicates a need for substantial fu-  
10 ture medical services;

11           “(E) misrepresents or falsifies information  
12 that is furnished—

13                   “(i) to the Secretary under this part,  
14 or

15                   “(ii) to an individual or to any other  
16 entity under this part;

17           “(F) fails to comply with the requirements  
18 of section 1852(j)(3); or

19           “(G) employs or contracts with any indi-  
20 vidual or entity that is excluded from participa-  
21 tion under this title under section 1128 or  
22 1128A for the provision of health care, utiliza-  
23 tion review, medical social work, or administra-  
24 tive services or employs or contracts with any  
25 entity for the provision (directly or indirectly)

1 through such an excluded individual or entity of  
2 such services;  
3 the Secretary may provide, in addition to any other  
4 remedies authorized by law, for any of the remedies  
5 described in paragraph (2).

6 “(2) REMEDIES.—The remedies described in  
7 this paragraph are—

8 “(A) civil money penalties of not more  
9 than \$25,000 for each determination under  
10 paragraph (1) or, with respect to a determina-  
11 tion under subparagraph (D) or (E)(i) of such  
12 paragraph, of not more than \$100,000 for each  
13 such determination, plus, with respect to a de-  
14 termination under paragraph (1)(B), double the  
15 excess amount charged in violation of such  
16 paragraph (and the excess amount charged  
17 shall be deducted from the penalty and returned  
18 to the individual concerned), and plus, with re-  
19 spect to a determination under paragraph  
20 (1)(D), \$15,000 for each individual not enrolled  
21 as a result of the practice involved,

22 “(B) suspension of enrollment of individ-  
23 uals under this part after the date the Sec-  
24 retary notifies the organization of a determina-  
25 tion under paragraph (1) and until the Sec-



1           retary is satisfied that the basis for such deter-  
2           mination has been corrected and is not likely to  
3           recur, or

4                   “(C) suspension of payment to the organi-  
5           zation under this part for individuals enrolled  
6           after the date the Secretary notifies the organi-  
7           zation of a determination under paragraph (1)  
8           and until the Secretary is satisfied that the  
9           basis for such determination has been corrected  
10          and is not likely to recur.

11           “(3) OTHER INTERMEDIATE SANCTIONS.—In  
12          the case of a MedicarePlus organization for which  
13          the Secretary makes a determination under sub-  
14          section (c)(2) the basis of which is not described in  
15          paragraph (1), the Secretary may apply the follow-  
16          ing intermediate sanctions:

17                   “(A) Civil money penalties of not more  
18           than \$25,000 for each determination under  
19           subsection (c)(2) if the deficiency that is the  
20           basis of the determination has directly adversely  
21           affected (or has the substantial likelihood of ad-  
22           versely affecting) an individual covered under  
23           the organization’s contract

24                   “(B) Civil money penalties of not more  
25           than \$10,000 for each week beginning after the

1 initiation of procedures by the Secretary under  
2 subsection (g) during which the deficiency that  
3 is the basis of a determination under subsection  
4 (c)(2) exists.

5 “(C) Suspension of enrollment of individ-  
6 uals under this part after the date the Sec-  
7 retary notifies the organization of a determina-  
8 tion under subsection (c)(2) and until the Sec-  
9 retary is satisfied that the deficiency that is the  
10 basis for the determination has been corrected  
11 and is not likely to recur.

12 “(h) PROCEDURES FOR TERMINATION.—

13 “(1) IN GENERAL.—The Secretary may termi-  
14 nate a contract with a MedicarePlus organization  
15 under this section in accordance with formal inves-  
16 tigation and compliance procedures established by  
17 the Secretary under which—

18 “(A) the Secretary provides the organiza-  
19 tion with the reasonable opportunity to develop  
20 and implement a corrective action plan to cor-  
21 rect the deficiencies that were the basis of the  
22 Secretary’s determination under subsection  
23 (c)(2);

24 “(B) the Secretary provides the organiza-  
25 tion with reasonable notice and opportunity for

1 hearing (including the right to appeal an initial  
2 decision) before terminating the contract.

3 “(2) CIVIL MONEY PENALTIES.—The provisions  
4 of section 1128A (other than subsections (a) and  
5 (b)) shall apply to a civil money penalty under sub-  
6 section (f) or under paragraph (2) or (3) of sub-  
7 section (g) in the same manner as they apply to a  
8 civil money penalty or proceeding under section  
9 1128A(a).

10 “(3) EXCEPTION FOR IMMINENT AND SERIOUS  
11 RISK TO HEALTH.—Paragraph (1) shall not apply if  
12 the Secretary determines that a delay in termi-  
13 nation, resulting from compliance with the proce-  
14 dures specified in such paragraph prior to termi-  
15 nation, would pose an imminent and serious risk to  
16 the health of individuals enrolled under this part  
17 with the organization.

18 “DEFINITIONS; MISCELLANEOUS PROVISIONS

19 “SEC. 1859. (a) DEFINITIONS RELATING TO  
20 MEDICAREPLUS ORGANIZATIONS.—In this part—

21 “(1) MEDICAREPLUS ORGANIZATION.—The  
22 term ‘MedicarePlus organization’ means a public or  
23 private entity that is certified under section 1856 as  
24 meeting the requirements and standards of this part  
25 for such an organization.

1           “(2) PROVIDER-SPONSORED ORGANIZATION.—

2           The term ‘provider-sponsored organization’ is de-  
3           fined in section 1855(e)(1).

4           “(b) DEFINITIONS RELATING TO MEDICAREPLUS  
5           PLANS.—

6           “(1) MEDICAREPLUS PLAN.—The term  
7           ‘MedicarePlus plan’ means health benefits coverage  
8           offered under a policy, contract, or plan by a  
9           MedicarePlus organization pursuant to and in ac-  
10          cordance with a contract under section 1857.

11          “(2) MSA PLAN.—

12                 “(A) IN GENERAL.—The term ‘MSA plan’  
13                 means a MedicarePlus plan that—

14                         “(i) provides reimbursement for at  
15                         least the items and services described in  
16                         section 1852(a)(1) in a year but only after  
17                         the enrollee incurs countable expenses (as  
18                         specified under the plan) equal to the  
19                         amount of an annual deductible (described  
20                         in subparagraph (B));

21                         “(ii) counts as such expenses (for pur-  
22                         poses of such deductible) at least all  
23                         amounts that would have been payable  
24                         under parts A and B, and that would have  
25                         been payable by the enrollee as deductibles,

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1 coinsurance, or copayments, if the enrollee  
2 had elected to receive benefits through the  
3 provisions of such parts; and

4 “(iii) provides, after such deductible is  
5 met for a year and for all subsequent ex-  
6 penses for items and services referred to in  
7 clause (i) in the year, for a level of reim-  
8 bursement that is not less than—

9 “(I) 100 percent of such ex-  
10 penses, or

11 “(II) 100 percent of the amounts  
12 that would have been paid (without  
13 regard to any deductibles or coinsur-  
14 ance) under parts A and B with re-  
15 spect to such expenses,

16 whichever is less.

17 “(B) DEDUCTIBLE.—The amount of an-  
18 nual deductible under an MSA plan—

19 “(i) for contract year 1999 shall be  
20 not more than \$6,000; and

21 “(ii) for a subsequent contract year  
22 shall be not more than the maximum  
23 amount of such deductible for the previous  
24 contract year under this subparagraph in-  
25 creased by the national per capita

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1 MedicarePlus growth percentage under  
2 section 1853(c)(6) for the year.

3 If the amount of the deductible under clause  
4 (ii) is not a multiple of \$50, the amount shall  
5 be rounded to the nearest multiple of \$50.

6 “(c) OTHER REFERENCES TO OTHER TERMS.—

7 “(1) MEDICAREPLUS ELIGIBLE INDIVIDUAL.—  
8 The term ‘MedicarePlus eligible individual’ is de-  
9 fined in section 1851(a)(3).

10 “(2) MEDICAREPLUS PAYMENT AREA.—The  
11 term ‘MedicarePlus payment area’ is defined in sec-  
12 tion 1853(d).

13 “(3) NATIONAL PER CAPITA MEDICAREPLUS  
14 GROWTH PERCENTAGE.—The ‘national per capita  
15 MedicarePlus growth percentage’ is defined in sec-  
16 tion 1853(c)(6).

17 “(4) MONTHLY PREMIUM; NET MONTHLY PRE-  
18 MIUM.—The terms ‘monthly premium’ and ‘net  
19 monthly premium’ are defined in section 1854(a)(2).

20 “(d) COORDINATED ACUTE AND LONG-TERM CARE  
21 BENEFITS UNDER A MEDICAREPLUS PLAN.—Nothing in  
22 this part shall be construed as preventing a State from  
23 coordinating benefits under a medicaid plan under title  
24 XIX with those provided under a MedicarePlus plan in  
25 a manner that assures continuity of a full-range of acute

1 care and long-term care services to poor elderly or disabled  
2 individuals eligible for benefits under this title and under  
3 such plan.

4 “(e) RESTRICTION ON ENROLLMENT FOR CERTAIN  
5 MEDICAREPLUS PLANS.—

6 “(1) IN GENERAL.—In the case of a  
7 MedicarePlus religious fraternal benefit society plan  
8 described in paragraph (2), notwithstanding any  
9 other provision of this part to the contrary and in  
10 accordance with regulations of the Secretary, the so-  
11 ciety offering the plan may restrict the enrollment of  
12 individuals under this part to individuals who are  
13 members of the church, convention, or group de-  
14 scribed in paragraph (3)(B) with which the society  
15 is affiliated.

16 “(2) MEDICAREPLUS RELIGIOUS FRATERNAL  
17 BENEFIT SOCIETY PLAN DESCRIBED.—For purposes  
18 of this subsection, a MedicarePlus religious fraternal  
19 benefit society plan described in this paragraph is a  
20 MedicarePlus plan described in section  
21 1851(a)(2)(A) that—

22 “(A) is offered by a religious fraternal ben-  
23 efit society described in paragraph (3) only to  
24 members of the church, convention, or group  
25 described in paragraph (3)(B); and

1           “(B) permits all such members to enroll  
2           under the plan without regard to health status-  
3           related factors.

4           Nothing in this subsection shall be construed as  
5           waiving any plan requirements relating to financial  
6           solvency. In developing solvency standards under  
7           section 1856, the Secretary shall take into account  
8           open contract and assessment features characteristic  
9           of fraternal insurance certificates.

10           “(3) RELIGIOUS FRATERNAL BENEFIT SOCIETY  
11           DEFINED.—For purposes of paragraph (2)(A), a ‘re-  
12           ligious fraternal benefit society’ described in this  
13           section is an organization that—

14                   “(A) is exempt from Federal income tax-  
15                   ation under section 501(c)(8) of the Internal  
16                   Revenue Code of 1986;

17                   “(B) is affiliated with, carries out the te-  
18                   nets of, and shares a religious bond with, a  
19                   church or convention or association of churches  
20                   or an affiliated group of churches;

21                   “(C) offers, in addition to a MedicarePlus  
22                   religious fraternal benefit society plan, health  
23                   coverage to individuals not entitled to benefits  
24                   under this title who are members of such  
25                   church, convention, or group; and



1           “(D) does not impose any limitation on  
2           membership in the society based on any health  
3           status-related factor.

4           “(4) PAYMENT ADJUSTMENT.—Under regula-  
5           tions of the Secretary, in the case of individuals en-  
6           rolled under this part under a MedicarePlus reli-  
7           gious fraternal benefit society plan described in  
8           paragraph (2), the Secretary shall provide for such  
9           adjustment to the payment amounts otherwise estab-  
10          lished under section 1854 as may be appropriate to  
11          assure an appropriate payment level, taking into ac-  
12          count the actuarial characteristics and experience of  
13          such individuals.”.

14          (b) REPORT ON COVERAGE OF BENEFICIARIES WITH  
15          END-STAGE RENAL DISEASE.—The Secretary of Health  
16          and Human Services shall provide for a study on the fea-  
17          sibility and impact of removing the limitation under sec-  
18          tion 1851(b)(3)(B) of the Social Security Act (as inserted  
19          by subsection (a)) on eligibility of most individuals medi-  
20          cally determined to have end-stage renal disease to enroll  
21          in MedicarePlus plans. By not later than October 1, 1998,  
22          the Secretary shall submit to Congress a report on such  
23          study and shall include in the report such recommenda-  
24          tions regarding removing or restricting the limitation as  
25          may be appropriate.

1 (c) REPORT ON MEDICAREPLUS TEACHING PRO-  
2 GRAMS AND USE OF DSH AND TEACHING HOSPITALS.—  
3 Based on the information provided to the Secretary of  
4 Health and Human Services under section 1852(k) of the  
5 Social Security Act and such information as the Secretary  
6 may obtain, by not later than October 1, 1999, the Sec-  
7 retary shall submit to Congress a report on graduate med-  
8 ical education programs operated by MedicarePlus organi-  
9 zations and the extent to which MedicarePlus organiza-  
10 tions are providing for payments to hospitals described in  
11 such section.

12 **SEC. 10002. TRANSITIONAL RULES FOR CURRENT MEDI-**  
13 **CARE HMO PROGRAM.**

14 (a) AUTHORIZING TRANSITIONAL WAIVER OF 50:50  
15 RULE.—Section 1876(f) (42 U.S.C. 1395mm(f)) is  
16 amended—

17 (1) in paragraph (2), by striking “The Sec-  
18 retary” and inserting “Subject to paragraph (4), the  
19 Secretary”, and

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

22 “(4) Effective for contract periods beginning after  
23 December 31, 1996, the Secretary may waive or modify  
24 the requirement imposed by paragraph (1) to the extent  
25 the Secretary finds that it is in the public interest.”.

1 (b) TRANSITION.—Section 1876 (42 U.S.C.  
2 1395mm) is amended by adding at the end the following  
3 new subsection:

4 “(k)(1) Except as provided in paragraph (3), the Sec-  
5 retary shall not enter into, renew, or continue any risk-  
6 sharing contract under this section with an eligible organi-  
7 zation for any contract year beginning on or after—

8 “(A) the date standards for MedicarePlus orga-  
9 nizations and plans are first established under sec-  
10 tion 1856 with respect to MedicarePlus organiza-  
11 tions that are insurers or health maintenance orga-  
12 nizations, or

13 “(B) in the case of such an organization with  
14 such a contract in effect as of the date such stand-  
15 ards were first established, 1 year after such date.

16 “(2) The Secretary shall not enter into, renew, or  
17 continue any risk-sharing contract under this section with  
18 an eligible organization for any contract year beginning  
19 on or after January 1, 2000.

20 “(3) An individual who is enrolled in part B only and  
21 is enrolled in an eligible organization with a risk-sharing  
22 contract under this section on December 31, 1998, may  
23 continue enrollment in such organization in accordance  
24 with regulations issued by not later than July 1, 1998.

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1 “(4) Notwithstanding subsection (a), the Secretary  
2 shall provide that payment amounts under risk-sharing  
3 contracts under this section for months in a year (begin-  
4 ning with January 1998) shall be computed—

5 “(A) with respect to individuals entitled to ben-  
6 efits under both parts A and B, by substituting pay-  
7 ment rates under section 1853(a) for the payment  
8 rates otherwise established under subsection  
9 1876(a), and

10 “(B) with respect to individuals only entitled to  
11 benefits under part B, by substituting an appro-  
12 priate proportion of such rates (reflecting the rel-  
13 ative proportion of payments under this title attrib-  
14 utable to such part) for the payment rates otherwise  
15 established under subsection (a).

16 For purposes of carrying out this paragraph for payments  
17 for months in 1998, the Secretary shall compute, an-  
18 nounce, and apply the payment rates under section  
19 1853(a) (notwithstanding any deadlines specified in such  
20 section) in as timely a manner as possible and may (to  
21 the extent necessary) provide for retroactive adjustment  
22 in payments made under this section not in accordance  
23 with such rates.”.

24 (c) ENROLLMENT TRANSITION RULE.—An individual  
25 who is enrolled on December 31, 1998, with an eligible

1 organization under section 1876 of the Social Security Act  
2 (42 U.S.C. 1395mm) shall be considered to be enrolled  
3 with that organization on January 1, 1999, under part  
4 C of title XVIII of such Act if that organization has a  
5 contract under that part for providing services on January  
6 1, 1999 (unless the individual has disenrolled effective on  
7 that date).

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

10 (1) in paragraph (1)—

11 (A) by inserting “1855(i),” after  
12 “1833(s),”, and

13 (B) by inserting “, MedicarePlus organiza-  
14 tion,” after “provider of services”; and

15 (2) in paragraph (2)(E), by inserting “or a  
16 MedicarePlus organization” after “section  
17 1833(a)(1)(A)”.

18 (e) EXTENSION OF PROVIDER REQUIREMENT.—Sec-  
19 tion 1866(a)(1)(O) (42 U.S.C. 1395cc(a)(1)(O)) is  
20 amended—

21 (1) by striking “in the case of hospitals and  
22 skilled nursing facilities,”;

23 (2) by striking “inpatient hospital and extended  
24 care”;

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1 (3) by inserting “with a MedicarePlus organiza-  
2 tion under part C or” after “any individual en-  
3 rolled”; and

4 (4) by striking “(in the case of hospitals) or  
5 limits (in the case of skilled nursing facilities)”.

6 (f) ADDITIONAL CONFORMING CHANGES.—

7 (1) CONFORMING REFERENCES TO PREVIOUS  
8 PART C.—Any reference in law (in effect before the  
9 date of the enactment of this Act) to part C of title  
10 XVIII of the Social Security Act is deemed a ref-  
11 erence to part D of such title (as in effect after such  
12 date).

13 (2) SECRETARIAL SUBMISSION OF LEGISLATIVE  
14 PROPOSAL.—Not later than 90 days after the date  
15 of the enactment of this Act, the Secretary of  
16 Health and Human Services shall submit to the ap-  
17 propriate committees of Congress a legislative pro-  
18 posal providing for such technical and conforming  
19 amendments in the law as are required by the provi-  
20 sions of this chapter.

21 (g) IMMEDIATE EFFECTIVE DATE FOR CERTAIN RE-  
22 QUIREMENTS FOR DEMONSTRATIONS.—Section  
23 1857(e)(2) of the Social Security Act (requiring contribu-  
24 tion to certain costs related to the enrollment process com-  
25 parative materials) applies to demonstrations with respect

1 to which enrollment is effected or coordinated under sec-  
2 tion 1851 of such Act.

3 (h) USE OF INTERIM, FINAL REGULATIONS.—In  
4 order to carry out the amendments made by this chapter  
5 in a timely manner, the Secretary of Health and Human  
6 Services may promulgate regulations that take effect on  
7 an interim basis, after notice and pending opportunity for  
8 public comment.

9 (i) TRANSITION RULE FOR PSO ENROLLMENT.—In  
10 applying subsection (g)(1) of section 1876 of the Social  
11 Security Act (42 U.S.C. 1395mm) to a risk-sharing con-  
12 tract entered into with an eligible organization that is a  
13 provider-sponsored organization (as defined in section  
14 1855(e)(1) of such Act, as inserted by section 10001) for  
15 a contract year beginning on or after January 1, 1998,  
16 there shall be substituted for the minimum number of en-  
17 rollees provided under such section the minimum number  
18 of enrollees permitted under section 1857(b)(1) of such  
19 Act (as so inserted).

20 **SEC. 10003. CONFORMING CHANGES IN MEDIGAP PRO-**  
21 **GRAM.**

22 (a) CONFORMING AMENDMENTS TO MEDICAREPLUS  
23 CHANGES.—

24 (1) IN GENERAL.—Section 1882(d)(3)(A)(i) (42  
25 U.S.C. 1395ss(d)(3)(A)(i)) is amended—

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1 (A) in the matter before subclause (I), by  
2 inserting “(including an individual electing a  
3 MedicarePlus plan under section 1851)” after  
4 “of this title”; and

5 (B) in subclause (II)—

6 (i) by inserting “in the case of an in-  
7 dividual not electing a MedicarePlus plan”  
8 after “(II)”, and

9 (ii) by inserting before the comma at  
10 the end the following: “or in the case of an  
11 individual electing a MedicarePlus plan, a  
12 medicare supplemental policy with knowl-  
13 edge that the policy duplicates health bene-  
14 fits to which the individual is otherwise en-  
15 titled under the MedicarePlus plan or  
16 under another medicare supplemental pol-  
17 icy”.

18 (2) CONFORMING AMENDMENTS.—Section  
19 1882(d)(3)(B)(i)(I) (42 U.S.C.  
20 1395ss(d)(3)(B)(i)(I)) is amended by inserting “(in-  
21 cluding any MedicarePlus plan)” after “health in-  
22 surance policies”.

23 (3) MEDICAREPLUS PLANS NOT TREATED AS  
24 MEDICARE SUPPLEMENTARY POLICIES.—Section  
25 1882(g)(1) (42 U.S.C. 1395ss(g)(1)) is amended by



1 inserting “or a MedicarePlus plan or” after “does  
2 not include”

3 (b) ADDITIONAL RULES RELATING TO INDIVIDUALS  
4 ENROLLED IN MSA PLANS.—Section 1882 (42 U.S.C.  
5 1395ss) is further amended by adding at the end the fol-  
6 lowing new subsection:

7 “(u)(1) It is unlawful for a person to sell or issue  
8 a policy described in paragraph (2) to an individual with  
9 knowledge that the individual has in effect under section  
10 1851 an election of an MSA plan.

11 “(2) A policy described in this subparagraph is a  
12 health insurance policy that provides for coverage of ex-  
13 penses that are otherwise required to be counted toward  
14 meeting the annual deductible amount provided under the  
15 MSA plan.”.

16 **Subchapter B—Special Rules for**  
17 **MedicarePlus Medical Savings Accounts**

18 **SEC. 10006. MEDICAREPLUS MSA.**

19 (a) IN GENERAL.—Part III of subchapter B of chap-  
20 ter 1 of the Internal Revenue Code of 1986 (relating to  
21 amounts specifically excluded from gross income) is  
22 amended by redesignating section 138 as section 139 and  
23 by inserting after section 137 the following new section:

1 **“SEC. 138. MEDICAREPLUS MSA.**

2       “(a) EXCLUSION.—Gross income shall not include  
3 any payment to the MedicarePlus MSA of an individual  
4 by the Secretary of Health and Human Services under  
5 part C of title XVIII of the Social Security Act.

6       “(b) MEDICAREPLUS MSA.—For purposes of this  
7 section, the term ‘MedicarePlus MSA’ means a medical  
8 savings account (as defined in section 220(d))—

9               “(1) which is designated as a MedicarePlus  
10 MSA,

11               “(2) with respect to which no contribution may  
12 be made other than—

13                       “(A) a contribution made by the Secretary  
14 of Health and Human Services pursuant to  
15 part C of title XVIII of the Social Security Act,  
16 or

17                       “(B) a trustee-to-trustee transfer described  
18 in subsection (c)(4),

19               “(3) the governing instrument of which pro-  
20 vides that trustee-to-trustee transfers described in  
21 subsection (c)(4) may be made to and from such ac-  
22 count, and

23               “(4) which is established in connection with an  
24 MSA plan described in section 1859(b)(2) of the So-  
25 cial Security Act.

26       “(c) SPECIAL RULES FOR DISTRIBUTIONS.—

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1           “(1) DISTRIBUTIONS FOR QUALIFIED MEDICAL  
2 EXPENSES.—In applying section 220 to a  
3 MedicarePlus MSA—

4           “(A) qualified medical expenses shall not  
5 include amounts paid for medical care for any  
6 individual other than the account holder, and

7           “(B) section 220(d)(2)(C) shall not apply.

8           “(2) PENALTY FOR DISTRIBUTIONS FROM  
9 MEDICAREPLUS MSA NOT USED FOR QUALIFIED  
10 MEDICAL EXPENSES IF MINIMUM BALANCE NOT  
11 MAINTAINED.—

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

19           “(i) the amount of such payment or  
20 distribution, over

21           “(ii) the excess (if any) of—

22           “(I) the fair market value of the  
23 assets in such MSA as of the close of  
24 the calendar year preceding the cal-

**[HVAC Reconciliation]**

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1           endar year in which the taxable year  
2           begins, over

3                   “(II) an amount equal to 60 per-  
4                   cent of the deductible under the  
5                   MedicarePlus MSA plan covering the  
6                   account holder as of January 1 of the  
7                   calendar year in which the taxable  
8                   year begins.

9           Section 220(f)(2) shall not apply to any pay-  
10          ment or distribution from a MedicarePlus MSA.

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

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

16                   “(ii) dies.

17           “(C) SPECIAL RULES.—For purposes of  
18          subparagraph (A)—

19                   “(i) all MedicarePlus MSAs of the ac-  
20                   count holder shall be treated as 1 account,

21                   “(ii) all payments and distributions  
22                   not used exclusively to pay the qualified  
23                   medical expenses of the account holder  
24                   during any taxable year shall be treated as  
25                   1 distribution, and

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

4           “(3) WITHDRAWAL OF ERRONEOUS CONTRIBU-  
5           TIONS.—Section 220(f)(2) and paragraph (2) of this  
6           subsection shall not apply to any payment or dis-  
7           tribution from a MedicarePlus MSA to the Secretary  
8           of Health and Human Services of an erroneous con-  
9           tribution to such MSA and of the net income attrib-  
10          utable to such contribution.

11          “(4) TRUSTEE-TO-TRUSTEE TRANSFERS.—Sec-  
12          tion 220(f)(2) and paragraph (2) of this subsection  
13          shall not apply to any trustee-to-trustee transfer  
14          from a MedicarePlus MSA of an account holder to  
15          another MedicarePlus MSA of such account holder.

16          “(d) SPECIAL RULES FOR TREATMENT OF ACCOUNT  
17          AFTER DEATH OF ACCOUNT HOLDER.—In applying sec-  
18          tion 220(f)(8)(A) to an account which was a MedicarePlus  
19          MSA of a decedent, the rules of section 220(f) shall apply  
20          in lieu of the rules of subsection (c) of this section with  
21          respect to the spouse as the account holder of such  
22          MedicarePlus MSA.

23          “(e) REPORTS.—In the case of a MedicarePlus MSA,  
24          the report under section 220(h)—

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1 “(1) shall include the fair market value of the  
2 assets in such MedicarePlus MSA as of the close of  
3 each calendar year, and

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

5 “(A) not later than January 31 of the cal-  
6 endar year following the calendar year to which  
7 such reports relate, and

8 “(B) in such manner as the Secretary pre-  
9 scribes in such regulations.

10 “(f) COORDINATION WITH LIMITATION ON NUMBER  
11 OF TAXPAYERS HAVING MEDICAL SAVINGS ACCOUNTS.—

12 Subsection (i) of section 220 shall not apply to an individ-  
13 ual with respect to a MedicarePlus MSA, and  
14 MedicarePlus MSA’s shall not be taken into account in  
15 determining whether the numerical limitations under sec-  
16 tion 220(j) are exceeded.”

17 (b) TECHNICAL AMENDMENTS.—

18 (1) The last sentence of section 4973(d) of such  
19 Code is amended by inserting “or section 138(c)(3)”  
20 after “section 220(f)(3)”.

21 (2) Subsection (b) of section 220 of such Code  
22 is amended by adding at the end the following new  
23 paragraph:

24 “(7) MEDICARE ELIGIBLE INDIVIDUALS.—The  
25 limitation under this subsection for any month with

1 respect to an individual shall be zero for the first  
2 month such individual is entitled to benefits under  
3 title XVIII of the Social Security Act and for each  
4 month thereafter.”

5 (3) The table of sections for part III of sub-  
6 chapter B of chapter 1 of such Code is amended by  
7 striking the last item and inserting the following:

“Sec. 138. MedicarePlus MSA.

“Sec. 139. Cross references to other Acts.”

8 (c) EFFECTIVE DATE.—The amendments made by  
9 this section shall apply to taxable years beginning after  
10 December 31, 1998.

11 **CHAPTER 2—INTEGRATED LONG-TERM**  
12 **CARE PROGRAMS**

13 **Subchapter A—Programs of All-inclusive**  
14 **Care for the Elderly (PACE)**

15 **SEC. 10011. COVERAGE OF PACE UNDER THE MEDICARE**  
16 **PROGRAM.**

17 Title XVIII (42 U.S.C. 1395 et seq.) is amended by  
18 adding at the end the following new section:

19 “PAYMENTS TO, AND COVERAGE OF BENEFITS UNDER,  
20 PROGRAMS OF ALL-INCLUSIVE CARE FOR THE EL-  
21 DERLY (PACE)

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

1           “(1) BENEFITS THROUGH ENROLLMENT IN A  
2 PACE PROGRAM.—In accordance with this section, in  
3 the case of an individual who is entitled to benefits  
4 under part A or enrolled under part B and who is  
5 a PACE program eligible individual (as defined in  
6 paragraph (5)) with respect to a PACE program of-  
7 fered by a PACE provider under a PACE program  
8 agreement—

9           “(A) the individual may enroll in the pro-  
10 gram under this section; and

11           “(B) so long as the individual is so en-  
12 rolled and in accordance with regulations—

13           “(i) the individual shall receive bene-  
14 fits under this title solely through such  
15 program, and

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

20           “(2) PACE PROGRAM DEFINED.—For purposes  
21 of this section and section 1932, the term ‘PACE  
22 program’ means a program of all-inclusive care for  
23 the elderly that meets the following requirements:



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

4           “(B) COMPREHENSIVE BENEFITS.—The  
5 program provides comprehensive health care  
6 services to PACE program eligible individuals  
7 in accordance with the PACE program agree-  
8 ment and regulations under this section.

9           “(C) TRANSITION.—In the case of an indi-  
10 vidual who is enrolled under the program under  
11 this section and whose enrollment ceases for  
12 any reason (including the individual no longer  
13 qualifies as a PACE program eligible individual,  
14 the termination of a PACE program agreement,  
15 or otherwise), the program provides assistance  
16 to the individual in obtaining necessary transi-  
17 tional care through appropriate referrals and  
18 making the individual’s medical records avail-  
19 able to new providers.

20           “(3) PACE PROVIDER DEFINED.—

21           “(A) IN GENERAL.—For purposes of this  
22 section, the term ‘PACE provider’ means an en-  
23 tity that—

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

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1 a private, nonprofit entity organized for  
2 charitable purposes under section  
3 501(c)(3) of the Internal Revenue Code of  
4 1986, and

5 “(ii) has entered into a PACE pro-  
6 gram agreement with respect to its oper-  
7 ation of a PACE program.

8 “(B) TREATMENT OF PRIVATE, FOR-PROF-  
9 IT PROVIDERS.—Clause (i) of subparagraph (A)  
10 shall not apply—

11 “(i) to entities subject to a dem-  
12 onstration project waiver under subsection  
13 (h); and

14 “(ii) after the date the report under  
15 section 10014(b) of the Balanced Budget  
16 Act of 1997 is submitted, unless the Sec-  
17 retary determines that any of the findings  
18 described in subparagraph (A), (B), (C) or  
19 (D) of paragraph (2) of such section are  
20 true.

21 “(4) PACE PROGRAM AGREEMENT DEFINED.—  
22 For purposes of this section, the term ‘PACE pro-  
23 gram agreement’ means, with respect to a PACE  
24 provider, an agreement, consistent with this section,  
25 section 1932 (if applicable), and regulations promul-

1 gated to carry out such sections, between the PACE  
2 provider and the Secretary, or an agreement between  
3 the PACE provider and a State administering agen-  
4 cy for the operation of a PACE program by the pro-  
5 vider under such sections.

6 “(5) PACE PROGRAM ELIGIBLE INDIVIDUAL  
7 DEFINED.—For purposes of this section, the term  
8 ‘PACE program eligible individual’ means, with re-  
9 spect to a PACE program, an individual who—

10 “(A) is 55 years of age or older;

11 “(B) subject to subsection (c)(4), is deter-  
12 mined under subsection (c) to require the level  
13 of care required under the State medicaid plan  
14 for coverage of nursing facility services;

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

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

21 “(6) PACE PROTOCOL.—For purposes of this  
22 section, the term ‘PACE protocol’ means the Proto-  
23 col for the Program of All-inclusive Care for the El-  
24 derly (PACE), as published by On Lok, Inc., as of  
25 April 14, 1995.

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

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

11                  “(B) Section 9412(b) of the Omnibus  
12                  Budget Reconciliation Act of 1986 (Public Law  
13                  99–509).

14           “(8) STATE ADMINISTERING AGENCY DE-  
15           FINED.—For purposes of this section, the term  
16           ‘State administering agency’ means, with respect to  
17           the operation of a PACE program in a State, the  
18           agency of that State (which may be the single agen-  
19           cy responsible for administration of the State plan  
20           under title XIX in the State) responsible for admin-  
21           istering PACE program agreements under this sec-  
22           tion and section 1932 in the State.

23           “(9) TRIAL PERIOD DEFINED.—

24                   “(A) IN GENERAL.—For purposes of this  
25                   section, the term ‘trial period’ means, with re-

1 spect to a PACE program operated by a PACE  
2 provider under a PACE program agreement,  
3 the first 3 contract years under such agreement  
4 with respect to such program.

5 “(B) TREATMENT OF ENTITIES PRE-  
6 VIOUSLY OPERATING PACE DEMONSTRATION  
7 WAIVER PROGRAMS.—Each contract year (in-  
8 cluding a year occurring before the effective  
9 date of this section) during which an entity has  
10 operated a PACE demonstration waiver pro-  
11 gram shall be counted under subparagraph (A)  
12 as a contract year during which the entity oper-  
13 ated a PACE program as a PACE provider  
14 under a PACE program agreement.

15 “(10) REGULATIONS.—For purposes of this  
16 section, the term ‘regulations’ refers to interim final  
17 or final regulations promulgated under subsection (f)  
18 to carry out this section and section 1932.

19 “(b) SCOPE OF BENEFITS; BENEFICIARY SAFE-  
20 GUARDS.—

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

23 “(A) provide to PACE program eligible in-  
24 dividuals, regardless of source of payment and

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1 directly or under contracts with other entities,  
2 at a minimum—

3 “(i) all items and services covered  
4 under this title (for individuals enrolled  
5 under this section) and all items and serv-  
6 ices covered under title XIX, but without  
7 any limitation or condition as to amount,  
8 duration, or scope and without application  
9 of deductibles, copayments, coinsurance, or  
10 other cost-sharing that would otherwise  
11 apply under this title or such title, respec-  
12 tively; and

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

16 “(B) provide such enrollees access to nec-  
17 essary covered items and services 24 hours per  
18 day, every day of the year;

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

24 “(D) specify the covered items and services  
25 that will not be provided directly by the entity,

1 and to arrange for delivery of those items and  
2 services through contracts meeting the require-  
3 ments of regulations.

4 “(2) QUALITY ASSURANCE; PATIENT SAFE-  
5 GUARDS.—The PACE program agreement shall re-  
6 quire the PACE provider to have in effect at a mini-  
7 mum—

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

11 “(B) written safeguards of the rights of  
12 enrolled participants (including a patient bill of  
13 rights and procedures for grievances and ap-  
14 peals) in accordance with regulations and with  
15 other requirements of this title and Federal and  
16 State law designed for the protection of pa-  
17 tients.

18 “(c) ELIGIBILITY DETERMINATIONS.—

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

22 “(A) shall be made under and in accord-  
23 ance with the PACE program agreement, and

24 “(B) who is entitled to medical assistance  
25 under title XIX, shall be made (or who is not

1 so entitled, may be made) by the State admin-  
2 istering agency.

3 “(2) CONDITION.—An individual is not a PACE  
4 program eligible individual (with respect to payment  
5 under this section) unless the individual’s health sta-  
6 tus has been determined, in accordance with regula-  
7 tions, to be comparable to the health status of indi-  
8 viduals who have participated in the PACE dem-  
9 onstration waiver programs. Such determination  
10 shall be based upon information on health status  
11 and related indicators (such as medical diagnoses  
12 and measures of activities of daily living, instrumen-  
13 tal activities of daily living, and cognitive impair-  
14 ment) that are part of a uniform minimum data set  
15 collected by PACE providers on potential eligible in-  
16 dividuals.

17 “(3) ANNUAL ELIGIBILITY RECERTIFI-  
18 CATIONS.—

19 “(A) IN GENERAL.—Subject to subpara-  
20 graph (B), the determination described in sub-  
21 section (a)(5)(B) for an individual shall be re-  
22 evaluated at least once a year.

23 “(B) EXCEPTION.—The requirement of  
24 annual reevaluation under subparagraph (A)  
25 may be waived during a period in accordance



1 with regulations in those cases where the State  
2 administering agency determines that there is  
3 no reasonable expectation of improvement or  
4 significant change in an individual's condition  
5 during the period because of the advanced age,  
6 severity of the advanced age, severity of chronic  
7 condition, or degree of impairment of functional  
8 capacity of the individual involved.

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

19 “(5) ENROLLMENT; DISENROLLMENT.—The en-  
20 rollment and disenrollment of PACE program eligi-  
21 ble individuals in a PACE program shall be pursu-  
22 ant to regulations and the PACE program agree-  
23 ment and shall permit enrollees to voluntarily  
24 disenroll without cause at any time.

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

3               “(1) IN GENERAL.—In the case of a PACE pro-  
4 vider with a PACE program agreement under this  
5 section, except as provided in this subsection or by  
6 regulations, the Secretary shall make prospective  
7 monthly payments of a capitation amount for each  
8 PACE program eligible individual enrolled under the  
9 agreement under this section in the same manner  
10 and from the same sources as payments are made  
11 to a MedicarePlus organization under section 1854  
12 (or, for periods beginning before January 1, 1999,  
13 to an eligible organization under a risk-sharing con-  
14 tract under section 1876). Such payments shall be  
15 subject to adjustment in the manner described in  
16 section 1854(a)(2) or section 1876(a)(1)(E), as the  
17 case may be.

18               “(2) CAPITATION AMOUNT.—The capitation  
19 amount to be applied under this subsection for a  
20 provider for a contract year shall be an amount  
21 specified in the PACE program agreement for the  
22 year. Such amount shall be based upon payment  
23 rates established for purposes of payment under sec-  
24 tion 1854 (or, for periods before January 1, 1999,  
25 for purposes of risk-sharing contracts under section

1 1876) and shall be adjusted to take into account the  
2 comparative frailty of PACE enrollees and such  
3 other factors as the Secretary determines to be ap-  
4 propriate. Such amount under such an agreement  
5 shall be computed in a manner so that the total pay-  
6 ment level for all PACE program eligible individuals  
7 enrolled under a program is less than the projected  
8 payment under this title for a comparable population  
9 not enrolled under a PACE program.

10 “(e) PACE PROGRAM AGREEMENT.—

11 “(1) REQUIREMENT.—

12 “(A) IN GENERAL.—The Secretary, in  
13 close cooperation with the State administering  
14 agency, shall establish procedures for entering  
15 into, extending, and terminating PACE pro-  
16 gram agreements for the operation of PACE  
17 programs by entities that meet the require-  
18 ments for a PACE provider under this section,  
19 section 1932, and regulations.

20 “(B) NUMERICAL LIMITATION.—

21 “(i) IN GENERAL.—The Secretary  
22 shall not permit the number of PACE pro-  
23 viders with which agreements are in effect  
24 under this section or under section 9412(b)

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1 of the Omnibus Budget Reconciliation Act  
2 of 1986 to exceed—

3 “(I) 40 as of the date of the en-  
4 actment of this section, or

5 “(II) as of each succeeding anni-  
6 versary of such date, the numerical  
7 limitation under this subparagraph for  
8 the preceding year plus 20.

9 Subclause (II) shall apply without regard  
10 to the actual number of agreements in ef-  
11 fect as of a previous anniversary date.

12 “(ii) TREATMENT OF CERTAIN PRI-  
13 VATE, FOR-PROFIT PROVIDERS.—The nu-  
14 merical limitation in clause (i) shall not  
15 apply to a PACE provider that—

16 “(I) is operating under a dem-  
17 onstration project waiver under sub-  
18 section (h), or

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

23 “(2) SERVICE AREA AND ELIGIBILITY.—

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

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

3 “(ii) may provide additional require-  
4 ments for individuals to qualify as PACE  
5 program eligible individuals with respect to  
6 the program;

7 “(iii) shall be effective for a contract  
8 year, but may be extended for additional  
9 contract years in the absence of a notice by  
10 a party to terminate and is subject to ter-  
11 mination by the Secretary and the State  
12 administering agency at any time for cause  
13 (as provided under the agreement);

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

17 “(v) shall have such additional terms  
18 and conditions as the parties may agree to  
19 consistent with this section and regula-  
20 tions.

21 “(B) SERVICE AREA OVERLAP.—In des-  
22 ignating a service area under a PACE program  
23 agreement under subparagraph (A)(i), the Sec-  
24 retary (in consultation with the State admin-  
25 istering agency) may exclude from designation

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1 an area that is already covered under another  
2 PACE program agreement, in order to avoid  
3 unnecessary duplication of services and avoid  
4 impairing the financial and service viability of  
5 an existing program.

6 “(3) DATA COLLECTION.—

7 “(A) IN GENERAL.—Under a PACE pro-  
8 gram agreement, the PACE provider shall—

9 “(i) collect data,

10 “(ii) maintain, and afford the Sec-  
11 retary and the State administering agency  
12 access to, the records relating to the pro-  
13 gram, including pertinent financial, medi-  
14 cal, and personnel records, and

15 “(iii) make to the Secretary and the  
16 State administering agency reports that  
17 the Secretary finds (in consultation with  
18 State administering agencies) necessary to  
19 monitor the operation, cost, and effective-  
20 ness of the PACE program under this title  
21 and title XIX.

22 “(B) REQUIREMENTS DURING TRIAL PE-  
23 RIOD.—During the first three years of oper-  
24 ation of a PACE program (either under this  
25 section or under a PACE demonstration waiver

1 program), the PACE provider shall provide  
2 such additional data as the Secretary specifies  
3 in regulations in order to perform the oversight  
4 required under paragraph (4)(A).

5 “(4) OVERSIGHT.—

6 “(A) ANNUAL, CLOSE OVERSIGHT DURING  
7 TRIAL PERIOD.—During the trial period (as de-  
8 fined in subsection (a)(9)) with respect to a  
9 PACE program operated by a PACE provider,  
10 the Secretary (in cooperation with the State ad-  
11 ministering agency) shall conduct a comprehen-  
12 sive annual review of the operation of the  
13 PACE program by the provider in order to as-  
14 sure compliance with the requirements of this  
15 section and regulations. Such a review shall in-  
16 clude—

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

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

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

24 “(iv) detailed analysis of the entity’s  
25 substantial compliance with all significant

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1 requirements of this section and regula-  
2 tions; and

3 “(v) any other elements the Secretary  
4 or State agency considers necessary or ap-  
5 propriate.

6 “(B) CONTINUING OVERSIGHT.—After the  
7 trial period, the Secretary (in cooperation with  
8 the State administering agency) shall continue  
9 to conduct such review of the operation of  
10 PACE providers and PACE programs as may  
11 be appropriate, taking into account the per-  
12 formance level of a provider and compliance of  
13 a provider with all significant requirements of  
14 this section and regulations.

15 “(C) DISCLOSURE.—The results of reviews  
16 under this paragraph shall be reported prompt-  
17 ly to the PACE provider, along with any rec-  
18 ommendations for changes to the provider’s  
19 program, and shall be made available to the  
20 public upon request.

21 “(5) TERMINATION OF PACE PROVIDER AGREE-  
22 MENTS.—

23 “(A) IN GENERAL.—Under regulations—



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1 “(i) the Secretary or a State admin-  
2 istering agency may terminate a PACE  
3 program agreement for cause, and

4 “(ii) a PACE provider may terminate  
5 such an agreement after appropriate notice  
6 to the Secretary, the State agency, and en-  
7 rollees.

8 “(B) CAUSES FOR TERMINATION.—In ac-  
9 cordance with regulations establishing proce-  
10 dures for termination of PACE program agree-  
11 ments, the Secretary or a State administering  
12 agency may terminate a PACE program agree-  
13 ment with a PACE provider for, among other  
14 reasons, the fact that—

15 “(i) the Secretary or State admin-  
16 istering agency determines that—

17 “(I) there are significant defi-  
18 ciencies in the quality of care provided  
19 to enrolled participants; or

20 “(II) the provider has failed to  
21 comply substantially with conditions  
22 for a program or provider under this  
23 section or section 1932; and

24 “(ii) the entity has failed to develop  
25 and successfully initiate, within 30 days of

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1 the date of the receipt of written notice of  
2 such a determination, and continue imple-  
3 mentation of a plan to correct the defi-  
4 ciencies.

5 “(C) TERMINATION AND TRANSITION PRO-  
6 CEDURES.—An entity whose PACE provider  
7 agreement is terminated under this paragraph  
8 shall implement the transition procedures re-  
9 quired under subsection (a)(2)(C).

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

12 “(A) IN GENERAL.—Under regulations, if  
13 the Secretary determines (after consultation  
14 with the State administering agency) that a  
15 PACE provider is failing substantially to com-  
16 ply with the requirements of this section and  
17 regulations, the Secretary (and the State ad-  
18 ministering agency) may take any or all of the  
19 following actions:

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

23 “(ii) Withhold some or all further  
24 payments under the PACE program agree-  
25 ment under this section or section 1932

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1 with respect to PACE program services  
2 furnished by such provider until the defi-  
3 ciencies have been corrected.

4 “(iii) Terminate such agreement.

5 “(B) APPLICATION OF INTERMEDIATE  
6 SANCTIONS.—Under regulations, the Secretary  
7 may provide for the application against a  
8 PACE provider of remedies described in section  
9 1857(f)(2) (or, for periods before January 1,  
10 1999, section 1876(i)(6)(B)) or 1903(m)(5)(B)  
11 in the case of violations by the provider of the  
12 type described in section 1857(f)(1) (or  
13 1876(i)(6)(A) for such periods) or  
14 1903(m)(5)(A), respectively (in relation to  
15 agreements, enrollees, and requirements under  
16 this section or section 1932, respectively).

17 “(7) PROCEDURES FOR TERMINATION OR IMPO-  
18 SITION OF SANCTIONS.—Under regulations, the pro-  
19 visions of section 1857(g) (or for periods before Jan-  
20 uary 1, 1999, section 1876(i)(9)) shall apply to ter-  
21 mination and sanctions respecting a PACE program  
22 agreement and PACE provider under this subsection  
23 in the same manner as they apply to a termination  
24 and sanctions with respect to a contract and a

1 MedicarePlus organization under part C (or for such  
2 periods an eligible organization under section 1876).

3 “(8) TIMELY CONSIDERATION OF APPLICATIONS  
4 FOR PACE PROGRAM PROVIDER STATUS.—In consid-  
5 ering an application for PACE provider program  
6 status, the application shall be deemed approved un-  
7 less the Secretary, within 90 days after the date of  
8 the submission of the application to the Secretary,  
9 either denies such request in writing or informs the  
10 applicant in writing with respect to any additional  
11 information that is needed in order to make a final  
12 determination with respect to the application. After  
13 the date the Secretary receives such additional infor-  
14 mation, the application shall be deemed approved  
15 unless the Secretary, within 90 days of such date,  
16 denies such request.

17 “(f) REGULATIONS.—

18 “(1) IN GENERAL.—The Secretary shall issue  
19 interim final or final regulations to carry out this  
20 section and section 1932.

21 “(2) USE OF PACE PROTOCOL.—

22 “(A) IN GENERAL.—In issuing such regu-  
23 lations, the Secretary shall, to the extent con-  
24 sistent with the provisions of this section, incor-  
25 porate the requirements applied to PACE dem-

1           onstration waiver programs under the PACE  
2           protocol.

3           “(B) FLEXIBILITY.—The Secretary (in  
4           close consultation with State administering  
5           agencies) may modify or waive such provisions  
6           of the PACE protocol in order to provide for  
7           reasonable flexibility in adapting the PACE  
8           service delivery model to the needs of particular  
9           organizations (such as those in rural areas or  
10          those that may determine it appropriate to use  
11          non-staff physicians accordingly to State licens-  
12          ing law requirements) under this section and  
13          section 1932 where such flexibility is not incon-  
14          sistent with and would not impair the essential  
15          elements, objectives, and requirements of the  
16          this section, including—

17                   “(i) the focus on frail elderly qualify-  
18                   ing individuals who require the level of  
19                   care provided in a nursing facility;

20                   “(ii) the delivery of comprehensive, in-  
21                   tegrated acute and long-term care services;

22                   “(iii) the interdisciplinary team ap-  
23                   proach to care management and service de-  
24                   livery;

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

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

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

9           “(A) IN GENERAL.—In issuing such regu-  
10          lations and subject to subparagraph (B), the  
11          Secretary may apply with respect to PACE pro-  
12          grams, providers, and agreements such require-  
13          ments of part C (or, for periods before January  
14          1, 1999, section 1876) and section 1903(m) re-  
15          lating to protection of beneficiaries and pro-  
16          gram integrity as would apply to MedicarePlus  
17          organizations under part C (or for such periods  
18          eligible organizations under risk-sharing con-  
19          tracts under section 1876) and to health main-  
20          tenance organizations under prepaid capitation  
21          agreements under section 1903(m).

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

24                 “(i) take into account the differences  
25                 between populations served and benefits

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1 provided under this section and under part  
2 C (or, for periods before January 1, 1999,  
3 section 1876) and section 1903(m);

4 “(ii) not include any requirement that  
5 conflicts with carrying out PACE pro-  
6 grams under this section; and

7 “(iii) not include any requirement re-  
8 stricting the proportion of enrollees who  
9 are eligible for benefits under this title or  
10 title XIX.

11 “(g) WAIVERS OF REQUIREMENTS.—With respect to  
12 carrying out a PACE program under this section, the fol-  
13 lowing requirements of this title (and regulations relating  
14 to such requirements) are waived and shall not apply:

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

17 “(2) Sections 1813, 1814, 1833, and 1886, in-  
18 sofar as such sections relate to rules for payment for  
19 benefits.

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

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

1           “(5) Sections 1862(a)(1) and 1862(a)(9), inso-  
2 far as they may prevent payment for PACE program  
3 services to individuals enrolled under PACE pro-  
4 grams.

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

7           “(1) IN GENERAL.—In order to demonstrate  
8 the operation of a PACE program by a private, for-  
9 profit entity, the Secretary (in close consultation  
10 with State administering agencies) shall grant waiv-  
11 ers from the requirement under subsection (a)(3)  
12 that a PACE provider may not be a for-profit, pri-  
13 vate entity.

14           “(2) SIMILAR TERMS AND CONDITIONS.—

15           “(A) IN GENERAL.—Except as provided  
16 under subparagraph (B), and paragraph (1),  
17 the terms and conditions for operation of a  
18 PACE program by a provider under this sub-  
19 section shall be the same as those for PACE  
20 providers that are nonprofit, private organiza-  
21 tions.

22           “(B) NUMERICAL LIMITATION.—The num-  
23 ber of programs for which waivers are granted  
24 under this subsection shall not exceed 10. Pro-  
25 grams with waivers granted under this sub-



1 section shall not be counted against the numeri-  
2 cal limitation specified in subsection (e)(1)(B).

3 “(i) CONSTRUCTION.—Nothing in this section or sec-  
4 tion 1932 shall be construed as preventing a PACE pro-  
5 vider from entering into contracts with other governmental  
6 or nongovernmental payers for the care of PACE program  
7 eligible individuals who are not eligible for benefits under  
8 part A, or enrolled under part B, or eligible for medical  
9 assistance under title XIX.”

10 **SEC. 10012. ESTABLISHMENT OF PACE PROGRAM AS MEDIC-**  
11 **AID STATE OPTION.**

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

13 (1) in section 1905(a) (42 U.S.C. 1396d(a))—

14 (A) by striking “and” at the end of para-  
15 graph (24);

16 (B) by redesignating paragraph (25) as  
17 paragraph (26); and

18 (C) by inserting after paragraph (24) the  
19 following new paragraph:

20 “(25) services furnished under a PACE pro-  
21 gram under section 1932 to PACE program eligible  
22 individuals enrolled under the program under such  
23 section; and”;

1           (2) by redesignating section 1932, as redesignig-  
2           nated by section 114(a) of Public Law 104–193, as  
3           section 1933, and

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

6   **“SEC. 1932. PROGRAM OF ALL-INCLUSIVE CARE FOR THE**  
7                           **ELDERLY (PACE).**

8           “(a) OPTION.—

9                   “(1) IN GENERAL.—A State may elect to pro-  
10           vide medical assistance under this section with re-  
11           spect to PACE program services to PACE program  
12           eligible individuals who are eligible for medical as-  
13           sistance under the State plan and who are enrolled  
14           in a PACE program under a PACE program agree-  
15           ment. Such individuals need not be eligible for bene-  
16           fits under part A, or enrolled under part B, of title  
17           XVIII to be eligible to enroll under this section.

18                   “(2) BENEFITS THROUGH ENROLLMENT IN  
19           PACE PROGRAM.—In the case of an individual en-  
20           rolled with a PACE program pursuant to such an  
21           election—

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

1           “(B) the PACE provider shall receive pay-  
2           ment in accordance with the PACE program  
3           agreement for provision of such benefits.

4           “(3) APPLICATION OF DEFINITIONS.—The defi-  
5           nitions of terms under section 1894(a) shall apply  
6           under this section in the same manner as they apply  
7           under section 1894.

8           “(b) APPLICATION OF MEDICARE TERMS AND CON-  
9           DITIONS.—Except as provided in this section, the terms  
10          and conditions for the operation and participation of  
11          PACE program eligible individuals in PACE programs of-  
12          fered by PACE providers under PACE program agree-  
13          ments under section 1894 shall apply for purposes of this  
14          section.

15          “(c) ADJUSTMENT IN PAYMENT AMOUNTS.—In the  
16          case of individuals enrolled in a PACE program under this  
17          section, the amount of payment under this section shall  
18          not be the amount calculated under section 1894(d), but  
19          shall be an amount, specified under the PACE agreement,  
20          which is less than the amount that would otherwise have  
21          been made under the State plan if the individuals were  
22          not so enrolled. The payment under this section shall be  
23          in addition to any payment made under section 1894 for  
24          individuals who are enrolled in a PACE program under  
25          such section.

1       “(d) WAIVERS OF REQUIREMENTS.—With respect to  
2 carrying out a PACE program under this section, the fol-  
3 lowing requirements of this title (and regulations relating  
4 to such requirements) shall not apply:

5           “(1) Section 1902(a)(1), relating to any re-  
6 quirement that PACE programs or PACE program  
7 services be provided in all areas of a State.

8           “(2) Section 1902(a)(10), insofar as such sec-  
9 tion relates to comparability of services among dif-  
10 ferent population groups.

11           “(3) Sections 1902(a)(23) and 1915(b)(4), re-  
12 lating to freedom of choice of providers under a  
13 PACE program.

14           “(4) Section 1903(m)(2)(A), insofar as it re-  
15 stricts a PACE provider from receiving prepaid capi-  
16 tation payments.

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

23       (b) CONFORMING AMENDMENTS.—

24           (1) Section 1902(j) (42 U.S.C. 1396a(j)) is  
25 amended by striking “(25)” and inserting “(26)”.

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

3                   (A) in the heading, by striking “FROM OR-  
4                   GANIZATIONS RECEIVING CERTAIN WAIVERS”  
5                   and inserting “UNDER PACE PROGRAMS”, and

6                   (B) by striking “from any organization”  
7                   and all that follows and inserting “under a  
8                   PACE demonstration waiver program (as de-  
9                   fined in subsection (a)(7) of section 1894) or  
10                  under a PACE program under section 1932.”.

11           (3) Section 1903(f)(4)(C) (42 U.S.C.  
12           1396b(f)(4)(C)) is amended by inserting “or who is  
13           a PACE program eligible individual enrolled in a  
14           PACE program under section 1932,” after “section  
15           1902(a)(10)(A),”.

16 **SEC. 10013. EFFECTIVE DATE; TRANSITION.**

17           (a) **TIMELY ISSUANCE OF REGULATIONS; EFFECTIVE**  
18 **DATE.**—The Secretary of Health and Human Services  
19 shall promulgate regulations to carry out this subchapter  
20 in a timely manner. Such regulations shall be designed  
21 so that entities may establish and operate PACE pro-  
22 grams under sections 1894 and 1932 for periods begin-  
23 ning not later than 1 year after the date of the enactment  
24 of this Act.

1 (b) EXPANSION AND TRANSITION FOR PACE DEM-  
2 ONSTRATION PROJECT WAIVERS.—

3 (1) EXPANSION IN CURRENT NUMBER AND EX-  
4 TENSION OF DEMONSTRATION PROJECTS.—Section  
5 9412(b) of the Omnibus Budget Reconciliation Act  
6 of 1986, as amended by section 4118(g) of the Om-  
7 nibus Budget Reconciliation Act of 1987, is amend-  
8 ed—

9 (A) in paragraph (1), by inserting before  
10 the period at the end the following: “, except  
11 that the Secretary shall grant waivers of such  
12 requirements to up to the applicable numerical  
13 limitation specified in section 1894(e)(1)(B) of  
14 the Social Security Act”; and

15 (B) in paragraph (2)—

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

21 (ii) in subparagraph (C), by adding at  
22 the end the following: “In granting further  
23 extensions, an organization shall not be re-  
24 quired to provide for reporting of informa-

1                   tion which is only required because of the  
2                   demonstration nature of the project.”.

3                   (2) ELIMINATION OF REPLICATION REQUIRE-  
4                   MENT.—Subparagraph (B) of paragraph (2) of such  
5                   section shall not apply to waivers granted under  
6                   such section after the date of the enactment of this  
7                   Act.

8                   (3) TIMELY CONSIDERATION OF APPLICA-  
9                   TIONS.—In considering an application for waivers  
10                  under such section before the effective date of re-  
11                  peals under subsection (c), subject to the numerical  
12                  limitation under the amendment made by paragraph  
13                  (1), the application shall be deemed approved unless  
14                  the Secretary of Health and Human Services, within  
15                  90 days after the date of its submission to the Sec-  
16                  retary, either denies such request in writing or in-  
17                  forms the applicant in writing with respect to any  
18                  additional information which is needed in order to  
19                  make a final determination with respect to the appli-  
20                  cation. After the date the Secretary receives such  
21                  additional information, the application shall be  
22                  deemed approved unless the Secretary, within 90  
23                  days of such date, denies such request.

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

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

9 (A) first, to entities that are operating a  
10 PACE demonstration waiver program (as de-  
11 fined in section 1894(a)(7) of such Act), and

12 (B) then entities that have applied to oper-  
13 ate such a program as of May 1, 1997.

14 (2) NEW WAIVERS.—The Secretary shall give  
15 priority, in the awarding of additional waivers under  
16 section 9412(b) of the Omnibus Budget Reconcili-  
17 ation Act of 1986—

18 (A) to any entities that have applied for  
19 such waivers under such section as of May 1,  
20 1997; and

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



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

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

11           (1) IN GENERAL.—Subject to paragraph (2),  
12 the following provisions of law are repealed:

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

15                   (B) Section 9220 of the Consolidated Om-  
16 nibus Budget Reconciliation Act of 1985 (Pub-  
17 lic Law 99–272).

18                   (C) Section 9412(b) of the Omnibus Budg-  
19 et Reconciliation Act of 1986 (Public Law 99–  
20 509).

21           (2) DELAY IN APPLICATION.—

22                   (A) IN GENERAL.—Subject to subpara-  
23 graph (B), the repeals made by paragraph (1)  
24 shall not apply to waivers granted before the

1 initial effective date of regulations described in  
2 subsection (a).

3 (B) APPLICATION TO APPROVED WAIV-  
4 ERS.—Such repeals shall apply to waivers  
5 granted before such date only after allowing  
6 such organizations a transition period (of up to  
7 24 months) in order to permit sufficient time  
8 for an orderly transition from demonstration  
9 project authority to general authority provided  
10 under the amendments made by this sub-  
11 chapter.

12 **SEC. 10014. STUDY AND REPORTS.**

13 (a) STUDY.—

14 (1) IN GENERAL.—The Secretary of Health and  
15 Human Services (in close consultation with State  
16 administering agencies, as defined in section  
17 1894(a)(8) of the Social Security Act) shall conduct  
18 a study of the quality and cost of providing PACE  
19 program services under the medicare and medicaid  
20 programs under the amendments made by this sub-  
21 chapter.

22 (2) STUDY OF PRIVATE, FOR-PROFIT PROVID-  
23 ERS.—Such study shall specifically compare the  
24 costs, quality, and access to services by entities that  
25 are private, for-profit entities operating under dem-

1 onstration projects waivers granted under section  
2 1894(h) of the Social Security Act with the costs,  
3 quality, and access to services of other PACE pro-  
4 viders.

5 (b) REPORT.—

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

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

16 (A) The number of covered lives enrolled  
17 with entities operating under demonstration  
18 project waivers under section 1894(h) of the  
19 Social Security Act is fewer than 800 (or such  
20 lesser number as the Secretary may find statis-  
21 tically sufficient to make determinations re-  
22 specting findings described in the succeeding  
23 subparagraphs).

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1           (B) The population enrolled with such en-  
2           tities is less frail than the population enrolled  
3           with other PACE providers.

4           (C) Access to or quality of care for individ-  
5           uals enrolled with such entities is lower than  
6           such access or quality for individuals enrolled  
7           with other PACE providers.

8           (D) The application of such section has re-  
9           sulted in an increase in expenditures under the  
10          medicare or medicaid programs above the ex-  
11          penditures that would have been made if such  
12          section did not apply.

13          (c) INFORMATION INCLUDED IN ANNUAL REC-  
14          COMMENDATIONS.—The Medicare Payment Advisory Com-  
15          mission shall include in its annual report under section  
16          1805(b)(1)(B) of the Social Security Act recommenda-  
17          tions on the methodology and level of payments made to  
18          PACE providers under section 1894(d) of such Act and  
19          on the treatment of private, for-profit entities as PACE  
20          providers.

1     **Subchapter B—Social Health Maintenance**  
2                                     **Organizations**

3     **SEC. 10015. SOCIAL HEALTH MAINTENANCE ORGANIZA-**  
4                                     **TIONS (SHMOS).**

5             (a) EXTENSION OF DEMONSTRATION PROJECT AU-  
6 THORITIES.—Section 4018(b) of the Omnibus Budget  
7 Reconciliation Act of 1987 is amended—

8                     (1) in paragraph (1), by striking “1997” and  
9             inserting “2000”, and

10                    (2) in paragraph (4), by striking “1998” and  
11             inserting “2001”.

12             (b) EXPANSION OF CAP.—Section 13567(c) of the  
13 Omnibus Budget Reconciliation Act of 1993 is amended  
14 by striking “12,000” and inserting “36,000”.

15             (b) REPORT ON INTEGRATION AND TRANSITION.—

16                     (1) IN GENERAL.—The Secretary of Health and  
17             Human Services shall submit to Congress, by not  
18             later than January 1, 1999, a plan for the integra-  
19             tion of health plans offered by social health mainte-  
20             nance organizations (including SHMO I and SHMO  
21             II sites developed under section 2355 of the Deficit  
22             Reduction Act of 1984 and under the amendment  
23             made by section 4207(b)(3)(B)(i) of OBRA–1990,  
24             respectively) and similar plans as an option under

1 the MedicarePlus program under part C of title  
2 XVIII of the Social Security Act.

3 (2) PROVISION FOR TRANSITION.—Such plan  
4 shall include a transition for social health mainte-  
5 nance organizations operating under demonstration  
6 project authority under such section.

7 (3) PAYMENT POLICY.—The report shall also  
8 include recommendations on appropriate payment  
9 levels for plans offered by such organizations, includ-  
10 ing an analysis of the application of risk adjustment  
11 factors appropriate to the population served by such  
12 organizations.

13 **Subchapter C—Other Programs**

14 **SEC. 10018. ORDERLY TRANSITION OF MUNICIPAL HEALTH**  
15 **SERVICE DEMONSTRATION PROJECTS.**

16 Section 9215 of the Consolidated Omnibus Budget  
17 Reconciliation Act of 1985, as amended by section 6135  
18 of OBRA–1989 and section 13557 of OBRA–1993, is fur-  
19 ther amended—

20 (1) by inserting “(a)” before “The Secretary”,  
21 and

22 (2) by adding at the end the following: “Subject  
23 to subsection (c), the Secretary may further extend  
24 such demonstration projects through December 31,

1 2000, but only with respect to individuals are en-  
2 rolled with such projects before January 1, 1998.

3 “(b) The Secretary shall work with each such dem-  
4 onstration project to develop a plan, to be submitted to  
5 the Committee on Ways and Means of the House of Rep-  
6 resentatives and the Committee on Finance of the Senate  
7 by March 31, 1998, for the orderly transition of dem-  
8 onstration projects and the project enrollees to a non-dem-  
9 onstration project health care delivery system, such as  
10 through integration with private or public health plan, in-  
11 cluding a medicaid managed care or MedicarePlus plan.

12 “(c) A demonstration project under subsection (a)  
13 which does not develop and submit a transition plan under  
14 subsection (b) by March 31, 1998, or, if later, 6 months  
15 after the date of the enactment of this Act, shall be discon-  
16 tinued as of December 31, 1998. The Secretary shall pro-  
17 vide appropriate technical assistance to assist in the tran-  
18 sition so that disruption of medical services to project en-  
19 rollees may be minimized.”.

20 **SEC. 10019. EXTENSION OF CERTAIN MEDICARE COMMU-**  
21 **NITY NURSING ORGANIZATION DEMONSTRA-**  
22 **TION PROJECTS.**

23 Notwithstanding any other provision of law, dem-  
24 onstration projects conducted under section 4079 of the  
25 Omnibus Budget Reconciliation Act of 1987 may be con-

1 ducted for an additional period of 2 years, and the dead-  
2 line for any report required relating to the results of such  
3 projects shall be not later than 6 months before the end  
4 of such additional period.

5           **CHAPTER 3—MEDICARE PAYMENT**  
6                           **ADVISORY COMMISSION**

7   **SEC. 10021. MEDICARE PAYMENT ADVISORY COMMISSION.**

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

10           “MEDICARE PAYMENT ADVISORY COMMISSION

11           “SEC. 1805. (a) ESTABLISHMENT.—There is hereby  
12 established the Medicare Payment Advisory Commission  
13 (in this section referred to as the ‘Commission’).

14           “(b) DUTIES.—

15                   “(1) REVIEW OF PAYMENT POLICIES AND AN-  
16 NUAL REPORTS.—The Commission shall—

17                           “(A) review payment policies under this  
18 title, including the topics described in para-  
19 graph (2);

20                           “(B) make recommendations to Congress  
21 concerning such payment policies;

22                           “(C) by not later than March 1 of each  
23 year (beginning with 1998), submit a report to  
24 Congress containing the results of such reviews  
25 and its recommendations concerning such poli-  
26 cies; and



1           “(D) by not later than June 1 of each year  
2           (beginning with 1998), submit a report to Con-  
3           gress containing an examination of issues af-  
4           fecting the medicare program, including the im-  
5           plications of changes in health care delivery in  
6           the United States and in the market for health  
7           care services on the medicare program.

8           “(2) SPECIFIC TOPICS TO BE REVIEWED.—

9           “(A) MEDICAREPLUS PROGRAM.—Specifi-  
10          cally, the Commission shall review, with respect  
11          to the MedicarePlus program under part C, the  
12          following:

13                 “(i) The methodology for making pay-  
14                 ment to plans under such program, includ-  
15                 ing the making of differential payments  
16                 and the distribution of differential updates  
17                 among different payment areas.

18                 “(ii) The mechanisms used to adjust  
19                 payments for risk and the need to adjust  
20                 such mechanisms to take into account  
21                 health status of beneficiaries.

22                 “(iii) The implications of risk selec-  
23                 tion both among MedicarePlus organiza-  
24                 tions and between the MedicarePlus option  
25                 and the medicare fee-for-service option.

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1           “(iv) The development and implemen-  
2           tation of mechanisms to assure the quality  
3           of care for those enrolled with  
4           MedicarePlus organizations.

5           “(v) The impact of the MedicarePlus  
6           program on access to care for medicare  
7           beneficiaries.

8           “(vi) Other major issues in implemen-  
9           tation and further development of the  
10          MedicarePlus program.

11          “(B) FEE-FOR-SERVICE SYSTEM.—Specifi-  
12          cally, the Commission shall review payment  
13          policies under parts A and B, including—

14               “(i) the factors affecting expenditures  
15               for services in different sectors, including  
16               the process for updating hospital, skilled  
17               nursing facility, physician, and other fees,

18               “(ii) payment methodologies, and

19               “(iii) their relationship to access and  
20               quality of care for medicare beneficiaries.

21          “(C) INTERACTION OF MEDICARE PAY-  
22          MENT POLICIES WITH HEALTH CARE DELIVERY  
23          GENERALLY.—Specifically, the Commission  
24          shall review the effect of payment policies under  
25          this title on the delivery of health care services

1 other than under this title and assess the impli-  
2 cations of changes in health care delivery in the  
3 United States and in the general market for  
4 health care services on the medicare program.

5 “(3) COMMENTS ON CERTAIN SECRETARIAL RE-  
6 PORTS.—If the Secretary submits to Congress (or a  
7 committee of Congress) a report that is required by  
8 law and that relates to payment policies under this  
9 title, the Secretary shall transmit a copy of the re-  
10 port to the Commission. The Commission shall re-  
11 view the report and, not later than 6 months after  
12 the date of submittal of the Secretary’s report to  
13 Congress, shall submit to the appropriate commit-  
14 tees of Congress written comments on such report.  
15 Such comments may include such recommendations  
16 as the Commission deems appropriate.

17 “(4) AGENDA AND ADDITIONAL REVIEWS.—The  
18 Commission shall consult periodically with the chair-  
19 men and ranking minority members of the appro-  
20 priate committees of Congress regarding the Com-  
21 mission’s agenda and progress towards achieving the  
22 agenda. The Commission may conduct additional re-  
23 views, and submit additional reports to the appro-  
24 priate committees of Congress, from time to time on  
25 such topics relating to the program under this title

1 as may be requested by such chairmen and members  
2 and as the Commission deems appropriate.

3 “(5) AVAILABILITY OF REPORTS.—The Com-  
4 mission shall transmit to the Secretary a copy of  
5 each report submitted under this subsection and  
6 shall make such reports available to the public.

7 “(6) APPROPRIATE COMMITTEES.—For pur-  
8 poses of this section, the term ‘appropriate commit-  
9 tees of Congress’ means the Committees on Ways  
10 and Means and Commerce of the House of Rep-  
11 resentatives and the Committee on Finance of the  
12 Senate.

13 “(c) MEMBERSHIP.—

14 “(1) NUMBER AND APPOINTMENT.—The Com-  
15 mission shall be composed of 19 members appointed  
16 by the Comptroller General.

17 “(2) QUALIFICATIONS.—

18 “(A) IN GENERAL.—The membership of  
19 the Commission shall include individuals with  
20 national recognition for their expertise in health  
21 finance and economics, actuarial science, health  
22 facility management, health plans and inte-  
23 grated delivery systems, reimbursement of  
24 health facilities, allopathic and osteopathic phy-  
25 sicians, and other providers of health services,

1 and other related fields, who provide a mix of  
2 different professionals, broad geographic rep-  
3 resentation, and a balance between urban and  
4 rural representatives.

5 “(B) INCLUSION.—The membership of the  
6 Commission shall include (but not be limited to)  
7 physicians and other health professionals, em-  
8 ployers, third party payers, individuals skilled  
9 in the conduct and interpretation of biomedical,  
10 health services, and health economics research  
11 and expertise in outcomes and effectiveness re-  
12 search and technology assessment. Such mem-  
13 bership shall also include representatives of con-  
14 sumers and the elderly.

15 “(C) MAJORITY NONPROVIDERS.—Individ-  
16 uals who are directly involved in the provision,  
17 or management of the delivery, of items and  
18 services covered under this title shall not con-  
19 stitute a majority of the membership of the  
20 Commission.

21 “(D) ETHICAL DISCLOSURE.—The Comp-  
22 troller General shall establish a system for pub-  
23 lic disclosure by members of the Commission of  
24 financial and other potential conflicts of interest  
25 relating to such members.

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1 “(3) TERMS.—

2 “(A) IN GENERAL.—The terms of mem-  
3 bers of the Commission shall be for 3 years ex-  
4 cept that the Comptroller General shall des-  
5 ignate staggered terms for the members first  
6 appointed.

7 “(B) VACANCIES.—Any member appointed  
8 to fill a vacancy occurring before the expiration  
9 of the term for which the member’s predecessor  
10 was appointed shall be appointed only for the  
11 remainder of that term. A member may serve  
12 after the expiration of that member’s term until  
13 a successor has taken office. A vacancy in the  
14 Commission shall be filled in the manner in  
15 which the original appointment was made.

16 “(4) COMPENSATION.—While serving on the  
17 business of the Commission (including traveltime), a  
18 member of the Commission shall be entitled to com-  
19 pensation at the per diem equivalent of the rate pro-  
20 vided for level IV of the Executive Schedule under  
21 section 5315 of title 5, United States Code; and  
22 while so serving away from home and member’s reg-  
23 ular place of business, a member may be allowed  
24 travel expenses, as authorized by the Chairman of  
25 the Commission. Physicians serving as personnel of

1 the Commission may be provided a physician com-  
2 parability allowance by the Commission in the same  
3 manner as Government physicians may be provided  
4 such an allowance by an agency under section 5948  
5 of title 5, United States Code, and for such purpose  
6 subsection (i) of such section shall apply to the Com-  
7 mission in the same manner as it applies to the Ten-  
8 nessee Valley Authority. For purposes of pay (other  
9 than pay of members of the Commission) and em-  
10 ployment benefits, rights, and privileges, all person-  
11 nel of the Commission shall be treated as if they  
12 were employees of the United States Senate.

13 “(5) CHAIRMAN; VICE CHAIRMAN.—The Comp-  
14 troller General shall designate a member of the  
15 Commission, at the time of appointment of the mem-  
16 ber, as Chairman and a member as Vice Chairman  
17 for that term of appointment.

18 “(6) MEETINGS.—The Commission shall meet  
19 at the call of the Chairman.

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

24 “(1) employ and fix the compensation of an Ex-  
25 ecutive Director (subject to the approval of the

1 Comptroller General) and such other personnel as  
2 may be necessary to carry out its duties (without re-  
3 gard to the provisions of title 5, United States Code,  
4 governing appointments in the competitive service);

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

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

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

14 “(5) provide transportation and subsistence for  
15 persons serving without compensation; and

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

19 “(e) POWERS.—

20 “(1) OBTAINING OFFICIAL DATA.—The Com-  
21 mission may secure directly from any department or  
22 agency of the United States information necessary  
23 to enable it to carry out this section. Upon request  
24 of the Chairman, the head of that department or



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1 agency shall furnish that information to the Com-  
2 mission on an agreed upon schedule.

3 “(2) DATA COLLECTION.—In order to carry out  
4 its functions, the Commission shall—

5 “(A) utilize existing information, both pub-  
6 lished and unpublished, where possible, collected  
7 and assessed either by its own staff or under  
8 other arrangements made in accordance with  
9 this section,

10 “(B) carry out, or award grants or con-  
11 tracts for, original research and experimen-  
12 tation, where existing information is inad-  
13 equate, and

14 “(C) adopt procedures allowing any inter-  
15 ested party to submit information for the Com-  
16 mission’s use in making reports and rec-  
17 ommendations.

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

22 “(4) PERIODIC AUDIT.—The Commission shall  
23 be subject to periodic audit by the Comptroller Gen-  
24 eral.

25 “(f) AUTHORIZATION OF APPROPRIATIONS.—

1           “(1) REQUEST FOR APPROPRIATIONS.—The  
2           Commission shall submit requests for appropriations  
3           in the same manner as the Comptroller General sub-  
4           mits requests for appropriations, but amounts ap-  
5           propriated for the Commission shall be separate  
6           from amounts appropriated for the Comptroller Gen-  
7           eral.

8           “(2) AUTHORIZATION.—There are authorized to  
9           be appropriated such sums as may be necessary to  
10          carry out the provisions of this section. 60 percent  
11          of such appropriation shall be payable from the Fed-  
12          eral Hospital Insurance Trust Fund, and 40 percent  
13          of such appropriation shall be payable from the Fed-  
14          eral Supplementary Medical Insurance Trust  
15          Fund.”.

16          (b) ABOLITION OF PROPAC AND PPRC.—

17                 (1) PROPAC.—

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

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

21                                 and

22                                 (ii) in paragraph (3), by striking “(A)  
23                                 The Commission” and all that follows  
24                                 through “(B)”.

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1 (B) CONFORMING AMENDMENT.—Section  
2 1862 (42 U.S.C. 1395y) is amended by striking  
3 “Prospective Payment Assessment Commis-  
4 sion” each place it appears in subsection  
5 (a)(1)(D) and subsection (i) and inserting  
6 “Medicare Payment Advisory Commission”.

7 (2) PPRC.—

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

10 (B) ELIMINATION OF CERTAIN RE-  
11 PORTS.—Section 1848 (42 U.S.C. 1395w–4) is  
12 amended—

13 (i) by striking subparagraph (F) of  
14 subsection (d)(2),

15 (ii) by striking subparagraph (B) of  
16 subsection (f)(1), and

17 (iii) in subsection (f)(3), by striking  
18 “Physician Payment Review Commission,”.

19 (C) CONFORMING AMENDMENTS.—Section  
20 1848 (42 U.S.C. 1395w–4) is amended by  
21 striking “Physician Payment Review Commis-  
22 sion” and inserting “Medicare Payment Advi-  
23 sory Commission” each place it appears in sub-  
24 sections (e)(2)(B)(iii), (g)(6)(C), and (g)(7)(C).

25 (c) EFFECTIVE DATE; TRANSITION.—

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1           (1) IN GENERAL.—The Comptroller General  
2 shall first provide for appointment of members to  
3 the Medicare Payment Advisory Commission (in this  
4 subsection referred to as “MedPAC”) by not later  
5 than September 30, 1997.

6           (2) TRANSITION.—As quickly as possible after  
7 the date a majority of members of MedPAC are first  
8 appointed, the Comptroller General, in consultation  
9 with the Prospective Payment Assessment Commis-  
10 sion (in this subsection referred to as “ProPAC”)  
11 and the Physician Payment Review Commission (in  
12 this subsection referred to as “PPRC”), shall pro-  
13 vide for the termination of the ProPAC and the  
14 PPRC. As of the date of termination of the respec-  
15 tive Commissions, the amendments made by para-  
16 graphs (1) and (2), respectively, of subsection (b)  
17 become effective. The Comptroller General, to the  
18 extent feasible, shall provide for the transfer to the  
19 MedPAC of assets and staff of the ProPAC and the  
20 PPRC, without any loss of benefits or seniority by  
21 virtue of such transfers. Fund balances available to  
22 the ProPAC or the PPRC for any period shall be  
23 available to the MedPAC for such period for like  
24 purposes.

1           (3) CONTINUING RESPONSIBILITY FOR RE-  
2           PORTS.—The MedPAC shall be responsible for the  
3           preparation and submission of reports required by  
4           law to be submitted (and which have not been sub-  
5           mitted by the date of establishment of the MedPAC)  
6           by the ProPAC and the PPRC, and, for this pur-  
7           pose, any reference in law to either such Commission  
8           is deemed, after the appointment of the MedPAC, to  
9           refer to the MedPAC.

10        **CHAPTER 4—MEDIGAP PROTECTIONS**

11        **SEC. 10031. MEDIGAP PROTECTIONS.**

12           (a) GUARANTEEING ISSUE WITHOUT PREEXISTING  
13           CONDITIONS FOR CONTINUOUSLY COVERED INDIVID-  
14           UALS.—Section 1882(s) (42 U.S.C. 1395ss(s)) is amend-  
15           ed—

16           (1) in paragraph (3), by striking “paragraphs  
17           (1) and (2)” and inserting “this subsection”,

18           (2) by redesignating paragraph (3) as para-  
19           graph (4), and

20           (3) by inserting after paragraph (2) the follow-  
21           ing new paragraph:

22           “(3)(A) The issuer of a medicare supplemental pol-  
23           icy—

24           “(i) may not deny or condition the issuance or  
25           effectiveness of a medicare supplemental policy de-

1 scribed in subparagraph (C) that is offered and is  
2 available for issuance to new enrollees by such is-  
3 suer;

4 “(ii) may not discriminate in the pricing of  
5 such policy, because of health status, claims experi-  
6 ence, receipt of health care, or medical condition;  
7 and

8 “(iii) may not impose an exclusion of benefits  
9 based on a pre-existing condition under such policy,  
10 in the case of an individual described in subparagraph (B)  
11 who seeks to enroll under the policy not later than 63 days  
12 after the date of the termination of enrollment described  
13 in such subparagraph and who submits evidence of the  
14 date of termination or disenrollment along with the appli-  
15 cation for such medicare supplemental policy.

16 “(B) An individual described in this subparagraph is  
17 an individual described in any of the following clauses:

18 “(i) The individual is enrolled under an em-  
19 ployee welfare benefit plan that provides health ben-  
20 efits that supplement the benefits under this title  
21 and the plan terminates or ceases to provide all such  
22 supplemental health benefits to the individual.

23 “(ii) The individual is enrolled with a  
24 MedicarePlus organization under a MedicarePlus  
25 plan under part C, and there are circumstances per-

1       mitting discontinuance of the individual’s election of  
2       the plan under section 1851(c)(4).

3           “(iii) The individual is enrolled with an eligible  
4       organization under a contract under section 1876, a  
5       similar organization operating under demonstration  
6       project authority, with an organization under an  
7       agreement under section 1833(a)(1)(A), or with an  
8       organization under a policy described in subsection  
9       (t), and such enrollment ceases under the same cir-  
10      cumstances that would permit discontinuance of an  
11      individual’s election of coverage under section  
12      1851(c)(4) and, in the case of a policy described in  
13      subsection (t), there is no provision under applicable  
14      State law for the continuation of coverage under  
15      such policy.

16           “(iv) The individual is enrolled under a medi-  
17      care supplemental policy under this section and such  
18      enrollment ceases because—

19           “(I) of the bankruptcy or insolvency of the  
20      issuer or because of other involuntary termi-  
21      nation of coverage or enrollment under such  
22      policy and there is no provision under applica-  
23      ble State law for the continuation of such cov-  
24      erage;

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1           “(II) the issuer of the policy substantially  
2 violated a material provision of the policy; or

3           “(III) the issuer (or an agent or other en-  
4 tity acting on the issuer’s behalf) materially  
5 misrepresented the policy’s provisions in mar-  
6 keting the policy to the individual.

7           “(v) The individual—

8           “(I) was enrolled under a medicare supple-  
9 mental policy under this section,

10           “(II) subsequently terminates such enroll-  
11 ment and enrolls, for the first time, with any  
12 MedicarePlus organization under a  
13 MedicarePlus plan under part C, any eligible  
14 organization under a contract under section  
15 1876, any similar organization operating under  
16 demonstration project authority, any organiza-  
17 tion under an agreement under section  
18 1833(a)(1)(A), or any policy described in sub-  
19 section (t), and

20           “(III) the subsequent enrollment under  
21 subelause (II) is terminated by the enrollee dur-  
22 ing the first 6 months (or 3 months for termi-  
23 nations occurring on or after January 1, 2003)  
24 of such enrollment.



1       “(C)(i) Subject to clauses (ii) and (iii), a medicare  
2 supplemental policy described in this subparagraph has a  
3 benefit package classified as ‘A’, ‘B’, ‘C’, or ‘F’ under the  
4 standards established under subsection (p)(2).

5       “(ii) Only for purposes of an individual described in  
6 subparagraph (B)(v), a medicare supplemental policy de-  
7 scribed in this subparagraph also includes (if available  
8 from the same issuer) the same medicare supplemental  
9 policy referred to in such subparagraph in which the indi-  
10 vidual was most recently previously enrolled.

11       “(iii) For purposes of applying this paragraph in the  
12 case of a State that provides for offering of benefit pack-  
13 ages other than under the classification referred to in  
14 clause (i), the references to benefit packages in such clause  
15 are deemed references to comparable benefit packages of-  
16 fered in such State.

17       “(D) At the time of an event described in subpara-  
18 graph (B) because of which an individual ceases enroll-  
19 ment or loses coverage or benefits under a contract or  
20 agreement, policy, or plan, the organization that offers the  
21 contract or agreement, the insurer offering the policy, or  
22 the administrator of the plan, respectively, shall notify the  
23 individual of the rights of the individual, and obligations  
24 of issuers of medicare supplemental policies, under sub-  
25 paragraph (A).”.

1 (b) LIMITATION ON IMPOSITION OF PREEXISTING  
2 CONDITION EXCLUSION DURING INITIAL OPEN ENROLL-  
3 MENT PERIOD.—Section 1882(s)(2) (42 U.S.C.  
4 1395ss(s)(2)) is amended—

5 (1) in subparagraph (B), by striking “subpara-  
6 graph (C)” and inserting “subparagraphs (C) and  
7 (D)”, and

8 (2) by adding at the end the following new sub-  
9 paragraph:

10 “(D) In the case of a policy issued during the 6-  
11 month period described in subparagraph (A) to an individ-  
12 ual who is 65 years of age or older as of the date of issu-  
13 ance and who as of the date of the application for enroll-  
14 ment has a continuous period of creditable coverage (as  
15 defined in 2701(c) of the Public Health Service Act) of—

16 “(i) at least 6 months, the policy may not ex-  
17 clude benefits based on a pre-existing condition; or

18 “(ii) of less than 6 months, if the policy ex-  
19 cludes benefits based on a preexisting condition, the  
20 policy shall reduce the period of any preexisting con-  
21 dition exclusion by the aggregate of the periods of  
22 creditable coverage (if any, as so defined) applicable  
23 to the individual as of the enrollment date.

1 The Secretary shall specify the manner of the reduction  
2 under clause (ii), based upon the rules used by the Sec-  
3 retary in carrying out section 2701(a)(3) of such Act.”.

4 (c) EFFECTIVE DATES.—

5 (1) GUARANTEED ISSUE.—The amendment  
6 made by subsection (a) shall take effect on July 1,  
7 1998.

8 (2) LIMIT ON PREEXISTING CONDITION EXCLU-  
9 SIONS.—The amendment made by subsection (b)  
10 shall apply to policies issued on or after July 1,  
11 1998.

12 (d) TRANSITION PROVISIONS.—

13 (1) IN GENERAL.—If the Secretary of Health  
14 and Human Services identifies a State as requiring  
15 a change to its statutes or regulations to conform its  
16 regulatory program to the changes made by this sec-  
17 tion, the State regulatory program shall not be con-  
18 sidered to be out of compliance with the require-  
19 ments of section 1882 of the Social Security Act due  
20 solely to failure to make such change until the date  
21 specified in paragraph (4).

22 (2) NAIC STANDARDS.—If, within 9 months  
23 after the date of the enactment of this Act, the Na-  
24 tional Association of Insurance Commissioners (in  
25 this subsection referred to as the “NAIC”) modifies

1 its NAIC Model Regulation relating to section 1882  
2 of the Social Security Act (referred to in such sec-  
3 tion as the 1991 NAIC Model Regulation, as modi-  
4 fied pursuant to section 171(m)(2) of the Social Se-  
5 curity Act Amendments of 1994 (Public Law 103–  
6 432) and as modified pursuant to section  
7 1882(d)(3)(A)(vi)(IV) of the Social Security Act, as  
8 added by section 271(a) of the Health Insurance  
9 Portability and Accountability Act of 1996 (Public  
10 Law 104–191) to conform to the amendments made  
11 by this section, such revised regulation incorporating  
12 the modifications shall be considered to be the appli-  
13 cable NAIC model regulation (including the revised  
14 NAIC model regulation and the 1991 NAIC Model  
15 Regulation) for the purposes of such section.

16 (3) SECRETARY STANDARDS.—If the NAIC  
17 does not make the modifications described in para-  
18 graph (2) within the period specified in such para-  
19 graph, the Secretary of Health and Human Services  
20 shall make the modifications described in such para-  
21 graph and such revised regulation incorporating the  
22 modifications shall be considered to be the appro-  
23 priate Regulation for the purposes of such section.

24 (4) DATE SPECIFIED.—

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1 (A) IN GENERAL.—Subject to subpara-  
2 graph (B), the date specified in this paragraph  
3 for a State is the earlier of—

4 (i) the date the State changes its stat-  
5 utes or regulations to conform its regu-  
6 latory program to the changes made by  
7 this section, or

8 (ii) 1 year after the date the NAIC or  
9 the Secretary first makes the modifications  
10 under paragraph (2) or (3), respectively.

11 (B) ADDITIONAL LEGISLATIVE ACTION RE-  
12 QUIRED.—In the case of a State which the Sec-  
13 retary identifies as—

14 (i) requiring State legislation (other  
15 than legislation appropriating funds) to  
16 conform its regulatory program to the  
17 changes made in this section, but

18 (ii) having a legislature which is not  
19 scheduled to meet in 1999 in a legislative  
20 session in which such legislation may be  
21 considered,

22 the date specified in this paragraph is the first  
23 day of the first calendar quarter beginning after  
24 the close of the first legislative session of the  
25 State legislature that begins on or after July 1,

1 1999. For purposes of the previous sentence, in  
2 the case of a State that has a 2-year legislative  
3 session, each year of such session shall be  
4 deemed to be a separate regular session of the  
5 State legislature.

6 **SEC. 10032. MEDICARE PREPAID COMPETITIVE PRICING**  
7 **DEMONSTRATION PROJECT.**

8 (a) ESTABLISHMENT OF PROJECT.—The Secretary  
9 of Health and Human Services shall provide, beginning  
10 not later than 1 year after the date of the enactment of  
11 this Act, for implementation of a project (in this section  
12 referred to as the “project”) to demonstrate the applica-  
13 tion of, and the consequences of applying, a market-ori-  
14 ented pricing system for the provision of a full range of  
15 medicare benefits in a geographic area.

16 (b) RESEARCH DESIGN ADVISORY COMMITTEE.—

17 (1) IN GENERAL.—Before implementing the  
18 project under this section, the Secretary shall ap-  
19 point a national advisory committee, including inde-  
20 pendent actuaries and individuals with expertise in  
21 competitive health plan pricing, to make rec-  
22 ommendations to the Secretary concerning the ap-  
23 propriate research design for implementing the  
24 project.

1           (2) INITIAL RECOMMENDATIONS.—The commit-  
2           tee initially shall submit recommendations respecting  
3           the method for area selection, benefit design among  
4           plans offered, structuring choice among health plans  
5           offered, methods for setting the price to be paid to  
6           plans, collection of plan information (including infor-  
7           mation concerning quality and access to care), infor-  
8           mation dissemination, and methods of evaluating the  
9           results of the project.

10           (3) ADVICE DURING IMPLEMENTATION.—Upon  
11           implementation of the project, the committee shall  
12           continue to advise the Secretary on the application  
13           of the design in different areas and changes in the  
14           project based on experience with its operations.

15           (c) AREA SELECTION.—

16           (1) IN GENERAL.—Taking into account the rec-  
17           ommendations of the advisory committee submitted  
18           under subsection (b), the Secretary shall designate  
19           areas in which the project will operate.

20           (2) APPOINTMENT OF AREA ADVISORY COMMIT-  
21           TEE.—Upon the designation of an area for inclusion  
22           in the project, the Secretary shall appoint an area  
23           advisory committee, composed of representatives of  
24           health plans, providers, and medicare beneficiaries in  
25           the area, to advise the Secretary concerning how the

1 project will actually be implemented in the area.  
2 Such advice may include advice concerning the mar-  
3 keting and pricing of plans in the area and other sa-  
4 lient factors relating.

5 (d) MONITORING AND REPORT.—

6 (1) MONITORING IMPACT.—Taking into consid-  
7 eration the recommendations of the general advisory  
8 committee (appointed under subsection (b)), the Sec-  
9 retary shall closely monitor the impact of projects in  
10 areas on the price and quality of, and access to,  
11 medicare covered services, choice of health plan,  
12 changes in enrollment, and other relevant factors.

13 (2) REPORT.—The Secretary shall periodically  
14 report to Congress on the progress under the project  
15 under this section.

16 (e) WAIVER AUTHORITY.—The Secretary of Health  
17 and Human Services may waive such requirements of sec-  
18 tion 1876 (and such requirements of part C of title XVIII,  
19 as amended by chapter 1), of the Social Security Act as  
20 may be necessary for the purposes of carrying out the  
21 project.



1 **CHAPTER 5—TAX TREATMENT OF HOS-**  
2 **PITALS PARTICIPATING IN PROVIDER-**  
3 **SPONSORED ORGANIZATIONS**

4 **SEC. 10041. TAX TREATMENT OF HOSPITALS WHICH PAR-**  
5 **TICIPATE IN PROVIDER-SPONSORED ORGANI-**  
6 **ZATIONS.**

7 (a) IN GENERAL.—Section 501 of the Internal Reve-  
8 nue Code of 1986 (relating to exemption from tax on cor-  
9 porations, certain trusts, etc.) is amended by redesignat-  
10 ing subsection (o) as subsection (p) and by inserting after  
11 subsection (n) the following new subsection:

12 “(o) TREATMENT OF HOSPITALS PARTICIPATING IN  
13 PROVIDER-SPONSORED ORGANIZATIONS.—An organiza-  
14 tion shall not fail to be treated as organized and operated  
15 exclusively for a charitable purpose for purposes of sub-  
16 section (c)(3) solely because a hospital which is owned and  
17 operated by such organization participates in a provider-  
18 sponsored organization (as defined in section 1853(e) of  
19 the Social Security Act), whether or not the provider-spon-  
20 sored organization is exempt from tax. For purposes of  
21 subsection (c)(3), any person with a material financial in-  
22 terest in such a provider-sponsored organization shall be  
23 treated as a private shareholder or individual with respect  
24 to the hospital.”

1 (b) EFFECTIVE DATE.—The amendment made by  
2 subsection (a) shall take effect on the date of the enact-  
3 ment of this Act.

## 4 **Subtitle B—Prevention Initiatives**

### 5 **SEC. 10101. SCREENING MAMMOGRAPHY.**

6 (a) PROVIDING ANNUAL SCREENING MAMMOGRAPHY  
7 FOR WOMEN OVER AGE 39.—Section 1834(c)(2)(A) (42  
8 U.S.C. 1395m(c)(2)(A)) is amended—

9 (1) in clause (iii), to read as follows:

10 “(iii) In the case of a woman over 39  
11 years of age, payment may not be made  
12 under this part for screening mammog-  
13 raphy performed within 11 months follow-  
14 ing the month in which a previous screen-  
15 ing mammography was performed.”; and

16 (2) by striking clauses (iv) and (v).

17 (b) WAIVER OF DEDUCTIBLE.—The first sentence of  
18 section 1833(b) (42 U.S.C. 1395l(b)) is amended—

19 (1) by striking “and” before “(4)”, and

20 (2) by inserting before the period at the end the  
21 following: “, and (5) such deductible shall not apply  
22 with respect to screening mammography (as de-  
23 scribed in section 1861(jj))”.

24 (c) CONFORMING AMENDMENT.—Section  
25 1834(c)(1)(C) of such Act (42 U.S.C. 1395m(c)(1)(C)) is

1 amended by striking “, subject to the deductible estab-  
2 lished under section 1833(b),”.

3 (d) EFFECTIVE DATE.—The amendments made by  
4 this section shall apply to items and services furnished on  
5 or after January 1, 1998.

6 **SEC. 10102. SCREENING PAP SMEAR AND PELVIC EXAMS.**

7 (a) COVERAGE OF PELVIC EXAM; INCREASING FRE-  
8 QUENCY OF COVERAGE OF PAP SMEAR.—Section  
9 1861(nn) (42 U.S.C. 1395x(nn)) is amended—

10 (1) in the heading, by striking “Smear” and in-  
11 serting “Smear; Screening Pelvic Exam”;

12 (2) by inserting “or vaginal” after “cervical”  
13 each place it appears;

14 (3) by striking “(nn)” and inserting “(nn)(1)”;

15 (4) by striking “3 years” and all that follows  
16 and inserting “3 years, or during the preceding year  
17 in the case of a woman described in paragraph (3).”;  
18 and

19 (5) by adding at the end the following new  
20 paragraphs:

21 “(2) The term ‘screening pelvic exam’ means an pel-  
22 vic examination provided to a woman if the woman in-  
23 volved has not had such an examination during the preced-  
24 ing 3 years, or during the preceding year in the case of

1 a woman described in paragraph (3), and includes a clini-  
2 cal breast examination.

3 “(3) A woman described in this paragraph is a  
4 woman who—

5 “(A) is of childbearing age and has not had a  
6 test described in this subsection during each of the  
7 preceding 3 years that did not indicate the presence  
8 of cervical or vaginal cancer; or

9 “(B) is at high risk of developing cervical or  
10 vaginal cancer (as determined pursuant to factors  
11 identified by the Secretary).”.

12 (b) WAIVER OF DEDUCTIBLE.—The first sentence of  
13 section 1833(b) (42 U.S.C. 1395l(b)), as amended by sec-  
14 tion 10101(b), is amended—

15 (1) by striking “and” before “(5)”, and

16 (2) by inserting before the period at the end the  
17 following: “, and (6) such deductible shall not apply  
18 with respect to screening pap smear and screening  
19 pelvic exam (as described in section 1861(nm))”.

20 (c) CONFORMING AMENDMENTS.—Sections  
21 1861(s)(14) and 1862(a)(1)(F) (42 U.S.C. 1395x(s)(14),  
22 1395y(a)(1)(F)) are each amended by inserting “and  
23 screening pelvic exam” after “screening pap smear”.

24 (d) PAYMENT UNDER PHYSICIAN FEE SCHEDULE.—  
25 Section 1848(j)(3)(42 U.S.C. 1395w-4(j)(3)) is amended

1 by striking “and (4)” and inserting “(4) and (14) (with  
2 respect to services described in section 1861(nn)(2))”.

3 (e) EFFECTIVE DATE.—The amendments made by  
4 this section shall apply to items and services furnished on  
5 or after January 1, 1998.

6 **SEC. 10103. PROSTATE CANCER SCREENING TESTS.**

7 (a) COVERAGE.—Section 1861 (42 U.S.C. 1395x) is  
8 amended—

9 (1) in subsection (s)(2)—

10 (A) by striking “and” at the end of sub-  
11 paragraphs (N) and (O), and

12 (B) by inserting after subparagraph (O)  
13 the following new subparagraph:

14 “(P) prostate cancer screening tests (as defined  
15 in subsection (oo)); and”; and

16 (2) by adding at the end the following new sub-  
17 section:

18 “Prostate Cancer Screening Tests

19 “(oo)(1) The term ‘prostate cancer screening test’  
20 means a test that consists of any (or all) of the procedures  
21 described in paragraph (2) provided for the purpose of  
22 early detection of prostate cancer to a man over 50 years  
23 of age who has not had such a test during the preceding  
24 year.

1 “(2) The procedures described in this paragraph are  
2 as follows:

3 “(A) A digital rectal examination.

4 “(B) A prostate-specific antigen blood test.

5 “(C) For years beginning after 2001, such  
6 other procedures as the Secretary finds appropriate  
7 for the purpose of early detection of prostate cancer,  
8 taking into account changes in technology and  
9 standards of medical practice, availability, effective-  
10 ness, costs, and such other factors as the Secretary  
11 considers appropriate.”.

12 (b) PAYMENT FOR PROSTATE-SPECIFIC ANTIGEN  
13 BLOOD TEST UNDER CLINICAL DIAGNOSTIC LABORA-  
14 TORY TEST FEE SCHEDULES.—Section 1833(h)(1)(A)  
15 (42 U.S.C. 1395l(h)(1)(A)) is amended by inserting after  
16 “laboratory tests” the following: “(including prostate can-  
17 cer screening tests under section 1861(o) consisting of  
18 prostate-specific antigen blood tests)”.

19 (c) CONFORMING AMENDMENT.—Section 1862(a)  
20 (42 U.S.C. 1395y(a)) is amended—

21 (1) in paragraph (1)—

22 (A) in subparagraph (E), by striking  
23 “and” at the end,

24 (B) in subparagraph (F), by striking the  
25 semicolon at the end and inserting “, and”, and

1 (C) by adding at the end the following new  
2 subparagraph:

3 “(G) in the case of prostate cancer screening  
4 tests (as defined in section 1861(oo)), which are per-  
5 formed more frequently than is covered under such  
6 section;”; and

7 (2) in paragraph (7), by striking “paragraph  
8 (1)(B) or under paragraph (1)(F)” and inserting  
9 “subparagraphs (B), (F), or (G) of paragraph (1)”.

10 (d) PAYMENT UNDER PHYSICIAN FEE SCHEDULE.—  
11 Section 1848(j)(3)(42 U.S.C. 1395w-4(j)(3)), as amended  
12 by section 10102, is amended by inserting “, (2)(P) (with  
13 respect to services described in subparagraphs (A) and (C)  
14 of section 1861(oo)” after “(2)(G)”

15 (e) EFFECTIVE DATE.—The amendments made by  
16 this section shall apply to items and services furnished on  
17 or after January 1, 1998.

18 **SEC. 10104. COVERAGE OF COLORECTAL SCREENING.**

19 (a) COVERAGE.—

20 (1) IN GENERAL.—Section 1861 (42 U.S.C.  
21 1395x), as amended by section 10103(a), is amend-  
22 ed—

23 (A) in subsection (s)(2)—

24 (i) by striking “and” at the end of  
25 subparagraph (P);

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1 (ii) by adding “and” at the end of  
2 subparagraph (Q); and

3 (iii) by adding at the end the follow-  
4 ing new subparagraph:

5 “(R) colorectal cancer screening tests (as de-  
6 fined in subsection (pp)); and”; and

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

9 “Colorectal Cancer Screening Tests

10 “(pp)(1) The term ‘colorectal cancer screening test’  
11 means any of the following procedures furnished to an in-  
12 dividual for the purpose of early detection of colorectal  
13 cancer:

14 “(A) Screening fecal-occult blood test.

15 “(B) Screening flexible sigmoidoscopy.

16 “(C) In the case of an individual at high risk  
17 for colorectal cancer, screening colonoscopy.

18 “(D) Screening barium enema, if found by the  
19 Secretary to be an appropriate alternative to screen-  
20 ing flexible sigmoidoscopy under subparagraph (B)  
21 or screening colonoscopy under subparagraph (C).

22 “(E) For years beginning after 2002, such  
23 other procedures as the Secretary finds appropriate  
24 for the purpose of early detection of colorectal can-  
25 cer, taking into account changes in technology and



1 standards of medical practice, availability, effective-  
2 ness, costs, and such other factors as the Secretary  
3 considers appropriate.

4 “(2) In paragraph (1)(C), an ‘individual at high risk  
5 for colorectal cancer’ is an individual who, because of fam-  
6 ily history, prior experience of cancer or precursor neo-  
7 plastic polyps, a history of chronic digestive disease condi-  
8 tion (including inflammatory bowel disease, Crohn’s Dis-  
9 ease, or ulcerative colitis), the presence of any appropriate  
10 recognized gene markers for colorectal cancer, or other  
11 predisposing factors, faces a high risk for colorectal can-  
12 cer.”.

13 (2) DEADLINE FOR DECISION ON COVERAGE OF  
14 SCREENING BARIUM ENEMA.—Not later than 2  
15 years after the date of the enactment of this section,  
16 the Secretary of Health and Human Services shall  
17 issue and publish a determination on the treatment  
18 of screening barium enema as a colorectal cancer  
19 screening test under section 1861(pp) (as added by  
20 subparagraph (B)) as an alternative procedure to a  
21 screening flexible sigmoidoscopy or screening  
22 colonoscopy.

23 (b) FREQUENCY AND PAYMENT LIMITS.—

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1           (1) IN GENERAL.—Section 1834 (42 U.S.C.  
2           1395m) is amended by inserting after subsection (c)  
3           the following new subsection:

4           “(d) FREQUENCY AND PAYMENT LIMITS FOR  
5           COLORECTAL CANCER SCREENING TESTS.—

6           “(1) SCREENING FECAL-OCCULT BLOOD  
7           TESTS.—

8           “(A) PAYMENT LIMIT.—In establishing fee  
9           schedules under section 1833(h) with respect to  
10          colorectal cancer screening tests consisting of  
11          screening fecal-occult blood tests, except as pro-  
12          vided by the Secretary under paragraph (4)(A),  
13          the payment amount established for tests per-  
14          formed—

15                 “(i) in 1998 shall not exceed \$5; and

16                 “(ii) in a subsequent year, shall not  
17                 exceed the limit on the payment amount  
18                 established under this subsection for such  
19                 tests for the preceding year, adjusted by  
20                 the applicable adjustment under section  
21                 1833(h) for tests performed in such year.

22           “(B) FREQUENCY LIMIT.—Subject to revi-  
23          sion by the Secretary under paragraph (4)(B),  
24          no payment may be made under this part for

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1 colorectal cancer screening test consisting of a  
2 screening fecal-occult blood test—

3 “(i) if the individual is under 50 years  
4 of age; or

5 “(ii) if the test is performed within  
6 the 11 months after a previous screening  
7 fecal-occult blood test.

8 “(2) SCREENING FLEXIBLE  
9 SIGMOIDOSCOPIES.—

10 “(A) FEE SCHEDULE.—The Secretary  
11 shall establish a payment amount under section  
12 1848 with respect to colorectal cancer screening  
13 tests consisting of screening flexible  
14 sigmoidoscopies that is consistent with payment  
15 amounts under such section for similar or relat-  
16 ed services, except that such payment amount  
17 shall be established without regard to sub-  
18 section (a)(2)(A) of such section.

19 “(B) PAYMENT LIMIT.—In the case of  
20 screening flexible sigmoidoscopy services—

21 “(i) the payment amount may not ex-  
22 ceed such amount as the Secretary speci-  
23 fies, based upon the rates recognized under  
24 this part for diagnostic flexible  
25 sigmoidoscopy services; and

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1           “(ii) that, in accordance with regula-  
2           tions, may be performed in an ambulatory  
3           surgical center and for which the Secretary  
4           permits ambulatory surgical center pay-  
5           ments under this part and that are per-  
6           formed in an ambulatory surgical center or  
7           hospital outpatient department, the pay-  
8           ment amount under this part may not ex-  
9           ceed the lesser of (I) the payment rate that  
10          would apply to such services if they were  
11          performed in a hospital outpatient depart-  
12          ment, or (II) the payment rate that would  
13          apply to such services if they were per-  
14          formed in an ambulatory surgical center.

15          “(C) SPECIAL RULE FOR DETECTED LE-  
16          SIONS.—If during the course of such screening  
17          flexible sigmoidoscopy, a lesion or growth is de-  
18          tected which results in a biopsy or removal of  
19          the lesion or growth, payment under this part  
20          shall not be made for the screening flexible  
21          sigmoidoscopy but shall be made for the proce-  
22          dure classified as a flexible sigmoidoscopy with  
23          such biopsy or removal.

24          “(D) FREQUENCY LIMIT.—Subject to revi-  
25          sion by the Secretary under paragraph (4)(B),

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1 no payment may be made under this part for  
2 a colorectal cancer screening test consisting of  
3 a screening flexible sigmoidoscopy—

4 “(i) if the individual is under 50 years  
5 of age; or

6 “(ii) if the procedure is performed  
7 within the 47 months after a previous  
8 screening flexible sigmoidoscopy.

9 “(3) SCREENING COLONOSCOPY FOR INDIVID-  
10 UALS AT HIGH RISK FOR COLORECTAL CANCER.—

11 “(A) FEE SCHEDULE.—The Secretary  
12 shall establish a payment amount under section  
13 1848 with respect to colorectal cancer screening  
14 test consisting of a screening colonoscopy for  
15 individuals at high risk for colorectal cancer (as  
16 defined in section 1861(pp)(2)) that is consist-  
17 ent with payment amounts under such section  
18 for similar or related services, except that such  
19 payment amount shall be established without  
20 regard to subsection (a)(2)(A) of such section.

21 “(B) PAYMENT LIMIT.—In the case of  
22 screening colonoscopy services—

23 “(i) the payment amount may not ex-  
24 ceed such amount as the Secretary speci-  
25 fies, based upon the rates recognized under

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1 this part for diagnostic colonoscopy serv-  
2 ices; and

3 “(ii) that are performed in an ambula-  
4 tory surgical center or hospital outpatient  
5 department, the payment amount under  
6 this part may not exceed the lesser of (I)  
7 the payment rate that would apply to such  
8 services if they were performed in a hos-  
9 pital outpatient department, or (II) the  
10 payment rate that would apply to such  
11 services if they were performed in an am-  
12 bulatory surgical center.

13 “(C) SPECIAL RULE FOR DETECTED LE-  
14 SIONS.—If during the course of such screening  
15 colonoscopy, a lesion or growth is detected  
16 which results in a biopsy or removal of the le-  
17 sion or growth, payment under this part shall  
18 not be made for the screening colonoscopy but  
19 shall be made for the procedure classified as a  
20 colonoscopy with such biopsy or removal.

21 “(D) FREQUENCY LIMIT.—Subject to revi-  
22 sion by the Secretary under paragraph (4)(B),  
23 no payment may be made under this part for  
24 a colorectal cancer screening test consisting of  
25 a screening colonoscopy for individuals at high

1 risk for colorectal cancer if the procedure is  
2 performed within the 23 months after a pre-  
3 vious screening colonoscopy.

4 “(4) REDUCTIONS IN PAYMENT LIMIT AND RE-  
5 VISION OF FREQUENCY.—

6 “(A) REDUCTIONS IN PAYMENT LIMIT FOR  
7 SCREENING FECAL-OCCULT BLOOD TESTS.—

8 The Secretary shall review from time to time  
9 the appropriateness of the amount of the pay-  
10 ment limit established for screening fecal-occult  
11 blood tests under paragraph (1)(A). The Sec-  
12 retary may, with respect to tests performed in  
13 a year after 2000, reduce the amount of such  
14 limit as it applies nationally or in any area to  
15 the amount that the Secretary estimates is re-  
16 quired to assure that such tests of an appro-  
17 priate quality are readily and conveniently  
18 available during the year.

19 “(B) REVISION OF FREQUENCY.—

20 “(i) REVIEW.—The Secretary shall re-  
21 view periodically the appropriate frequency  
22 for performing colorectal cancer screening  
23 tests based on age and such other factors  
24 as the Secretary believes to be pertinent.

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1           “(ii) REVISION OF FREQUENCY.—The  
2           Secretary, taking into consideration the re-  
3           view made under clause (i), may revise  
4           from time to time the frequency with  
5           which such tests may be paid for under  
6           this subsection, but no such revision shall  
7           apply to tests performed before January 1,  
8           2001.

9           “(5) LIMITING CHARGES OF NONPARTICIPATING  
10          PHYSICIANS.—

11           “(A) IN GENERAL.—In the case of a  
12           colorectal cancer screening test consisting of a  
13           screening flexible sigmoidoscopy or a screening  
14           colonoscopy provided to an individual at high  
15           risk for colorectal cancer for which payment  
16           may be made under this part, if a nonpartici-  
17           pating physician provides the procedure to an  
18           individual enrolled under this part, the physi-  
19           cian may not charge the individual more than  
20           the limiting charge (as defined in section  
21           1848(g)(2)).

22           “(B) ENFORCEMENT.—If a physician or  
23           supplier knowing and willfully imposes a charge  
24           in violation of subparagraph (A), the Secretary  
25           may apply sanctions against such physician or



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1 supplier in accordance with section  
2 1842(j)(2).”.

3 (2) SPECIAL RULE FOR SCREENING BARIUM  
4 ENEMA.—If the Secretary of Health and Human  
5 Services issues a determination under subsection  
6 (a)(2) that screening barium enema should be cov-  
7 ered as a colorectal cancer screening test under sec-  
8 tion 1861(pp) (as added by subsection (a)(1)(B)),  
9 the Secretary shall establish frequency limits (in-  
10 cluding revisions of frequency limits) for such proce-  
11 dure consistent with the frequency limits for other  
12 colorectal cancer screening tests under section  
13 1834(d) (as added by subsection (b)(1)), and shall  
14 establish payment limits (including limits on charges  
15 of nonparticipating physicians) for such procedure  
16 consistent with the payment limits under part B of  
17 title XVIII for diagnostic barium enema procedures.

18 (c) CONFORMING AMENDMENTS.—(1) Paragraphs  
19 (1)(D) and (2)(D) of section 1833(a) (42 U.S.C. 1395l(a))  
20 are each amended by inserting “or section 1834(d)(1)”  
21 after “subsection (h)(1)”.

22 (2) Section 1833(h)(1)(A) (42 U.S.C.  
23 1395l(h)(1)(A)) is amended by striking “The Secretary”  
24 and inserting “Subject to paragraphs (1) and (4)(A) of  
25 section 1834(d), the Secretary”.

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1 (3) Clauses (i) and (ii) of section 1848(a)(2)(A) (42  
2 U.S.C. 1395w-4(a)(2)(A)) are each amended by inserting  
3 after “a service” the following: “(other than a colorectal  
4 cancer screening test consisting of a screening colonoscopy  
5 provided to an individual at high risk for colorectal cancer  
6 or a screening flexible sigmoidoscopy)”.

7 (4) Section 1862(a) (42 U.S.C. 1395y(a)), as amend-  
8 ed by section 10103(c), is amended—

9 (A) in paragraph (1)—

10 (i) in subparagraph (F), by striking “and”  
11 at the end,

12 (ii) in subparagraph (G), by striking the  
13 semicolon at the end and inserting “, and”, and

14 (iii) by adding at the end the following new  
15 subparagraph:

16 “(H) in the case of colorectal cancer screening  
17 tests, which are performed more frequently than is  
18 covered under section 1834(d);”; and

19 (B) in paragraph (7), by striking “or (G)” and  
20 inserting “(G), or (H)”.

21 (d) EFFECTIVE DATE.—The amendments made by  
22 this section shall apply to items and services furnished on  
23 or after January 1, 1998.

1 **SEC. 10105. DIABETES SCREENING TESTS.**

2 (a) COVERAGE OF DIABETES OUTPATIENT SELF-  
3 MANAGEMENT TRAINING SERVICES.—

4 (1) IN GENERAL.—Section 1861 (42 U.S.C.  
5 1395x), as amended by sections 10103(a) and  
6 10104(a), is amended—

7 (A) in subsection (s)(2)—

8 (i) by striking “and” at the end of  
9 subparagraph (Q);

10 (ii) by adding “and” at the end of  
11 subparagraph (R); and

12 (iii) by adding at the end the follow-  
13 ing new subparagraph:

14 “(S) diabetes outpatient self-management train-  
15 ing services (as defined in subsection (qq)); and”;  
16 and

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

19 “Diabetes Outpatient Self-Management Training Services

20 “(qq)(1) The term ‘diabetes outpatient self-manage-  
21 ment training services’ means educational and training  
22 services furnished to an individual with diabetes by a cer-  
23 tified provider (as described in paragraph (2)(A)) in an  
24 outpatient setting by an individual or entity who meets  
25 the quality standards described in paragraph (2)(B), but  
26 only if the physician who is managing the individual’s dia-

1 betic condition certifies that such services are needed  
2 under a comprehensive plan of care related to the individ-  
3 ual’s diabetic condition to provide the individual with nec-  
4 essary skills and knowledge (including skills related to the  
5 self-administration of injectable drugs) to participate in  
6 the management of the individual’s condition.

7 “(2) In paragraph (1)—

8 “(A) a ‘certified provider’ is a physician, or  
9 other individual or entity designated by the Sec-  
10 retary, that, in addition to providing diabetes out-  
11 patient self-management training services, provides  
12 other items or services for which payment may be  
13 made under this title; and

14 “(B) a physician, or such other individual or  
15 entity, meets the quality standards described in this  
16 paragraph if the physician, or individual or entity,  
17 meets quality standards established by the Sec-  
18 retary, except that the physician or other individual  
19 or entity shall be deemed to have met such stand-  
20 ards if the physician or other individual or entity  
21 meets applicable standards originally established by  
22 the National Diabetes Advisory Board and subse-  
23 quently revised by organizations who participated in  
24 the establishment of standards by such Board, or is  
25 recognized by an organization that represents indi-

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1       viduals (including individuals under this title) with  
2       diabetes as meeting standards for furnishing the  
3       services.”.

4               (2) PAYMENT UNDER PHYSICIAN FEE SCHED-  
5       ULE.—Section 1848(j)(3)(42 U.S.C. 1395w-4(j)(3))  
6       as amended in sections 10102 and 10103, is amend-  
7       ed by inserting “(2)(S),” before “(3),”.

8               (3) CONSULTATION WITH ORGANIZATIONS IN  
9       ESTABLISHING PAYMENT AMOUNTS FOR SERVICES  
10       PROVIDED BY PHYSICIANS.—In establishing payment  
11       amounts under section 1848 of the Social Security  
12       Act for physicians’ services consisting of diabetes  
13       outpatient self-management training services, the  
14       Secretary of Health and Human Services shall con-  
15       sult with appropriate organizations, including such  
16       organizations representing individuals or medicare  
17       beneficiaries with diabetes, in determining the rel-  
18       ative value for such services under section  
19       1848(e)(2) of such Act.

20               (b) BLOOD-TESTING STRIPS FOR INDIVIDUALS WITH  
21       DIABETES.—

22               (1) INCLUDING STRIPS AND MONITORS AS DU-  
23       RABLE MEDICAL EQUIPMENT.—The first sentence of  
24       section 1861(n) (42 U.S.C. 1395x(n)) is amended by  
25       inserting before the semicolon the following: “, and

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1 includes blood-testing strips and blood glucose mon-  
2 itors for individuals with diabetes without regard to  
3 whether the individual has Type I or Type II diabe-  
4 tes or to the individual's use of insulin (as deter-  
5 mined under standards established by the Secretary  
6 in consultation with the appropriate organizations)".

7 (2) 10 PERCENT REDUCTION IN PAYMENTS FOR  
8 TESTING STRIPS.—Section 1834(a)(2)(B)(iv) (42  
9 U.S.C. 1395m(a)(2)(B)(iv)) is amended by adding  
10 before the period the following: "(reduced by 10 per-  
11 cent, in the case of a blood glucose testing strip fur-  
12 nished after 1997 for an individual with diabetes)".

13 (c) ESTABLISHMENT OF OUTCOME MEASURES FOR  
14 BENEFICIARIES WITH DIABETES.—

15 (1) IN GENERAL.—The Secretary of Health and  
16 Human Services, in consultation with appropriate  
17 organizations, shall establish outcome measures, in-  
18 cluding glycolated hemoglobin (past 90-day average  
19 blood sugar levels), for purposes of evaluating the  
20 improvement of the health status of medicare bene-  
21 ficiaries with diabetes mellitus.

22 (2) RECOMMENDATIONS FOR MODIFICATIONS  
23 TO SCREENING BENEFITS.—Taking into account in-  
24 formation on the health status of medicare bene-  
25 ficiaries with diabetes mellitus as measured under

1 the outcome measures established under subpara-  
2 graph (A), the Secretary shall from time to time  
3 submit recommendations to Congress regarding  
4 modifications to the coverage of services for such  
5 beneficiaries under the medicare program.

6 (d) EFFECTIVE DATE.—The amendments made by  
7 this section shall apply to items and services furnished on  
8 or after January 1, 1998.

9 **SEC. 10106. STANDARDIZATION OF MEDICARE COVERAGE**  
10 **OF BONE MASS MEASUREMENTS.**

11 (a) IN GENERAL.—Section 1861 (42 U.S.C. 1395x),  
12 as amended by sections 10103(a), 10104(a), 10105(a), is  
13 amended—

14 (1) in subsection (s)—

15 (A) in paragraph (12)(C), by striking  
16 “and” at the end,

17 (B) by striking the period at the end of  
18 paragraph (14) and inserting “; and”,

19 (C) by redesignating paragraphs (15) and  
20 (16) as paragraphs (16) and (17), respectively,  
21 and

22 (D) by inserting after paragraph (14) the  
23 following new paragraph:

24 “(15) bone mass measurement (as defined in  
25 subsection (rr)).”; and

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1 (2) by inserting after subsection (qq) the follow-  
2 ing new subsection:

3 “Bone Mass Measurement

4 “(rr)(1) The term ‘bone mass measurement’ means  
5 a radiologic or radioisotopic procedure or other procedure  
6 approved by the Food and Drug Administration performed  
7 on a qualified individual (as defined in paragraph (2)) for  
8 the purpose of identifying bone mass or detecting bone  
9 loss or determining bone quality, and includes a physi-  
10 cian’s interpretation of the results of the procedure.

11 “(2) For purposes of this subsection, the term ‘quali-  
12 fied individual’ means an individual who is (in accordance  
13 with regulations prescribed by the Secretary)—

14 “(A) an estrogen-deficient woman at clinical  
15 risk for osteoporosis;

16 “(B) an individual with vertebral abnormalities;

17 “(C) an individual receiving long-term  
18 glucocorticoid steroid therapy;

19 “(D) an individual with primary  
20 hyperparathyroidism; or

21 “(E) an individual being monitored to assess  
22 the response to or efficacy of an approved  
23 osteoporosis drug therapy.

24 “(3) The Secretary shall establish such standards re-  
25 garding the frequency with which a qualified individual



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1 shall be eligible to be provided benefits for bone mass  
2 measurement under this title.”.

3 (b) PAYMENT UNDER PHYSICIAN FEE SCHEDULE.—

4 Section 1848(j)(3) (42 U.S.C. 1395w-4(j)(3)), as amend-  
5 ed by sections 10102, 10103, and 10105, is amended—

6 (1) by striking “(4) and (14)” and inserting  
7 “(4), (14)” and

8 (2) by inserting “ and (15)” after  
9 “1861(mn)(2)”.

10 (c) CONFORMING AMENDMENTS.—Sections 1864(a),

11 1902(a)(9)(C), and 1915(a)(1)(B)(ii)(I) (42 U.S.C.

12 1395aa(a), 1396a(a)(9)(C), and 1396n(a)(1)(B)(ii)(I)

13 are amended by striking “paragraphs (15) and (16)” each

14 place it appears and inserting “paragraphs (16) and

15 (17)”.

16 (d) EFFECTIVE DATE.—The amendments made by

17 this section shall apply to bone mass measurements per-

18 formed on or after July 1, 1998.

19 **SEC. 10107. VACCINES OUTREACH EXPANSION.**

20 (a) EXTENSION OF INFLUENZA AND PNEUMOCOCCAL

21 VACCINATION CAMPAIGN.—In order to increase utilization

22 of pneumococcal and influenza vaccines in medicare bene-

23 ficiaries, the Influenza and Pneumococcal Vaccination

24 Campaign carried out by the Health Care Financing Ad-

25 ministration in conjunction with the Centers for Disease

1 Control and Prevention and the National Coalition for  
2 Adult Immunization, is extended until the end of fiscal  
3 year 2002.

4 (b) AUTHORIZATION OF APPROPRIATION.—There are  
5 hereby authorized to be appropriated for each of fiscal  
6 years 1998 through 2002, \$8,000,000 for the Campaign  
7 described in subsection (a). Of the amount so authorized  
8 to be appropriated in each fiscal year, 60 percent of the  
9 amount so appropriated shall be payable from the Federal  
10 Hospital Insurance Trust Fund, and 40 percent shall be  
11 payable from the Federal Supplementary Medical Insur-  
12 ance Trust Fund.

13 **SEC. 10108. STUDY ON PREVENTIVE BENEFITS.**

14 (a) STUDY.—The Secretary of Health and Human  
15 Services shall request the National Academy of Sciences,  
16 in conjunction with the United States Preventive Services  
17 Task Force, to analyze the expansion or modification of  
18 preventive benefits provided to medicare beneficiaries  
19 under title XVIII of the Social Security Act. The analysis  
20 shall consider both the short term and long term benefits,  
21 and costs to the medicare program, of such expansion or  
22 modification,

23 (b) REPORT.—

24 (1) INITIAL REPORT.—Not later than 2 years  
25 after the date of the enactment of this Act, the Sec-

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1       retary shall submit a report on the findings of the  
2       analysis conducted under subsection (a) to the Com-  
3       mittee on Ways and Means and the Committee on  
4       Commerce of the House of Representatives and the  
5       Committee on Finance of the Senate.

6               (2) CONTENTS.—Such report shall include spe-  
7       cific findings with respect to coverage of the follow-  
8       ing preventive benefits:

9                       (A) Nutrition therapy, including parenteral  
10                      and enteral nutrition.

11                     (B) Medically necessary dental care.

12                     (C) Routine patient care costs for bene-  
13                      ficiaries enrolled in approved clinical trial pro-  
14                      grams.

15                     (D) Elimination of time limitation for cov-  
16                      erage of immunosuppressive drugs for trans-  
17                      plant patients.

18               (3) FUNDING.—From funds appropriated to the  
19       Department of Health and Human Services for fis-  
20       cal years 1998 and 1999, the Secretary shall provide  
21       for such funding as may be necessary for the con-  
22       duct of the analysis by the National Academy of  
23       Sciences under this section.

1           **Subtitle C—Rural Initiatives**

2   **SEC. 10201. RURAL PRIMARY CARE HOSPITAL PROGRAM.**

3           (a) RURAL PRIMARY CARE HOSPITAL PROGRAM.—

4   Section 1820 (42 U.S.C. 1395i–4) is amended to read as  
5 follows:

6   “MEDICARE RURAL PRIMARY CARE HOSPITAL PROGRAM

7           “SEC. 1820. (a) STATE DESIGNATION OF FACILI-  
8 TIES.—

9                   “(1) IN GENERAL.—A State may designate one  
10           or more facilities as a rural primary care hospital in  
11           accordance with paragraph (2).

12                   “(2) CRITERIA FOR DESIGNATION AS RURAL  
13           PRIMARY CARE HOSPITAL.—A State may designate a  
14           facility as a rural primary care hospital if the facil-  
15           ity—

16                           “(A) is a nonprofit or public hospital, and  
17           is located in a county (or equivalent unit of  
18           local government) in a rural area (as defined in  
19           section 1886(d)(2)(D)) that—

20                                   “(i) is located a distance that cor-  
21                                   responds to a travel time of greater than  
22                                   30 minutes (using the guidelines specified  
23                                   under part IB1(b) of Appendix A to part  
24                                   5 of title 42, Code of Federal Regulations,  
25                                   as in effect on October 1, 1996), from a

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1 hospital, or another facility described in  
2 this subsection, or

3 “(ii) is certified by the State as being  
4 a necessary provider of health care services  
5 to residents in the area because of local ge-  
6 ography or service patterns;

7 “(B) makes available 24-hour emergency  
8 care services;

9 “(C) provides at any time not more than  
10 15 acute care inpatient beds (meeting such  
11 standards as the Secretary may establish) for  
12 providing inpatient care for a period not to ex-  
13 ceed 96 hours (unless a longer period is re-  
14 quired because transfer to a hospital is pre-  
15 cluded because of inclement weather or other  
16 emergency conditions), except that a peer re-  
17 view organization or equivalent entity may, on  
18 request, waive the 96-hour restriction on a case-  
19 by-case basis;

20 “(D) meets such staffing requirements as  
21 would apply under section 1861(e) to a hospital  
22 located in a rural area, except that—

23 “(i) the facility need not meet hospital  
24 standards relating to the number of hours  
25 during a day, or days during a week, in

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1 which the facility must be open and fully  
2 staffed, except insofar as the facility is re-  
3 quired to make available emergency care  
4 services as determined under subparagraph  
5 (B) and must have nursing services avail-  
6 able on a 24-hour basis, but need not oth-  
7 erwise staff the facility except when an in-  
8 patient is present,

9 “(ii) the facility may provide any serv-  
10 ices otherwise required to be provided by a  
11 full-time, on-site dietitian, pharmacist, lab-  
12 oratory technician, medical technologist,  
13 and radiological technologist on a part-  
14 time, off-site basis under arrangements as  
15 defined in section 1861(w)(1), and

16 “(iii) the inpatient care described in  
17 subparagraph (C) may be provided by a  
18 physician’s assistant, nurse practitioner, or  
19 clinical nurse specialist subject to the over-  
20 sight of a physician who need not be  
21 present in the facility;

22 “(E) meets the requirements of subpara-  
23 graph (I) of paragraph (2) of section 1861(aa);  
24 and

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1           “(F) has executed and in effect an agree-  
2           ment described in subsection (b)(1).

3           “(b) AGREEMENTS.—

4           “(1) IN GENERAL.—Each rural primary care  
5           hospital shall have an agreement with respect to  
6           each item described in paragraph (2) with at least  
7           1 hospital (as defined in section 1861(e)).

8           “(2) ITEMS DESCRIBED.—The items described  
9           in this paragraph are the following:

10           “(A) Patient referral and transfer.

11           “(B) The development and use of commu-  
12           nications systems including (where feasible)—

13           “(i) telemetry systems, and

14           “(ii) systems for electronic sharing of  
15           patient data.

16           “(C) The provision of emergency and non-  
17           emergency transportation between the facility  
18           and the hospital.

19           “(3) CREDENTIALING AND QUALITY ASSUR-  
20           ANCE.—Each rural primary care hospital shall have  
21           an agreement with respect to credentialing and qual-  
22           ity assurance with at least 1—

23           “(A) hospital,

24           “(B) peer review organization or equivalent  
25           entity, or

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1                   “(C) other appropriate and qualified entity  
2                   identified by the State.

3                   “(c) CERTIFICATION BY THE SECRETARY.—The Sec-  
4                   retary shall certify a facility as a rural primary care hos-  
5                   pital if the facility—

6                   “(1) is designated as a rural primary care hos-  
7                   pital by the State in which it is located; and

8                   “(2) meets such other criteria as the Secretary  
9                   may require.

10                  “(d) PERMITTING MAINTENANCE OF SWING BEDS.—  
11                  Nothing in this section shall be construed to prohibit a  
12                  State from designating or the Secretary from certifying  
13                  a facility as a rural primary care hospital solely because,  
14                  at the time the facility applies to the State for designation  
15                  as a rural primary care hospital, there is in effect an  
16                  agreement between the facility and the Secretary under  
17                  section 1883 under which the facility’s inpatient hospital  
18                  facilities are used for the provision of extended care serv-  
19                  ices, so long as the total number of beds that may be used  
20                  at any time for the furnishing of either such services or  
21                  acute care inpatient services does not exceed 25 beds and  
22                  the number of beds used at any time for acute care inpa-  
23                  tient services does not exceed 15 beds. For purposes of  
24                  the previous sentence, any bed of a unit of the facility that  
25                  is licensed as a distinct-part skilled nursing facility at the



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1 time the facility applies to the State for designation as  
2 a rural primary care hospital shall not be counted.

3 “(e) WAIVER OF CONFLICTING PART A PROVI-  
4 SIONS.—The Secretary is authorized to waive such provi-  
5 sions of this part and part C as are necessary to conduct  
6 the program established under this section.”.

7 (b) PAYMENT ON A REASONABLE COST BASIS.—

8 (1) MEDICARE PART A.—Section 1814(l) (42  
9 U.S.C. 1395f(1)) is amended to read as follows:

10 “(l) PAYMENT FOR INPATIENT RURAL PRIMARY  
11 CARE HOSPITAL SERVICES.—The amount of payment  
12 under this part for inpatient rural primary care hospital  
13 services is the reasonable costs of the rural primary care  
14 hospital in providing such services.”.

15 (2) MEDICARE PART B.—Section 1834(g) (42  
16 U.S.C. 1395m(g)) is amended to read as follows:

17 “(g) PAYMENT FOR OUTPATIENT RURAL PRIMARY  
18 CARE HOSPITAL SERVICES.—The amount of payment  
19 under this part for outpatient rural primary care hospital  
20 services is the reasonable costs of the rural primary care  
21 hospital in providing such services.”.

22 (c) LENGTHENING MAXIMUM PERIOD OF PER-  
23 MITTED INPATIENT STAY.—Section 1814(a)(8) (42  
24 U.S.C. 1395f(a)(8)) is amended by striking “72 hours”  
25 and inserting “96 hours”.

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1 (d) PAYMENT CONTINUED TO DESIGNATED ESSEN-  
2 TIAL ACCESS COMMUNITY HOSPITALS AND DESIGNATED  
3 RURAL PRIMARY CARE HOSPITALS.—

4 (1) ESSENTIAL ACCESS COMMUNITY HOS-  
5 PITALS.—Section 1886(d)(5)(D) (42 U.S.C.  
6 1395ww(d)(5)(D)) is amended—

7 (A) in clause (iii)(III), by inserting “as in  
8 effect on September 30, 1997” before the pe-  
9 riod at the end; and

10 (B) in clause (v), by inserting “as in effect  
11 on September 30, 1997” after “1820(i)(1)” and  
12 after “1820(g)”.

13 (2) RURAL PRIMARY CARE HOSPITALS.—Section  
14 1861(mm)(1) (42 U.S.C. 1395x(mm)(1)) is amend-  
15 ed by striking “1820(i)(2).” and inserting “1820(e),  
16 and includes a facility designated by the Secretary  
17 under section 1820(i)(2) as in effect on September  
18 30, 1997.”.

19 (3) MEDICAL ASSISTANCE FACILITY.—Any fa-  
20 cility that, as of March 1, 1997, operated as a lim-  
21 ited service rural hospital under a demonstration de-  
22 scribed in section 4008(i)(1) of the Omnibus Budget  
23 Reconciliation Act of 1990 (42 U.S.C. 1395b–1  
24 note) shall be treated as a rural primary care hos-  
25 pital for the purposes of title XVIII of the Social Se-

1 security Act so long as it continues to meet the re-  
2 quirements of the demonstration protocol relating to  
3 staffing, services, quality assurance, and related fac-  
4 tors.

5 (e) CONFORMING AMENDMENT.—Section 1883(a)(1)  
6 (42 U.S.C. 1395tt(a)(1)) is amended by inserting “or  
7 rural primary care hospital” after “Any hospital”.

8 (f) EFFECTIVE DATE.—The amendments made by  
9 this section shall apply to services furnished in cost report-  
10 ing periods beginning on or after October 1, 1997.

11 **SEC. 10202. PROHIBITING DENIAL OF REQUEST BY RURAL**  
12 **REFERRAL CENTERS FOR RECLASSIFICA-**  
13 **TION ON BASIS OF COMPARABILITY OF**  
14 **WAGES.**

15 (a) IN GENERAL.—Section 1886(d)(10)(D) (42  
16 U.S.C. 1395ww(d)(10)(D)) is amended—

17 (1) by redesignating clause (iii) as clause (iv);

18 and

19 (2) by inserting after clause (ii) the following  
20 new clause:

21 “(iii) Under the guidelines published by the Secretary  
22 under clause (i), in the case of a hospital which has ever  
23 been classified by the Secretary as a rural referral center  
24 under paragraph (5)(C), the Board may not reject the ap-  
25 plication of the hospital under this paragraph on the basis

1 of any comparison between the average hourly wage of the  
2 hospital and the average hourly wage of hospitals in the  
3 area in which it is located.”.

4 (b) CONTINUING TREATMENT OF PREVIOUSLY DES-  
5 IGNATED CENTERS.—

6 (1) IN GENERAL.—Any hospital classified as a  
7 rural referral center by the Secretary of Health and  
8 Human Services under section 1886(d)(5)(C) of the  
9 Social Security Act for fiscal year 1991 shall be clas-  
10 sified as such a rural referral center for fiscal year  
11 1998 and each subsequent fiscal year.

12 (2) BUDGET NEUTRALITY.—The provisions of  
13 section 1886(d)(8)(D) of the Social Security Act  
14 shall apply to reclassifications made pursuant to  
15 paragraph (1) in the same manner as such provi-  
16 sions apply to a reclassification under section  
17 1886(d)(10) of such Act.

18 **SEC. 10203. HOSPITAL GEOGRAPHIC RECLASSIFICATION**  
19 **PERMITTED FOR PURPOSES OF DISPROPOR-**  
20 **TIONATE SHARE PAYMENT ADJUSTMENTS.**

21 (a) IN GENERAL.—Section 1886(d)(10)(C)(i) (42  
22 U.S.C. 1395ww(d)(10)(C)(i)) is amended—

23 (1) by striking “or” at the end of subclause (I);

24 (2) by striking the period at the end of sub-  
25 clause (II) and inserting “, or”; and

1           (3) by inserting after subclause (II) the follow-  
2           ing:

3           “(III) eligibility for and amount of additional  
4           payment amounts under paragraph (5)(F).”.

5           (b) APPLICABLE GUIDELINES.—Such Board shall  
6           apply the guidelines established for reclassification under  
7           subclause (I) of section 1886(d)(10)(C)(i) of such Act to  
8           reclassification under subclause (III) of such section until  
9           the Secretary of Health and Human Services promulgates  
10          separate guidelines for reclassification under such sub-  
11          clause (III).

12 **SEC. 10204. MEDICARE-DEPENDENT, SMALL RURAL HOS-**  
13 **PITAL PAYMENT EXTENSION.**

14          (a) SPECIAL TREATMENT EXTENDED.—

15                (1) PAYMENT METHODOLOGY.—Section  
16                1886(d)(5)(G) (42 U.S.C. 1395ww(d)(5)(G)) is  
17                amended—

18                        (A) in clause (i), by striking “October 1,  
19                        1994,” and inserting “October 1, 1994, or be-  
20                        ginning on or after October 1, 1997, and before  
21                        October 1, 2001,”; and

22                        (B) in clause (ii)(II), by striking “October  
23                        1, 1994,” and inserting “October 1, 1994, or  
24                        beginning on or after October 1, 1997, and be-  
25                        fore October 1, 2001.”.

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1           (2) EXTENSION OF TARGET AMOUNT.—Section  
2           1886(b)(3)(D) (42 U.S.C. 1395ww(b)(3)(D)) is  
3           amended—

4                   (A) in the matter preceding clause (i), by  
5                   striking “September 30, 1994,” and inserting  
6                   “September 30, 1994, and for cost reporting  
7                   periods beginning on or after October 1, 1997,  
8                   and before October 1, 2001,”;

9                   (B) in clause (ii), by striking “and” at the  
10                  end;

11                  (C) in clause (iii), by striking the period at  
12                  the end and inserting “, and”; and

13                  (D) by adding after clause (iii) the follow-  
14                  ing new clause:

15                   “(iv) with respect to discharges occurring dur-  
16                   ing fiscal year 1998 through fiscal year 2000, the  
17                   target amount for the preceding year increased by  
18                   the applicable percentage increase under subpara-  
19                   graph (B)(iv).”.

20           (3) PERMITTING HOSPITALS TO DECLINE RE-  
21           CLASSIFICATION.—Section 13501(e)(2) of OBRA–93  
22           (42 U.S.C. 1395ww note) is amended by striking  
23           “or fiscal year 1994” and inserting “, fiscal year  
24           1994, fiscal year 1998, fiscal year 1999, or fiscal  
25           year 2000”.

1 (b) EFFECTIVE DATE.—The amendments made by  
2 subsection (a) shall apply with respect to discharges occur-  
3 ring on or after October 1, 1997.

4 **SEC. 10205. GEOGRAPHIC RECLASSIFICATION FOR CERTAIN**  
5 **DISPROPORTIONATELY LARGE HOSPITALS.**

6 (a) NEW GUIDELINES FOR RECLASSIFICATION.—  
7 Notwithstanding the guidelines published under subpara-  
8 graph (D)(i)(I) of section 1886(d)(10) of the Social Secu-  
9 rity Act (42 U.S.C. 1395ww(d)(10)), the Secretary of  
10 Health and Human Services shall publish and use alter-  
11 native guidelines under which a hospital described in sub-  
12 section (b) qualifies for geographic reclassification under  
13 such section for a fiscal year beginning with fiscal year  
14 1998.

15 (b) HOSPITALS COVERED.—A hospital described in  
16 this subsection is a hospital that demonstrates that—

17 (1) the average hourly wage paid by the hos-  
18 pital is not less than 108 percent of the average  
19 hourly wage paid by all other hospitals located in the  
20 Metropolitan Statistical Area (or the New England  
21 County Metropolitan Area) in which the hospital is  
22 located; and

23 (2) not less than 40 percent of the adjusted  
24 uninflated wages paid by all hospitals located in such Area  
25 is attributable to wages paid by the hospital.

1 **SEC. 10206. FLOOR ON AREA WAGE INDEX.**

2 (a) IN GENERAL.—For purposes of section  
3 1886(d)(3)(E) of the Social Security Act for discharges  
4 occurring on or after October 1, 1997, the area wage index  
5 applicable under such section to any hospital which is not  
6 located in a rural area (as defined in section  
7 1886(d)(2)(D) of such Act) may not be less than the area  
8 wage indices applicable under such section to hospitals lo-  
9 cated in rural areas in the State in which the hospital is  
10 located.

11 (b) IMPLEMENTATION.—The Secretary of Health and  
12 Human Services shall adjust the area wage indices re-  
13 ferred to in subsection (a) for hospitals not described in  
14 such subsection in a manner which assures that the aggre-  
15 gate payments made under section 1886(d) of the Social  
16 Security Act in a fiscal year for the operating costs of in-  
17 patient hospital services are not greater or less than those  
18 which would have been made in the year if this section  
19 did not apply.

20 **SEC. 10207. INFORMATICS, TELEMEDICINE, AND EDU-**  
21 **CATION DEMONSTRATION PROJECT.**

22 (a) PURPOSE AND AUTHORIZATION.—

23 (1) IN GENERAL.—Not later than 9 months  
24 after the date of enactment of this section, the Sec-  
25 retary of Health and Human Services shall provide



1 for a demonstration project described in paragraph  
2 (2).

3 (2) DESCRIPTION OF PROJECT.—

4 (A) IN GENERAL.—The demonstration  
5 project described in this paragraph is a single  
6 demonstration project to use eligible health care  
7 provider telemedicine networks to apply high-  
8 capacity computing and advanced networks to  
9 improve primary care (and prevent health care  
10 complications) to medicare beneficiaries with di-  
11 abetes mellitus who are residents of medically  
12 underserved rural areas or residents of medi-  
13 cally underserved inner-city areas.

14 (B) MEDICALLY UNDERSERVED DE-  
15 FINED.—As used in this paragraph, the term  
16 “medically underserved” has the meaning given  
17 such term in section 330(b)(3) of the Public  
18 Health Service Act (42 U.S.C. 254b(b)(3)).

19 (3) WAIVER.—The Secretary shall waive such  
20 provisions of title XVIII of the Social Security Act  
21 as may be necessary to provide for payment for serv-  
22 ices under the project in accordance with subsection  
23 (d).

24 (4) DURATION OF PROJECT.—The project shall  
25 be conducted over a 4-year period.

1 (b) OBJECTIVES OF PROJECT.—The objectives of the  
2 project include the following:

3 (1) Improving patient access to and compliance  
4 with appropriate care guidelines for individuals with  
5 diabetes mellitus through direct telecommunications  
6 link with information networks in order to improve  
7 patient quality-of-life and reduce overall health care  
8 costs.

9 (2) Developing a curriculum to train, and pro-  
10 viding standards for credentialing and licensure of,  
11 health professionals (particularly primary care  
12 health professionals) in the use of medical  
13 informatics and telecommunications.

14 (3) Demonstrating the application of advanced  
15 technologies, such as video-conferencing from a pa-  
16 tient's home, remote monitoring of a patient's medi-  
17 cal condition, interventional informatics, and apply-  
18 ing individualized, automated care guidelines, to as-  
19 sist primary care providers in assisting patients with  
20 diabetes in a home setting.

21 (4) Application of medical informatics to resi-  
22 dents with limited English language skills.

23 (5) Developing standards in the application of  
24 telemedicine and medical informatics.

1           (6) Developing a model for the cost-effective de-  
2           livery of primary and related care both in a managed  
3           care environment and in a fee-for-service environ-  
4           ment.

5           (c) ELIGIBLE HEALTH CARE PROVIDER TELEMEDI-  
6           CINE NETWORK DEFINED.—For purposes of this section,  
7           the term “eligible health care provider telemedicine net-  
8           work” means a consortium that includes at least one ter-  
9           tiary care hospital (but no more than 2 such hospitals),  
10          at least one medical school, no more than 4 facilities in  
11          rural or urban areas, and at least one regional tele-  
12          communications provider and that meets the following re-  
13          quirements:

14               (1) The consortium is located in an area with  
15               one of the highest concentrations of medical schools  
16               and tertiary care facilities in the United States and  
17               has appropriate arrangements (within or outside the  
18               consortium) with such schools and facilities, univer-  
19               sities, and telecommunications providers, in order to  
20               conduct the project.

21               (2) The consortium submits to the Secretary an  
22               application at such time, in such manner, and con-  
23               taining such information as the Secretary may re-  
24               quire, including a description of the use to which the  
25               consortium would apply any amounts received under

1 the project and the source and amount of non-Fed-  
2 eral funds used in the project.

3 (3) The consortium guarantees that it will be  
4 responsible for payment for all costs of the project  
5 that are not paid under this section and that the  
6 maximum amount of payment that may be made to  
7 the consortium under this section shall not exceed  
8 the amount specified in subsection (d)(3).

9 (d) COVERAGE AS MEDICARE PART B SERVICES.—

10 (1) IN GENERAL.—Subject to the succeeding  
11 provisions of this subsection, services related to the  
12 treatment or management of (including prevention  
13 of complications from) diabetes for medicare bene-  
14 ficiaries furnished under the project shall be consid-  
15 ered to be services covered under part B of title  
16 XVIII of the Social Security Act.

17 (2) PAYMENTS.—

18 (A) IN GENERAL.—Subject to paragraph  
19 (3), payment for such services shall be made at  
20 a rate of 50 percent of the costs that are rea-  
21 sonable and related to the provision of such  
22 services. In computing such costs, the Secretary  
23 shall include costs described in subparagraph  
24 (B), but may not include costs described in sub-  
25 paragraph (C).

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1 (B) COSTS THAT MAY BE INCLUDED.—The  
2 costs described in this subparagraph are the  
3 permissible costs (as recognized by the Sec-  
4 retary) for the following:

5 (i) The acquisition of telemedicine  
6 equipment for use in patients' homes (but  
7 only in the case of patients located in  
8 medically underserved areas).

9 (ii) Curriculum development and  
10 training of health professionals in medical  
11 informatics and telemedicine.

12 (iii) Payment of telecommunications  
13 costs (including salaries and maintenance  
14 of equipment), including costs of tele-  
15 communications between patients' homes  
16 and the eligible network and between the  
17 network and other entities under the ar-  
18 rangements described in subsection (c)(1).

19 (iv) Payments to practitioners and  
20 providers under the medicare programs.

21 (C) COSTS NOT INCLUDED.—The costs de-  
22 scribed in this subparagraph are costs for any  
23 of the following:

24 (i) The purchase or installation of  
25 transmission equipment (other than such

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1 equipment used by health professionals to  
2 deliver medical informatics services under  
3 the project).

4 (ii) The establishment or operation of  
5 a telecommunications common carrier net-  
6 work.

7 (iii) Construction (except for minor  
8 renovations related to the installation of  
9 reimbursable equipment) or the acquisition  
10 or building of real property.

11 (3) LIMITATION.—The total amount of the pay-  
12 ments that may be made under this section shall not  
13 exceed \$30,000,000.

14 (4) LIMITATION ON COST-SHARING.—The  
15 project may not impose cost sharing on a medicare  
16 beneficiary for the receipt of services under the  
17 project in excess of 20 percent of the recognized  
18 costs of the project attributable to such services.

19 (e) REPORTS.—The Secretary shall submit to the  
20 Committees on Ways and Means and Commerce of the  
21 House of Representatives and the Committee on Finance  
22 of the Senate interim reports on the project and a final  
23 report on the project within 6 months after the conclusion  
24 of the project. The final report shall include an evaluation  
25 of the impact of the use of telemedicine and medical

1 informatics on improving access of medicare beneficiaries  
2 to health care services, on reducing the costs of such serv-  
3 ices, and on improving the quality of life of such bene-  
4 ficiaries.

5 (f) DEFINITIONS.—For purposes of this section:

6 (1) INTERVENTIONAL INFORMATICS.—The term  
7 “interventional informatics” means using informa-  
8 tion technology and virtual reality technology to in-  
9 tervene in patient care.

10 (2) MEDICAL INFORMATICS.—The term “medi-  
11 cal informatics” means the storage, retrieval, and  
12 use of biomedical and related information for prob-  
13 lem solving and decision-making through computing  
14 and communications technologies.

15 (3) PROJECT.—The term “project” means the  
16 demonstration project under this section.

17 **Subtitle D—Anti-Fraud and Abuse**  
18 **Provisions**

19 **SEC. 10301. PERMANENT EXCLUSION FOR THOSE CON-**  
20 **VICTED OF 3 HEALTH CARE RELATED**  
21 **CRIMES.**

22 Section 1128(c)(3) (42 U.S.C. 1320a–7(e)(3)) is  
23 amended—

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1 (1) in subparagraph (A), by inserting “or in the  
2 case described in subparagraph (G)” after “sub-  
3 section (b)(12)”;

4 (2) in subparagraphs (B) and (D), by striking  
5 “In the case” and inserting “Subject to subpara-  
6 graph (G), in the case”; and

7 (3) by adding at the end the following new sub-  
8 paragraph:

9 “(G) In the case of an exclusion of an individual  
10 under subsection (a) based on a conviction occurring on  
11 or after the date of the enactment of this subparagraph,  
12 if the individual has (before, on, or after such date and  
13 before the date of the conviction for which the exclusion  
14 is imposed) been convicted—

15 “(i) on one previous occasion of one or more of-  
16 fenses for which an exclusion may be effected under  
17 such subsection, the period of the exclusion shall be  
18 not less than 10 years, or

19 “(ii) on 2 or more previous occasions of one or  
20 more offenses for which an exclusion may be effected  
21 under such subsection, the period of the exclusion  
22 shall be permanent.”.



1 **SEC. 10302. AUTHORITY TO REFUSE TO ENTER INTO MEDI-**  
2 **CARE AGREEMENTS WITH INDIVIDUALS OR**  
3 **ENTITIES CONVICTED OF FELONIES.**

4 (a) MEDICARE PART A.—Section 1866(b)(2) (42  
5 U.S.C. 1395cc(b)(2)) is amended—

6 (1) by striking “or” at the end of subparagraph  
7 (B);

8 (2) by striking the period at the end of sub-  
9 paragraph (C) and inserting “, or”; and

10 (3) by adding after subparagraph (C) the fol-  
11 lowing new subparagraph:

12 “(D) has ascertained that the provider has  
13 been convicted of a felony under Federal or  
14 State law for an offense which the Secretary de-  
15 termines is inconsistent with the best interests  
16 of program beneficiaries.”.

17 (b) MEDICARE PART B.—Section 1842 (42 U.S.C.  
18 1395u) is amended by adding after subsection (r) the fol-  
19 lowing new subsection:

20 “(s) The Secretary may refuse to enter into an agree-  
21 ment with a physician or supplier under subsection (h)  
22 or may terminate or refuse to renew such agreement, in  
23 the event that such physician or supplier has been con-  
24 victed of a felony under Federal or State law for an of-  
25 fense which the Secretary determines is inconsistent with  
26 the best interests of program beneficiaries.”.

1 (c) MEDICAID.—For provisions amending title XIX  
2 of the Social Security Act to provide similar treatment  
3 under the medicaid program, see section \_\_\_\_.

4 (d) EFFECTIVE DATE.—The amendments made by  
5 this section shall take effect on the date of the enactment  
6 of this Act and apply to the entry and renewal of contracts  
7 on or after such date.

8 **SEC. 10303. INCLUSION OF TOLL-FREE NUMBER TO REPORT**  
9 **MEDICARE WASTE, FRAUD, AND ABUSE IN EX-**  
10 **PLANATION OF BENEFITS FORMS.**

11 (a) IN GENERAL.—Section 1842(h)(7) (42 U.S.C.  
12 1395u(h)(7)) is amended—

13 (1) by striking “and” at the end of subpara-  
14 graph (C),

15 (2) by striking the period at the end of sub-  
16 paragraph (D) and inserting “; and”, and

17 (3) by adding at the end the following new sub-  
18 paragraph:

19 “(E) a toll-free telephone number maintained  
20 by the Inspector General in the Department of  
21 Health and Human Services for the receipt of com-  
22 plaints and information about waste, fraud, and  
23 abuse in the provision or billing of services under  
24 this title.”.

1 (b) EFFECTIVE DATE.—The amendments made by  
2 subsection (a) shall apply to explanations of benefits pro-  
3 vided on or after such date (not later than January 1,  
4 1999) as the Secretary of Health and Human Services  
5 shall provide.

6 **SEC. 10304. LIABILITY OF MEDICARE CARRIERS AND FIS-**  
7 **CAL INTERMEDIARIES FOR CLAIMS SUBMIT-**  
8 **TED BY EXCLUDED PROVIDERS.**

9 (a) REIMBURSEMENT TO THE SECRETARY FOR  
10 AMOUNTS PAID TO EXCLUDED PROVIDERS.—

11 (1) REQUIREMENTS FOR FISCAL  
12 INTERMEDIARIES.—

13 (A) IN GENERAL.—Section 1816 (42  
14 U.S.C. 1395h) is amended by adding at the end  
15 the following new subsection:

16 “(m) An agreement with an agency or organization  
17 under this section shall require that such agency or orga-  
18 nization reimburse the Secretary for any amounts paid by  
19 the agency or organization for a service under this title  
20 which is furnished, directed, or prescribed by an individual  
21 or entity during any period for which the individual or  
22 entity is excluded pursuant to section 1128, 1128A, or  
23 1156, from participation in the program under this title,  
24 if the amounts are paid after the Secretary notifies the  
25 agency or organization of the exclusion.”.

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1 (B) CONFORMING AMENDMENT.—Sub-  
2 section (i) of such section is amended by adding  
3 at the end the following new paragraph:

4 “(4) Nothing in this subsection shall be construed to  
5 prohibit reimbursement by an agency or organization  
6 under subsection (m).”.

7 (2) REQUIREMENTS FOR CARRIERS.—Section  
8 1842(b)(3) (42 U.S.C. 1395u(b)(3)) is amended—

9 (A) by striking “and” at the end of sub-  
10 paragraph (I); and

11 (B) by inserting after subparagraph (I) the  
12 following new subparagraph:

13 “(J) will reimburse the Secretary for any  
14 amounts paid by the carrier for an item or service  
15 under this part which is furnished, directed, or pre-  
16 scribed by an individual or entity during any period  
17 for which the individual or entity is excluded pursu-  
18 ant to section 1128, 1128A, or 1156, from partici-  
19 pation in the program under this title, if the  
20 amounts are paid after the Secretary notifies the  
21 carrier of the exclusion, and”.

22 (3) REFERENCE TO MEDICAID PROVISION.—For  
23 provision imposing similar restrictions on States  
24 under the medicaid program under title XIX of the  
25 Social Security Act, see section \_\_\_\_.

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1 (b) CONFORMING REPEAL OF MANDATORY PAYMENT  
2 RULE.—Paragraph (2) of section 1862(e) (42 U.S.C.  
3 1395y(e)) is amended to read as follows:

4 “(2) No individual or entity may bill (or collect any  
5 amount from) any individual for any item or service for  
6 which payment is denied under paragraph (1). No person  
7 is liable for payment of any amounts billed for such an  
8 item or service in violation of the previous sentence.”.

9 (c) EFFECTIVE DATES.—The amendments made by  
10 this section shall apply to contracts and agreements en-  
11 tered into, renewed, or extended after the date of the en-  
12 actment of this Act, but only with respect to claims sub-  
13 mitted on or after the later of January 1, 1998, or the  
14 date such entry, renewal, or extension becomes effective.

15 **SEC. 10305. EXCLUSION OF ENTITY CONTROLLED BY FAM-  
16 ILY MEMBER OF A SANCTIONED INDIVIDUAL.**

17 (a) IN GENERAL.—Section 1128 (42 U.S.C. 1320a-  
18 7) is amended—

19 (1) in subsection (b)(8)(A)—

20 (A) by striking “or” at the end of clause  
21 (i), and

22 (B) by striking the dash at the end of  
23 clause (ii) and inserting “; or”, and

24 (C) by inserting after clause (ii) the follow-  
25 ing:

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1           “(iii) who was described in clause (i) but  
2           is no longer so described because of a transfer  
3           of ownership or control interest, in anticipation  
4           of (or following) a conviction, assessment, or ex-  
5           clusion described in subparagraph (B) against  
6           the person, to an immediate family member (as  
7           defined in subsection (j)(1)) or a member of the  
8           household of the person (as defined in sub-  
9           section (j)(2)) who continues to maintain an in-  
10          terest described in such clause—”; and

11          (2) by adding after subsection (i) the following  
12          new subsection:

13          “(j) DEFINITION OF IMMEDIATE FAMILY MEMBER  
14          AND MEMBER OF HOUSEHOLD.—For purposes of sub-  
15          section (b)(8)(A)(iii):

16                 “(1) The term ‘immediate family member’  
17                 means, with respect to a person—

18                         “(A) the husband or wife of the person;

19                         “(B) the natural or adoptive parent, child,  
20                         or sibling of the person;

21                         “(C) the stepparent, stepchild, stepbrother,  
22                         or stepsister of the person;

23                         “(D) the father-, mother-, daughter-, son-  
24                         , brother-, or sister-in-law of the person;

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1           “(E) the grandparent or grandchild of the  
2           person; and

3           “(F) the spouse of a grandparent or  
4           grandchild of the person.

5           “(2) The term ‘member of the household’  
6           means, with respect to an person, any individual  
7           sharing a common abode as part of a single family  
8           unit with the person, including domestic employees  
9           and others who live together as a family unit, but  
10          not including a roomer or boarder.”.

11          (b) EFFECTIVE DATE.—The amendments made by  
12          subsection (a) shall take effect on the date that is 45 days  
13          after the date of the enactment of this Act.

14          **SEC. 10306. IMPOSITION OF CIVIL MONEY PENALTIES.**

15          (a) CIVIL MONEY PENALTIES FOR PERSONS THAT  
16          CONTRACT WITH EXCLUDED INDIVIDUALS.—Section  
17          1128A(a) (42 U.S.C. 1320a-7a(a)) is amended—

18                  (1) by striking “or” at the end of paragraph  
19                  (4);

20                  (2) by adding “or” at the end of paragraph (5);  
21                  and

22                  (3) by adding after paragraph (5) the following  
23                  new paragraph:

24                  “(6) arranges or contracts (by employment or  
25                  otherwise) with an individual or entity that the per-

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1 son knows or should know is excluded from partici-  
2 pation in a Federal health care program (as defined  
3 in section 1128B(f)), for the provision of items or  
4 services for which payment may be made under such  
5 a program;”.

6 (b) CIVIL MONEY PENALTIES FOR SERVICES OR-  
7 DERED OR PRESCRIBED BY AN EXCLUDED INDIVIDUAL  
8 OR ENTITY.—Section 1128A(a)(1) (42 U.S.C. 1320a-  
9 7a(a)(1)) is amended—

10 (1) in subparagraph (D)—

11 (A) by inserting “, ordered, or prescribed  
12 by such person” after “other item or service  
13 furnished”;

14 (B) by inserting “(pursuant to this title or  
15 title XVIII)” after “period in which the person  
16 was excluded”; and

17 (C) by striking “pursuant to a determina-  
18 tion by the Secretary” and all that follows  
19 through “the provisions of section 1842(j)(2)”;  
20 and

21 (D) by striking “or” at the end;

22 (2) by redesignating subparagraph (E) as sub-  
23 paragraph (F); and

24 (3) by inserting after subparagraph (D) the fol-  
25 lowing new subparagraph:



1           “(E) is for a medical or other item or serv-  
2           ice ordered or prescribed by a person excluded  
3           (pursuant to this title or title XVIII) from the  
4           program under which the claim was made, and  
5           the person furnishing such item or service  
6           knows or should know of such exclusion, or”.

7           (c) EFFECTIVE DATES.—

8           (1) CONTRACTS WITH EXCLUDED PERSONS.—

9           The amendments made by subsection (a) shall apply  
10          to arrangements and contracts entered into after the  
11          date of the enactment of this Act.

12          (2) SERVICES ORDERED OR PRESCRIBED.—The  
13          amendments made by subsection (b) shall apply to  
14          items and services furnished ordered or prescribed  
15          after the date of the enactment of this Act.

16 **SEC. 10307. DISCLOSURE OF INFORMATION AND SURETY**  
17 **BONDS.**

18          (a) DISCLOSURE OF INFORMATION AND SURETY  
19 BOND REQUIREMENT FOR SUPPLIERS OF DURABLE MED-  
20 ICAL EQUIPMENT.—Section 1834(a) (42 U.S.C.  
21 1395m(a)) is amended by inserting after paragraph (15)  
22 the following new paragraph:

23           “(16) CONDITIONS FOR ISSUANCE OF PROVIDER  
24          NUMBER.—The Secretary shall not provide for the  
25          issuance (or renewal) of a provider number for a

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1 supplier of durable medical equipment, for purposes  
2 of payment under this part for durable medical  
3 equipment furnished by the supplier, unless the sup-  
4 plier provides the Secretary on a continuing basis  
5 with—

6 “(A)(i) full and complete information as to  
7 the identity of each person with an ownership  
8 or control interest (as defined in section  
9 1124(a)(3)) in the supplier or in any sub-  
10 contractor (as defined by the Secretary in regu-  
11 lations) in which the supplier directly or indi-  
12 rectly has a 5 percent or more ownership inter-  
13 est, and

14 “(ii) to the extent determined to be feasible  
15 under regulations of the Secretary, the name of  
16 any disclosing entity (as defined in section  
17 1124(a)(2)) with respect to which a person with  
18 such an ownership or control interest in the  
19 supplier is a person with such an ownership or  
20 control interest in the disclosing entity; and

21 “(B) a surety bond in a form specified by  
22 the Secretary and in an amount that is not less  
23 than \$50,000.

24 The Secretary may waive the requirement of a bond  
25 under subparagraph (B) in the case of a supplier

1 that provides a comparable surety bond under State  
2 law.”.

3 (b) SURETY BOND REQUIREMENT FOR HOME  
4 HEALTH AGENCIES.—

5 (1) IN GENERAL.—Section 1861(o) (42 U.S.C.  
6 1395x(o)) is amended—

7 (A) in paragraph (7), by inserting “and in-  
8 cluding providing the Secretary on a continuing  
9 basis with a surety bond in a form specified by  
10 the Secretary and in an amount that is not less  
11 than \$50,000” after “financial security of the  
12 program”, and

13 (B) by adding at the end the following:  
14 “The Secretary may waive the requirement of a  
15 bond under paragraph (7) in the case of an  
16 agency or organization that provides a com-  
17 parable surety bond under State law.”.

18 (2) CONFORMING AMENDMENTS.—Section  
19 1861(v)(1)(H) (42 U.S.C. 1395x(v)(1)(H)) is  
20 amended—

21 (A) in clause (i), by striking “the financial  
22 security requirement” and inserting “the finan-  
23 cial security and surety bond requirements”;  
24 and

1 (B) in clause (ii), by striking “the financial  
2 security requirement described in subsection  
3 (o)(7) applies” and inserting “the financial se-  
4 curity and surety bond requirements described  
5 in subsection (o)(7) apply”.

6 (3) REFERENCE TO CURRENT DISCLOSURE RE-  
7 QUIREMENT.—For provision of current law requiring  
8 home health agencies to disclose information on  
9 ownership and control interests, see section 1124 of  
10 the Social Security Act.

11 (c) AUTHORIZING APPLICATION OF DISCLOSURE AND  
12 SURETY BOND REQUIREMENTS TO AMBULANCE SERV-  
13 ICES AND CERTAIN CLINICS.—Section 1834(a)(16) (42  
14 U.S.C. 1395m(a)(16)), as added by subsection (a), is  
15 amended by adding at the end the following: “The Sec-  
16 retary, in the Secretary’s discretion, may impose the re-  
17 quirements of the previous sentence with respect to some  
18 or all classes of suppliers of ambulance services described  
19 in section 1861(s)(7) and clinics that furnish medical and  
20 other health services (other than physicians’ services)  
21 under this part.”.

22 (d) APPLICATION TO COMPREHENSIVE OUTPATIENT  
23 REHABILITATION FACILITIES (CORFs).—Section  
24 1861(cc)(2) (42 U.S.C. 1395x(cc)(2)) is amended—

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1 (1) in subparagraph (I), by inserting before the  
2 period at the end the following: “and providing the  
3 Secretary on a continuing basis with a surety bond  
4 in a form specified by the Secretary and in an  
5 amount that is not less than \$50,000”, and

6 (2) by adding after and below subparagraph (I)  
7 the following:

8 “The Secretary may waive the requirement of a bond  
9 under subparagraph (I) in the case of a facility that pro-  
10 vides a comparable surety bond under State law.”.

11 (e) APPLICATION TO REHABILITATION AGENCIES.—  
12 Section 1861(p) (42 U.S.C. 1395x(p)) is amended—

13 (1) in paragraph (4)(A)(v), by inserting after  
14 “as the Secretary may find necessary,” the follow-  
15 ing: “and provides the Secretary, to the extent re-  
16 quired by the Secretary, on a continuing basis with  
17 a surety bond in a form specified by the Secretary  
18 and in an amount that is not less than \$50,000,”,  
19 and

20 (2) by adding at the end the following: “The  
21 Secretary may waive the requirement of a bond  
22 under paragraph (4)(A)(v) in the case of a clinic or  
23 agency that provides a comparable surety bond  
24 under State law.”.

1 (f) EFFECTIVE DATES.—(1) The amendment made  
2 by subsection (a) shall apply to suppliers of durable medi-  
3 cal equipment with respect to such equipment furnished  
4 on or after January 1, 1998.

5 (2) The amendments made by subsection (b) shall  
6 apply to home health agencies with respect to services fur-  
7 nished on or after such date. The Secretary of Health and  
8 Human Services shall modify participation agreements  
9 under section 1866(a)(1) of the Social Security Act with  
10 respect to home health agencies to provide for implementa-  
11 tion of such amendments on a timely basis.

12 (3) The amendments made by subsections (c)  
13 through (e) shall take effect on the date of the enactment  
14 of this Act and may be applied with respect to items and  
15 services furnished on or after the date specified in para-  
16 graph (1).

17 **SEC. 10308. PROVISION OF CERTAIN IDENTIFICATION NUM-**  
18 **BERS.**

19 (a) REQUIREMENTS TO DISCLOSE EMPLOYER IDEN-  
20 TIFICATION NUMBERS (EINS) AND SOCIAL SECURITY AC-  
21 COUNT NUMBERS (SSNs).—Section 1124(a)(1) (42  
22 U.S.C. 1320a–3(a)(1)) is amended by inserting before the  
23 period at the end the following: “and supply the Secretary  
24 with the both the employer identification number (as-  
25 signed pursuant to section 6109 of the Internal Revenue

1 Code of 1986) and social security account number (as-  
2 signed under section 205(c)(2)(B)) of the disclosing en-  
3 tity, each person with an ownership or control interest (as  
4 defined in subsection (a)(3)), and any subcontractor in  
5 which the entity directly or indirectly has a 5 percent or  
6 more ownership interest”.

7 (b) OTHER MEDICARE PROVIDERS.—Section 1124A  
8 (42 U.S.C. 1320a–3a) is amended—

9 (1) in subsection (a)—

10 (A) by striking “and” at the end of para-  
11 graph (1);

12 (B) by striking the period at the end of  
13 paragraph (2) and inserting “; and”; and

14 (C) by adding at the end the following new  
15 paragraph:

16 “(3) including the employer identification num-  
17 ber (assigned pursuant to section 6109 of the Inter-  
18 nal Revenue Code of 1986) and social security ac-  
19 count number (assigned under section 205(c)(2)(B))  
20 of the disclosing part B provider and any person,  
21 managing employee, or other entity identified or de-  
22 scribed under paragraph (1) or (2).”; and

23 (2) in subsection (c) by inserting “(or, for pur-  
24 poses of subsection (a)(3), any entity receiving pay-  
25 ment)” after “on an assignment-related basis”.

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1 (c) VERIFICATION BY SOCIAL SECURITY ADMINIS-  
2 TRATION (SSA).—Section 1124A (42 U.S.C. 1320a–3a) is  
3 amended—

4 (1) by redesignating subsection (c) as sub-  
5 section (d); and

6 (2) by inserting after subsection (b) the follow-  
7 ing new subsection:

8 “(c) VERIFICATION.—

9 “(1) TRANSMITTAL BY HHS.—The Secretary  
10 shall transmit—

11 “(A) to the Commissioner of Social Secu-  
12 rity information concerning each social security  
13 account number (assigned under section  
14 205(c)(2)(B)), and

15 “(B) to the Secretary of the Treasury in-  
16 formation concerning each employer identifica-  
17 tion number (assigned pursuant to section 6109  
18 of the Internal Revenue Code of 1986),

19 supplied to the Secretary pursuant to subsection  
20 (a)(3) or section 1124(c) to the extent necessary for  
21 verification of such information in accordance with  
22 paragraph (2).

23 “(2) VERIFICATION.—The Commissioner of So-  
24 cial Security and the Secretary of the Treasury shall  
25 verify the accuracy of, or correct, the information



1 supplied by the Secretary to such official pursuant  
2 to paragraph (1), and shall report such verifications  
3 or corrections to the Secretary.

4 “(3) FEES FOR VERIFICATION.—The Secretary  
5 shall reimburse the Commissioner and Secretary of  
6 the Treasury, at a rate negotiated between the Sec-  
7 retary and such official, for the costs incurred by  
8 such official in performing the verification and cor-  
9 rection services described in this subsection.”.

10 (d) REPORT.—The Secretary of Health and Human  
11 Services shall submit to Congress a report on steps the  
12 Secretary has taken to assure the confidentiality of social  
13 security account numbers that will be provided to the Sec-  
14 retary under the amendments made by this section.

15 (e) EFFECTIVE DATES.—

16 (1) The amendment made by subsection (a)  
17 shall apply to the application of conditions of partici-  
18 pation, and entering into and renewal of contracts  
19 and agreements, occurring more than 90 days after  
20 the date of submission of the report under sub-  
21 section (d).

22 (2) The amendments made by subsection (b)  
23 shall apply to payment for items and services fur-  
24 nished more than 90 days after the date of submis-  
25 sion of such report.

1 **SEC. 10309. ADVISORY OPINIONS REGARDING CERTAIN**  
2 **PHYSICIAN SELF-REFERRAL PROVISIONS.**

3 Section 1877(g) (42 U.S.C. 1395nn(g)) is amended  
4 by adding at the end the following new paragraph:

5 “(6) ADVISORY OPINIONS.—

6 “(A) IN GENERAL.—The Secretary shall  
7 issue written advisory opinions concerning  
8 whether a referral relating to designated health  
9 services (other than clinical laboratory services)  
10 is prohibited under this section.

11 “(B) BINDING AS TO SECRETARY AND  
12 PARTIES INVOLVED.—Each advisory opinion is-  
13 sued by the Secretary shall be binding as to the  
14 Secretary and the party or parties requesting  
15 the opinion.

16 “(C) APPLICATION OF CERTAIN PROCE-  
17 DURES.—The Secretary shall, to the extent  
18 practicable, apply the regulations promulgated  
19 under section 1128D(b)(5) to the issuance of  
20 advisory opinions under this paragraph.

21 “(D) APPLICABILITY.—This paragraph  
22 shall apply to requests for advisory opinions  
23 made during the period described in section  
24 1128D(b)(6).”.

1 **SEC. 10310. OTHER FRAUD AND ABUSE RELATED PROVI-**  
2 **SIONS.**

3 (a) REFERENCE CORRECTION.—(1) Section  
4 1128D(b)(2)(D) (42 U.S.C. 1320a–7d(b)(2)(D)), as  
5 added by section 205 of the Health Insurance Portability  
6 and Accountability Act of 1996, is amended by striking  
7 “1128B(b)” and inserting “1128A(b)”.

8 (2) Section 1128E(g)(3)(C) (42 U.S.C. 1320a–  
9 7e(g)(3)(C)) is amended by striking “Veterans’ Adminis-  
10 tration” and inserting “Department of Veterans Affairs”.

11 (b) LANGUAGE IN DEFINITION OF CONVICTION.—  
12 Section 1128E(g)(5) (42 U.S.C. 1320a–7e(g)(5)), as in-  
13 serted by section 221(a) of the Health Insurance Port-  
14 ability and Accountability Act of 1996, is amended by  
15 striking “paragraph (4)” and inserting “paragraphs (1)  
16 through (4)”.

17 (c) IMPLEMENTATION OF EXCLUSIONS.—Section  
18 1128 (42 U.S.C. 1320a–7) is amended—

19 (1) in subsection (a), by striking “any program  
20 under title XVIII and shall direct that the following  
21 individuals and entities be excluded from participa-  
22 tion in any State health care program (as defined in  
23 subsection (h))” and inserting “any Federal health  
24 care program (as defined in section 1128B(f))”; and

25 (2) in subsection (b), by striking “any program  
26 under title XVIII and may direct that the following

1 individuals and entities be excluded from participa-  
2 tion in any State health care program” and inserting  
3 “any Federal health care program (as defined in  
4 section 1128B(f))”.

5 (d) SANCTIONS FOR FAILURE TO REPORT.—Section  
6 1128E(b) (42 U.S.C. 1320a–7e(b)), as inserted by section  
7 221(a) of the Health Insurance Portability and Account-  
8 ability Act of 1996, is amended by adding at the end the  
9 following:

10 “(6) SANCTIONS FOR FAILURE TO REPORT.—

11 “(A) HEALTH PLANS.—Any health plan  
12 that fails to report information on an adverse  
13 action required to be reported under this sub-  
14 section shall be subject to a civil money penalty  
15 of not more than \$25,000 for each such adverse  
16 action not reported. Such penalty shall be im-  
17 posed and collected in the same manner as civil  
18 money penalties under subsection (a) of section  
19 1128A are imposed and collected under that  
20 section.

21 “(B) GOVERNMENTAL AGENCIES.—The  
22 Secretary shall provide for a publication of a  
23 public report that identifies those Government  
24 agencies that have failed to report information

1 on adverse actions as required to be reported  
2 under this subsection.”.

3 (e) EFFECTIVE DATES.—

4 (1) IN GENERAL.—Except as provided in this  
5 subsection, the amendments made by this section  
6 shall be effective as if included in the enactment of  
7 the Health Insurance Portability and Accountability  
8 Act of 1996.

9 (2) FEDERAL HEALTH PROGRAM.—The amend-  
10 ments made by subsection (c) shall take effect on  
11 the date of the enactment of this Act.

12 (3) SANCTION FOR FAILURE TO REPORT.—The  
13 amendment made by subsection (d) shall apply to  
14 failures occurring on or after the date of the enact-  
15 ment of this Act.

16 **Subtitle E—Prospective Payment**  
17 **Systems**

18 **CHAPTER 1—PAYMENT UNDER PART A**

19 **SEC. 10401. PROSPECTIVE PAYMENT FOR SKILLED NURS-**  
20 **ING FACILITY SERVICES.**

21 (a) IN GENERAL.—Section 1888 (42 U.S.C. 1395yy)  
22 is amended by adding at the end the following new sub-  
23 section:

24 “(e) PROSPECTIVE PAYMENT.—

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1           “(1) PAYMENT PROVISION.—Notwithstanding  
2 any other provision of this title, subject to para-  
3 graph (7), the amount of the payment for all costs  
4 (as defined in paragraph (2)(B)) of covered skilled  
5 nursing facility services (as defined in paragraph  
6 (2)(A)) for each day of such services furnished—

7           “(A) in a cost reporting period during the  
8 transition period (as defined in paragraph  
9 (2)(E)), is equal to the sum of—

10           “(i) the non-Federal percentage of the  
11 facility-specific per diem rate (computed  
12 under paragraph (3)), and

13           “(ii) the Federal percentage of the ad-  
14 justed Federal per diem rate (determined  
15 under paragraph (4)) applicable to the fa-  
16 cility; and

17           “(B) after the transition period is equal to  
18 the adjusted Federal per diem rate applicable to  
19 the facility.

20           “(2) DEFINITIONS.—For purposes of this sub-  
21 section:

22           “(A) COVERED SKILLED NURSING FACIL-  
23 ITY SERVICES.—

24           “(i) IN GENERAL.—The term ‘covered  
25 skilled nursing facility services’—

**[HVAC Reconciliation]**

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1           “(I) means post-hospital ex-  
2           tended care services as defined in sec-  
3           tion 1861(i) for which benefits are  
4           provided under part A; and

5           “(II) includes all items and serv-  
6           ices (other than services described in  
7           clause (ii)) for which payment may be  
8           made under part B and which are fur-  
9           nished to an individual who is a resi-  
10          dent of a skilled nursing facility dur-  
11          ing the period in which the individual  
12          is provided covered post-hospital ex-  
13          tended care services.

14          “(ii) SERVICES EXCLUDED.—Services  
15          described in this clause are physicians’  
16          services, services described by clauses (i)  
17          through (iii) of section 1861(s)(2)(K), cer-  
18          tified nurse-midwife services, qualified psy-  
19          chologist services, services of a certified  
20          registered nurse anesthetist, items and  
21          services described in subparagraphs in (F)  
22          and (O) of section 1861(s)(2), and, only  
23          with respect to services furnished during  
24          1998, the transportation costs of  
25          electrocardiogram equipment for electro-

[HVAC Reconciliation]

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1           cardiogram tests services (HCPCS Code  
2           R0076). Services described in this clause  
3           do not include any physical, occupational,  
4           or speech-language therapy services re-  
5           gardless of whether or not the services are  
6           furnished by, or under the supervision of,  
7           a physician or other health care profes-  
8           sional.

9           “(B) ALL COSTS.—The term ‘all costs’  
10          means routine service costs, ancillary costs, and  
11          capital-related costs of covered skilled nursing  
12          facility services, but does not include costs asso-  
13          ciated with approved educational activities.

14          “(C) NON-FEDERAL PERCENTAGE; FED-  
15          ERAL PERCENTAGE.—For—

16               “(i) the first cost reporting period (as  
17               defined in subparagraph (D)) of a facility,  
18               the ‘non-Federal percentage’ is 75 percent  
19               and the ‘Federal percentage’ is 25 percent;

20               “(ii) the next cost reporting period of  
21               such facility, the ‘non-Federal percentage’  
22               is 50 percent and the ‘Federal percentage’  
23               is 50 percent; and

24               “(iii) the subsequent cost reporting  
25               period of such facility, the ‘non-Federal



**[HVAC Reconciliation]**

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1 percentage' is 25 percent and the 'Federal  
2 percentage' is 75 percent.

3 “(D) FIRST COST REPORTING PERIOD.—

4 The term 'first cost reporting period' means,  
5 with respect to a skilled nursing facility, the  
6 first cost reporting period of the facility begin-  
7 ning on or after July 1, 1998.

8 “(E) TRANSITION PERIOD.—

9 “(i) IN GENERAL.—The term 'transi-  
10 tion period' means, with respect to a  
11 skilled nursing facility, the 3 cost reporting  
12 periods of the facility beginning with the  
13 first cost reporting period.

14 “(ii) TREATMENT OF NEW SKILLED  
15 NURSING FACILITIES.—In the case of a  
16 skilled nursing facility that does not have  
17 a settled cost report for a cost reporting  
18 period before July 1, 1998, payment for  
19 such services shall be made under this sub-  
20 section as if all services were furnished  
21 after the transition period.

22 “(3) DETERMINATION OF FACILITY SPECIFIC  
23 PER DIEM RATES.—The Secretary shall determine a  
24 facility-specific per diem rate for each skilled nurs-  
25 ing facility for a cost reporting period as follows:

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1           “(A) DETERMINING BASE PAYMENTS.—  
2           The Secretary shall determine, on a per diem  
3           basis, the total of—

4                   “(i) the allowable costs of extended  
5                   care services for the facility for cost report-  
6                   ing periods beginning in 1995 with appro-  
7                   priate adjustments (as determined by the  
8                   Secretary) to non-settled cost reports, and

9                   “(ii) an estimate of the amounts that  
10                  would be payable under part B (disregard-  
11                  ing any applicable deductibles, coinsurance  
12                  and copayments) for covered skilled nurs-  
13                  ing facility services described in paragraph  
14                  (2)(A)(i)(II) furnished during such period  
15                  to an individual who is a resident of the fa-  
16                  cility, regardless of whether or not the pay-  
17                  ment was made to the facility or to an-  
18                  other entity.

19                  “(B) UPDATE TO COST REPORTING PE-  
20                  RIOD BEFORE FIRST COST REPORTING PE-  
21                  RIOD.—The Secretary shall update the amount  
22                  determined under subparagraph (A), for each  
23                  cost reporting period after the cost reporting  
24                  period described in subparagraph (A)(i) and up  
25                  to the cost reporting period immediately preced-

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1 ing the first cost reporting period, by the skilled  
2 nursing facility historical trend factor.

3 “(C) UPDATING TO APPLICABLE COST RE-  
4 PORTING PERIOD.—The Secretary shall further  
5 update such amount for each cost reporting pe-  
6 riod beginning with the first cost reporting pe-  
7 riod and up to and including the cost reporting  
8 period involved by a factor equal to the skilled  
9 nursing facility market basket percentage in-  
10 crease.

11 “(4) FEDERAL PER DIEM RATE.—

12 “(A) DETERMINATION OF HISTORICAL PER  
13 DIEM FOR FREESTANDING FACILITIES.—For  
14 each freestanding skilled nursing facility that  
15 received payments for post-hospital extended  
16 care services during a cost reporting period be-  
17 ginning in fiscal year 1995 and that was sub-  
18 ject to (and not exempted from) the per diem  
19 limits referred to in paragraph (1) or (2) of  
20 subsection (a) (and facilities described in sub-  
21 section (d), if appropriate), the Secretary shall  
22 estimate, on a per diem basis for such cost re-  
23 porting period, the total of—

24 “(i) the allowable costs of extended  
25 care services for the facility for cost report-

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1 ing periods beginning in 1995 with appro-  
2 priate adjustments (as determined by the  
3 Secretary) to non-settled cost reports, and  
4 “(ii) an estimate of the amounts that  
5 would be payable under part B (disregard-  
6 ing any applicable deductibles, coinsurance  
7 and copayments) for covered skilled nurs-  
8 ing facility services described in paragraph  
9 (2)(A)(i)(II) furnished during such period  
10 to an individual who is a resident of the fa-  
11 cility, regardless of whether or not the pay-  
12 ment was made to the facility or to an-  
13 other entity.

14 “(B) UPDATE TO FISCAL YEAR 1998.—The  
15 Secretary shall update the amount determined  
16 under subparagraph (A), for each cost report-  
17 ing period after the cost reporting period de-  
18 scribed in subparagraph (A)(i) and up to the  
19 cost reporting period immediately preceding the  
20 first cost reporting period, by the skilled nurs-  
21 ing facility historical trend factor for such pe-  
22 riod.

23 “(C) COMPUTATION OF STANDARDIZED  
24 PER DIEM RATE.—The Secretary shall stand-

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1           ardize the amount updated under subparagraph  
2           (B) for each facility by—

3                   “(i) adjusting for variations among  
4                   facility by area in the average facility wage  
5                   level per diem, and

6                   “(ii) adjusting for variations in case  
7                   mix per diem among facilities.

8           “(D) COMPUTATION OF WEIGHTED AVER-  
9           AGE PER DIEM RATE.—The Secretary shall  
10           compute a weighted average per diem rate by  
11           computing an average of the standardized  
12           amounts computed under subparagraph (C),  
13           weighted for each facility by number of days of  
14           extended care services furnished during the cost  
15           reporting period referred to in subparagraph  
16           (A). The Secretary may compute and apply  
17           such average separately for facilities located in  
18           urban and rural areas (as defined in section  
19           1886(d)(2)(D)).

20           “(E) UPDATING.—

21                   “(i) FISCAL YEAR 1998.—For fiscal  
22                   year 1998, the Secretary shall compute for  
23                   each skilled nursing facility an unadjusted  
24                   Federal per diem rate equal to the weight-  
25                   ed average per diem rate computed under

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1 subparagraph (D) and applicable to the fa-  
2 cility increased by skilled nursing facility  
3 market basket percentage change for the  
4 fiscal year involved.

5 “(ii) SUBSEQUENT FISCAL YEARS.—  
6 For each subsequent fiscal year the Sec-  
7 retary shall compute for each skilled nurs-  
8 ing facility an unadjusted Federal per diem  
9 rate equal to the Federal per diem rate  
10 computed under this subparagraph for the  
11 previous fiscal year and applicable to the  
12 facility increased by the skilled nursing fa-  
13 cility market basket percentage change for  
14 the fiscal year involved.

15 “(F) ADJUSTMENT FOR CASE MIX  
16 CREEP.—Insofar as the Secretary deter-  
17 mines that such adjustments under sub-  
18 paragraph (G)(i) for a previous fiscal year  
19 (or estimates that such adjustments for a  
20 future fiscal year) did (or are likely to) re-  
21 sult in a change in aggregate payments  
22 under this subsection during the fiscal year  
23 that are a result of changes in the coding  
24 or classification of residents that do not re-  
25 flect real changes in case mix, the Sec-

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1           retary may adjust unadjusted Federal per  
2           diem rates for subsequent years so as to  
3           discount the effect of such coding or classi-  
4           fication changes.

5           “(G) APPLICATION TO SPECIFIC FACILI-  
6           TIES.—The Secretary shall compute for each  
7           skilled nursing facility for each fiscal year (be-  
8           ginning with fiscal year 1998) an adjusted Fed-  
9           eral per diem rate equal to the unadjusted Fed-  
10          eral per diem rate determined under subpara-  
11          graph (E), as adjusted under subparagraph  
12          (F), and as further adjusted as follows:

13           “(i) ADJUSTMENT FOR CASE MIX.—  
14           The Secretary shall provide for an appro-  
15           priate adjustment to account for case mix.  
16           Such adjustment shall be based on a resi-  
17           dent classification system, established by  
18           the Secretary, that accounts for the rel-  
19           ative resource utilization of different pa-  
20           tient types. The case mix adjustment shall  
21           be based on resident assessment data and  
22           other data that the Secretary considers ap-  
23           propriate.

24           “(ii) ADJUSTMENT FOR GEOGRAPHIC  
25           VARIATIONS IN LABOR COSTS.—The Sec-

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1           retary shall adjust the portion of such per  
2           diem rate attributable to wages and wage-  
3           related costs for the area in which the fa-  
4           cility is located compared to the national  
5           average of such costs using an appropriate  
6           wage index as determined by the Sec-  
7           retary. Such adjustment shall be done in a  
8           manner that does not result in aggregate  
9           payments under this subsection that are  
10          greater or less than those that would oth-  
11          erwise be made if such adjustment had not  
12          been made.

13           “(H) PUBLICATION OF INFORMATION ON  
14          PER DIEM RATES.—The Secretary shall provide  
15          for publication in the Federal Register, before  
16          the July 1 preceding each fiscal year (beginning  
17          with fiscal year 1999), of—

18                   “(i) the unadjusted Federal per diem  
19                   rates to be applied to days of covered  
20                   skilled nursing facility services furnished  
21                   during the fiscal year,

22                   “(ii) the case mix classification system  
23                   to be applied under subparagraph (G)(i)  
24                   with respect to such services during the  
25                   fiscal year, and



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1           “(iii) the factors to be applied in mak-  
2           ing the area wage adjustment under sub-  
3           paragraph (G)(ii) with respect to such  
4           services.

5           “(5) SKILLED NURSING FACILITY MARKET BAS-  
6           KET INDEX, PERCENTAGE, AND HISTORICAL TREND  
7           FACTOR.—For purposes of this subsection:

8           “(A) SKILLED NURSING FACILITY MARKET  
9           BASKET INDEX.—The Secretary shall establish  
10          a skilled nursing facility market basket index  
11          that reflects changes over time in the prices of  
12          an appropriate mix of goods and services in-  
13          cluded in covered skilled nursing facility serv-  
14          ices.

15          “(B) SKILLED NURSING FACILITY MARKET  
16          BASKET PERCENTAGE.—The term ‘skilled nurs-  
17          ing facility market basket percentage’ means,  
18          for a fiscal year or other annual period and as  
19          calculated by the Secretary, the percentage  
20          change in the skilled nursing facility market  
21          basket index (established under subparagraph  
22          (A)) from the midpoint of the prior fiscal year  
23          (or period) to the midpoint of the fiscal year (or  
24          other period) involved.

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1           “(C) SKILLED NURSING FACILITY HISTORI-  
2           CAL TREND FACTOR.—The term ‘skilled nurs-  
3           ing facility historical trend factor’ means, for a  
4           fiscal year or other annual period and as cal-  
5           culated by the Secretary, the percentage change  
6           in the skilled nursing facility routine cost index  
7           (used in applying per diem routine cost limits  
8           under subsection (a)) from the midpoint of the  
9           prior fiscal year (or period) to the midpoint of  
10          the fiscal year (or other period) involved, re-  
11          duced (on an annualized basis) by 1 percentage  
12          point.

13          “(6) SUBMISSION OF RESIDENT ASSESSMENT  
14          DATA.—A skilled nursing facility shall provide the  
15          Secretary, in a manner and within the timeframes  
16          prescribed by the Secretary, the resident assessment  
17          data necessary to develop and implement the rates  
18          under this subsection. For purposes of meeting such  
19          requirement, a skilled nursing facility may submit  
20          the resident assessment data required under section  
21          1819(b)(3), using the standard instrument des-  
22          ignated by the State under section 1819(e)(5).

23          “(7) TRANSITION FOR MEDICARE LOW VOLUME  
24          SKILLED NURSING FACILITIES AND SWING BED HOS-  
25          PITALS.—

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1           “(A) IN GENERAL.—The Secretary shall  
2 determine an appropriate manner in which to  
3 apply this subsection to the facilities described  
4 in subparagraph (B), taking into account the  
5 purposes of this subsection, and shall provide  
6 that at the end of the transition period (as de-  
7 fined in paragraph (2)(E)) such facilities shall  
8 be paid only under this subsection. Payment  
9 shall not be made under this subsection to such  
10 facilities for cost reporting periods beginning  
11 before such date (not earlier than July 1, 1999)  
12 as the Secretary specifies.

13           “(B) FACILITIES DESCRIBED.—The facili-  
14 ties described in this subparagraph are—

15           “(i) skilled nursing facilities for which  
16 payment is made for routine service costs  
17 during a cost reporting period, ending  
18 prior to the date of the implementation of  
19 this paragraph, on the basis of prospective  
20 payments under section 1888(d), or

21           “(ii) facilities that have in effect an  
22 agreement described in section 1883, for  
23 which payment is made for the furnishing  
24 of extended care services on a reasonable

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1 cost basis under section 1814(l) (as in ef-  
2 fect on and after such date).

3 “(8) LIMITATION ON REVIEW.—There shall be  
4 no administrative or judicial review under section  
5 1869, 1878, or otherwise of—

6 “(A) the establishment of facility specific  
7 per diem rates under paragraph (3);

8 “(B) the establishment of Federal per  
9 diem rates under paragraph (4), including the  
10 computation of the standardized per diem rates  
11 under paragraph (4)(C), adjustments and cor-  
12 rections for case mix under paragraphs (4)(F)  
13 and (4)(G)(i), and adjustments for variations in  
14 labor-related costs under paragraph (4)(G)(ii);  
15 and

16 “(C) the establishment of transitional  
17 amounts under paragraph (7).”.

18 (b) CONSOLIDATED BILLING.—

19 (1) FOR SNF SERVICES.—Section 1862(a) (42  
20 U.S.C. 1395y(a)) is amended—

21 (A) by striking “or” at the end of para-  
22 graph (15),

23 (B) by striking the period at the end of  
24 paragraph (16) and inserting “; or”, and

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1 (C) by inserting after paragraph (16) the  
2 following new paragraph:

3 “(17) which are covered skilled nursing facility  
4 services described in section 1888(e)(2)(A)(i) and  
5 which are furnished to an individual who is a resi-  
6 dent of a skilled nursing facility by an entity other  
7 than the skilled nursing facility, unless the services  
8 are furnished under arrangements (as defined in sec-  
9 tion 1861(w)(1)) with the entity made by the skilled  
10 nursing facility.”.

11 (2) REQUIRING PAYMENT FOR ALL PART B  
12 ITEMS AND SERVICES TO BE MADE TO FACILITY.—  
13 The first sentence of section 1842(b)(6) (42 U.S.C.  
14 1395u(b)(6)) is amended—

15 (A) by striking “and (D)” and inserting  
16 “(D)”; and

17 (B) by striking the period at the end and  
18 inserting the following: “, and (E) in the case  
19 of an item or service (other than services de-  
20 scribed in section 1888(e)(2)(A)(ii)) furnished  
21 to an individual who (at the time the item or  
22 service is furnished) is a resident of a skilled  
23 nursing facility, payment shall be made to the  
24 facility (without regard to whether or not the  
25 item or service was furnished by the facility, by

1 others under arrangement with them made by  
2 the facility, under any other contracting or con-  
3 sulting arrangement, or otherwise).”.

4 (3) PAYMENT RULES.—Section 1888(e) (42  
5 U.S.C. 1395yy(e)), as added by subsection (a), is  
6 amended by adding at the end the following:

7 “(9) PAYMENT FOR CERTAIN SERVICES.—In  
8 the case of an item or service furnished by a skilled  
9 nursing facility (or by others under arrangement  
10 with them made by a skilled nursing facility or  
11 under any other contracting or consulting arrange-  
12 ment or otherwise) for which payment would other-  
13 wise (but for this paragraph) be made under part B  
14 in an amount determined in accordance with section  
15 1833(a)(2)(B), the amount of the payment under  
16 such part shall be based on such existing or other  
17 fee schedules as the Secretary establishes.

18 “(10) REQUIRED CODING.—No payment may  
19 be made under part B for items and services (other  
20 than services described in paragraph (2)(A)(ii)) fur-  
21 nished to an individual who is a resident of a skilled  
22 nursing facility unless the claim for such payment  
23 includes a code (or codes) under a uniform coding  
24 system specified by the Secretary that identifies the  
25 items or services delivered.”.

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1 (4) CONFORMING AMENDMENTS.—

2 (A) Section 1819(b)(3)(C)(i) (42 U.S.C.  
3 1395i–3(b)(3)(C)(i)) is amended by striking  
4 “Such” and inserting “Subject to the time-  
5 frames prescribed by the Secretary under sec-  
6 tion 1888(t)(6), such”.

7 (B) Section 1832(a)(1) (42 U.S.C.  
8 1395k(a)(1)) is amended by striking “(2);” and  
9 inserting “(2) and section 1842(b)(6)(E);”.

10 (C) Section 1833(a)(2)(B) (42 U.S.C.  
11 1395l(a)(2)(B)) is amended by inserting “or  
12 section 1888(e)(9)” after “section 1886”.

13 (D) Section 1861(h) (42 U.S.C 1395x(h))  
14 is amended—

15 (i) in the opening paragraph, by strik-  
16 ing “paragraphs (3) and (6)” and insert-  
17 ing “paragraphs (3), (6), and (7)”, and

18 (ii) in paragraph (7), after “skilled  
19 nursing facilities”, by inserting “, or by  
20 others under arrangements with them  
21 made by the facility”.

22 (E) Section 1866(a)(1)(H) (42 U.S.C.  
23 1395cc(a)(1)(H)) is amended—

24 (i) by redesignating clauses (i) and

25 (ii) as subclauses (I) and (II) respectively,

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1 (ii) by inserting “(i)” after “(H)”,

2 and

3 (iii) by adding after clause (i), as so

4 redesignated, the following new clause:

5 “(ii) in the case of skilled nursing facilities

6 which provide covered skilled nursing facility serv-

7 ices—

8 “(I) that are furnished to an individual

9 who is a resident of the skilled nursing facility,

10 and

11 “(II) for which the individual is entitled to

12 have payment made under this title,

13 to have items and services (other than services de-

14 scribed in section 1888(e)(2)(A)(ii)) furnished by the

15 skilled nursing facility or otherwise under arrange-

16 ments (as defined in section 1861(w)(1)) made by

17 the skilled nursing facility,”.

18 (c) MEDICAL REVIEW PROCESS.—In order to ensure

19 that medicare beneficiaries are furnished appropriate serv-

20 ices in skilled nursing facilities, the Secretary of Health

21 and Human Services shall establish and implement a thor-

22 ough medical review process to examine the effects of the

23 amendments made by this section on the quality of covered

24 skilled nursing facility services furnished to medicare

25 beneficiaries. In developing such a medical review process,



1 the Secretary shall place a particular emphasis on the  
2 quality of non-routine covered services and physicians'  
3 services for which payment is made under title XVIII of  
4 the Social Security Act for which payment is made under  
5 section 1848 of such Act.

6 (d) EFFECTIVE DATE.—The amendments made by  
7 this section are effective for cost reporting periods begin-  
8 ning on or after July 1, 1998; except that the amendments  
9 made by subsection (b) shall apply to items and services  
10 furnished on or after July 1, 1998.

11 **SEC. 10402. PROSPECTIVE PAYMENT FOR INPATIENT REHA-**  
12 **BILITATION HOSPITAL SERVICES.**

13 (a) IN GENERAL.—Section 1886 (42 U.S.C.  
14 1395ww) is amended by adding at the end the following  
15 new subsection:

16 “(j) PROSPECTIVE PAYMENT FOR INPATIENT REHA-  
17 BILITATION SERVICES.—

18 “(1) PAYMENT DURING TRANSITION PERIOD.—

19 “(A) IN GENERAL.—Notwithstanding sec-  
20 tion 1814(b), but subject to the provisions of  
21 section 1813, the amount of the payment with  
22 respect to the operating and capital costs of in-  
23 patient hospital services of a rehabilitation hos-  
24 pital or a rehabilitation unit (in this subsection  
25 referred to as a ‘rehabilitation facility’), in a

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1 cost reporting period beginning on or after Oc-  
2 tober 1, 2000, and before October 1, 2003, is  
3 equal to the sum of—

4 “(i) the TEFRA percentage (as de-  
5 fined in subparagraph (C)) of the amount  
6 that would have been paid under part A  
7 with respect to such costs if this subsection  
8 did not apply, and

9 “(ii) the prospective payment percent-  
10 age (as defined in subparagraph (C)) of  
11 the product of (I) the per unit payment  
12 rate established under this subsection for  
13 the fiscal year in which the payment unit  
14 of service occurs, and (II) the number of  
15 such payment units occurring in the cost  
16 reporting period.

17 “(B) FULLY IMPLEMENTED SYSTEM.—  
18 Notwithstanding section 1814(b), but subject to  
19 the provisions of section 1813, the amount of  
20 the payment with respect to the operating and  
21 capital costs of inpatient hospital services of a  
22 rehabilitation facility for a payment unit in a  
23 cost reporting period beginning on or after Oc-  
24 tober 1, 2003, is equal to the per unit payment  
25 rate established under this subsection for the

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1 fiscal year in which the payment unit of service  
2 occurs.

3 “(C) TEFRA AND PROSPECTIVE PAYMENT  
4 PERCENTAGES SPECIFIED.—For purposes of  
5 subparagraph (A), for a cost reporting period  
6 beginning—

7 “(i) on or after October 1, 2000, and  
8 before October 1, 2001, the ‘TEFRA per-  
9 centage’ is 75 percent and the ‘prospective  
10 payment percentage’ is 25 percent;

11 “(ii) on or after October 1, 2001, and  
12 before October 1, 2002, the ‘TEFRA per-  
13 centage’ is 50 percent and the ‘prospective  
14 payment percentage’ is 50 percent; and

15 “(iii) on or after October 1, 2002, and  
16 before October 1, 2003, the ‘TEFRA per-  
17 centage’ is 25 percent and the ‘prospective  
18 payment percentage’ is 75 percent.

19 “(D) PAYMENT UNIT.—For purposes of  
20 this subsection, the term ‘payment unit’ means  
21 a discharge, day of inpatient hospital services,  
22 or other unit of payment defined by the Sec-  
23 retary.

24 “(2) PATIENT CASE MIX GROUPS.—

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1           “(A) ESTABLISHMENT.—The Secretary  
2 shall establish—

3           “(i) classes of patients of rehabilita-  
4 tion facilities (each in this subsection re-  
5 ferred to as a ‘case mix group’), based on  
6 such factors as the Secretary deems appro-  
7 priate, which may include impairment, age,  
8 related prior hospitalization, comorbidities,  
9 and functional capability of the patient;  
10 and

11           “(ii) a method of classifying specific  
12 patients in rehabilitation facilities within  
13 these groups.

14           “(B) WEIGHTING FACTORS.—For each  
15 case mix group the Secretary shall assign an  
16 appropriate weighting which reflects the relative  
17 facility resources used with respect to patients  
18 classified within that group compared to pa-  
19 tients classified within other groups.

20           “(C) ADJUSTMENTS FOR CASE MIX.—

21           “(i) IN GENERAL.—The Secretary  
22 shall from time to time adjust the classi-  
23 fications and weighting factors established  
24 under this paragraph as appropriate to re-  
25 flect changes in treatment patterns, tech-

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1 nology, case mix, number of payment units  
2 for which payment is made under this title,  
3 and other factors which may affect the rel-  
4 ative use of resources. Such adjustments  
5 shall be made in a manner so that changes  
6 in aggregate payments under the classifica-  
7 tion system are a result of real changes  
8 and are not a result of changes in coding  
9 that are unrelated to real changes in case  
10 mix.

11 “(ii) ADJUSTMENT.—Insofar as the  
12 Secretary determines that such adjust-  
13 ments for a previous fiscal year (or esti-  
14 mates that such adjustments for a future  
15 fiscal year) did (or are likely to) result in  
16 a change in aggregate payments under the  
17 classification system during the fiscal year  
18 that are a result of changes in the coding  
19 or classification of patients that do not re-  
20 flect real changes in case mix, the Sec-  
21 retary shall adjust the per payment unit  
22 payment rate for subsequent years so as to  
23 discount the effect of such coding or classi-  
24 fication changes.

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1           “(D) DATA COLLECTION.—The Secretary  
2 is authorized to require rehabilitation facilities  
3 that provide inpatient hospital services to sub-  
4 mit such data as the Secretary deems necessary  
5 to establish and administer the prospective pay-  
6 ment system under this subsection.

7           “(3) PAYMENT RATE.—

8           “(A) IN GENERAL.—The Secretary shall  
9 determine a prospective payment rate for each  
10 payment unit for which such rehabilitation fa-  
11 cility is entitled to receive payment under this  
12 title. Subject to subparagraph (B), such rate  
13 for payment units occurring during a fiscal year  
14 shall be based on the average payment per pay-  
15 ment unit under this title for inpatient operat-  
16 ing and capital costs of rehabilitation facilities  
17 using the most recent data available (as esti-  
18 mated by the Secretary as of the date of estab-  
19 lishment of the system) adjusted—

20           “(i) by updating such per-payment-  
21 unit amount to the fiscal year involved by  
22 the weighted average of the applicable per-  
23 centage increases provided under sub-  
24 section (b)(3)(B)(ii) (for cost reporting pe-  
25 riods beginning during the fiscal year) cov-

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1 ering the period from the midpoint of the  
2 period for such data through the midpoint  
3 of fiscal year 2000 and by an increase fac-  
4 tor (described in subparagraph (C)) speci-  
5 fied by the Secretary for subsequent fiscal  
6 years up to the fiscal year involved;

7 “(ii) by reducing such rates by a fac-  
8 tor equal to the proportion of payments  
9 under this subsection (as estimated by the  
10 Secretary) based on prospective payment  
11 amounts which are additional payments de-  
12 scribed in paragraph (4) (relating to  
13 outlier and related payments) or paragraph  
14 (7);

15 “(iii) for variations among rehabilita-  
16 tion facilities by area under paragraph (6);

17 “(iv) by the weighting factors estab-  
18 lished under paragraph (2)(B); and

19 “(v) by such other factors as the Sec-  
20 retary determines are necessary to properly  
21 reflect variations in necessary costs of  
22 treatment among rehabilitation facilities.

23 “(B) BUDGET NEUTRAL RATES.—The Sec-  
24 retary shall establish the prospective payment  
25 amounts under this subsection for payment

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1 units during fiscal years 2001 through 2004 at  
2 levels such that, in the Secretary's estimation,  
3 the amount of total payments under this sub-  
4 section for such fiscal years (including any pay-  
5 ment adjustments pursuant to paragraphs (4),  
6 (6), and (7)) shall be equal to 99 percent of the  
7 amount of payments that would have been  
8 made under this title during the fiscal years for  
9 operating and capital costs of rehabilitation fa-  
10 cilities had this subsection not been enacted. In  
11 establishing such payment amounts, the Sec-  
12 retary shall consider the effects of the prospec-  
13 tive payment system established under this sub-  
14 section on the total number of payment units  
15 from rehabilitation facilities and other factors  
16 described in subparagraph (A).

17 “(C) INCREASE FACTOR.—For purposes of  
18 this subsection for payment units in each fiscal  
19 year (beginning with fiscal year 2001), the Sec-  
20 retary shall establish an increase factor. Such  
21 factor shall be based on an appropriate percent-  
22 age increase in a market basket of goods and  
23 services comprising services for which payment  
24 is made under this subsection, which may be



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1 the market basket percentage increase described  
2 in subsection (b)(3)(B)(iii).

3 “(4) OUTLIER AND SPECIAL PAYMENTS.—

4 “(A) OUTLIERS.—

5 “(i) IN GENERAL.—The Secretary  
6 may provide for an additional payment to  
7 a rehabilitation facility for patients in a  
8 case mix group, based upon the patient  
9 being classified as an outlier based on an  
10 unusual length of stay, costs, or other fac-  
11 tors specified by the Secretary.

12 “(ii) PAYMENT BASED ON MARGINAL  
13 COST OF CARE.—The amount of such addi-  
14 tional payment under clause (i) shall be  
15 determined by the Secretary and shall ap-  
16 proximate the marginal cost of care beyond  
17 the cutoff point applicable under clause (i).

18 “(iii) TOTAL PAYMENTS.—The total  
19 amount of the additional payments made  
20 under this subparagraph for payment units  
21 in a fiscal year may not exceed 5 percent  
22 of the total payments projected or esti-  
23 mated to be made based on prospective  
24 payment rates for payment units in that  
25 year.

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1           “(B) ADJUSTMENT.—The Secretary may  
2           provide for such adjustments to the payment  
3           amounts under this subsection as the Secretary  
4           deems appropriate to take into account the  
5           unique circumstances of rehabilitation facilities  
6           located in Alaska and Hawaii.

7           “(5) PUBLICATION.—The Secretary shall pro-  
8           vide for publication in the Federal Register, on or  
9           before September 1 before each fiscal year (begin-  
10          ning with fiscal year 2001, of the classification and  
11          weighting factors for case mix groups under para-  
12          graph (2) for such fiscal year and a description of  
13          the methodology and data used in computing the  
14          prospective payment rates under this subsection for  
15          that fiscal year.

16          “(6) AREA WAGE ADJUSTMENT.—The Secretary  
17          shall adjust the proportion, (as estimated by the  
18          Secretary from time to time) of rehabilitation facili-  
19          ties’ costs which are attributable to wages and wage-  
20          related costs, of the prospective payment rates com-  
21          puted under paragraph (3) for area differences in  
22          wage levels by a factor (established by the Sec-  
23          retary) reflecting the relative hospital wage level in  
24          the geographic area of the rehabilitation facility  
25          compared to the national average wage level for such

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1 facilities. Not later than October 1, 2001 (and at  
2 least every 36 months thereafter), the Secretary  
3 shall update the factor under the preceding sentence  
4 on the basis of a survey conducted by the Secretary  
5 (and updated as appropriate) of the wages and  
6 wage-related costs incurred in furnishing rehabilita-  
7 tion services. Any adjustments or updates made  
8 under this paragraph for a fiscal year shall be made  
9 in a manner that assures that the aggregated pay-  
10 ments under this subsection in the fiscal year are  
11 not greater or less than those that would have been  
12 made in the year without such adjustment.

13 “(7) ADDITIONAL ADJUSTMENTS.—The Sec-  
14 retary may provide by regulation for—

15 “(A) an additional payment to take into  
16 account indirect costs of medical education and  
17 the special circumstances of hospitals that serve  
18 a significantly disproportionate number of low-  
19 income patients in a manner similar to that  
20 provided under subparagraphs (B) and (F), re-  
21 spectively, of subsection (d)(5); and

22 “(B) such other exceptions and adjust-  
23 ments to payment amounts under this sub-  
24 section in a manner similar to that provided

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1 under subsection (d)(5)(I) in relation to pay-  
2 ments under subsection (d).

3 “(8) LIMITATION ON REVIEW.—There shall be  
4 no administrative or judicial review under section  
5 1869, 1878, or otherwise of—

6 “(A) the establishment of case mix groups,  
7 of the methodology for the classification of pa-  
8 tients within such groups, and of the appro-  
9 priate weighting factors thereof under para-  
10 graph (2),

11 “(B) the establishment of the prospective  
12 payment rates under paragraph (3),

13 “(C) the establishment of outlier and spe-  
14 cial payments under paragraph (4),

15 “(D) the establishment of area wage ad-  
16 justments under paragraph (6), and

17 “(E) the establishment of additional ad-  
18 justments under paragraph (7).”.

19 (b) CONFORMING AMENDMENTS.—Section 1886(b)  
20 of such Act (42 U.S.C. 1395ww(b)) is amended—

21 (1) in paragraph (1), by inserting “and other  
22 than a rehabilitation facility described in subsection  
23 (j)(1)” after “subsection (d)(1)(B)”, and

1           (2) in paragraph (3)(B)(i), by inserting “and  
2           subsection (j)” after “For purposes of subsection  
3           (d)”.

4           (c) EFFECTIVE DATE.—The amendments made by  
5 this section shall apply to cost reporting periods beginning  
6 on or after October 1, 2000, except that the Secretary of  
7 Health and Human Services may require the submission  
8 of data under section 1886(j)(2)(D) of the Social Security  
9 Act (as added by subsection (a)) on and after the date  
10 of the enactment of this section.

11           **CHAPTER 2—PAYMENT UNDER PART B**

12                   **Subchapter A—Payment for Hospital**

13                           **Outpatient Department Services**

14           **SEC. 10411. ELIMINATION OF FORMULA-DRIVEN OVERPAY-**  
15                           **MENTS (FDO) FOR CERTAIN OUTPATIENT**  
16                           **HOSPITAL SERVICES.**

17           (a) ELIMINATION OF FDO FOR AMBULATORY SUR-  
18           GICAL                   CENTER                   PROCEDURES.—Section  
19 1833(i)(3)(B)(i)(II) (42 U.S.C. 1395l(i)(3)(B)(i)(II)) is  
20 amended—

21                   (1) by striking “of 80 percent”; and

22                   (2) by striking the period at the end and insert-  
23           ing the following: “, less the amount a provider may  
24           charge as described in clause (ii) of section  
25           1866(a)(2)(A).”.

[HVAC Reconciliation]

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1 (b) ELIMINATION OF FDO FOR RADIOLOGY SERV-  
2 ICES AND DIAGNOSTIC PROCEDURES.—Section  
3 1833(n)(1)(B)(i) (42 U.S.C. 1395l(n)(1)(B)(i)) is amend-  
4 ed—

5 (1) by striking “of 80 percent”, and

6 (2) by inserting before the period at the end the  
7 following: “, less the amount a provider may charge  
8 as described in clause (ii) of section 1866(a)(2)(A)”.

9 (c) EFFECTIVE DATE.—The amendments made by  
10 this section shall apply to services furnished during por-  
11 tions of cost reporting periods occurring on or after Octo-  
12 ber 1, 1997.

13 **SEC. 10412. EXTENSION OF REDUCTIONS IN PAYMENTS FOR**  
14 **COSTS OF HOSPITAL OUTPATIENT SERVICES.**

15 (a) REDUCTION IN PAYMENTS FOR CAPITAL-RELAT-  
16 ED COSTS.—Section 1861(v)(1)(S)(ii)(I) (42 U.S.C.  
17 1395x(v)(1)(S)(ii)(I)) is amended by striking “through  
18 1998” and inserting “through 1999 and during fiscal year  
19 2000 before January 1, 2000”.

20 (b) REDUCTION IN PAYMENTS FOR OTHER COSTS.—  
21 Section 1861(v)(1)(S)(ii)(II) (42 U.S.C.  
22 1395x(v)(1)(S)(ii)(II)) is amended by striking “through  
23 1998” and inserting “through 1999 and during fiscal year  
24 2000 before January 1, 2000”.

1 **SEC. 10413. PROSPECTIVE PAYMENT SYSTEM FOR HOS-**  
2 **PITAL OUTPATIENT DEPARTMENT SERVICES.**

3 (a) IN GENERAL.—Section 1833 (42 U.S.C. 1395l)  
4 is amended by adding at the end the following:

5 “(t) PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL  
6 OUTPATIENT DEPARTMENT SERVICES.—

7 “(1) IN GENERAL.—With respect to hospital  
8 outpatient services designated by the Secretary (in  
9 this section referred to as ‘covered OPD services’)  
10 and furnished during a year beginning with 1999,  
11 the amount of payment under this part shall be de-  
12 termined under a prospective payment system estab-  
13 lished by the Secretary in accordance with this sub-  
14 section.

15 “(2) SYSTEM REQUIREMENTS.—Under the pay-  
16 ment system—

17 “(A) the Secretary shall develop a classi-  
18 fication system for covered OPD services;

19 “(B) the Secretary may establish groups of  
20 covered OPD services, within the classification  
21 system described in subparagraph (A), so that  
22 services classified within each group are com-  
23 parable clinically and with respect to the use of  
24 resources;

25 “(C) the Secretary shall, using data on  
26 claims from 1996 and using data from the most

[HVAC Reconciliation]

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1 recent available cost reports, establish relative  
2 payment weights for covered OPD services (and  
3 any groups of such services described in sub-  
4 paragraph (B)) based on median hospital costs  
5 and shall determine projections of the frequency  
6 of utilization of each such service (or group of  
7 services) in 1999;

8 “(D) the Secretary shall determine a wage  
9 adjustment factor to adjust the portion of pay-  
10 ment and coinsurance attributable to labor-re-  
11 lated costs for relative differences in labor and  
12 labor-related costs across geographic regions in  
13 a budget neutral manner;

14 “(E) the Secretary shall establish other ad-  
15 justments, in a budget neutral manner, as de-  
16 termined to be necessary to ensure equitable  
17 payments, such as outlier adjustments, adjust-  
18 ments to account for variations in coinsurance  
19 payments for procedures with similar resource  
20 costs, or adjustments for certain classes of hos-  
21 pitals; and

22 “(F) the Secretary shall develop a method  
23 for controlling unnecessary increases in the vol-  
24 ume of covered OPD services.

25 “(3) CALCULATION OF BASE AMOUNTS.—



[HVAC Reconciliation]

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1           “(A) AGGREGATE AMOUNTS THAT WOULD  
2 BE PAYABLE IF DEDUCTIBLES WERE DIS-  
3 REGARDED.—The Secretary shall estimate the  
4 total amounts that would be payable from the  
5 Trust Fund under this part for covered OPD  
6 services in 1999, determined without regard to  
7 this subsection, as though the deductible under  
8 section 1833(b) did not apply, and as though  
9 the coinsurance described in section  
10 1866(a)(2)(A)(ii) (as in effect before the date  
11 of the enactment of this subsection) continued  
12 to apply.

13           “(B) UNADJUSTED COPAYMENT  
14 AMOUNT.—

15           “(i) IN GENERAL.—For purposes of  
16 this subsection, subject to clause (ii), the  
17 ‘unadjusted copayment amount’ applicable  
18 to a covered OPD service (or group of such  
19 services) is 20 percent of national median  
20 of the charges for the service (or services  
21 within the group) furnished during 1996,  
22 updated to 1999 using the Secretary’s esti-  
23 mate of charge growth during the period.

24           “(ii) ADJUSTED TO BE 20 PERCENT  
25 WHEN FULLY PHASED IN.—If the pre-de-

[HVAC Reconciliation]

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1 ductible payment percentage for a covered  
2 OPD service (or group of such services)  
3 furnished in a year would be equal to or  
4 exceed 80 percent, then the unadjusted co-  
5 payment amount shall be 25 percent of  
6 amount determined under subparagraph  
7 (D)(i).

8 “(iii) RULES FOR NEW SERVICES.—  
9 The Secretary shall establish rules for es-  
10 tablishment of an unadjusted copayment  
11 amount for a covered OPD service not fur-  
12 nished during 1996, based upon its classi-  
13 fication within a group of such services.

14 “(C) CALCULATION OF CONVERSION FAC-  
15 TORS.—

16 “(i) FOR 1999.—

17 “(I) IN GENERAL.—The Sec-  
18 retary shall establish a 1999 conver-  
19 sion factor for determining the medi-  
20 care pre-deductible OPD fee payment  
21 amounts for each covered OPD serv-  
22 ice (or group of such services) fur-  
23 nished in 1999. Such conversion fac-  
24 tor shall be established on the basis of  
25 the weights and frequencies described

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1 in paragraph (2)(C) and in a manner  
2 such that the sum for all services and  
3 groups of the products (described in  
4 subclause (II) for each such service or  
5 group) equals the total projected  
6 amount described in subparagraph  
7 (A).

8 “(II) PRODUCT DESCRIBED.—The  
9 product described in this subclause, for a  
10 service or group, is the product of the med-  
11 icare pre-deductible OPD fee payment  
12 amounts (taking into account appropriate  
13 adjustments described in paragraphs  
14 (2)(D) and (2)(E)) and the frequencies for  
15 such service or group.

16 “(ii) SUBSEQUENT YEARS.—Subject  
17 to paragraph (8)(B), the Secretary shall  
18 establish a conversion factor for covered  
19 OPD services furnished in subsequent  
20 years in an amount equal to the conversion  
21 factor established under this subparagraph  
22 and applicable to such services furnished in  
23 the previous year increased by the OPD  
24 payment increase factor specified under  
25 clause (iii) for the year involved.

[HVAC Reconciliation]

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1           “(iii) OPD PAYMENT INCREASE FAC-  
2 TOR.—For purposes of this subparagraph,  
3 the ‘OPD payment increase factor’ for  
4 services furnished in a year is equal to the  
5 sum of—

6                   “(I) market basket percentage in-  
7 crease (applicable under section  
8 1886(b)(3)(B)(iii) to hospital dis-  
9 charges occurring during the fiscal  
10 year ending in such year, and

11                   “(II) in the case of a covered  
12 OPD service (or group of such serv-  
13 ices) furnished in a year in which the  
14 pre-deductible payment percentage  
15 would not exceed 80 percent, 3.5 per-  
16 centage points, but in no case greater  
17 than such number of percentage  
18 points as will result in the pre-deduct-  
19 ible payment percentage exceeding 80  
20 percent.

21           In applying the previous sentence for years  
22 beginning with 2000, the Secretary may  
23 substitute for the market basket percent-  
24 age increase under subclause (I) an annual  
25 percentage increase that is computed and

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1 applied with respect to covered OPD serv-  
2 ices furnished in a year in the same man-  
3 ner as the market basket percentage in-  
4 crease is determined and applied to inpa-  
5 tient hospital services for discharges occur-  
6 ring in a fiscal year.

7 “(D) PRE-DEDUCTIBLE PAYMENT PER-  
8 CENTAGE.—The pre-deductible payment per-  
9 centage for a covered OPD service (or group of  
10 such services) furnished in a year is equal to  
11 the ratio of—

12 “(i) the conversion factor established  
13 under subparagraph (C) for the year, mul-  
14 tiplied by the weighting factor established  
15 under paragraph (2)(C) for the service (or  
16 group), to

17 “(ii) the sum of the amount deter-  
18 mined under clause (i) and the unadjusted  
19 copayment amount determined under sub-  
20 paragraph (B) for such service or group.

21 “(E) CALCULATION OF MEDICARE OPD  
22 FEE SCHEDULE AMOUNTS.—The Secretary  
23 shall compute a medicare OPD fee schedule  
24 amount for each covered OPD service (or group

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1 of such services) furnished in a year, in an  
2 amount equal to the product of—

3 “(i) the conversion factor computed  
4 under subparagraph (C) for the year, and

5 “(ii) the relative payment weight (de-  
6 termined under paragraph (2)(C)) for the  
7 service or group.

8 “(4) MEDICARE PAYMENT AMOUNT.—The  
9 amount of payment made from the Trust Fund  
10 under this part for a covered OPD service (and such  
11 services classified within a group) furnished in a  
12 year is determined as follows:

13 “(A) FEE SCHEDULE AND COPAYMENT  
14 AMOUNT.—Add (i) the medicare OPD fee  
15 schedule amount (computed under paragraph  
16 (3)(E)) for the service or group and year, and  
17 (ii) the unadjusted copayment amount (deter-  
18 mined under paragraph (3)(B)) for the service  
19 or group.

20 “(B) SUBTRACT APPLICABLE DEDUCT-  
21 IBLE.—Reduce the sum determined under sub-  
22 paragraph (A) by the amount of the deductible  
23 under section 1833(b), to the extent applicable.

24 “(C) APPLY PAYMENT PROPORTION TO RE-  
25 MAINDER.—Multiply the amount so determined

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1 under subparagraph (B) by the pre-deductible  
2 payment percentage (as determined under para-  
3 graph (3)(D)) for the service or group and year  
4 involved.

5 “(D) LABOR-RELATED ADJUSTMENT.—  
6 The amount of payment is the product deter-  
7 mined under subparagraph (C) with the labor-  
8 related portion of such product adjusted for rel-  
9 ative differences in the cost of labor and other  
10 factors determined by the Secretary, as com-  
11 puted under paragraph (2)(D).

12 “(5) COPAYMENT AMOUNT.—

13 “(A) IN GENERAL.—Except as provided in  
14 subparagraph (B), the copayment amount  
15 under this subsection is determined as follows:

16 “(i) UNADJUSTED COPAYMENT.—  
17 Compute the amount by which the amount  
18 described in paragraph (4)(B) exceeds the  
19 amount of payment determined under  
20 paragraph (4)(C).

21 “(ii) LABOR ADJUSTMENT.—The co-  
22 payment amount is the difference deter-  
23 mined under clause (i) with the labor-relat-  
24 ed portion of such difference adjusted for  
25 relative differences in the cost of labor and

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1 other factors determined by the Secretary,  
2 as computed under paragraphs (2)(D).  
3 The adjustment under this clause shall be  
4 made in a manner that does not result in  
5 any change in the aggregate copayments  
6 made in any year if the adjustment had  
7 not been made.

8 “(B) ELECTION TO OFFER REDUCED CO-  
9 PAYMENT AMOUNT.—The Secretary shall estab-  
10 lish a procedure under which a hospital, before  
11 the beginning of a year (beginning with 1999),  
12 may elect to reduce the copayment amount oth-  
13 erwise established under subparagraph (A) for  
14 some or all covered OPD services to an amount  
15 that is not less than 25 percent of the medicare  
16 OPD fee schedule amount (computed under  
17 paragraph (3)(E)) for the service involved, ad-  
18 justed for relative differences in the cost of  
19 labor and other factors determined by the Sec-  
20 retary, as computed under subparagraphs (D)  
21 and (E) of paragraph (2). Under such proce-  
22 dures, such reduced copayment amount may  
23 not be further reduced or increased during the  
24 year involved and the hospital may disseminate



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1 information on the reduction of copayment  
2 amount effected under this subparagraph.

3 “(C) NO IMPACT ON DEDUCTIBLES.—  
4 Nothing in this paragraph shall be construed as  
5 affecting a hospital’s authority to waive the  
6 charging of a deductible under section 1833(b).

7 “(6) PERIODIC REVIEW AND ADJUSTMENTS  
8 COMPONENTS OF PROSPECTIVE PAYMENT SYSTEM.—

9 “(A) PERIODIC REVIEW.—The Secretary  
10 may periodically review and revise the groups,  
11 the relative payment weights, and the wage and  
12 other adjustments described in paragraph (2) to  
13 take into account changes in medical practice,  
14 changes in technology, the addition of new serv-  
15 ices, new cost data, and other relevant informa-  
16 tion and factors.

17 “(B) BUDGET NEUTRALITY ADJUST-  
18 MENT.—If the Secretary makes adjustments  
19 under subparagraph (A), then the adjustments  
20 for a year may not cause the estimated amount  
21 of expenditures under this part for the year to  
22 increase or decrease from the estimated amount  
23 of expenditures under this part that would have  
24 been made if the adjustments had not been  
25 made.

[HVAC Reconciliation]

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1           “(C) UPDATE FACTOR.—If the Secretary  
2 determines under methodologies described in  
3 subparagraph (2)(F) that the volume of services  
4 paid for under this subsection increased beyond  
5 amounts established through those methodolo-  
6 gies, the Secretary may appropriately adjust the  
7 update to the conversion factor otherwise appli-  
8 cable in a subsequent year.

9           “(7) SPECIAL RULE FOR AMBULANCE SERV-  
10 ICES.—The Secretary shall pay for hospital out-  
11 patient services that are ambulance services on the  
12 basis described in the matter in subsection (a)(1)  
13 preceding subparagraph (A).

14           “(8) SPECIAL RULES FOR CERTAIN HOS-  
15 PITALS.—In the case of hospitals described in sec-  
16 tion 1886(d)(1)(B)(v)—

17           “(A) the system under this subsection shall  
18 not apply to covered OPD services furnished be-  
19 fore January 1, 2000; and

20           “(B) the Secretary may establish a sepa-  
21 rate conversion factor for such services in a  
22 manner that specifically takes into account the  
23 unique costs incurred by such hospitals by vir-  
24 tue of their patient population and service in-  
25 tensity.

[HVAC Reconciliation]

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1           “(9) LIMITATION ON REVIEW.—There shall be  
2 no administrative or judicial review under section  
3 1869, 1878, or otherwise of—

4           “(A) the development of the classification  
5 system under paragraph (2), including the es-  
6 tablishment of groups and relative payment  
7 weights for covered OPD services, of wage ad-  
8 justment factors, other adjustments, and meth-  
9 ods described in paragraph (2)(F);

10           “(B) the calculation of base amounts  
11 under paragraph (3);

12           “(C) periodic adjustments made under  
13 paragraph (6); and

14           “(D) the establishment of a separate con-  
15 version factor under paragraph (8)(B).”.

16       (b) COINSURANCE.—Section 1866(a)(2)(A)(ii) (42  
17 U.S.C. 1395cc(a)(2)(A)(ii)) is amended by adding at the  
18 end the following: “In the case of items and services for  
19 which payment is made under part B under the prospec-  
20 tive payment system established under section 1833(t),  
21 clause (ii) of the first sentence shall be applied by sub-  
22 stituting for 20 percent of the reasonable charge, the ap-  
23 plicable copayment amount established under section  
24 1833(t)(5).”.

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1 (c) TREATMENT OF REDUCTION IN COPAYMENT  
2 AMOUNT.—Section 1128A(i)(6) (42 U.S.C. 1320a–  
3 7a(i)(6)) is amended—

4 (1) by striking “or” at the end of subparagraph  
5 (B),

6 (2) by striking the period at the end of sub-  
7 paragraph (C) and inserting “; or”, and

8 (3) by adding at the end the following new sub-  
9 paragraph:

10 “(D) a reduction in the copayment amount  
11 for covered OPD services under section  
12 1833(t)(5)(B).”.

13 (d) CONFORMING AMENDMENTS.—

14 (1) APPROVED ASC PROCEDURES PERFORMED  
15 IN HOSPITAL OUTPATIENT DEPARTMENTS.—

16 (A)(i) Section 1833(i)(3)(A) (42 U.S.C.  
17 13951(i)(3)(A)) is amended—

18 (I) by inserting “before January 1,  
19 1999,” after “furnished”, and

20 (II) by striking “in a cost reporting  
21 period”.

22 (ii) The amendment made by clause (i)  
23 shall apply to services furnished on or after  
24 January 1, 1999.

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1 (B) Section 1833(a)(4) (42 U.S.C.  
2 13951(a)(4)) is amended by inserting “or sub-  
3 section (t)” before the semicolon.

4 (2) RADIOLOGY AND OTHER DIAGNOSTIC PRO-  
5 CEDURES.—

6 (A) Section 1833(n)(1)(A) (42 U.S.C.  
7 13951(n)(1)(A)) is amended by inserting “and  
8 before January 1, 1999,” after “October 1,  
9 1988,” and after “October 1, 1989,”.

10 (B) Section 1833(a)(2)(E) (42 U.S.C.  
11 13951(a)(2)(E)) is amended by inserting “or,  
12 for services or procedures performed on or after  
13 January 1, 1999, (t)” before the semicolon.

14 (3) OTHER HOSPITAL OUTPATIENT SERV-  
15 ICES.—Section 1833(a)(2)(B) (42 U.S.C.  
16 13951(a)(2)(B)) is amended—

17 (A) in clause (i), by inserting “furnished  
18 before January 1, 1999,” after “(i),”

19 (B) in clause (ii), by inserting “before Jan-  
20 uary 1, 1999,” after “furnished”,

21 (C) by redesignating clause (iii) as clause  
22 (iv),and

23 (D) by inserting after clause (ii), the fol-  
24 lowing new clause:

1                   “(iii) if such services are furnished on  
2                   or after January 1, 1999, the amount de-  
3                   termined under subsection (t), or”.

4                   **Subchapter B—Rehabilitation Services**

5                   **SEC. 10421. REHABILITATION AGENCIES AND SERVICES.**

6                   (a) PAYMENT BASED ON FEE SCHEDULE.—

7                   (1) SPECIAL PAYMENT RULES.—Section  
8                   1833(a) (42 U.S.C. 1395l(a)) is amended—

9                   (A) in paragraph (2) in the matter before  
10                  subparagraph (A), by inserting “(C),” before  
11                  “(D)”;

12                  (B) in paragraph (6), by striking “and” at  
13                  the end;

14                  (C) in paragraph (7), by striking the pe-  
15                  riod at the end and inserting “; and”;

16                  (D) by adding at the end the following new  
17                  paragraph:

18                  “(8) in the case of services described in section  
19                  1832(a)(2)(C) (that are not described in section  
20                  1832(a)(2)(B)), the amounts described in section  
21                  1834(k).”.

22                  (2) PAYMENT RATES.—Section 1834 (42  
23                  U.S.C. 1395m) is amended by adding at the end the  
24                  following new subsection:

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1 “(k) PAYMENT FOR OUTPATIENT THERAPY SERV-  
2 ICES.—

3 “(1) IN GENERAL.—With respect to outpatient  
4 physical therapy services (which includes outpatient  
5 speech-language pathology services) and outpatient  
6 occupational therapy services for which payment is  
7 determined under this subsection, the payment basis  
8 shall be—

9 “(A) for services furnished during 1998,  
10 the amount determined under paragraph (2); or

11 “(B) for services furnished during a subse-  
12 quent year, 80 percent of the lesser of—

13 “(i) the actual charge for the services,  
14 or

15 “(ii) the applicable fee schedule  
16 amount (as defined in paragraph (3)) for  
17 the services.

18 “(2) PAYMENT IN 1998 BASED UPON ADJUSTED  
19 REASONABLE COSTS.—The amount under this para-  
20 graph for services is the lesser of—

21 “(A) the charges imposed for the services,  
22 or

23 “(B) the adjusted reasonable costs (as de-  
24 fined in paragraph (4)) for the services,

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1 less 20 percent of the amount of the charges im-  
2 posed for such services.

3 “(3) APPLICABLE FEE SCHEDULE AMOUNT.—

4 In this paragraph, the term ‘applicable fee schedule  
5 amount’ means, with respect to services furnished in  
6 a year, the fee schedule amount established under  
7 section 1848 for such services furnished during the  
8 year or, if there is no such fee schedule amount es-  
9 tablished for such services, for such comparable  
10 services as the Secretary specifies.

11 “(4) ADJUSTED REASONABLE COSTS.—In para-  
12 graph (2), the term ‘adjusted reasonable costs’  
13 means reasonable costs determined reduced by—

14 “(A) 5.8 percent of the reasonable costs  
15 for operating costs, and

16 “(B) 10 percent of the reasonable costs for  
17 capital costs.

18 “(5) UNIFORM CODING.—For claims for serv-  
19 ices submitted on or after April 1, 1998, for which  
20 the amount of payment is determined under this  
21 subsection, the claim shall include a code (or codes)  
22 under a uniform coding system specified by the Sec-  
23 retary that identifies the services furnished.

24 “(6) RESTRAINT ON BILLING.—The provisions  
25 of subparagraphs (A) and (B) of section



1 1842(b)(18) shall apply to therapy services for  
2 which payment is made under this subsection in the  
3 same manner as they apply to services provided by  
4 a practitioner described in section 1842(b)(18)(C).”.

5 (b) APPLICATION OF STANDARDS TO OUTPATIENT  
6 OCCUPATIONAL AND PHYSICAL THERAPY SERVICES PRO-  
7 VIDED AS AN INCIDENT TO A PHYSICIAN’S PROFESSIONAL  
8 SERVICES.—Section 1862(a), as amended by section  
9 10401(b), (42 U.S.C. 1395y(a)) is amended—

10 (1) by striking “or” at the end of paragraph  
11 (16);

12 (2) by striking the period at the end of para-  
13 graph (17) and inserting “; or”; and

14 (3) by inserting after paragraph (17) the fol-  
15 lowing:

16 “(18) in the case of outpatient occupational  
17 therapy services or outpatient physical therapy serv-  
18 ices furnished as an incident to a physician’s profes-  
19 sional services (as described in section  
20 1861(s)(2)(A)), that do not meet the standards and  
21 conditions under the second sentence of section  
22 1861(g) or 1861(p) as such standards and condi-  
23 tions would apply to such therapy services if fur-  
24 nished by a therapist.”.

1 (c) APPLYING FINANCIAL LIMITATION TO ALL RE-  
2 HABILITATION SERVICES.—Section 1833(g) (42 U.S.C.  
3 1395l(g)) is amended—

4 (1) in the first sentence, by striking “services  
5 described in the second sentence of section 1861(p)”  
6 and inserting “physical therapy services of the type  
7 described in section 1861(p) (regardless of who fur-  
8 nishes the services or whether the services may be  
9 covered as physicians’ services so long as the serv-  
10 ices are furnished other than in a hospital setting)”,  
11 and

12 (2) in the second sentence, by striking “out-  
13 patient occupational therapy services which are de-  
14 scribed in the second sentence of section 1861(p)  
15 through the operation of section 1861(g)” and in-  
16 sserting “occupational therapy services (of the type  
17 that are described in section 1861(p) through the  
18 operation of section 1861(g)), regardless of who fur-  
19 nishes the services or whether the services may be  
20 covered as physicians’ services so long as the serv-  
21 ices are furnished other than in a hospital setting”.

22 (d) INDEXING LIMITATION.—Section 1833(g) (42  
23 U.S.C. 1395l(g)), as amended by subsection (c), is further  
24 amended—

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1 (1) by striking “\$900” each place it appears  
2 and inserting “the amount specified in paragraph  
3 (2) for the year”,

4 (2) by inserting “(1)” after “(g)”,

5 (3) by designating the last sentence as a para-  
6 graph (3), and

7 (4) by inserting before paragraph (3), as so  
8 designated, the following:

9 “(2) The amount specified in this paragraph—

10 “(A) for 1999, and each preceding year, is  
11 \$900, and

12 “(B) for a subsequent year is the amount speci-  
13 fied in this paragraph for the preceding year in-  
14 creased by the Secretary’s estimate of the projected  
15 percentage growth in real gross domestic product  
16 per capita from the fiscal year ending in the preced-  
17 ing year to the fiscal year ending in such subsequent  
18 year.”.

19 (e) EFFECTIVE DATE.—The amendments made by  
20 this section apply to services furnished on or after Janu-  
21 ary 1, 1998; except that the amendments made by sub-  
22 section (c) apply to services furnished on or after January  
23 1, 1999.

1 **SEC. 10422. COMPREHENSIVE OUTPATIENT REHABILITA-**  
2 **TION FACILITIES (CORF).**

3 (a) PAYMENT BASED ON FEE SCHEDULE.—

4 (1) SPECIAL PAYMENT RULES.—Section  
5 1833(a) (42 U.S.C. 1395l(a)), as amended by sec-  
6 tion 10421(a), is amended—

7 (A) in paragraph (3), by striking “sub-  
8 paragraphs (D) and (E) of section 1832(a)(2)”  
9 and inserting “section 1832(a)(2)(E)”;

10 (B) in paragraph (7), by striking “and” at  
11 the end;

12 (C) in paragraph (8), by striking the pe-  
13 riod at the end and inserting “; and”;

14 (D) by adding at the end the following new  
15 paragraph:

16 “(9) in the case of services described in section  
17 1832(a)(2)(E), the amounts described in section  
18 1834(k).”.

19 (2) PAYMENT RATES.—Section 1834(k) (42  
20 U.S.C. 1395m(k)), as added by section 10421(a), is  
21 amended—

22 (A) in the heading, by inserting “AND  
23 COMPREHENSIVE OUTPATIENT REHABILITA-  
24 TION FACILITY SERVICES” after “THERAPY  
25 SERVICES”; and

1 (B) in paragraph (1), by inserting “and  
2 with respect to comprehensive outpatient reha-  
3 bilitation facility services” after “occupational  
4 therapy services”.

5 (b) EFFECTIVE DATE.—The amendments made by  
6 subsection (a) shall apply to services furnished on or after  
7 January 1, 1998, and to portions of cost reporting periods  
8 occurring on or after such date.

9 **Subchapter C—Ambulance Services**

10 **SEC. 10431. PAYMENTS FOR AMBULANCE SERVICES.**

11 (a) INTERIM REDUCTIONS.—

12 (1) PAYMENTS DETERMINED ON REASONABLE  
13 COST BASIS.—Section 1861(v)(1) (42 U.S.C.  
14 1395x(v)(1)) is amended by adding at the end the  
15 following new subparagraph:

16 “(U) In determining the reasonable cost of am-  
17 bulance services (as described in subsection (s)(7))  
18 provided during a fiscal year (beginning with fiscal  
19 year 1998 and ending with fiscal year 2002), the  
20 Secretary shall not recognize any costs in excess of  
21 costs recognized as reasonable for ambulance serv-  
22 ices provided during the previous fiscal year after  
23 application of this subparagraph, increased by the  
24 percentage increase in the consumer price index for  
25 all urban consumers (U.S. city average) as estimated

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1 by the Secretary for the 12-month period ending  
2 with the midpoint of the fiscal year involved reduced  
3 (in the case of each of fiscal years 1998 and 1999)  
4 by 1 percentage point.”.

5 (2) PAYMENTS DETERMINED ON REASONABLE  
6 CHARGE BASIS.—Section 1842(b) (42 U.S.C.  
7 1395u(b)) is amended by adding at the end the fol-  
8 lowing new paragraph:

9 “(19) For purposes of section 1833(a)(1), the reason-  
10 able charge for ambulance services (as described in section  
11 1861(s)(7)) provided during a fiscal year (beginning with  
12 fiscal year 1998 and ending with fiscal year 2002) may  
13 not exceed the reasonable charge for such services pro-  
14 vided during the previous fiscal year after the application  
15 of this paragraph, increased by the percentage increase  
16 in the consumer price index for all urban consumers (U.S.  
17 city average) as estimated by the Secretary for the 12-  
18 month period ending with the midpoint of the year in-  
19 volved reduced (in the case of each of fiscal years 1998  
20 and 1999) by 1 percentage point.”.

21 (b) ESTABLISHMENT OF PROSPECTIVE FEE SCHED-  
22 ULE.—

23 (1) PAYMENT IN ACCORDANCE WITH FEE  
24 SCHEDULE.—Section 1833(a)(1) (42 U.S.C.

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1 1395l(a)(1)), as amended by section 10619(b)(1), is  
2 amended—

3 (A) by striking “and (P)” and inserting  
4 “(P)”; and

5 (B) by striking the semicolon at the end  
6 and inserting the following: “, and (Q) with re-  
7 spect to ambulance service, the amounts paid  
8 shall be 80 percent of the lesser of the actual  
9 charge for the services or the amount deter-  
10 mined by a fee schedule established by the Sec-  
11 retary under section 1834(l);”.

12 (2) ESTABLISHMENT OF SCHEDULE.—Section  
13 1834 (42 U.S.C. 1395m), as amended by section  
14 10421(a)(2), is amended by adding at the end the  
15 following new subsection:

16 “(1) ESTABLISHMENT OF FEE SCHEDULE FOR AM-  
17 BULANCE SERVICES.—

18 “(1) IN GENERAL.—The Secretary shall estab-  
19 lish a fee schedule for payment for ambulance serv-  
20 ices under this part through a negotiated rulemaking  
21 process described in title 5, United States Code, and  
22 in accordance with the requirements of this sub-  
23 section.

24 “(2) CONSIDERATIONS.—In establishing such  
25 fee schedule the Secretary shall—

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1           “(A) establish mechanisms to control in-  
2 creases in expenditures for ambulance services  
3 under this part;

4           “(B) establish definitions for ambulance  
5 services which link payments to the type of  
6 services provided;

7           “(C) consider appropriate regional and  
8 operational differences;

9           “(D) consider adjustments to payment  
10 rates to account for inflation and other relevant  
11 factors; and

12           “(E) phase in the application of the pay-  
13 ment rates under the fee schedule in an effi-  
14 cient and fair manner.

15           “(3) SAVINGS.—In establishing such fee sched-  
16 ule the Secretary shall—

17           “(A) ensure that the aggregate amount of  
18 payments made for ambulance services under  
19 this part during 2000 does not exceed the ag-  
20 gregate amount of payments which would have  
21 been made for such services under this part  
22 during such year if the amendments made by  
23 section 10431 of the Balanced Budget Act of  
24 1997 had not been made; and



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1           “(B) set the payment amounts provided  
2           under the fee schedule for services furnished in  
3           2001 and each subsequent year at amounts  
4           equal to the payment amounts under the fee  
5           schedule for service furnished during the pre-  
6           vious year, increased by the percentage increase  
7           in the consumer price index for all urban con-  
8           sumers (U.S. city average) for the 12-month  
9           period ending with June of the previous year.

10           “(4) CONSULTATION.—In establishing the fee  
11           schedule for ambulance services under this sub-  
12           section, the Secretary shall consult with various na-  
13           tional organizations representing individuals and en-  
14           tities who furnish and regulate ambulance services  
15           and share with such organizations relevant data in  
16           establishing such schedule.

17           “(5) LIMITATION ON REVIEW.—There shall be  
18           no administrative or judicial review under section  
19           1869 or otherwise of the amounts established under  
20           the fee schedule for ambulance services under this  
21           subsection, including matters described in paragraph  
22           (2).

23           “(6) RESTRAINT ON BILLING.—The provisions  
24           of subparagraphs (A) and (B) of section  
25           1842(b)(18) shall apply to ambulance services for

1 which payment is made under this subsection in the  
2 same manner as they apply to services provided by  
3 a practitioner described in section 1842(b)(18)(C).”.

4 (3) EFFECTIVE DATE.—The amendments made  
5 by this section apply to ambulance services furnished  
6 on or after January 1, 2000.

7 (c) AUTHORIZING PAYMENT FOR PARAMEDIC INTER-  
8 CEPT SERVICE PROVIDERS IN RURAL COMMUNITIES.—In  
9 promulgating regulations to carry out section 1861(s)(7)  
10 of the Social Security Act (42 U.S.C. 1395x(s)(7)) with  
11 respect to the coverage of ambulance service, the Secretary  
12 of Health and Human Services may include coverage of  
13 advanced life support services (in this subsection referred  
14 to as “ALS intercept services”) provided by a paramedic  
15 intercept service provider in a rural area if the following  
16 conditions are met:

17 (1) The ALS intercept services are provided  
18 under a contract with one or more volunteer ambu-  
19 lance services and are medically necessary based on  
20 the health condition of the individual being trans-  
21 ported.

22 (2) The volunteer ambulance service involved—  
23 (A) is certified as qualified to provide am-  
24 bulance service for purposes of such section,

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1 (B) provides only basic life support serv-  
2 ices at the time of the intercept, and

3 (C) is prohibited by State law from billing  
4 for any services.

5 (3) The entity supplying the ALS intercept  
6 services—

7 (A) is certified as qualified to provide such  
8 services under the medicare program under title  
9 XVIII of the Social Security Act, and

10 (B) bills all recipients who receive ALS  
11 intercept services from the entity, regardless of  
12 whether or not such recipients are medicare  
13 beneficiaries.

14 **SEC. 10432. DEMONSTRATION OF COVERAGE OF AMBU-**  
15 **LANCE SERVICES UNDER MEDICARE**  
16 **THROUGH CONTRACTS WITH UNITS OF**  
17 **LOCAL GOVERNMENT.**

18 (a) DEMONSTRATION PROJECT CONTRACTS WITH  
19 LOCAL GOVERNMENTS.—The Secretary of Health and  
20 Human Services shall establish up to 3 demonstration  
21 projects under which, at the request of a county or parish,  
22 the Secretary enters into a contract with the county or  
23 parish under which—

24 (1) the county or parish furnishes (or arranges  
25 for the furnishing) of ambulance services for which

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1 payment may be made under part B of title XVIII  
2 of the Social Security Act for individuals residing in  
3 the county or parish who are enrolled under such  
4 part, except that the county or parish may not enter  
5 into the contract unless the contract covers at least  
6 80 percent of the individuals residing in the county  
7 or parish who are enrolled under such part;

8 (2) any individual or entity furnishing ambu-  
9 lance services under the contract meets the require-  
10 ments otherwise applicable to individuals and enti-  
11 ties furnishing such services under such part; and

12 (3) for each month during which the contract is  
13 in effect, the Secretary makes a capitated payment  
14 to the county or parish in accordance with sub-  
15 section (b).

16 The projects may extend over a period of not to exceed  
17 3 years each.

18 (b) AMOUNT OF PAYMENT.—

19 (1) IN GENERAL.—The amount of the monthly  
20 payment made for months occurring during a cal-  
21 endar year to a county or parish under a demonstra-  
22 tion project contract under subsection (a) shall be  
23 equal to the product of—

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1 (A) the Secretary's estimate of the number  
2 of individuals covered under the contract for the  
3 month; and

4 (B)  $\frac{1}{12}$  of the capitated payment rate for  
5 the year established under paragraph (2).

6 (2) CAPITATED PAYMENT RATE DEFINED.—In  
7 this subsection, the “capitated payment rate” appli-  
8 cable to a contract under this subsection for a cal-  
9 endar year is equal to 95 percent of—

10 (A) for the first calendar year for which  
11 the contract is in effect, the average annual per  
12 capita payment made under part B of title  
13 XVIII of the Social Security Act with respect to  
14 ambulance services furnished to such individ-  
15 uals during the 3 most recent calendar years  
16 for which data on the amount of such payment  
17 is available; and

18 (B) for a subsequent year, the amount pro-  
19 vided under this paragraph for the previous  
20 year increased by the percentage increase in the  
21 consumer price index for all urban consumers  
22 (U.S. city average) for the 12-month period  
23 ending with June of the previous year.

24 (c) OTHER TERMS OF CONTRACT.—The Secretary  
25 and the county or parish may include in a contract under

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1 this section such other terms as the parties consider ap-  
2 propriate, including—

3 (1) covering individuals residing in additional  
4 counties or parishes (under arrangements entered  
5 into between such counties or parishes and the coun-  
6 ty or parish involved);

7 (2) permitting the county or parish to transport  
8 individuals to non-hospital providers if such provid-  
9 ers are able to furnish quality services at a lower  
10 cost than hospital providers; or

11 (3) implementing such other innovations as the  
12 county or parish may propose to improve the quality  
13 of ambulance services and control the costs of such  
14 services.

15 (d) CONTRACT PAYMENTS IN LIEU OF OTHER BENE-  
16 FITS.—Payments under a contract to a county or parish  
17 under this section shall be instead of the amounts which  
18 (in the absence of the contract) would otherwise be pay-  
19 able under part B of title XVIII of the Social Security  
20 Act for the services covered under the contract which are  
21 furnished to individuals who reside in the county or parish.

22 (e) REPORT ON EFFECTS OF CAPITATED CON-  
23 TRACTS.—

24 (1) STUDY.—The Secretary shall evaluate the  
25 demonstration projects conducted under this section.

1 Such evaluation shall include an analysis of the  
2 quality and cost-effectiveness of ambulance services  
3 furnished under the projects.

4 (2) REPORT.—Not later than January 1, 2000,  
5 the Secretary shall submit a report to Congress on  
6 the study conducted under paragraph (1), and shall  
7 include in the report such recommendations as the  
8 Secretary considers appropriate, including rec-  
9 ommendations regarding modifications to the meth-  
10 odology used to determine the amount of payments  
11 made under such contracts and extending or expand-  
12 ing such projects.

13 **CHAPTER 3—PAYMENT UNDER PARTS A**  
14 **AND B**

15 **SEC. 10441. PROSPECTIVE PAYMENT FOR HOME HEALTH**  
16 **SERVICES.**

17 (a) IN GENERAL.—Title XVIII (42 U.S.C. 1395 et  
18 seq.), as amended by section 10011, is amended by adding  
19 at the end the following new section:

20 “PROSPECTIVE PAYMENT FOR HOME HEALTH SERVICES

21 “SEC. 1895. (a) IN GENERAL.—Notwithstanding sec-  
22 tion 1861(v), the Secretary shall provide, for cost report-  
23 ing periods beginning on or after October 1, 1999, for pay-  
24 ments for home health services in accordance with a pro-  
25 spective payment system established by the Secretary  
26 under this section.

1       “(b) SYSTEM OF PROSPECTIVE PAYMENT FOR HOME  
2 HEALTH SERVICES.—

3           “(1) IN GENERAL.—The Secretary shall estab-  
4 lish under this subsection a prospective payment sys-  
5 tem for payment for all costs of home health serv-  
6 ices. Under the system under this subsection all  
7 services covered and paid on a reasonable cost basis  
8 under the medicare home health benefit as of the  
9 date of the enactment of the this section, including  
10 medical supplies, shall be paid for on the basis of a  
11 prospective payment amount determined under this  
12 subsection and applicable to the services involved. In  
13 implementing the system, the Secretary may provide  
14 for a transition (of not longer than 4 years) during  
15 which a portion of such payment is based on agency-  
16 specific costs, but only if such transition does not re-  
17 sult in aggregate payments under this title that ex-  
18 ceed the aggregate payments that would be made if  
19 such a transition did not occur.

20           “(2) UNIT OF PAYMENT.—In defining a pro-  
21 spective payment amount under the system under  
22 this subsection, the Secretary shall consider an ap-  
23 propriate unit of service and the number, type, and  
24 duration of visits provided within that unit, potential  
25 changes in the mix of services provided within that



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1 unit and their cost, and a general system design that  
2 provides for continued access to quality services.

3 “(3) PAYMENT BASIS.—

4 “(A) INITIAL BASIS.—

5 “(i) IN GENERAL.—Under such sys-  
6 tem the Secretary shall provide for com-  
7 putation of a standard prospective pay-  
8 ment amount (or amounts). Such amount  
9 (or amounts) shall initially be based on the  
10 most current audited cost report data  
11 available to the Secretary and shall be  
12 computed in a manner so that the total  
13 amounts payable under the system for fis-  
14 cal year 2000 shall be equal to the total  
15 amount that would have been made if the  
16 system had not been in effect but if the re-  
17 duction in limits described in clause (ii)  
18 had been in effect. Such amount shall be  
19 standardized in a manner that eliminates  
20 the effect of variations in relative case mix  
21 and wage levels among different home  
22 health agencies in a budget neutral manner  
23 consistent with the case mix and wage level  
24 adjustments provided under paragraph  
25 (4)(A). Under the system, the Secretary

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1 may recognize regional differences or dif-  
2 ferences based upon whether or not the  
3 services or agency are in an urbanized  
4 area.

5 “(ii) REDUCTION.—The reduction de-  
6 scribed in this clause is a reduction by 15  
7 percent in the cost limits and per bene-  
8 ficiary limits described in section  
9 1861(v)(1)(L), as those limits are in effect  
10 on September 30, 1999.

11 “(B) ANNUAL UPDATE.—

12 “(i) IN GENERAL.—The standard pro-  
13 spective payment amount (or amounts)  
14 shall be adjusted for each fiscal year (be-  
15 ginning with fiscal year 2001) in a pro-  
16 spective manner specified by the Secretary  
17 by the home health market basket percent-  
18 age increase applicable to the fiscal year  
19 involved.

20 “(ii) HOME HEALTH MARKET BASKET  
21 PERCENTAGE INCREASE.—For purposes of  
22 this subsection, the term ‘home health  
23 market basket percentage increase’ means,  
24 with respect to a fiscal year, a percentage  
25 (estimated by the Secretary before the be-

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1           ginning of the fiscal year) determined and  
2           applied with respect to the mix of goods  
3           and services included in home health serv-  
4           ices in the same manner as the market  
5           basket percentage increase under section  
6           1886(b)(3)(B)(iii) is determined and ap-  
7           plied to the mix of goods and services com-  
8           prising inpatient hospital services for the  
9           fiscal year.

10           “(C) ADJUSTMENT FOR OUTLIERS.—The  
11           Secretary shall reduce the standard prospective  
12           payment amount (or amounts) under this para-  
13           graph applicable to home health services fur-  
14           nished during a period by such proportion as  
15           will result in an aggregate reduction in pay-  
16           ments for the period equal to the aggregate in-  
17           crease in payments resulting from the applica-  
18           tion of paragraph (5) (relating to outliers).

19           “(4) PAYMENT COMPUTATION.—

20           “(A) IN GENERAL.—The payment amount  
21           for a unit of home health services shall be the  
22           applicable standard prospective payment  
23           amount adjusted as follows:

24           “(i) CASE MIX ADJUSTMENT.—The  
25           amount shall be adjusted by an appro-

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1           appropriate case mix adjustment factor (estab-  
2           lished under subparagraph (B)).

3           “(ii) AREA WAGE ADJUSTMENT.—The  
4           portion of such amount that the Secretary  
5           estimates to be attributable to wages and  
6           wage-related costs shall be adjusted for ge-  
7           ographic differences in such costs by an  
8           area wage adjustment factor (established  
9           under subparagraph (C)) for the area in  
10          which the services are furnished or such  
11          other area as the Secretary may specify.

12          “(B) ESTABLISHMENT OF CASE MIX AD-  
13          JUSTMENT FACTORS.—The Secretary shall es-  
14          tablish appropriate case mix adjustment factors  
15          for home health services in a manner that ex-  
16          plains a significant amount of the variation in  
17          cost among different units of services.

18          “(C) ESTABLISHMENT OF AREA WAGE AD-  
19          JUSTMENT FACTORS.—The Secretary shall es-  
20          tablish area wage adjustment factors that re-  
21          flect the relative level of wages and wage-related  
22          costs applicable to the furnishing of home  
23          health services in a geographic area compared  
24          to the national average applicable level. Such

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1 factors may be the factors used by the Sec-  
2 retary for purposes of section 1886(d)(3)(E).

3 “(5) OUTLIERS.—The Secretary may provide  
4 for an addition or adjustment to the payment  
5 amount otherwise made in the case of outliers be-  
6 cause of unusual variations in the type or amount of  
7 medically necessary care. The total amount of the  
8 additional payments or payment adjustments made  
9 under this paragraph with respect to a fiscal year  
10 may not exceed 5 percent of the total payments pro-  
11 jected or estimated to be made based on the prospec-  
12 tive payment system under this subsection in that  
13 year.

14 “(6) PRORATION OF PROSPECTIVE PAYMENT  
15 AMOUNTS.—If a beneficiary elects to transfer to, or  
16 receive services from, another home health agency  
17 within the period covered by the prospective payment  
18 amount, the payment shall be prorated between the  
19 home health agencies involved.

20 “(c) REQUIREMENTS FOR PAYMENT INFORMA-  
21 TION.—With respect to home health services furnished on  
22 or after October 1, 1998, no claim for such a service may  
23 be paid under this title unless—

24 “(1) the claim has the unique identifier (pro-  
25 vided under section 1842(r)) for the physician who

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1 prescribed the services or made the certification de-  
2 scribed in section 1814(a)(2) or 1835(a)(2)(A); and

3 “(2) in the case of a service visit described in  
4 paragraph (1), (2), (3), or (4) of section 1861(m),  
5 the claim has information (coded in an appropriate  
6 manner) on the length of time of the service visit,  
7 as measured in 15 minute increments.

8 “(d) LIMITATION ON REVIEW.—There shall be no ad-  
9 ministrative or judicial review under section 1869, 1878,  
10 or otherwise of—

11 “(1) the establishment of a transition period  
12 under subsection (b)(1);

13 “(2) the definition and application of payment  
14 units under subsection (b)(2);

15 “(3) the computation of initial standard pro-  
16 spective payment amounts under subsection  
17 (b)(3)(A) (including the reduction described in  
18 clause (ii) of such subsection);

19 “(4) the establishment of the adjustment for  
20 outliers under subsection (b)(3)(C);

21 “(5) the establishment of case mix and area  
22 wage adjustments under subsection (b)(4);

23 “(6) the establishment of any adjustments for  
24 outliers under subsection (b)(5); and

1           “(7) the amounts or types of adjustments under  
2           subsection (b)(7).”.

3           (b) ELIMINATION OF PERIODIC INTERIM PAYMENTS  
4           FOR HOME HEALTH AGENCIES.—Section 1815(e)(2) (42  
5           U.S.C. 1395g(e)(2)) is amended—

6           (1) by inserting “and” at the end of subpara-  
7           graph (C),

8           (2) by striking subparagraph (D), and

9           (3) by redesignating subparagraph (E) as sub-  
10          paragraph (D).

11          (c) CONFORMING AMENDMENTS.—

12          (1) PAYMENTS UNDER PART A.—Section  
13          1814(b) (42 U.S.C. 1395f(b)) is amended in the  
14          matter preceding paragraph (1) by striking “and  
15          1886” and inserting “1886, and 1895”.

16          (2) TREATMENT OF ITEMS AND SERVICES PAID  
17          UNDER PART B.—

18                  (A) PAYMENTS UNDER PART B.—Section  
19                  1833(a)(2) (42 U.S.C. 1395l(a)(2)) is amend-  
20                  ed—

21                          (i) by amending subparagraph (A) to  
22                          read as follows:

23                                  “(A) with respect to home health services  
24                                  (other than a covered osteoporosis drug) (as de-  
25                                  fined in section 1861(kk)), the amount deter-

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1 mined under the prospective payment system  
2 under section 1895;”;

3 (ii) by striking “and” at the end of  
4 subparagraph (E);

5 (iii) by adding “and” at the end of  
6 subparagraph (F); and

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

9 “(G) with respect to items and services de-  
10 scribed in section 1861(s)(10)(A), the lesser  
11 of—

12 “(i) the reasonable cost of such serv-  
13 ices, as determined under section 1861(v),  
14 or

15 “(ii) the customary charges with re-  
16 spect to such services,

17 or, if such services are furnished by a public  
18 provider of services, or by another provider  
19 which demonstrates to the satisfaction of the  
20 Secretary that a significant portion of its pa-  
21 tients are low-income (and requests that pay-  
22 ment be made under this provision), free of  
23 charge or at nominal charges to the public, the  
24 amount determined in accordance with section  
25 1814(b)(2);”.



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1 (B) REQUIRING PAYMENT FOR ALL ITEMS  
2 AND SERVICES TO BE MADE TO AGENCY.—

3 (i) IN GENERAL.—The first sentence  
4 of section 1842(b)(6) (42 U.S.C.  
5 1395u(b)(6)), as amended by section  
6 10401(b)(2), is amended—

7 (I) by striking “and (E)” and in-  
8 serting “(E)”; and

9 (II) by striking the period at the  
10 end and inserting the following: “,  
11 and (F) in the case of home health  
12 services furnished to an individual  
13 who (at the time the item or service is  
14 furnished) is under a plan of care of  
15 a home health agency, payment shall  
16 be made to the agency (without re-  
17 gard to whether or not the item or  
18 service was furnished by the agency,  
19 by others under arrangement with  
20 them made by the agency, or when  
21 any other contracting or consulting  
22 arrangement, or otherwise).”.

23 (ii) CONFORMING AMENDMENT.—Sec-  
24 tion 1832(a)(1) (42 U.S.C. 1395k(a)(1)),  
25 as amended by section 10401(b), is amend-

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1 ed by striking “and section 1842(b)(6)(E)”  
2 and inserting “, section 1842(b)(6)(E),  
3 and section 1842(b)(6)(F)”.

4 (C) EXCLUSIONS FROM COVERAGE.—Sec-  
5 tion 1862(a) (42 U.S.C. 1395y(a)), as amended  
6 by sections 10401(b) and 10421(b), is amend-  
7 ed—

8 (i) by striking “or” at the end of  
9 paragraph (17);

10 (ii) by striking the period at the end  
11 of paragraph (18) and inserting “; or”;  
12 and

13 (iii) inserting after paragraph (18) the  
14 following new paragraph:

15 “(19) where such expenses are for home health  
16 services furnished to an individual who is under a  
17 plan of care of the home health agency if the claim  
18 for payment for such services is not submitted by  
19 the agency.”.

20 (d) EFFECTIVE DATE.—Except as otherwise pro-  
21 vided, the amendments made by this section shall apply  
22 to cost reporting periods beginning on or after October  
23 1, 1999.

1 **Subtitle F—Provisions Relating to**  
2 **Part A**

3 **CHAPTER 1—PAYMENT OF PPS**  
4 **HOSPITALS**

5 **SEC. 10501. PPS HOSPITAL PAYMENT UPDATE.**

6 Section 1886(b)(3)(B)(i) (42 U.S.C.

7 1395ww(b)(3)(B)(i)) is amended—

8 (1) by striking “and” at the end of subclause  
9 (XII), and

10 (2) by striking subclause (XIII) and inserting  
11 the following:

12 “(XIII) for fiscal year 1998, 0 percent,

13 “(XIV) for each of the fiscal years 1999  
14 through 2002, the market basket percentage in-  
15 crease minus 1.0 percentage point for hospitals in all  
16 areas, and

17 “(XV) for fiscal year 2003 and each subsequent  
18 fiscal year, the market basket percentage increase  
19 for hospitals in all areas.”.

20 **SEC. 10502. CAPITAL PAYMENTS FOR PPS HOSPITALS.**

21 (a) MAINTAINING SAVINGS FROM TEMPORARY RE-  
22 DUCTION IN PPS CAPITAL RATES.—Section  
23 1886(g)(1)(A) (42 U.S.C. 1395ww(g)(1)(A)) is amended  
24 by adding at the end the following: “In addition to the  
25 reduction described in the preceding sentence, for dis-

1 charges occurring on or after October 1, 1997, the Sec-  
2 retary shall apply the budget neutrality adjustment factor  
3 used to determine the Federal capital payment rate in ef-  
4 fect on September 30, 1995 (as described in section  
5 412.352 of title 42 of the Code of Federal Regulations),  
6 to (i) the unadjusted standard Federal capital payment  
7 rate (as described in section 412.308(c) of that title, as  
8 in effect on September 30, 1997), and (ii) the unadjusted  
9 hospital-specific rate (as described in section  
10 412.328(e)(1) of that title, as in effect on September 30,  
11 1997).”.

12 (b) REVISION OF EXCEPTIONS PROCESS UNDER  
13 PROSPECTIVE PAYMENT SYSTEM FOR CERTAIN  
14 PROJECTS.—

15 (1) IN GENERAL.—Section 1886(g)(1) (42  
16 U.S.C. 1395ww(g)(1)) is amended—

17 (A) by redesignating subparagraph (C) as  
18 subparagraph (F), and

19 (B) by inserting after subparagraph (B)  
20 the following subparagraphs:

21 “(C) The exceptions under the system provided by  
22 the Secretary under subparagraph (B)(iii) shall include  
23 the provision of exception payments under the special ex-  
24 ceptions process provided under section 412.348(g) of title  
25 42, Code of Federal Regulations (as in effect on Septem-

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1 ber 1, 1995), except that the Secretary shall revise such  
2 process, effective for discharges occurring after September  
3 30, 1997, as follows:

4 “(i) A hospital with at least 100 beds which is  
5 located in an urban area shall be eligible under such  
6 process without regard to its disproportionate pa-  
7 tient percentage under subsection (d)(5)(F) or  
8 whether it qualifies for additional payment amounts  
9 under such subsection.

10 “(ii) The minimum payment level for qualifying  
11 hospitals shall be 85 percent (or such lower percent-  
12 age, but no lower than 75 percent, as the Secretary  
13 may provide to comply with subparagraph (D)).

14 “(iii) A hospital shall be considered to meet the  
15 requirement that it complete the project involved no  
16 later than the end of the hospital’s last cost report-  
17 ing period beginning before October 1, 2001, if—

18 “(I) the hospital has obtained a certificate  
19 of need for the project approved by the State or  
20 a local planning authority by September 1,  
21 1995, and

22 “(II) by September 1, 1995, the hospital  
23 has expended on the project at least \$750,000  
24 or 10 percent of the estimated cost of the  
25 project.

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1           “(iv) Offsetting amounts, as described in sec-  
2           tion 412.348(g)(8)(ii) of title 42, Code of Federal  
3           Regulations, shall apply except that subparagraph  
4           (B) of such section shall be revised to require that  
5           the additional payment that would otherwise be pay-  
6           able for the cost reporting period shall be reduced by  
7           the amount (if any) by which the hospital’s current  
8           year medicare capital payments (excluding, if appli-  
9           cable, 75 percent of the hospital’s capital-related dis-  
10          proportionate share payments) exceeds its medicare  
11          capital costs for such year.

12          “(D) The Secretary may reduce the percent specified  
13          under subparagraph (C)(ii) (but not below 75 percent)  
14          and shall reduce the Federal capital rate for a fiscal year  
15          by such percentage as the Secretary determines to be nec-  
16          essary to ensure that the application of subparagraph (C)  
17          does not result in an increase in the total amount that  
18          would have been paid under this subsection in the fiscal  
19          year if such subparagraph did not apply.

20          “(E) The Secretary shall provide for publication in  
21          the Federal Register each year (beginning with 1999) a  
22          description of the distributional impact of the application  
23          of subparagraph (C) on hospitals which receive, and do  
24          not receive, an exception payment under such subpara-  
25          graph.”.

1           (2) CONFORMING AMENDMENT.—Section  
2           1886(g)(1)(B)(iii) (42 U.S.C. 1395ww(g)(1)(B)(iii))  
3           is amended by striking “may provide” and inserting  
4           “shall provide (in accordance with subparagraph  
5           (C))”.

6 **SEC. 10503. FREEZE IN DISPROPORTIONATE SHARE.**

7           (a) NO UPDATE IN DISPROPORTIONATE SHARE FOR  
8 FISCAL YEARS 1998 AND 1999.—Section 1886(d)(5)(F)  
9 (42 U.S.C. 1395ww(d)(5)(F)) is amended in clause (ii) by  
10 adding at the end the following new sentence: “For dis-  
11 charges occurring on or after October 1, 1997, the sum  
12 described in subclause (I) shall be determined as if the  
13 applicable percentage increase described in subsection  
14 (b)(3)(B)(i) for discharges for fiscal years 1998 and 1999  
15 were zero percent.”.

16           (b) DEVELOPMENT OF REVISED QUALIFYING CRI-  
17 TERIA AND PAYMENT METHODOLOGY FOR HOSPITALS  
18 THAT SERVE A DISPROPORTIONATE SHARE OF LOW-IN-  
19 COME PATIENTS.—

20           (1) DEVELOPMENT OF PROPOSAL.—The Sec-  
21 retary of Health and Human Services shall develop  
22 a proposal to modify the current qualifying criteria  
23 and payment methodology under which hospitals  
24 that are paid under section 1886(d) of the Social Se-  
25 curity Act (42 U.S.C. 1395ww(d)) receive an addi-

1 tional payment because they serve a disproportionate  
2 share of low-income patients.

3 (2) REPORT.—Not later than April 1, 1999, the  
4 Secretary shall transmit the proposal developed  
5 under paragraph (1) to the Committee on Ways and  
6 Means of the House of Representatives and the  
7 Committee on Finance of the Senate.

8 **SEC. 10504. MEDICARE CAPITAL ASSET SALES PRICE**  
9 **EQUAL TO BOOK VALUE.**

10 (a) IN GENERAL.—Section 1861(v)(1)(O) (42 U.S.C.  
11 1395x(v)(1)(O)) is amended—

12 (1) in clause (i)—

13 (A) by striking “and (if applicable) a re-  
14 turn on equity capital”;

15 (B) by striking “hospital or skilled nursing  
16 facility” and inserting “provider of services”;

17 (C) by striking “clause (iv)” and inserting  
18 “clause (iii)”; and

19 (D) by striking “the lesser of the allowable  
20 acquisition cost” and all that follows and insert-  
21 ing “the historical cost of the asset, as recog-  
22 nized under this title, less depreciation allowed,  
23 to the owner of record as of the date of enact-  
24 ment of the Balanced Budget Act of 1997 (or,  
25 in the case of an asset not in existence as of



1 that date, the first owner of record of the asset  
2 after that date).”;

3 (2) by striking clause (ii); and

4 (3) by redesignating clauses (iii) and (iv) as  
5 clauses (ii) and (iii), respectively.

6 (b) EFFECTIVE DATE.—The amendments made by  
7 subsection (a) apply to changes of ownership that occur  
8 after the third month beginning after the date of enact-  
9 ment of this section.

10 **SEC. 10505. ELIMINATION OF IME AND DSH PAYMENTS AT-**  
11 **TRIBUTABLE TO OUTLIER PAYMENTS.**

12 (a) INDIRECT MEDICAL EDUCATION.—Section  
13 1886(d)(5)(B)(i)(I) (42 U.S.C. 1395ww(d)(5)(B)(i)(I)) is  
14 amended by inserting “, for cases qualifying for additional  
15 payment under subparagraph (A)(i),” before “the amount  
16 paid to the hospital under subparagraph (A)”.

17 (b) DISPROPORTIONATE SHARE ADJUSTMENTS.—  
18 Section 1886(d)(5)(F)(ii)(I) (42 U.S.C.  
19 1395ww(d)(5)(F)(ii)(I)) is amended by inserting “, for  
20 cases qualifying for additional payment under subpara-  
21 graph (A)(i),” before “the amount paid to the hospital  
22 under subparagraph (A)”.

23 (c) COST OUTLIER PAYMENTS.—Section  
24 1886(d)(5)(A)(ii) (42 U.S.C. 1395ww(d)(5)(A)(ii)) is  
25 amended by striking “exceed the applicable DRG prospec-

1 tive payment rate” and inserting “exceed the sum of the  
2 applicable DRG prospective payment rate plus any  
3 amounts payable under paragraphs (d)(5)(B) and  
4 (d)(5)(F)”.

5 (d) EFFECTIVE DATE.—The amendments made by  
6 this section apply to discharges occurring after September  
7 30, 1997.

8 **SEC. 10506. REDUCTION IN ADJUSTMENT FOR INDIRECT**  
9 **MEDICAL EDUCATION.**

10 (a) IN GENERAL.—Section 1886(d)(5)(B)(ii) (42  
11 U.S.C. 1395ww(d)(5)(B)(ii)) is amended to read as fol-  
12 lows:

13 “(ii) For purposes of clause (i)(II), the indirect  
14 teaching adjustment factor for discharges occur-  
15 ring—

16 “(I) on or after October 1, 1988 and be-  
17 fore October 1, 1997, is equal to  $1.89 \times$   
18  $((1+r)^n - 1)$ ,

19 “(II) during fiscal year 1998, is equal to  
20  $1.62 \times ((1+r)^n - 1)$ , and

21 “(III) during or after fiscal year 1999, is  
22 equal to  $1.35 \times ((1+r)^n - 1)$ ,

23 where ‘r’ is the ratio of the hospital’s full-time equiv-  
24 alent interns and residents to beds and ‘n’ equals  
25 0.405, subject to clause (vi).”.

1 (b) CONFORMING AMENDMENT RELATING TO DE-  
2 TERMINATION OF STANDARDIZED AMOUNTS.—Section  
3 1886(d)(2)(C)(i) (42 U.S.C. 1395ww(d)(2)(C)(i)) is  
4 amended by adding at the end the following: “except that  
5 the Secretary shall not take into account any reductions  
6 in the amount of additional payments under paragraph  
7 (5)(B)(ii) resulting from the amendments made by section  
8 10506(a) of the Balanced Budget Act of 1997,”.

9 (c) LIMITATION ON NUMBER OF RESIDENTS FOR  
10 CERTAIN FISCAL YEARS.—Section 1886(d)(5)(B) (42  
11 U.S.C. 1395ww(d)(5)(B)), as amended by subsection (a),  
12 is amended by adding at the end the following new clauses:

13 (v) In determining the adjustment with re-  
14 spect to a hospital for discharges occurring on or  
15 after October 1, 1997, the total number of interns  
16 and residents in either a hospital or non-hospital set-  
17 ting may not exceed the number of interns and resi-  
18 dents in the hospital with respect to the hospital’s  
19 cost reporting period beginning on or before Decem-  
20 ber 31, 1996.

21 (vi) For purposes of clause (ii)—

22 (I) ‘r’ may not exceed the ratio of the  
23 number of interns and residents as determined  
24 under clause (v) with respect to the hospital for  
25 its most recent cost reporting period, to the

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1 hospital's available beds (as defined by the Sec-  
2 retary) during that cost reporting period,

3 “(II) for the hospital's first cost reporting  
4 period beginning on or after October 1, 1997,  
5 subject to the limits described in clauses (iv)  
6 and (v), the total number of full-time equivalent  
7 residents for payment purposes shall equal the  
8 average of the actual full-time equivalent resi-  
9 dent count for the hospital's most recent cost  
10 reporting period and the preceding cost report-  
11 ing period, and

12 “(III) for the cost reporting period begin-  
13 ning on or after October 1, 1998, and each sub-  
14 sequent cost reporting period, subject to the  
15 limits described in clauses (iv) and (v), the total  
16 number of full-time equivalent residents for  
17 payment purposes shall equal the average of the  
18 actual full-time equivalent resident count for  
19 the cost reporting period and the preceding two  
20 cost reporting periods.

21 “(vii) If the hospital's fiscal year 1998 or later  
22 cost reporting period is not equal to twelve months,  
23 the Secretary shall make appropriate modifications  
24 to ensure that the average full-time equivalent resi-  
25 dency count pursuant to subclauses (II) and (III) of

1 clause (vi) is based on the equivalent of full twelve  
2 month cost reporting periods.

3 “(viii) The Secretary may establish rules, con-  
4 sistent with the policies in clauses (v) through (vii)  
5 and in subsection (h)(6)(A)(ii), with respect to the  
6 application of clauses (v) through (vii) in the case of  
7 medical residency training programs established on  
8 or after January 1, 1997.”.

9 **SEC. 10507. TREATMENT OF TRANSFER CASES.**

10 (a) TRANSFERS TO PPS EXEMPT HOSPITALS AND  
11 SKILLED NURSING FACILITIES.—Section 1886(d)(5)(I)  
12 (42 U.S.C. 1395ww(d)(5)(I)) is amended by adding at the  
13 end the following new clause:

14 “(iii) In carrying out this subparagraph, the Sec-  
15 retary shall treat the term ‘transfer case’ as including the  
16 case of an individual who, upon discharge from a sub-  
17 section (d) hospital—

18 “(I) is admitted as an inpatient to a hospital or  
19 hospital unit that is not a subsection (d) hospital for  
20 the receipt of inpatient hospital services; or

21 “(II) is admitted to a skilled nursing facility or  
22 facility described in section 1861(y)(1) for the re-  
23 ceipt of extended care services.”.

24 (b) TRANSFERS FOR PURPOSES OF HOME HEALTH  
25 SERVICES.—Section 1886(d)(5)(I)(iii) (42 U.S.C.

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1 1395ww(d)(5)(I)(iii)), as amended by subsection (a), is  
2 amended—

3 (1) in subclause (I), by striking “or”;

4 (2) in subclause (II), by striking the period at  
5 the end and inserting “; or” and

6 (2) by adding at the end the following new sub-  
7 clause:

8 “(III) receives home health services from a  
9 home health agency, if such services relate to the  
10 condition or diagnosis for which such individual re-  
11 ceived inpatient hospital services from the subsection  
12 (d) hospital, and if such services are provided within  
13 an appropriate period as determined by the Sec-  
14 retary in regulations promulgated not later than  
15 September 1, 1998.”.

16 (c) EFFECTIVE DATES.—

17 (1) The amendment made by subsection (a)  
18 shall apply with respect to discharges occurring on  
19 or after October 1, 1997.

20 (2) The amendment made by subsection (b)  
21 shall apply with respect to discharges occurring on  
22 or after October 1, 1998.

1 **SEC. 10508. INCREASE BASE PAYMENT RATE TO PUERTO**  
2 **RICO HOSPITALS.**

3 Section 1886(d)(9)(A) (42 U.S.C. 1395ww(d)(9)(A))  
4 is amended—

5 (1) in the matter preceding clause (i), by strik-  
6 ing “in a fiscal year beginning on or after October  
7 1, 1987,”

8 (2) in clause (i), by striking “75 percent” and  
9 inserting, “for discharges beginning on or after Oc-  
10 tober 1, 1997, 50 percent (and for discharges be-  
11 tween October 1, 1987, and September 30, 1997, 75  
12 percent)”, and

13 (3) in clause (ii), by striking “25 percent” and  
14 inserting, “for discharges beginning in a fiscal year  
15 beginning on or after October 1, 1997, 50 percent  
16 (and for discharges between October 1, 1987 and  
17 September 30, 1997, 25 percent)”.

18 **CHAPTER 2—PAYMENT OF PPS EXEMPT**  
19 **HOSPITALS**

20 **SEC. 10511. PAYMENT UPDATE.**

21 (a) IN GENERAL.—Section 1886(b)(3)(B) (42 U.S.C.  
22 1395ww(b)(3)(B)) is amended—

23 (1) in clause (ii)—

24 (A) by striking “and” at the end of sub-  
25 clause (V),

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1 (B) by redesignating subclause (VI) as  
2 subclause (VIII); and

3 (C) by inserting after subclause (V), the  
4 following subclauses:

5 “(VI) for fiscal year 1998, is 0 percent;

6 “(VII) for fiscal years 1999 through 2002, is  
7 the applicable update factor specified under clause  
8 (vi) for the fiscal year; and”; and

9 (2) by adding at the end the following new  
10 clause:

11 “(vi) For purposes of clause (ii)(VII) for a fiscal year,  
12 if a hospital’s allowable operating costs of inpatient hos-  
13 pital services recognized under this title for the most re-  
14 cent cost reporting period for which information is avail-  
15 able—

16 “(I) is equal to, or exceeds, 110 percent of the  
17 hospital’s target amount (as determined under sub-  
18 paragraph (A)) for such cost reporting period, the  
19 applicable update factor specified under this clause  
20 is the market basket percentage;

21 “(II) exceeds 100 percent, but is less than 110  
22 percent, of such target amount for the hospital, the  
23 applicable update factor specified under this clause  
24 is 0 percent or, if greater, the market basket per-  
25 centage minus 0.25 percentage points for each per-



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1 centage point by which such allowable operating  
2 costs (expressed as a percentage of such target  
3 amount) is less than 110 percent of such target  
4 amount;

5 “(III) is equal to, or less than 100 percent, but  
6 exceeds  $\frac{2}{3}$  of such target amount for the hospital,  
7 the applicable update factor specified under this  
8 clause is 0 percent or, if greater, the market basket  
9 percentage minus 2.5 percentage points; or

10 “(IV) does not exceed  $\frac{2}{3}$  of such target amount  
11 for the hospital, the applicable update factor speci-  
12 fied under this clause is 0 percent.”.

13 (b) NO EFFECT OF PAYMENT REDUCTION ON EX-  
14 CEPTIONS AND ADJUSTMENTS.—Section  
15 1886(b)(4)(A)(ii) (42 U.S.C. 1395ww(b)(4)(A)(ii)) is  
16 amended by adding at the end the following new sentence:  
17 “In making such reductions, the Secretary shall treat the  
18 applicable update factor described in paragraph (3)(B)(vi)  
19 for a fiscal year as being equal to the market basket per-  
20 centage for that year.”.

21 **SEC. 10512. REDUCTIONS TO CAPITAL PAYMENTS FOR CER-**  
22 **TAIN PPS-EXEMPT HOSPITALS AND UNITS.**

23 Section 1886(g) (42 U.S.C. 1395ww(g)) is amended  
24 by adding at the end the following new paragraph:

1       “(4) In determining the amount of the payments that  
2 are attributable to portions of cost reporting periods oc-  
3 ccurring during fiscal years 1998 through 2002 and that  
4 may be made under this title with respect to capital-relat-  
5 ed costs of inpatient hospital services of a hospital which  
6 is described in clause (i), (ii), or (iv) of subsection  
7 (d)(1)(B) or a unit described in the matter after clause  
8 (v) of such subsection, the Secretary shall reduce the  
9 amounts of such payments otherwise determined under  
10 this title by 10 percent.”.

11 **SEC. 10513. CAP ON TEFRA LIMITS.**

12       Section 1886(b)(3) (42 U.S.C. 1395ww(b)(3)) is  
13 amended—

14           (1) in subparagraph (A) by striking “subpara-  
15           graphs (C), (D), and (E)” and inserting “subpara-  
16           graph (C) and succeeding subparagraphs”, and

17           (2) by adding at the end the following:

18       “(F)(i) In the case of a hospital or unit that is within  
19 a class of hospital described in clause (ii), for cost report-  
20 ing periods beginning on or after October 1, 1997, and  
21 before October 1, 2002, such target amount may not be  
22 greater than the 90th percentile of the target amounts for  
23 such hospitals within such class for cost reporting periods  
24 beginning during that fiscal year.

1 “(ii) For purposes of this subparagraph, each of the  
2 following shall be treated as a separate class of hospital:

3 “(I) Hospitals described in clause (i) of sub-  
4 section (d)(1)(B) and psychiatric units described in  
5 the matter following clause (v) of such subsection.

6 “(II) Hospitals described in clause (ii) of such  
7 subsection and rehabilitation units described in the  
8 matter following clause (v) of such subsection.

9 “(III) Hospitals described in clause (iv) of such  
10 subsection.”.

11 **SEC. 10514. CHANGE IN BONUS AND RELIEF PAYMENTS.**

12 (a) CHANGE IN BONUS PAYMENT.—Section  
13 1886(b)(1)(A) (42 U.S.C. 1395ww(b)(1)(A)) is amended  
14 by striking all that follows “plus—” and inserting the fol-  
15 lowing:

16 “(i) 10 percent of the amount by which the  
17 target amount exceeds the amount of the oper-  
18 ating costs, or

19 “(ii) 1 percent of the operating costs,  
20 whichever is less;”.

21 (b) CHANGE IN RELIEF PAYMENTS.—Section  
22 1886(b)(1) (42 U.S.C. 1395ww(b)(1)) is amended—  
23 (1) in subparagraph (B)—

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1 (A) by striking “greater than the target  
2 amount” and inserting “greater than 110 per-  
3 cent of the target amount”,

4 (B) by striking “exceed the target  
5 amount” and inserting “exceed 110 percent of  
6 the target amount”,

7 (C) by striking “10 percent” and inserting  
8 “20 percent”, and

9 (D) by redesignating such subparagraph as  
10 subparagraph (C); and

11 (2) by inserting after subparagraph (A) the fol-  
12 lowing new subparagraph:

13 “(B) are greater than the target amount but do  
14 not exceed 110 percent of the target amount, the  
15 amount of the payment with respect to those operat-  
16 ing costs payable under part A on a per discharge  
17 basis shall equal the target amount; or”.

18 **SEC. 10515. CHANGE IN PAYMENT AND TARGET AMOUNT**

19 **FOR NEW PROVIDERS.**

20 Section 1886(b) (42 U.S.C. 1395ww(b)) is amend-  
21 ed—

22 (1) by inserting after paragraph (1) the follow-  
23 ing new paragraph:

24 “(2)(A) Notwithstanding paragraph (1), in the case  
25 of a hospital or unit that is within a class of hospital de-

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1 scribed in subparagraph (B) which first receives payments  
2 under this section on or after October 1, 1997—

3 “(i) for each of the first 2 full or partial cost  
4 reporting periods, the amount of the payment with  
5 respect to operating costs described in paragraph (1)  
6 under part A on a per discharge or per admission  
7 basis (as the case may be) is equal to the lesser of—

8 “(I) the amount of operating costs for such  
9 respective period, or

10 “(II) 150 percent of the national median  
11 of the operating costs for hospitals in the same  
12 class as the hospital for cost reporting periods  
13 beginning during the same fiscal year, as ad-  
14 justed under subparagraph (C); and

15 “(ii) for purposes of computing the target  
16 amount for the subsequent cost reporting period, the  
17 target amount for the preceding cost reporting pe-  
18 riod is equal to the amount determined under clause  
19 (i) for such preceding period.

20 “(B) For purposes of this paragraph, each of the fol-  
21 lowing shall be treated as a separate class of hospital:

22 “(i) Hospitals described in clause (i) of sub-  
23 section (d)(1)(B) and psychiatric units described in  
24 the matter following clause (v) of such subsection.

1           “(ii) Hospitals described in clause (ii) of such  
2           subsection and rehabilitation units described in the  
3           matter following clause (v) of such subsection.

4           “(iii) A class of hospitals described in sub-  
5           section (d)(1)(B)(iv) that the Secretary shall estab-  
6           lish based upon a measure of case mix that takes  
7           into account acuity.

8           “(iv) Hospitals described in subsection  
9           (d)(1)(B)(iv) that are not within the class described  
10          in clause (iii).

11          “(C) In applying subparagraph (A)(i)(II) in the case  
12          of a hospital or unit, the Secretary shall provide for an  
13          appropriate adjustment to the labor-related portion of the  
14          amount determined under such subparagraph to take into  
15          account differences between average wage-related costs in  
16          the area of the hospital and the national average of such  
17          costs within the same class of hospital.”; and

18                 (2) in paragraph (3)(A), as amended in section  
19          10513, by inserting “and in paragraph (2)(A)(ii),”  
20          before “for purposes of”.

21 **SEC. 10516. REBASING.**

22          (a) OPTION OF REBASING FOR HOSPITALS IN OPER-  
23          ATION BEFORE 1990.—Section 1886(b)(3)(42 U.S.C.  
24          1395ww(b)(3)), as amended in section 10513, is amended  
25          by adding at the end the following new subparagraph:

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1 “(G)(i) In the case of a hospital (or unit described  
2 in the matter following clause (v) of subsection (d)(1)(B))  
3 that received payment under this subsection for inpatient  
4 hospital services furnished during cost reporting periods  
5 before October 1, 1990, that is within a class of hospital  
6 described in clause (iii), and that elects (in a form and  
7 manner determined by the Secretary) this subparagraph  
8 to apply to the hospital, the target amount for the hos-  
9 pital’s 12-month cost reporting period beginning during  
10 fiscal year 1998 is equal to the average described in clause  
11 (ii).

12 “(ii) The average described in this clause for a hos-  
13 pital or unit shall be determined by the Secretary as fol-  
14 lows:

15 “(I) The Secretary shall determine the allow-  
16 able operating costs for inpatient hospital services  
17 for the hospital or unit for each of the 5 cost report-  
18 ing periods for which the Secretary has the most re-  
19 cent settled cost reports as of the date of the enact-  
20 ment of this subparagraph.

21 “(II) The Secretary shall increase the amount  
22 determined under subclause (I) for each cost report-  
23 ing period by the applicable percentage increase  
24 under subparagraph (B)(ii) for each subsequent cost

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1 reporting period up to the cost reporting period de-  
2 scribed in clause (i).

3 “(III) The Secretary shall identify among such  
4 5 cost reporting periods the cost reporting periods  
5 for which the amount determined under subclause  
6 (II) is the highest, and the lowest.

7 “(IV) The Secretary shall compute the averages  
8 of the amounts determined under subclause (II) for  
9 the 3 cost reporting periods not identified under  
10 subclause (III).

11 “(iii) For purposes of this subparagraph, each of the  
12 following shall be treated as a separate class of hospital:

13 “(I) Hospitals described in clause (i) of sub-  
14 section (d)(1)(B) and psychiatric units described in  
15 the matter following clause (v) of such subsection.

16 “(II) Hospitals described in clause (ii) of such  
17 subsection and rehabilitation units described in the  
18 matter following clause (v) of such subsection.

19 “(III) Hospitals described in clause (iii) of such  
20 subsection.

21 “(IV) Hospitals described in clause (iv) of such  
22 subsection.

23 “(V) Hospitals described in clause (v) of such  
24 subsection.”.



1 (b) CERTAIN LONG-TERM CARE HOSPITALS.—Sec-  
2 tion 1886(b)(3) (42 U.S.C. 1395ww(b)(3)), as amended  
3 by subsection (a), is amended by adding at the end the  
4 following new subparagraph:

5 “(H)(i) In the case of a qualified long-term care hos-  
6 pital (as defined in clause (ii)) that elects (in a form and  
7 manner determined by the Secretary) this subparagraph  
8 to apply to the hospital, the target amount for the hos-  
9 pital’s 12-month cost reporting period beginning during  
10 fiscal year 1998 is equal to the allowable operating costs  
11 of inpatient hospital services (as defined in subsection  
12 (a)(4)) recognized under this title for the hospital for the  
13 12-month cost reporting period beginning during fiscal  
14 year 1996, increased by the applicable percentage increase  
15 for the cost reporting period beginning during fiscal year  
16 1997.

17 “(ii) In clause (i), a ‘qualified long-term care hospital’  
18 means, with respect to a cost reporting period, a hospital  
19 described in clause (iv) of subsection (d)(1)(B) during  
20 each of the 2 cost reporting periods for which the Sec-  
21 retary has the most recent settled cost reports as of the  
22 date of the enactment of this subparagraph for each of  
23 which—

24 “(I) the hospital’s allowable operating costs of  
25 inpatient hospital services recognized under this title

1 exceeded 115 percent of the hospital's target  
2 amount, and

3 “(II) the hospital would have a disproportionate  
4 patient percentage of at least 70 percent (as deter-  
5 mined by the Secretary under subsection  
6 (d)(5)(F)(vi)) if the hospital were a subsection (d)  
7 hospital.”.

8 (c) CERTAIN LONG-TERM CARE CANCER HOS-  
9 PITALS.—

10 (1) IN GENERAL.—Section 1886(d)(1)(B)(iv)  
11 (42 U.S.C. 1395ww(d)(1)(B)(iv)) is amended by  
12 adding at the end the following: “a hospital that  
13 first received payment under this subsection in 1986  
14 which has an average inpatient length of stay (as de-  
15 termined by the Secretary) of greater than 20 days  
16 and that has 80 percent or more of its annual total  
17 inpatient discharges with a principal diagnosis that  
18 reflects a finding of neoplastic disease, or”.

19 (2) EFFECTIVE DATE.—The amendment made  
20 by paragraph (1) shall apply to cost reporting peri-  
21 ods beginning on or after the date of the enactment  
22 of this Act.

1 **SEC. 10517. TREATMENT OF CERTAIN LONG-TERM CARE**  
2 **HOSPITALS.**

3 (a) IN GENERAL.—Section 1886(d)(1)(B) (42 U.S.C.  
4 1395ww(d)(1)(B)) is amended by adding at the end the  
5 following new sentence: “A hospital that was classified by  
6 the Secretary on or before September 30, 1995, as a hos-  
7 pital described in clause (iv) shall continue to be so classi-  
8 fied notwithstanding that it is located in the same building  
9 as, or on the same campus as, another hospital.”.

10 (b) EFFECTIVE DATE.—The amendment made by  
11 subsection (a) shall apply to discharges occurring on or  
12 after October 1, 1995.

13 **SEC. 10518. ELIMINATION OF EXEMPTIONS; REPORT ON EX-**  
14 **CEPTIONS AND ADJUSTMENTS.**

15 (a) ELIMINATION OF EXEMPTIONS.—

16 (1) IN GENERAL.—Section 1886(b)(4)(A)(i) (42  
17 U.S.C. 1395ww(b)(4)(A)(i)) is amended by striking  
18 “exemption from, or an exception and adjustment  
19 to,” and inserting “an exception and adjustment to”  
20 each place it appears.

21 (2) EFFECTIVE DATE.—The amendments made  
22 by paragraph (1) shall apply to hospitals or units  
23 that first qualify as a hospital or unit described in  
24 section 1886(d)(1)(B) (42 U.S.C. 1395ww(d)(1)(B))  
25 on or after October 1, 1997.

1 (b) REPORT.—The Secretary of Health and Human  
2 Services shall publish annually in the Federal Register a  
3 report describing the total amount of payments made to  
4 hospitals by reason of section 1886(b)(4) of the Social Se-  
5 curity Act (42 U.S.C. 1395ww(b)(4)), as amended by sub-  
6 section (a), for cost reporting periods ending during the  
7 previous fiscal year.

8 **CHAPTER 3—PROVISIONS RELATED TO**  
9 **HOSPICE SERVICES**

10 **SEC. 10521. PAYMENTS FOR HOSPICE SERVICES.**

11 (a) PAYMENT UPDATE.—Section 1814(i)(1)(C)(ii)  
12 (42 U.S.C. 1395f(i)(1)(C)(ii)) is amended—

13 (1) in subclause (V), by striking “and” at the  
14 end;

15 (2) by redesignating subclause (VI) as sub-  
16 clause (VII); and

17 (3) by inserting after subclause (V) the follow-  
18 ing new subclause:

19 “(VI) for each of fiscal years 1998 through  
20 2002, the market basket percentage increase for the  
21 fiscal year involved minus 1.0 percentage points;  
22 and”.

23 (b) REPORT.—Section 1814(i) (42 U.S.C. 1395f(i))  
24 is amended by adding at the end the following new para-  
25 graph:

1 “(3) The Secretary shall provide for the collection of  
2 data, from hospice programs providing hospice care for  
3 which payment is made under this subsection, with respect  
4 to the costs for providing such care for each fiscal year  
5 beginning with fiscal year 1999.”.

6 **SEC. 10522. PAYMENT FOR HOME HOSPICE CARE BASED ON**  
7 **LOCATION WHERE CARE IS FURNISHED.**

8 (a) IN GENERAL.—Section 1814(i)(2) (42 U.S.C.  
9 1395f(i)(2)) is amended by adding at the end the follow-  
10 ing:

11 “(D) A hospice program shall submit claims for pay-  
12 ment for hospice care furnished in an individual’s home  
13 under this title only on the basis of the geographic location  
14 at which the service is furnished, as determined by the  
15 Secretary.”.

16 (b) EFFECTIVE DATE.—The amendment made by  
17 subsection (a) applies to cost reporting periods beginning  
18 on or after October 1, 1997.

19 **SEC. 10523. HOSPICE CARE BENEFITS PERIODS.**

20 (a) RESTRUCTURING OF BENEFIT PERIOD.—Section  
21 1812 (42 U.S.C. 1395d) is amended, in subsections (a)(4)  
22 and (d)(1), by striking “, a subsequent period of 30 days,  
23 and a subsequent extension period” and inserting “and  
24 an unlimited number of subsequent periods of 60 days  
25 each”.

1 (b) CONFORMING AMENDMENTS.—(1) Section 1812  
2 (42 U.S.C. 1395d) is amended in subsection (d)(2)(B) by  
3 striking “90- or 30-day period or a subsequent extension  
4 period” and inserting “90-day period or a subsequent 60-  
5 day period”.

6 (2) Section 1814(a)(7)(A) (42 U.S.C.  
7 1395f(a)(7)(A)) is amended—

8 (A) in clause (i), by inserting “and” at the end;

9 (B) in clause (ii)—

10 (i) by striking “30-day” and inserting “60-  
11 day”; and

12 (ii) by striking “, and” at the end and in-  
13 serting a period; and

14 (C) by striking clause (iii).

15 **SEC. 10524. OTHER ITEMS AND SERVICES INCLUDED IN**  
16 **HOSPICE CARE.**

17 Section 1861(dd)(1) (42 U.S.C. 1395x(dd)(1)) is  
18 amended—

19 (1) in subparagraph (G), by striking “and” at  
20 the end;

21 (2) in subparagraph (H), by striking the period  
22 at the end and inserting “, and”; and

23 (3) by inserting after subparagraph (H) the fol-  
24 lowing:

1           “(I) any other item or service which is specified  
2           in the plan and for which payment may otherwise be  
3           made under this title.”.

4 **SEC. 10525. CONTRACTING WITH INDEPENDENT PHYSI-**  
5           **CIANS OR PHYSICIAN GROUPS FOR HOSPICE**  
6           **CARE SERVICES PERMITTED.**

7           Section 1861(dd)(2) (42 U.S.C. 1395x(dd)(2)) is  
8 amended—

9           (1) in subparagraph (A)(ii)(I), by striking  
10          “(F),”; and

11          (2) in subparagraph (B)(i), by inserting “or, in  
12          the case of a physician described in subclause (I),  
13          under contract with” after “employed by”.

14 **SEC. 10526. WAIVER OF CERTAIN STAFFING REQUIRE-**  
15           **MENTS FOR HOSPICE CARE PROGRAMS IN**  
16           **NON-URBANIZED AREAS.**

17          Section 1861(dd)(5) (42 U.S.C. 1395x(dd)(5)) is  
18 amended—

19          (1) in subparagraph (B), by inserting “or (C)”  
20          after “subparagraph (A)” each place it appears; and

21          (2) by adding at the end the following:

22          “(C) The Secretary may waive the requirements of  
23          paragraph (2)(A)(i) and (2)(A)(ii) for an agency or orga-  
24          nization with respect to the services described in para-

1 graph (1)(B) and, with respect to dietary counseling,  
2 paragraph (1)(H), if such agency or organization—

3 “(i) is located in an area which is not an urban-  
4 ized area (as defined by the Bureau of Census), and

5 “(ii) demonstrates to the satisfaction of the  
6 Secretary that the agency or organization has been  
7 unable, despite diligent efforts, to recruit appro-  
8 priate personnel.”.

9 **SEC. 10527. LIMITATION ON LIABILITY OF BENEFICIARIES**  
10 **FOR CERTAIN HOSPICE COVERAGE DENIALS.**

11 Section 1879(g) (42 U.S.C. 1395pp(g)) is amend-  
12 ed—

13 (1) by redesignating paragraphs (1) and (2) as  
14 subparagraphs (A) and (B), respectively, and mov-  
15 ing such subparagraphs 2 ems to the right;

16 (2) by striking “is,” and inserting “is—”;

17 (3) by making the remaining text of subsection  
18 (g), as amended, that follows “is—” a new para-  
19 graph (1) and indenting such paragraph 2 ems to  
20 the right;

21 (4) by striking the period at the end and insert-  
22 ing “; and”; and

23 (5) by adding at the end the following new  
24 paragraph:



1           “(2) with respect to the provision of hospice  
2           care to an individual, a determination that the indi-  
3           vidual is not terminally ill.”.

4 **SEC. 10528. EXTENDING THE PERIOD FOR PHYSICIAN CER-**  
5                                   **TIFICATION OF AN INDIVIDUAL’S TERMINAL**  
6                                   **ILLNESS.**

7           Section       1814(a)(7)(A)(i)       (42       U.S.C.  
8 1395f(a)(7)(A)(i)) is amended, in the matter following  
9 subclause (II), by striking “, not later than 2 days after  
10 hospice care is initiated (or, if each certify verbally not  
11 later than 2 days after hospice care is initiated, not later  
12 than 8 days after such care is initiated)” and inserting  
13 “at the beginning of the period”.

14 **SEC. 10529. EFFECTIVE DATE.**

15       Except as otherwise provided in this chapter, the  
16 amendments made by this chapter apply to benefits pro-  
17 vided on or after the date of the enactment of this chapter,  
18 regardless of whether or not an individual has made an  
19 election under section 1812(d) of the Social Security Act  
20 (42 U.S.C. 1395d(d)) before such date.

1     **CHAPTER 4—MODIFICATION OF PART A**  
2                     **HOME HEALTH BENEFIT**

3     **SEC. 10531. MODIFICATION OF PART A HOME HEALTH BEN-**  
4                     **EFIT FOR INDIVIDUALS ENROLLED UNDER**  
5                     **PART B.**

6             (a) IN GENERAL.—Section 1812 (42 U.S.C. 1395d)  
7 is amended—

8                     (1) in subsection (a)(3), by striking “home  
9 health services” and inserting “for individuals not  
10 enrolled in part B, home health services, and for in-  
11 dividuals so enrolled, part A home health services  
12 (as defined in subsection (g))”;

13                     (2) by redesignating subsection (g) as sub-  
14 section (h); and

15                     (3) by inserting after subsection (f) the follow-  
16 ing new subsection:

17             “(g)(1) For purposes of this section, the term ‘part  
18 A home health services’ means—

19                     “(A) for services furnished during each year be-  
20 ginning with 1998 and ending with 2002, home  
21 health services subject to the transition reduction  
22 applied under paragraph (2)(C) for services fur-  
23 nished during the year, and

24                     “(B) for services furnished on or after January  
25 1, 2003, post-institutional home health services for

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1 up to 100 visits during a home health spell of ill-  
2 ness.

3 “(2) For purposes of paragraph (1)(B), the Secretary  
4 shall specify, before the beginning of each year beginning  
5 with 1998 and ending with 2002, a transition reduction  
6 in the home health services benefit under this part as fol-  
7 lows:

8 “(A) The Secretary first shall estimate the  
9 amount of payments that would have been made  
10 under this part for home health services furnished  
11 during the year if—

12 “(i) part A home health services were all  
13 home health services, and

14 “(ii) part A home health services were lim-  
15 ited to services described in paragraph (1)(B).

16 “(B)(i) The Secretary next shall compute a  
17 transfer reduction amount equal to the appropriate  
18 proportion (specified under clause (ii)) of the  
19 amount by which the amount estimated under sub-  
20 paragraph (A)(i) for the year exceeds the amount es-  
21 timated under subparagraph (A)(ii) for the year.

22 “(ii) For purposes of clause (i), the ‘appropriate  
23 proportion’ is equal to—

24 “(I)  $\frac{1}{6}$  for 1998,

25 “(II)  $\frac{2}{6}$  for 1999,

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1 “(III)  $\frac{3}{6}$  for 2000,

2 “(IV)  $\frac{4}{6}$  for 2001, and

3 “(V)  $\frac{5}{6}$  for 2002.

4 “(C) The Secretary shall establish a transition  
5 reduction by specifying such a visit limit (during a  
6 home health spell of illness) or such a post-institu-  
7 tional limitation on home health services furnished  
8 under this part during the year as the Secretary es-  
9 timates will result in a reduction in the amount of  
10 payments that would otherwise be made under this  
11 part for home health services furnished during the  
12 year equal to the transfer amount computed under  
13 subparagraph (B)(i) for the year.

14 “(3) Payment under this part for home health serv-  
15 ices furnished an individual enrolled under part B—

16 “(A) during a year beginning with 1998  
17 and ending with 2003, may not be made for  
18 services that are not within the visit limit or  
19 other limitation specified by the Secretary  
20 under the transition reduction under paragraph  
21 (3)(C) for services furnished during the year; or

22 “(B) on or after January 1, 2004, may not  
23 be made for home health services that are not  
24 post-institutional home health services or for  
25 post-institutional furnished to the individual

1 after such services have been furnished to the  
2 individual for a total of 100 visits during a  
3 home health spell of illness.

4 “(4) With respect to computing the monthly actuarial  
5 rate for enrollees age 65 and over for purposes of applying  
6 section 1839, such rate shall be computed as though any  
7 reference in a previous provision of this subsection to 2002  
8 or 2003 is a reference to the succeeding year and as  
9 through the appropriate proportion described in para-  
10 graph (3)(B)(ii) were equal to—

11 “(A)  $\frac{1}{7}$  for 1998,

12 “(B)  $\frac{2}{7}$  for 1999,

13 “(C)  $\frac{3}{7}$  for 2000,

14 “(D)  $\frac{4}{7}$  for 2001,

15 “(E)  $\frac{5}{7}$  for 2002, and

16 “(F)  $\frac{6}{7}$  for 2003.”.

17 (b) POST-INSTITUTIONAL HOME HEALTH SERVICES  
18 DEFINED.—Section 1861 (42 U.S.C. 1395x), as amended  
19 by section 10105(a)(1)(B) is amended by adding at the  
20 end the following:

21 “Post-Institutional Home Health Services; Home Health  
22 Spell of Illness

23 “(rr)(1) The term ‘post-institutional home health  
24 services’ means home health services furnished to an indi-  
25 vidual—

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1           “(A) after discharge from a hospital or rural  
2           primary care hospital in which the individual was an  
3           inpatient for not less than 3 consecutive days before  
4           such discharge if such home health services were ini-  
5           tiated within 14 days after the date of such dis-  
6           charge; or

7           “(B) after discharge from a skilled nursing fa-  
8           cility in which the individual was provided post-hos-  
9           pital extended care services if such home health serv-  
10          ices were initiated within 14 days after the date of  
11          such discharge.

12          “(2) The term ‘home health spell of illness’ with re-  
13          spect to any individual means a period of consecutive  
14          days—

15                 “(A) beginning with the first day (not included  
16                 in a previous home health spell of illness) (i) on  
17                 which such individual is furnished post-institutional  
18                 home health services, and (B) which occurs in a  
19                 month for which the individual is entitled to benefits  
20                 under part A, and

21                 “(B) ending with the close of the first period of  
22                 60 consecutive days thereafter on each of which the  
23                 individual is neither an inpatient of a hospital or  
24                 rural primary care hospital nor an inpatient of a fa-

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1 cility described in section 1819(a)(1) or subsection  
2 (y)(1) nor provided home health services.”.

3 (c) MAINTAINING APPEAL RIGHTS FOR HOME  
4 HEALTH SERVICES.—Section 1869(b)(2)(B) (42 U.S.C.  
5 1395ff(b)(2)(B)) is amended by inserting “(or \$100 in the  
6 case of home health services)” after “\$500”.

7 (d) MAINTAINING SEAMLESS ADMINISTRATION  
8 THROUGH FISCAL INTERMEDIARIES.—Section 1842(b)(2)  
9 (42 U.S.C. 1395u(b)(2)) is amended by adding at the end  
10 the following:

11 “(E) With respect to the payment of claims for home  
12 health services under this part that, but for the amend-  
13 ments made by section 10531 of the Balanced Budget Act  
14 of 1997, would be payable under part A instead of under  
15 this part, the Secretary shall continue administration of  
16 such claims through fiscal intermediaries under section  
17 1816.”.

18 (e) EFFECTIVE DATE.—The amendments made by  
19 this section apply to services furnished on or after Janu-  
20 ary 1, 1998. For purpose of applying such amendments,  
21 any home health spell of illness that began, but not end,  
22 before such date shall be considered to have begun as of  
23 such date.

1                   **CHAPTER 5—OTHER PAYMENT**  
2                   **PROVISIONS**

3   **SEC. 10541. REDUCTIONS IN PAYMENTS FOR ENROLLEE**  
4                   **BAD DEBT.**

5           Section 1861(v)(1) (42 U.S.C. 1395x(v)(1)) is  
6 amended by adding at the end the following new subpara-  
7 graph:

8           “(T) In determining such reasonable costs for hos-  
9 pitals, the amount of bad debts otherwise treated as allow-  
10 able costs which are attributable to the deductibles and  
11 coinsurance amounts under this title shall be reduced—

12                   “(i) for cost reporting periods beginning during  
13 fiscal year 1998, by 25 percent of such amount oth-  
14 erwise allowable,

15                   “(ii) for cost reporting periods beginning during  
16 fiscal year 1999, by 40 percent of such amount oth-  
17 erwise allowable, and

18                   “(iii) for cost reporting periods beginning dur-  
19 ing a subsequent fiscal year, by 50 percent of such  
20 amount otherwise allowable.”.

21   **SEC. 10542. PERMANENT EXTENSION OF HEMOPHILIA PASS-**  
22                   **THROUGH.**

23           Effective October 1, 1997, section 6011(d) of  
24 OBRA–1989 (as amended by section 13505 of OBRA–



1 1993) is amended by striking “and shall expire September  
2 30, 1994”.

3 **SEC. 10543. REDUCTION IN PART A MEDICARE PREMIUM**  
4 **FOR CERTAIN PUBLIC RETIREES.**

5 (a) IN GENERAL.—Section 1818(d) (42 U.S.C.  
6 1395i–2(d)) is amended—

7 (1) in paragraph (2), by striking “paragraph  
8 (4)” and inserting “paragraphs (4) and (5)”; and

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

11 “(5)(A) The amount of the monthly premium shall  
12 be zero in the case of an individual who is a person de-  
13 scribed in subparagraph (B) for a month, if—

14 “(i) the individual’s premium under this section  
15 for the month is not (and will not be) paid for, in  
16 whole or in part, by a State (under title XIX or oth-  
17 erwise), a political subdivision of a State, or an  
18 agency or instrumentality of one or more States or  
19 political subdivisions thereof; and

20 “(ii) in each of 60 months before such month,  
21 the individual was enrolled in this part under this  
22 section and the payment of the individual’s premium  
23 under this section for the month was not paid for,  
24 in whole or in part, by a State (under title XIX or  
25 otherwise), a political subdivision of a State, or an

1 agency or instrumentality of one or more States or  
2 political subdivisions thereof.

3 “(B) A person described in this subparagraph for an  
4 month is a person who establishes to the satisfaction of  
5 the Secretary that, as of the last day of the previous  
6 month—

7 “(i)(I) the person was receiving cash benefits  
8 under a qualified State or local government retire-  
9 ment system (as defined in subparagraph (C)) on  
10 the basis of the person’s employment in one or more  
11 positions covered under any such system, and (II)  
12 the person would have at least 40 quarters of cov-  
13 erage under title II if remuneration for medicare  
14 qualified government employment (as defined in  
15 paragraph (1) of section 210(p), but determined  
16 without regard to paragraph (3) of such section)  
17 paid to such person were treated as wages paid to  
18 such person and credited for purposes of determin-  
19 ing quarters of coverage under section 213;

20 “(ii)(I) the person was married (and had been  
21 married for the previous 1-year period) to an indi-  
22 vidual who is described in clause (i), or (II) the per-  
23 son met the requirement of clause (i)(II) and was  
24 married (and had been married for the previous 1-

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1 year period) to an individual described in clause  
2 (i)(I);

3 “(iii) the person had been married to an indi-  
4 vidual for a period of at least 1 year (at the time  
5 of such individual’s death) if (I) the individual was  
6 described in clause (i) at the time of the individual’s  
7 death, or (II) the person met the requirement of  
8 clause (i)(II) and the individual was described in  
9 clause (i)(I) at the time of the individual’s death; or

10 “(iv) the person is divorced from an individual  
11 and had been married to the individual for a period  
12 of at least 10 years (at the time of the divorce) if  
13 (I) the individual was described in clause (i) at the  
14 time of the divorce, or (II) the person met the re-  
15 quirement of clause (i)(II) and the individual was  
16 described in clause (i)(I) at the time of the divorce.

17 “(C) For purposes of subparagraph (B)(i)(I), the  
18 term ‘qualified State or local government retirement sys-  
19 tem’ means a retirement system that—

20 “(i) is established or maintained by a State or  
21 political subdivision thereof, or an agency or instru-  
22 mentality of one or more States or political subdivi-  
23 sions thereof;

1           “(ii) covers positions of some or all employees  
2 of such a State, subdivision, agency, or instrumen-  
3 tality; and

4           “(iii) does not adjust cash retirement benefits  
5 based on eligibility for a reduction in premium under  
6 this paragraph.”.

7       (b) EFFECTIVE DATE.—The amendments made by  
8 subsection (a) shall apply to premiums for months begin-  
9 ning with January 1998, and months before such month  
10 may be taken into account for purposes of meeting the  
11 requirement of section 1818(d)(5)(B)(iii) of the Social Se-  
12 curity Act, as added by subsection (a).

13       **Subtitle G—Provisions Relating to**  
14                       **Part B Only**

15       **CHAPTER 1—PHYSICIANS’ SERVICES**

16       **SEC. 10601. ESTABLISHMENT OF SINGLE CONVERSION FAC-**  
17                       **TOR FOR 1998.**

18       (a) IN GENERAL.—Section 1848(d)(1) (42 U.S.C.  
19 1395w–4(d)(1)) is amended—

20           (1) by redesignating subparagraph (C) as sub-  
21 paragraph (D), and

22           (2) by inserting after subparagraph (B) the fol-  
23 lowing:

24                       “(C) SPECIAL RULES FOR 1998.—The sin-  
25 gular conversion factor for 1998 under this sub-

1 section shall be the conversion factor for pri-  
2 mary care services for 1997, increased by the  
3 Secretary’s estimate of the weighted average of  
4 the three separate updates that would otherwise  
5 occur were it not for the enactment of chapter  
6 1 of subtitle G of title X of the Balanced Budg-  
7 et Act of 1997.”.

8 (b) CONFORMING AMENDMENTS.—Section 1848 (42  
9 U.S.C. 1395w–4) is amended—

10 (1) by striking “(or factors)” each place it ap-  
11 pears in subsection (d)(1)(A) and (d)(1)(D)(ii) (as  
12 redesignated by subsection (a)(1)),

13 (2) in subsection (d)(1)(A), by striking “or up-  
14 dates”,

15 (3) in subsection (d)(1)(D) (as redesignated by  
16 subsection (a)(1)), by striking “(or updates)” each  
17 place it appears, and

18 (4) in subsection (i)(1)(C), by striking “conver-  
19 sion factors” and inserting “the conversion factor”.

20 **SEC. 10602. ESTABLISHING UPDATE TO CONVERSION FAC-**  
21 **TOR TO MATCH SPENDING UNDER SUSTAIN-**  
22 **ABLE GROWTH RATE.**

23 (a) UPDATE.—

1           (1) IN GENERAL.—Section 1848(d)(3) (42  
2 U.S.C. 1395w-4(d)(3)) is amended to read as fol-  
3 lows:

4           “(3) UPDATE.—

5                   “(A) IN GENERAL.—Unless otherwise pro-  
6 vided by law, subject to subparagraph (D) and  
7 the budget-neutrality factor determined by the  
8 Secretary under subsection (c)(2)(B)(ii), the  
9 update to the single conversion factor estab-  
10 lished in paragraph (1)(C) for a year beginning  
11 with 1999 is equal to the product of—

12                           “(i) 1 plus the Secretary’s estimate of  
13 the percentage increase in the MEI (as de-  
14 fined in section 1842(i)(3)) for the year  
15 (divided by 100), and

16                           “(ii) 1 plus the Secretary’s estimate of  
17 the update adjustment factor for the year  
18 (divided by 100),

19 minus 1 and multiplied by 100.

20                   “(B) UPDATE ADJUSTMENT FACTOR.—For  
21 purposes of subparagraph (A)(ii), the ‘update  
22 adjustment factor’ for a year is equal to the  
23 quotient (as estimated by the Secretary) of—

24                           “(i) the difference between (I) the  
25 sum of the allowed expenditures for physi-

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1           cians' services (as determined under sub-  
2           paragraph (C)) during the period begin-  
3           ning July 1, 1997, and ending on June 30  
4           of the year involved, and (II) the sum of  
5           the amount of actual expenditures for phy-  
6           sicians' services furnished during the pe-  
7           riod beginning July 1, 1997, and ending  
8           on June 30 of the preceding year; divided  
9           by

10           “(ii) the actual expenditures for physi-  
11           cians' services for the 12-month period  
12           ending on June 30 of the preceding year,  
13           increased by the sustainable growth rate  
14           under subsection (f) for the fiscal year  
15           which begins during such 12-month period.

16           “(C) DETERMINATION OF ALLOWED EX-  
17           PENDITURES.—For purposes of this paragraph,  
18           the allowed expenditures for physicians' services  
19           for the 12-month period ending with June 30  
20           of—

21           “(i) 1997 is equal to the actual ex-  
22           penditures for physicians' services fur-  
23           nished during such 12-month period, as es-  
24           timated by the Secretary; or

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1           “(ii) a subsequent year is equal to the  
2           allowed expenditures for physicians’ serv-  
3           ices for the previous year, increased by the  
4           sustainable growth rate under subsection  
5           (f) for the fiscal year which begins during  
6           such 12-month period.

7           “(D) RESTRICTION ON VARIATION FROM  
8           MEDICARE ECONOMIC INDEX.—Notwithstanding  
9           the amount of the update adjustment factor de-  
10          termined under subparagraph (B) for a year,  
11          the update in the conversion factor under this  
12          paragraph for the year may not be—

13                 “(i) greater than 100 times the fol-  
14                 lowing amount:  $(1.03 + (\text{MEI percentage}/$   
15                  $100)) - 1$ ; or

16                 “(ii) less than 100 times the following  
17                 amount:  $(0.93 + (\text{MEI percentage}/100))$   
18                  $-1$ ,

19                 where ‘MEI percentage’ means the Secretary’s  
20                 estimate of the percentage increase in the MEI  
21                 (as defined in section 1842(i)(3)) for the year  
22                 involved.”.

23           (2) EFFECTIVE DATE.—The amendment made  
24           by paragraph (1) shall apply to the update for years  
25           beginning with 1999.



1 (b) ELIMINATION OF REPORT.—Section 1848(d) (42  
2 U.S.C. 1395w-4(d)) is amended by striking paragraph  
3 (2).

4 **SEC. 10603. REPLACEMENT OF VOLUME PERFORMANCE**  
5 **STANDARD WITH SUSTAINABLE GROWTH**  
6 **RATE.**

7 (a) IN GENERAL.—Section 1848(f) (42 U.S.C.  
8 1395w-4(f)) is amended by striking paragraphs (2)  
9 through (5) and inserting the following:

10 “(2) SPECIFICATION OF GROWTH RATE.—The  
11 sustainable growth rate for all physicians’ services  
12 for a fiscal year (beginning with fiscal year 1998)  
13 shall be equal to the product of—

14 “(A) 1 plus the Secretary’s estimate of the  
15 weighted average percentage increase (divided  
16 by 100) in the fees for all physicians’ services  
17 in the fiscal year involved,

18 “(B) 1 plus the Secretary’s estimate of the  
19 percentage change (divided by 100) in the aver-  
20 age number of individuals enrolled under this  
21 part (other than MedicarePlus plan enrollees)  
22 from the previous fiscal year to the fiscal year  
23 involved,

24 “(C) 1 plus the Secretary’s estimate of the  
25 projected percentage growth in real gross do-

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1 domestic product per capita (divided by 100) from  
2 the previous fiscal year to the fiscal year in-  
3 volved, and

4 “(D) 1 plus the Secretary’s estimate of the  
5 percentage change (divided by 100) in expendi-  
6 tures for all physicians’ services in the fiscal  
7 year (compared with the previous fiscal year)  
8 which will result from changes in law and regu-  
9 lations, determined without taking into account  
10 estimated changes in expenditures due to  
11 changes in the volume and intensity of physi-  
12 cians’ services resulting from changes in the up-  
13 date to the conversion factor under subsection  
14 (d)(3),

15 minus 1 and multiplied by 100.

16 “(3) DEFINITIONS.—In this subsection:

17 “(A) SERVICES INCLUDED IN PHYSICIANS’  
18 SERVICES.—The term ‘physicians’ services’ in-  
19 cludes other items and services (such as clinical  
20 diagnostic laboratory tests and radiology serv-  
21 ices), specified by the Secretary, that are com-  
22 monly performed or furnished by a physician or  
23 in a physician’s office, but does not include  
24 services furnished to a MedicarePlus plan en-  
25 rollee.

1           “(B) MEDICAREPLUS PLAN ENROLLEE.—  
2           The term ‘MedicarePlus plan enrollee’ means,  
3           with respect to a fiscal year, an individual en-  
4           rolled under this part who has elected to receive  
5           benefits under this title for the fiscal year  
6           through a MedicarePlus plan offered under part  
7           C, and also includes an individual who is receiv-  
8           ing benefits under this part through enrollment  
9           with an eligible organization with a risk-sharing  
10          contract under section 1876.”.

11          (b) CONFORMING AMENDMENTS.—Section 1848(f)  
12 (42 U.S.C. 1395w–4(f)) is amended—

13           (1) in the heading, by striking “VOLUME PER-  
14          FORMANCE STANDARD RATES OF INCREASE” and  
15          inserting “SUSTAINABLE GROWTH RATE”; and

16           (2) in paragraph (1)—

17           (A) in the heading, by striking “VOLUME  
18          PERFORMANCE STANDARD RATES OF IN-  
19          CREASE” and inserting “SUSTAINABLE GROWTH  
20          RATE”,

21           (B) by striking subparagraphs (A) and  
22          (B); and

23           (C) in paragraph (1)(C)—

24           (i) in the heading, by striking “PER-  
25          FORMANCE STANDARD RATES OF IN-

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1           CREASE” and inserting “SUSTAINABLE  
2           GROWTH RATE”;

3           (ii) in the first sentence, by striking  
4           “with 1991), the performance standard  
5           rates of increase” and all that follows  
6           through the first period and inserting  
7           “with 1999), the sustainable growth rate  
8           for the fiscal year beginning in that year.”;  
9           and

10           (iii) in the second sentence, by strik-  
11           ing “January 1, 1990, the performance  
12           standard rate of increase under subpara-  
13           graph (D) for fiscal year 1990” and insert-  
14           ing “January 1, 1999, the sustainable  
15           growth rate for fiscal year 1999”.

16 **SEC. 10604. PAYMENT RULES FOR ANESTHESIA SERVICES.**

17           (a) IN GENERAL.—Section 1848(d)(1) (42 U.S.C.  
18 1395w-4(d)(1)), as amended by section 10601(a), is  
19 amended—

20           (1) in subparagraph (C), striking “The single”  
21           and inserting “Except as provided in subparagraph  
22           (D), the single”;

23           (2) by redesignating subparagraph (D) as sub-  
24           paragraph (E); and

1 (3) by inserting after subparagraph (C) the fol-  
2 lowing new subparagraph:

3 “(D) SPECIAL RULES FOR ANESTHESIA  
4 SERVICES.—The separate conversion factor for  
5 anesthesia services for a year shall be equal to  
6 46 percent of the single conversion factor estab-  
7 lished for other physicians’ services, except as  
8 adjusted for changes in work, practice expense,  
9 or malpractice relative value units. ”.

10 (b) CLASSIFICATION OF ANESTHESIA SERVICES.—  
11 The first sentence of section 1848(j)(1) (42 U.S.C.  
12 1395w-4(j)(1)) is amended—

13 (1) by striking “and including anesthesia serv-  
14 ices”; and

15 (2) by inserting before the period the following:  
16 “(including anesthesia services)”.

17 (c) EFFECTIVE DATE.—The amendments made by  
18 this section shall apply to services furnished on or after  
19 January 1, 1998.

20 **SEC. 10605. IMPLEMENTATION OF RESOURCE-BASED PHYSI-**  
21 **CIAN PRACTICE EXPENSE.**

22 (a) 1-YEAR DELAY IN IMPLEMENTATION.—Section  
23 1848(c) (42 U.S.C. 1395w-4(c)) is amended—

24 (1) in paragraph (2)(C)(ii), in the matter before  
25 subclause (I) and after subclause (II), by striking

1 “1998” and inserting “1999” each place it appears;

2 and

3 (2) in paragraph (3)(C)(ii), by striking “1998”

4 and inserting “1999”.

5 (b) PHASED-IN IMPLEMENTATION.—Section

6 1848(c)(2)(C)(ii) (42 U.S.C. 1395w-4(c)(2)(C)(ii)) is fur-

7 ther amended—

8 (1) in subparagraph (C)(ii), in the matter fol-

9 lowing subclause (II), by inserting “, to the extent

10 provided under subparagraph (G),” after “based”,

11 and

12 (2) by adding at the end the following new sub-

13 paragraph:

14 “(G) TRANSITIONAL RULE FOR RESOURCE-

15 BASED PRACTICE EXPENSE UNITS.—In applying

16 subparagraph (C)(ii) for 1999, 2000, 2001, and

17 any subsequent year, the number of units under

18 such subparagraph shall be based 75 percent,

19 50 percent, 25 percent, and 0 percent, respec-

20 tively, on the practice expense relative value

21 units in effect in 1998 (or the Secretary’s im-

22 putation of such units for new or revised codes)

23 and the remainder on the relative value expense

24 resources involved in furnishing the service.”.

1 **SEC. 10606. DISSEMINATION OF INFORMATION ON HIGH**  
2 **PER DISCHARGE RELATIVE VALUES FOR IN-**  
3 **HOSPITAL PHYSICIANS' SERVICES.**

4 (a) DETERMINATION AND NOTICE CONCERNING  
5 HOSPITAL-SPECIFIC PER DISCHARGE RELATIVE VAL-  
6 UES.—

7 (1) IN GENERAL.—For 1999 and 2001 the Sec-  
8 retary of Health and Human Services shall deter-  
9 mine for each hospital—

10 (A) the hospital-specific per discharge rel-  
11 ative value under subsection (b); and

12 (B) whether the hospital-specific relative  
13 value is projected to be excessive (as determined  
14 based on such value represented as a percent-  
15 age of the median of hospital-specific per dis-  
16 charge relative values determined under sub-  
17 section (b)).

18 (2) NOTICE TO MEDICAL STAFFS AND CAR-  
19 RIERS.—The Secretary shall notify the medical exec-  
20 utive committee of each hospital identifies under  
21 paragraph (1)(B) as having an excessive hospital-  
22 specific relative value, of the determinations made  
23 with respect to the medical staff under paragraph  
24 (1).

25 (b) DETERMINATION OF HOSPITAL-SPECIFIC PER  
26 DISCHARGE RELATIVE VALUES.—

1           (1) IN GENERAL.—For purposes of this section,  
2           the hospital-specific per discharge relative value for  
3           the medical staff of a hospital (other than a teaching  
4           hospital) for a year, shall be equal to the average  
5           per discharge relative value (as determined under  
6           section 1848(c)(2) of the Social Security Act) for  
7           physicians’ services furnished to inpatients of the  
8           hospital by the hospital’s medical staff (excluding in-  
9           terns and residents) during the second year preced-  
10          ing that calendar year, adjusted for variations in  
11          case-mix and disproportionate share status among  
12          hospitals (as determined by the Secretary under  
13          paragraph (3)).

14          (2) SPECIAL RULE FOR TEACHING HOS-  
15          PITALS.—The hospital-specific relative value pro-  
16          jected for a teaching hospital in a year shall be equal  
17          to the sum of—

18                 (A) the average per discharge relative  
19                 value (as determined under section 1848(c)(2)  
20                 of such Act) for physicians’ services furnished  
21                 to inpatients of the hospital by the hospital’s  
22                 medical staff (excluding interns and residents)  
23                 during the second year preceding that calendar  
24                 year, and



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1 (B) the equivalent per discharge relative  
2 value (as determined under such section) for  
3 physicians' services furnished to inpatients of  
4 the hospital by interns and residents of the hos-  
5 pital during the second year preceding that cal-  
6 endar year, adjusted for variations in case-mix,  
7 disproportionate share status, and teaching sta-  
8 tus among hospitals (as determined by the Sec-  
9 retary under paragraph (3)).

10 The Secretary shall determine the equivalent relative  
11 value unit per discharge for interns and residents  
12 based on the best available data and may make such  
13 adjustment in the aggregate.

14 (3) ADJUSTMENT FOR TEACHING AND DIS-  
15 PROPORTIONATE SHARE HOSPITALS.—The Secretary  
16 shall adjust the allowable per discharge relative val-  
17 ues otherwise determined under this subsection to  
18 take into account the needs of teaching hospitals  
19 and hospitals receiving additional payments under  
20 subparagraphs (F) and (G) of section 1886(d)(5) of  
21 the Social Security Act. The adjustment for teaching  
22 status or disproportionate share shall not be less  
23 than zero.

24 (c) DEFINITIONS.—For purposes of this section:

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1 (1) HOSPITAL.—The term “hospital” means a  
2 subsection (d) hospital as defined in section 1886(d)  
3 of the Social Security Act (42 U.S.C. 1395ww(d)) .

4 (2) MEDICAL STAFF.—An individual furnishing  
5 a physician’s service is considered to be on the medi-  
6 cal staff of a hospital—

7 (A) if (in accordance with requirements for  
8 hospitals established by the Joint Commission  
9 on Accreditation of Health Organizations)—

10 (i) the individual is subject to bylaws,  
11 rules, and regulations established by the  
12 hospital to provide a framework for the  
13 self-governance of medical staff activities,

14 (ii) subject to the bylaws, rules, and  
15 regulations, the individual has clinical  
16 privileges granted by the hospital’s govern-  
17 ing body, and

18 (iii) under the clinical privileges, the  
19 individual may provide physicians’ services  
20 independently within the scope of the indi-  
21 vidual’s clinical privileges, or

22 (B) if the physician provides at least one  
23 service to an individual entitled to benefits  
24 under this title in that hospital.

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1           (3) PHYSICIANS' SERVICES.—The term “physi-  
2           cians” services” means the services described in sec-  
3           tion 1848(j)(3) of the Social Security Act (42 U.S.C.  
4           1395w-4(j)(3)).

5           (4) RURAL AREA; URBAN AREA.—The terms  
6           “rural area” and “urban area” have the meaning  
7           given those terms under section 1886(d)(2)(D) of  
8           such Act (42 U.S.C. 1395ww(d)(2)(D)).

9           (5) SECRETARY.—The term “Secretary” means  
10          the Secretary of Health and Human Services .

11          (6) TEACHING HOSPITAL.—The term “teaching  
12          hospital” means a hospital which has a teaching pro-  
13          gram approved as specified in section 1861(b)(6) of  
14          the Social Security Act (42 U.S.C. 1395x(b)(6)).

15 **SEC. 10607. NO X-RAY REQUIRED FOR CHIROPRACTIC SERV-**  
16 **ICES.**

17          (a) IN GENERAL.—Section 1861(r)(5) (42 U.S.C.  
18          1395x(r)(5)) is amended by striking “demonstrated by X-  
19          ray to exist”.

20          (b) EFFECTIVE DATE.—The amendment made by  
21          subsection (a) applies to services furnished on or after  
22          January 1, 1998.

1 **SEC. 10608. TEMPORARY COVERAGE RESTORATION FOR**  
2 **PORTABLE ELECTROCARDIOGRAM TRANS-**  
3 **PORTATION.**

4 (a) IN GENERAL.—Effective for electrocardiogram  
5 tests furnished during 1998, the Secretary of Health and  
6 Human Services shall restore separate payment, under  
7 part B of title XVIII of the Social Security Act, for the  
8 transportation of electrocardiogram equipment (HCPCS  
9 code R0076) based upon the status code and relative value  
10 units established for such service as of December 31,  
11 1996.

12 (b) DETERMINATION.—By not later than July 1,  
13 1998, the Secretary of Health and Human Services shall  
14 determine, taking into account the study of coverage of  
15 portable electrocardiogram transportation conducted by  
16 the Comptroller General and other relevant information,  
17 including information submitted by interested parties,  
18 whether coverage of portable electrocardiogram transpor-  
19 tation should be provided under part B of title XVIII of  
20 the Social Security Act.

21 **CHAPTER 2—OTHER PAYMENT**  
22 **PROVISIONS**

23 **SEC. 10611. PAYMENTS FOR DURABLE MEDICAL EQUIP-**  
24 **MENT.**

25 (a) REDUCTION IN PAYMENT AMOUNTS FOR ITEMS  
26 OF DURABLE MEDICAL EQUIPMENT.—

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1           (1) FREEZE IN UPDATE FOR COVERED  
2 ITEMS.—Section 1834(a)(14) (42 U.S.C.  
3 1395m(a)(14)) is amended—

4           (A) by striking “and” at the end of sub-  
5 paragraph (A);

6           (B) in subparagraph (B)—

7           (i) by striking “a subsequent year”  
8 and inserting “1993, 1994, 1995, 1996,  
9 and 1997”, and

10           (ii) by striking the period at the end  
11 and inserting a semicolon; and

12           (C) by adding at the end the following:

13           “(C) for each of the years 1998 through  
14 2002, 0 percentage points; and

15           “(D) for a subsequent year, the percentage  
16 increase in the consumer price index for all  
17 urban consumers (U.S. urban average) for the  
18 12-month period ending with June of the pre-  
19 vious year.”.

20           (2) UPDATE FOR ORTHOTICS AND PROSTHET-  
21 ICS.—Section 1834(h)(4)(A) (42 U.S.C.  
22 1395m(h)(4)(A)) is amended—

23           (A) by striking “, and” at the end of  
24 clause (iii) and inserting a semicolon;

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1 (B) in clause (iv), by striking “a subse-  
2 quent year” and inserting “1996 and 1997”,  
3 and

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

6 “(v) for each of the years 1998  
7 through 2002, 1 percent, and

8 “(vi) for a subsequent year, the per-  
9 centage increase in the consumer price  
10 index for all urban consumers (United  
11 States city average) for the 12-month pe-  
12 riod ending with June of the previous  
13 year;”.

14 (c) PAYMENT FREEZE FOR PARENTERAL AND EN-  
15 TERAL NUTRIENTS, SUPPLIES, AND EQUIPMENT.—In de-  
16 termining the amount of payment under part B of title  
17 XVIII of the Social Security Act with respect to parenteral  
18 and enteral nutrients, supplies, and equipment during  
19 each of the years 1998 through 2002, the charges deter-  
20 mined to be reasonable with respect to such nutrients,  
21 supplies, and equipment may not exceed the charges deter-  
22 mined to be reasonable with respect to such nutrients,  
23 supplies, and equipment during 1995.

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1 **SEC. 10612. OXYGEN AND OXYGEN EQUIPMENT.**

2 Section 1834(a)(9)(C) (42 U.S.C. 1395m(a)(9)(C))  
3 is amended—

4 (1) by striking “and” at the end of clause (iii);

5 (2) in clause (iv)—

6 (A) by striking “a subsequent year” and  
7 inserting “1993, 1994, 1995, 1996, and 1997”,  
8 and

9 (B) by striking the period at the end and  
10 inserting a semicolon; and

11 (3) by adding at the end the following new  
12 clauses:

13 “(v) in each of the years 1998  
14 through 2002, is 80 percent of the national  
15 limited monthly payment rate computed  
16 under subparagraph (B) for the item for  
17 the year; and

18 “(vi) in a subsequent year, is the na-  
19 tional limited monthly payment rate com-  
20 puted under subparagraph (B) for the item  
21 for the year.”.

22 **SEC. 10613. REDUCTION IN UPDATES TO PAYMENT**  
23 **AMOUNTS FOR CLINICAL DIAGNOSTIC LAB-**  
24 **ORATORY TESTS.**

25 (a) CHANGE IN UPDATE.—Section  
26 1833(h)(2)(A)(ii)(IV) (42 U.S.C. 1395l(h)(2)(A)(ii)(IV))

1 is amended by inserting “and 1998 through 2002” after  
2 “1995”.

3 (b) LOWERING CAP ON PAYMENT AMOUNTS.—Sec-  
4 tion 1833(h)(4)(B) (42 U.S.C. 1395l(h)(4)(B)) is amend-  
5 ed—

6 (1) in clause (vi), by striking “and” at the end;

7 (2) in clause (vii)—

8 (A) by inserting “and before January 1,  
9 1998,” after “1995,” and

10 (B) by striking the period at the end and  
11 inserting “, and”; and

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

14 “(viii) after December 31, 1997, is equal to 72  
15 percent of such median.”.

16 **SEC. 10614. SIMPLIFICATION IN ADMINISTRATION OF LAB-**  
17 **ORATORY TESTS.**

18 (a) SELECTION OF REGIONAL CARRIERS.—

19 (1) IN GENERAL.—The Secretary of Health and  
20 Human Services (in this section referred to as the  
21 “Secretary”) shall—

22 (A) divide the United States into no more  
23 than 5 regions, and

24 (B) designate a single carrier for each such  
25 region,



1 for the purpose of payment of claims under part B  
2 of title XVIII of the Social Security Act with respect  
3 to clinical diagnostic laboratory tests (other than for  
4 independent physician offices) furnished on or after  
5 such date (not later than January 1, 1999) as the  
6 Secretary specifies.

7 (2) DESIGNATION.—In designating such car-  
8 riers, the Secretary shall consider, among other cri-  
9 teria—

10 (A) a carrier’s timeliness, quality, and ex-  
11 perience in claims processing, and

12 (B) a carrier’s capacity to conduct elec-  
13 tronic data interchange with laboratories and  
14 data matches with other carriers.

15 (3) SINGLE DATA RESOURCE.—The Secretary  
16 may select one of the designated carriers to serve as  
17 a central statistical resource for all claims informa-  
18 tion relating to such clinical diagnostic laboratory  
19 tests handled by all the designated carriers under  
20 such part.

21 (4) ALLOCATION OF CLAIMS.—The allocation of  
22 claims for clinical diagnostic laboratory tests to par-  
23 ticular designated carriers shall be based on whether  
24 a carrier serves the geographic area where the lab-

1 oratory specimen was collected or other method  
2 specified by the Secretary.

3 (b) ADOPTION OF UNIFORM POLICIES FOR CLINICAL  
4 LABORATORY TESTS.—

5 (1) IN GENERAL.—Not later than July 1, 1998,  
6 the Secretary shall first adopt, consistent with para-  
7 graph (2), uniform coverage, administration, and  
8 payment policies for clinical diagnostic laboratory  
9 tests under part B of title XVIII of the Social Secu-  
10 rity Act, using a negotiated rulemaking process  
11 under subchapter III of chapter 5 of title 5, United  
12 States Code.

13 (2) CONSIDERATIONS IN DESIGN OF UNIFORM  
14 POLICIES.—The policies under paragraph (1) shall  
15 be designed to promote uniformity and program in-  
16 tegrity and reduce administrative burdens with re-  
17 spect to clinical diagnostic laboratory tests payable  
18 under such part in connection with the following:

19 (A) Beneficiary information required to be  
20 submitted with each claim or order for labora-  
21 tory tests.

22 (B) Physicians' obligations regarding docu-  
23 mentation requirements and recordkeeping.

24 (C) Procedures for filing claims and for  
25 providing remittances by electronic media.

1 (D) The documentation of medical neces-  
2 sity.

3 (E) Limitation on frequency of coverage  
4 for the same tests performed on the same indi-  
5 vidual.

6 (3) CHANGES IN CARRIER REQUIREMENTS  
7 PENDING ADOPTION OF UNIFORM POLICY.—During  
8 the period that begins on the date of the enactment  
9 of this Act and ends on the date the Secretary first  
10 implements uniform policies pursuant to regulations  
11 promulgated under this subsection, a carrier under  
12 such part may implement changes relating to re-  
13 quirements for the submission of a claim for clinical  
14 diagnostic laboratory tests.

15 (4) USE OF INTERIM REGIONAL POLICIES.—  
16 After the date the Secretary first implements such  
17 uniform policies, the Secretary shall permit any car-  
18 rier to develop and implement interim policies of the  
19 type described in paragraph (1), in accordance with  
20 guidelines established by the Secretary, in cases in  
21 which a uniform national policy has not been estab-  
22 lished under this subsection and there is a dem-  
23 onstrated need for a policy to respond to aberrant  
24 utilization or provision of unnecessary services. Ex-  
25 cept as the Secretary specifically permits, no policy

1 shall be implemented under this paragraph for a pe-  
2 riod of longer than 2 years.

3 (5) INTERIM NATIONAL POLICIES.—After the  
4 date the Secretary first designates regional carriers  
5 under subsection (a), the Secretary shall establish a  
6 process under which designated carriers can collec-  
7 tively develop and implement interim national stand-  
8 ards of the type described in paragraph (1). No such  
9 policy shall be implemented under this paragraph for  
10 a period of longer than 2 years.

11 (6) BIENNIAL REVIEW PROCESS.—Not less  
12 often than once every 2 years, the Secretary shall  
13 solicit and review comments regarding changes in  
14 the uniform policies established under this sub-  
15 section. As part of such biennial review process, the  
16 Secretary shall specifically review and consider  
17 whether to incorporate or supersede interim, re-  
18 gional, or national policies developed under para-  
19 graph (4) or (5). Based upon such review, the Sec-  
20 retary may provide for appropriate changes in the  
21 uniform policies previously adopted under this sub-  
22 section.

23 (7) NOTICE.— Before a carrier implements a  
24 change or policy under paragraph (3), (4), or (5),  
25 the carrier shall provide for advance notice to inter-

1       ested parties and a 45-day period in which such par-  
2       ties may submit comments on the proposed change.

3       (c) INCLUSION OF LABORATORY REPRESENTATIVE  
4 ON CARRIER ADVISORY COMMITTEES.—The Secretary  
5 shall direct that any advisory committee established by  
6 such a carrier, to advise with respect to coverage, adminis-  
7 tration or payment policies under part B of title XVIII  
8 of the Social Security Act, shall include an individual to  
9 represent the interest and views of independent clinical  
10 laboratories and such other laboratories as the Secretary  
11 deems appropriate. Such individual shall be selected by  
12 such committee from among nominations submitted by na-  
13 tional and local organizations that represent independent  
14 clinical laboratories.

15 **SEC. 10615. UPDATES FOR AMBULATORY SURGICAL SERV-**  
16 **ICES.**

17       Section 1833(i)(2)(C) (42 U.S.C. 1395l(i)(2)(C)) is  
18 amended by striking all that follows “shall be increased”  
19 and inserting the following: “as follows:

20               “(i) For fiscal years 1996 and 1997, by the  
21       percentage increase in the consumer price index for  
22       all urban consumers (U.S. city average) as estimated  
23       by the Secretary for the 12-month period ending  
24       with the midpoint of the year involved.

1           “(ii) For each of fiscal years 1998 through  
2           2002 by such percentage increase minus 2.0 percent-  
3           age points.

4           “(iii) For each succeeding fiscal year by such  
5           percentage increase.”.

6 **SEC. 10616. REIMBURSEMENT FOR DRUGS AND**  
7           **BIOLOGICALS.**

8           (a) IN GENERAL.—Section 1842 (42 U.S.C. 1395u)  
9           is amended by inserting after subsection (n) the following  
10          new subsection:

11          “(o) If a physician’s, supplier’s, or any other person’s  
12          bill or request for payment for services includes a charge  
13          for a drug or biological for which payment may be made  
14          under this part and the drug or biological is not paid on  
15          a cost or prospective payment basis as otherwise provided  
16          in this part, the amount payable for the drug or biological  
17          is equal to 95 percent of the average wholesale price.”.

18          (b) EFFECTIVE DATE.—The amendments made by  
19          subsection (a) apply to drugs and biologicals furnished on  
20          or after January 1, 1998.

21 **SEC. 10617. COVERAGE OF ORAL ANTI-NAUSEA DRUGS**  
22           **UNDER CHEMOTHERAPEUTIC REGIMEN.**

23          (a) IN GENERAL.—Section 1861(s)(2) (42 U.S.C.  
24          1395x(s)(2)), as amended, is further amended—

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1 (1) by striking “and” at the end of subpara-  
2 graph (R); and

3 (2) by inserting after subparagraph (S) the fol-  
4 lowing new subparagraph:

5 “(T) an oral drug (which is approved by the  
6 Federal Food and Drug Administration) prescribed  
7 for use as an acute anti-emetic used as part of an  
8 anticancer chemotherapeutic regimen if the drug is  
9 administered by a physician (or under the super-  
10 vision of a physician)—

11 “(i) for use immediately before, imme-  
12 diately after, or at the time of the administra-  
13 tion of the anticancer chemotherapeutic agent;  
14 and

15 “(ii) as a full replacement for the anti-  
16 emetic therapy which would otherwise be ad-  
17 ministered intravenously.”.

18 (b) PAYMENT LEVELS.—Section 1834 (42 U.S.C.  
19 1395m), as amended by sections 10421(a)(2) and  
20 10431(b)(2), is amended by adding at the end the follow-  
21 ing new subsection:

22 “(m) SPECIAL RULES FOR PAYMENT FOR ORAL  
23 ANTI-NAUSEA DRUGS.—

24 “(1) LIMITATION ON PER DOSE PAYMENT  
25 BASIS.—Subject to paragraph (2), the per dose pay-

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1 ment basis under this part for oral anti-nausea  
2 drugs (as defined in paragraph (3)) administered  
3 during a year shall not exceed 90 percent of the av-  
4 erage per dose payment basis for the equivalent in-  
5 travenous anti-emetics administered during the year,  
6 as computed based on the payment basis applied  
7 during 1996.

8 “(2) AGGREGATE LIMIT.—The Secretary shall  
9 make such adjustment in the coverage of, or pay-  
10 ment basis for, oral anti-nausea drugs so that cov-  
11 erage of such drugs under this part does not result  
12 in any increase in aggregate payments per capita  
13 under this part above the levels of such payments  
14 per capita that would otherwise have been made if  
15 there were no coverage for such drugs under this  
16 part.

17 “(3) ORAL ANTI-NAUSEA DRUGS DEFINED.—  
18 For purposes of this subsection, the term ‘oral anti-  
19 nausea drugs’ means drugs for which coverage is  
20 provided under this part pursuant to section  
21 1861(s)(2)(P).”.

22 (c) EFFECTIVE DATE.—The amendments made by  
23 this section shall apply to items and services furnished on  
24 or after January 1, 1998.



1 **SEC. 10618. RURAL HEALTH CLINIC SERVICES.**

2 (a) PER-VISIT PAYMENT LIMITS FOR PROVIDER-  
3 BASED CLINICS.—

4 (1) EXTENSION OF LIMIT.—

5 (A) IN GENERAL.—The matter in section  
6 1833(f) (42 U.S.C. 1395l(f)) preceding para-  
7 graph (1) is amended by striking “independent  
8 rural health clinics” and inserting “rural health  
9 clinics (other than such clinics in rural hospitals  
10 with less than 50 beds)”.

11 (B) EFFECTIVE DATE.—The amendment  
12 made by subparagraph (A) applies to services  
13 furnished after 1997.

14 (2) TECHNICAL CLARIFICATION.—Section  
15 1833(f)(1) (42 U.S.C. 1395l(f)(1)) is amended by  
16 inserting “per visit” after “\$46”.

17 (b) ASSURANCE OF QUALITY SERVICES.—

18 (1) IN GENERAL.—Subparagraph (I) of the  
19 first sentence of section 1861(aa)(2) (42 U.S.C.  
20 1395x(aa)(2)) is amended to read as follows:

21 “(I) has a quality assessment and performance  
22 improvement program, and appropriate procedures  
23 for review of utilization of clinic services, as the Sec-  
24 retary may specify.”.

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1           (2) EFFECTIVE DATE.—The amendment  
2           made by paragraph (1) shall take effect on Jan-  
3           uary 1, 1998.

4           (c) WAIVER OF CERTAIN STAFFING REQUIREMENTS  
5 LIMITED TO CLINICS IN PROGRAM.—

6           (1) IN GENERAL.—Section 1861(aa)(7)(B) (42  
7           U.S.C. 1395x(aa)(7)(B)) is amended by inserting  
8           before the period at the end the following: “, or if  
9           the facility has not yet been determined to meet the  
10          requirements (including subparagraph (J) of the  
11          first sentence of paragraph (2)) of a rural health  
12          clinic”.

13          (2) EFFECTIVE DATE.—The amendment made  
14          by paragraph (1) applies to waiver requests made  
15          after 1997.

16          (d) REFINEMENT OF SHORTAGE AREA REQUIRE-  
17 MENTS.—

18          (1) DESIGNATION REVIEWED TRIENNIALLY.—  
19          Section 1861(aa)(2) (42 U.S.C. 1395x(aa)(2)) is  
20          amended in the second sentence, in the matter in  
21          clause (i) preceding subclause (I)—

22                  (A) by striking “and that is designated”  
23                  and inserting “and that, within the previous  
24                  three-year period, has been designated”; and

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1 (B) by striking “or that is designated” and  
2 inserting “or designated”.

3 (2) AREA MUST HAVE SHORTAGE OF HEALTH  
4 CARE PRACTITIONERS.—Section 1861(aa)(2) (42  
5 U.S.C. 1395x(aa)(2)), as amended by paragraph (1),  
6 is further amended in the second sentence, in the  
7 matter in clause (i) preceding subclause (I)—

8 (A) by striking the comma after “personal  
9 health services”; and

10 (B) by inserting “and in which there are  
11 insufficient numbers of needed health care prac-  
12 titioners (as determined by the Secretary),”  
13 after “Bureau of the Census)”.

14 (3) PREVIOUSLY QUALIFYING CLINICS GRAND-  
15 FATHERED ONLY TO PREVENT SHORTAGE.—Section  
16 1861(aa)(2) (42 U.S.C. 1395x(aa)(2)) is amended in  
17 the third sentence by inserting before the period “if  
18 it is determined, in accordance with criteria estab-  
19 lished by the Secretary in regulations, to be essential  
20 to the delivery of primary care services that would  
21 otherwise be unavailable in the geographic area  
22 served by the clinic”.

23 (4) EFFECTIVE DATES; IMPLEMENTING REGU-  
24 LATIONS.—

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1 (A) IN GENERAL.—Except as otherwise  
2 provided, the amendments made by the preced-  
3 ing paragraphs take effect on January 1 of the  
4 first calendar year beginning at least one month  
5 after enactment of this Act.

6 (B) CURRENT RURAL HEALTH CLINICS.—  
7 The amendments made by the preceding para-  
8 graphs take effect, with respect to entities that  
9 are rural health clinics under title XVIII of the  
10 Social Security Act on the date of enactment of  
11 this Act, on January 1 of the second calendar  
12 year following the calendar year specified in  
13 subparagraph (A).

14 (C) GRANDFATHERED CLINICS.—

15 (i) IN GENERAL.—The amendment  
16 made by paragraph (3) shall take effect on  
17 the effective date of regulations issued by  
18 the Secretary under clause (ii).

19 (ii) REGULATIONS.—The Secretary  
20 shall issue final regulations implementing  
21 paragraph (3) that shall take effect no  
22 later than January 1 of the third calendar  
23 year beginning at least one month after en-  
24 actment of this Act.

1 **SEC. 10619. INCREASED MEDICARE REIMBURSEMENT FOR**  
2 **NURSE PRACTITIONERS AND CLINICAL**  
3 **NURSE SPECIALISTS.**

4 (a) REMOVAL OF RESTRICTIONS ON SETTINGS.—

5 (1) IN GENERAL.—Clause (ii) of section  
6 1861(s)(2)(K) (42 U.S.C. 1395x(s)(2)(K)) is  
7 amended to read as follows:

8 “(ii) services which would be physicians’ serv-  
9 ices if furnished by a physician (as defined in sub-  
10 section (r)(1)) and which are performed by a nurse  
11 practitioner or clinical nurse specialist (as defined in  
12 subsection (aa)(5)) working in collaboration (as de-  
13 fined in subsection (aa)(6)) with a physician (as de-  
14 fined in subsection (r)(1)) which the nurse practi-  
15 tioner or clinical nurse specialist is legally authorized  
16 to perform by the State in which the services are  
17 performed, and such services and supplies furnished  
18 as an incident to such services as would be covered  
19 under subparagraph (A) if furnished incident to a  
20 physician’s professional service, but only if no facil-  
21 ity or other provider charges or is paid any amounts  
22 with respect to the furnishing of such services;”.

23 (2) CONFORMING AMENDMENTS.—(A) Section  
24 1861(s)(2)(K) of such Act (42 U.S.C.  
25 1395x(s)(2)(K)) is further amended—

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1 (i) in clause (i), by inserting “and such  
2 services and supplies furnished as incident to  
3 such services as would be covered under sub-  
4 paragraph (A) if furnished incident to a physi-  
5 cian’s professional service,” after “are per-  
6 formed,”; and

7 (ii) by striking clauses (iii) and (iv).

8 (B) Section 1861(b)(4) (42 U.S.C.  
9 1395x(b)(4)) is amended by striking “clauses (i) or  
10 (iii) of subsection (s)(2)(K)” and inserting “sub-  
11 section (s)(2)(K)”.

12 (C) Section 1862(a)(14) (42 U.S.C.  
13 1395y(a)(14)) is amended by striking “section  
14 1861(s)(2)(K)(i) or 1861(s)(2)(K)(iii)” and insert-  
15 ing “section 1861(s)(2)(K)”.

16 (D) Section 1866(a)(1)(H) (42 U.S.C.  
17 1395cc(a)(1)(H)) is amended by striking “section  
18 1861(s)(2)(K)(i) or 1861(s)(2)(K)(iii)” and insert-  
19 ing “section 1861(s)(2)(K)”.

20 (E) Section 1888(e)(2)(A)(ii) (42 U.S.C.  
21 1395yy(e)(2)(A)(ii)), as added by section 10401(a),  
22 is amended by striking “through (iii)” and inserting  
23 “and (ii)”.

24 (b) INCREASED PAYMENT.—

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1           (1) FEE SCHEDULE AMOUNT.—Clause (O) of  
2 section 1833(a)(1) (42 U.S.C. 1395l(a)(1)) is  
3 amended to read as follows: “(O) with respect to  
4 services described in section 1861(s)(2)(K)(ii) (relat-  
5 ing to nurse practitioner or clinical nurse specialist  
6 services), the amounts paid shall be equal to 80 per-  
7 cent of (i) the lesser of the actual charge or 85 per-  
8 cent of the fee schedule amount provided under sec-  
9 tion 1848, or (ii) in the case of services as an assist-  
10 ant at surgery, the lesser of the actual charge or 85  
11 percent of the amount that would otherwise be rec-  
12 ognized if performed by a physician who is serving  
13 as an assistant at surgery; and”.

14           (2) CONFORMING AMENDMENTS.—(A) Section  
15 1833(r) (42 U.S.C. 1395l(r)) is amended—

16           (i) in paragraph (1), by striking “section  
17 1861(s)(2)(K)(iii) (relating to nurse practi-  
18 tioner or clinical nurse specialist services pro-  
19 vided in a rural area)” and inserting “section  
20 1861(s)(2)(K)(ii) (relating to nurse practitioner  
21 or clinical nurse specialist services)”;

22           (ii) by striking paragraph (2);

23           (iii) in paragraph (3), by striking “section  
24 1861(s)(2)(K)(iii)” and inserting “section  
25 1861(s)(2)(K)(ii)”;

1 (iv) by redesignating paragraph (3) as  
2 paragraph (2).

3 (B) Section 1842(b)(12)(A) (42 U.S.C.  
4 1395u(b)(12)(A)) is amended, in the matter preced-  
5 ing clause (i), by striking “clauses (i), (ii), or (iv) of  
6 section 1861(s)(2)(K) (relating to a physician assist-  
7 ants and nurse practitioners)” and inserting “sec-  
8 tion 1861(s)(2)(K)(i) (relating to physician assist-  
9 ants),”.

10 (c) DIRECT PAYMENT FOR NURSE PRACTITIONERS  
11 AND CLINICAL NURSE SPECIALISTS.—

12 (1) IN GENERAL.—Section 1832(a)(2)(B)(iv)  
13 (42 U.S.C. 1395k(a)(2)(B)(iv)) is amended by strik-  
14 ing “provided in a rural area (as defined in section  
15 1886(d)(2)(D))” and inserting “but only if no facil-  
16 ity or other provider charges or is paid any amounts  
17 with respect to the furnishing of such services”.

18 (2) CONFORMING AMENDMENT.—Section  
19 1842(b)(6)(C) (42 U.S.C. 1395u(b)(6)(C)) is  
20 amended—

21 (A) by striking “clauses (i), (ii), or (iv)”  
22 and inserting “clause (i)”; and

23 (B) by striking “or nurse practitioner”.



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1 (d) DEFINITION OF CLINICAL NURSE SPECIALIST

2 CLARIFIED.— Section 1861(aa)(5) (42 U.S.C.

3 1395x(aa)(5)) is amended—

4 (1) by inserting “(A)” after “(5)”;

5 (2) by striking “The term ‘physician assistant’

6 ” and all that follows through “who performs” and

7 inserting “The term ‘physician assistant’ and the

8 term ‘nurse practitioner’ mean, for purposes of this

9 title, a physician assistant or nurse practitioner who

10 performs”; and

11 (3) by adding at the end the following new sub-

12 paragraph:

13 “(B) The term ‘clinical nurse specialist’ means, for

14 purposes of this title, an individual who—

15 “(i) is a registered nurse and is licensed to

16 practice nursing in the State in which the clinical

17 nurse specialist services are performed; and

18 “(ii) holds a master’s degree in a defined clini-

19 cal area of nursing from an accredited educational

20 institution.”.

21 (e) EFFECTIVE DATE.—The amendments made by

22 this section shall apply with respect to services furnished

23 and supplies provided on and after January 1, 1998.

1 **SEC. 10620. INCREASED MEDICARE REIMBURSEMENT FOR**  
2 **PHYSICIAN ASSISTANTS.**

3 (a) REMOVAL OF RESTRICTION ON SETTINGS.—Sec-  
4 tion 1861(s)(2)(K)(i) (42 U.S.C. 1395x(s)(2)(K)(i)) is  
5 amended—

6 (1) by striking “(I) in a hospital” and all that  
7 follows through “shortage area,” and

8 (2) by adding at the end the following: “but  
9 only if no facility or other provider charges or is  
10 paid any amounts with respect to the furnishing of  
11 such services,”.

12 (b) INCREASED PAYMENT.—Paragraph (12) of sec-  
13 tion 1842(b) (42 U.S.C. 1395u(b)), as amended by section  
14 10619(b)(2)(B), is amended to read as follows:

15 “(12) With respect to services described in section  
16 1861(s)(2)(K)(i)—

17 “(A) payment under this part may only be  
18 made on an assignment-related basis; and

19 “(B) the amounts paid under this part shall be  
20 equal to 80 percent of (i) the lesser of the actual  
21 charge or 85 percent of the fee schedule amount  
22 provided under section 1848 for the same service  
23 provided by a physician who is not a specialist; or  
24 (ii) in the case of services as an assistant at surgery,  
25 the lesser of the actual charge or 85 percent of the  
26 amount that would otherwise be recognized if per-

1 formed by a physician who is serving as an assistant  
2 at surgery.”.

3 (c) REMOVAL OF RESTRICTION ON EMPLOYMENT  
4 RELATIONSHIP.—Section 1842(b)(6) (42 U.S.C.  
5 1395u(b)(6)) is amended by adding at the end the follow-  
6 ing new sentence: “For purposes of clause (C) of the first  
7 sentence of this paragraph, an employment relationship  
8 may include any independent contractor arrangement, and  
9 employer status shall be determined in accordance with  
10 the law of the State in which the services described in such  
11 clause are performed.”.

12 (d) EFFECTIVE DATE.—The amendments made by  
13 this section shall apply with respect to services furnished  
14 and supplies provided on and after January 1, 1998.

15 **SEC. 10621. RENAL DIALYSIS-RELATED SERVICES.**

16 (a) AUDITING OF COST REPORTS.—The Secretary  
17 shall audit a sample of cost reports of renal dialysis pro-  
18 viders for 1995 and for each third year thereafter.

19 (b) IMPLEMENTATION OF QUALITY STANDARDS.—  
20 The Secretary of Health and Human Services shall de-  
21 velop and implement, by not later than January 1, 1999,  
22 a method to measure and report quality of renal dialysis  
23 services provided under the medicare program under title  
24 XVIII of the Social Security Act in order to reduce pay-  
25 ments for inappropriate or low quality care.

1           **CHAPTER 3—PART B PREMIUM**

2   **SEC. 10631. PART B PREMIUM.**

3           (a) IN GENERAL.—The first, second and third sen-  
4 tences of section 1839(a)(3) (42 U.S.C. 1395r(a)(3)) are  
5 amended to read as follows: “The Secretary, during Sep-  
6 tember of each year, shall determine and promulgate a  
7 monthly premium rate for the succeeding calendar year.  
8 That monthly premium rate shall be equal to 50 percent  
9 of the monthly actuarial rate for enrollees age 65 and over,  
10 determined according to paragraph (1), for that succeed-  
11 ing calendar year.”.

12           (b) CONFORMING AND TECHNICAL AMENDMENTS.—

13               (1) SECTION 1839.—Section 1839 (42 U.S.C.  
14 1395r) is amended—

15                       (A) in subsection (a)(2), by striking “(b)  
16 and (e)” and inserting “(b), (c), and (f)”,

17                       (B) in the last sentence of subsection  
18 (a)(3)—

19                               (i) by inserting “rate” after “pre-  
20 mium”, and

21                               (ii) by striking “and the derivation of  
22 the dollar amounts specified in this para-  
23 graph”,

24                       (C) by striking subsection (e), and

1 (D) by redesignating subsection (g) as sub-  
2 section (e) and inserting that subsection after  
3 subsection (d).

4 (2) SECTION 1844.—Subparagraphs (A)(i) and  
5 (B)(i) of section 1844(a)(1) (42 U.S.C.  
6 1395w(a)(1)) are each amended by striking “or  
7 1839(e), as the case may be”.

8 **Subtitle H—Provisions Relating to**  
9 **Parts A and B**

10 **CHAPTER 1—PROVISIONS RELATING TO**  
11 **MEDICARE SECONDARY PAYER**

12 **SEC. 10701. PERMANENT EXTENSION AND REVISION OF**  
13 **CERTAIN SECONDARY PAYER PROVISIONS.**

14 (a) APPLICATION TO DISABLED INDIVIDUALS IN  
15 LARGE GROUP HEALTH PLANS.—

16 (1) IN GENERAL.—Section 1862(b)(1)(B) (42  
17 U.S.C. 1395y(b)(1)(B)) is amended—

18 (A) in clause (i), by striking “clause (iv)”  
19 and inserting “clause (iii)”,

20 (B) by striking clause (iii), and

21 (C) by redesignating clause (iv) as clause  
22 (iii).

23 (2) CONFORMING AMENDMENTS.—Paragraphs  
24 (1) through (3) of section 1837(i) (42 U.S.C.  
25 1395p(i)) and the second sentence of section

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1 1839(b) (42 U.S.C. 1395r(b)) are each amended by  
2 striking “1862(b)(1)(B)(iv)” each place it appears  
3 and inserting “1862(b)(1)(B)(iii)”.

4 (b) INDIVIDUALS WITH END STAGE RENAL DIS-  
5 EASE.—

6 (1) IN GENERAL.—Section 1862(b)(1)(C) (42  
7 U.S.C. 1395y(b)(1)(C)) is amended—

8 (A) in the first sentence, by striking “12-  
9 month” each place it appears and inserting  
10 “30-month”, and

11 (B) by striking the second sentence.

12 (2) EFFECTIVE DATE.—The amendments made  
13 by paragraph (1) shall apply to items and services  
14 furnished on or after the date of the enactment of  
15 this Act and with respect to periods beginning on or  
16 after the date that is 18 months prior to such date.

17 (c) IRS-SSA-HCFA DATA MATCH.—

18 (1) SOCIAL SECURITY ACT.—Section  
19 1862(b)(5)(C) (42 U.S.C. 1395y(b)(5)(C)) is  
20 amended by striking clause (iii).

21 (2) INTERNAL REVENUE CODE.—Section  
22 6103(l)(12) of the Internal Revenue Code of 1986 is  
23 amended by striking subparagraph (F).

1 **SEC. 10702. CLARIFICATION OF TIME AND FILING LIMITA-**  
2 **TIONS.**

3 (a) **EXTENSION OF CLAIMS FILING PERIOD.**—Sec-  
4 tion 1862(b)(2)(B) (42 U.S.C. 1395y(b)(2)(B)) is amend-  
5 ed by adding at the end the following new clause:

6 “(v) **CLAIMS-FILING PERIOD.**—Not-  
7 withstanding any other time limits that  
8 may exist for filing a claim under an em-  
9 ployer group health plan, the United  
10 States may seek to recover conditional pay-  
11 ments in accordance with this subpara-  
12 graph where the request for payment is  
13 submitted to the entity required or respon-  
14 sible under this subsection to pay with re-  
15 spect to the item or service (or any portion  
16 thereof) under a primary plan within the  
17 3-year period beginning on the date on  
18 which the item or service was furnished.”.

19 (b) **EFFECTIVE DATE.**—The amendment made by  
20 subsection (a) applies to items and services furnished after  
21 1990. The previous sentence shall not be construed as per-  
22 mitting any waiver of the 3-year-period requirement (im-  
23 posed by such amendment) in the case of items and serv-  
24 ices furnished more than 3 years before the date of the  
25 enactment of this Act.

1 **SEC. 10703. PERMITTING RECOVERY AGAINST THIRD**  
2 **PARTY ADMINISTRATORS.**

3 (a) PERMITTING RECOVERY AGAINST THIRD PARTY  
4 ADMINISTRATORS OF PRIMARY PLANS.—Section  
5 1862(b)(2)(B)(ii) (42 U.S.C. 1395y(b)(2)(B)(ii)) is  
6 amended—

7 (1) by striking “under this subsection to pay”  
8 and inserting “(directly, as a third-party adminis-  
9 trator, or otherwise) to make payment”, and

10 (2) by adding at the end the following: “The  
11 United States may not recover from a third-party  
12 administrator under this clause in cases where the  
13 third-party administrator would not be able to re-  
14 cover the amount at issue from the employer or  
15 group health plan for whom it provides administra-  
16 tive services due to the insolvency or bankruptcy of  
17 the employer or plan.”.

18 (b) CLARIFICATION OF BENEFICIARY LIABILITY.—  
19 Section 1862(b)(1) (42 U.S.C. 1395y(b)(1)) is amended  
20 by adding at the end the following new subparagraph:

21 “(F) LIMITATION ON BENEFICIARY LIABIL-  
22 ITY.—An individual who is entitled to benefits  
23 under this title and is furnished an item or  
24 service for which such benefits are incorrectly  
25 paid is not liable for repayment of such benefits



1 under this paragraph unless payment of such  
2 benefits was made to the individual.”.

3 (c) EFFECTIVE DATE.—The amendments made by  
4 this section apply to items and services furnished on or  
5 after the date of the enactment of this Act.

6 **CHAPTER 2—HOME HEALTH SERVICES**

7 **SEC. 10711. RECAPTURING SAVINGS RESULTING FROM**  
8 **TEMPORARY FREEZE ON PAYMENT IN-**  
9 **CREASES FOR HOME HEALTH SERVICES.**

10 (a) BASING UPDATES TO PER VISIT COST LIMITS ON  
11 LIMITS FOR FISCAL YEAR 1993.—Section 1861(v)(1)(L)  
12 (42 U.S.C. 1395x(v)(1)(L)) is amended by adding at the  
13 end the following:

14 “(iv) In establishing limits under this subparagraph  
15 for cost reporting periods beginning after September 30,  
16 1997, the Secretary shall not take into account any  
17 changes in the home health market basket, as determined  
18 by the Secretary, with respect to cost reporting periods  
19 which began on or after July 1, 1994, and before July  
20 1, 1996.”.

21 (b) NO EXCEPTIONS PERMITTED BASED ON AMEND-  
22 MENT.—The Secretary of Health and Human Services  
23 shall not consider the amendment made by subsection (a)  
24 in making any exemptions and exceptions pursuant to sec-

1 tion 1861(v)(1)(L)(ii) of the Social Security Act (42  
2 U.S.C. 1395x(v)(1)(L)(ii)).

3 **SEC. 10712. INTERIM PAYMENTS FOR HOME HEALTH SERV-**  
4 **ICES.**

5 (a) REDUCTIONS IN COST LIMITS.—Section  
6 1861(v)(1)(L)(i) (42 U.S.C. 1395x(v)(1)(L)(i)) is amend-  
7 ed—

8 (1) by moving the indentation of subclauses (I)  
9 through (III) 2-ems to the left;

10 (2) in subclause (I), by inserting “of the mean  
11 of the labor-related and nonlabor per visit costs for  
12 freestanding home health agencies” before the  
13 comma at the end;

14 (3) in subclause (II), by striking “, or” and in-  
15 serting “of such mean,”;

16 (4) in subclause (III)—

17 (A) by inserting “and before October 1,  
18 1997,” after “July 1, 1987,” and

19 (B) by striking the comma at the end and  
20 inserting “of such mean, or”; and

21 (5) by striking the matter following subclause  
22 (III) and inserting the following:

23 “(IV) October 1, 1997, 105 percent of the me-  
24 dian of the labor-related and nonlabor per visit costs  
25 for freestanding home health agencies.”.

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1 (b) DELAY IN UPDATES.—Section 1861(v)(1)(L)(iii)  
2 (42 U.S.C. 1395x(v)(1)(L)(iii)) is amended by inserting  
3 “, or on or after July 1, 1997, and before October 1,  
4 1997” after “July 1, 1996”.

5 (c) ADDITIONS TO COST LIMITS.—Section  
6 1861(v)(1)(L) (42 U.S.C. 1395x(v)(1)(L)), as amended by  
7 section 10711(a), is amended by adding at the end the  
8 following new clauses:

9 “(v) For services furnished by home health agencies  
10 for cost reporting periods beginning on or after October  
11 1, 1997, the Secretary shall provide for an interim system  
12 of limits. Payment shall not exceed the costs determined  
13 under the preceding provisions of this subparagraph or,  
14 if lower, the product of—

15 “(I) an agency-specific per beneficiary annual  
16 limitation calculated based 75 percent on the reason-  
17 able costs (including nonroutine medical supplies)  
18 for the agency’s 12-month cost reporting period end-  
19 ing during 1994, and based 25 percent on the stand-  
20 ardized regional average of such costs for the agen-  
21 cy’s region, as applied to such agency, for cost re-  
22 porting periods ending during 1994, such costs up-  
23 dated by the home health market basket index; and

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1           “(II) the agency’s unduplicated census count of  
2           patients (entitled to benefits under this title) for the  
3           cost reporting period subject to the limitation.

4           “(vi) For services furnished by home health agencies  
5           for cost reporting periods beginning on or after October  
6           1, 1997, the following rules apply:

7           “(I) For new providers and those providers  
8           without a 12-month cost reporting period ending in  
9           calendar year 1994, the per beneficiary limitation  
10          shall be equal to the median of these limits (or the  
11          Secretary’s best estimates thereof) applied to other  
12          home health agencies as determined by the Sec-  
13          retary. A home health agency that has altered its  
14          corporate structure or name shall not be considered  
15          a new provider for this purpose.

16          “(II) For beneficiaries who use services fur-  
17          nished by more than one home health agency, the  
18          per beneficiary limitations shall be prorated among  
19          the agencies.”.

20          (d) DEVELOPMENT OF CASE MIX SYSTEM.—The  
21          Secretary of Health and Human Services shall expand re-  
22          search on a prospective payment system for home health  
23          agencies under the medicare program that ties prospective  
24          payments to a unit of service, including an intensive effort

1 to develop a reliable case mix adjuster that explains a sig-  
2 nificant amount of the variances in costs.

3 (e) SUBMISSION OF DATA FOR CASE MIX SYSTEM.—  
4 Effective for cost reporting periods beginning on or after  
5 October 1, 1997, the Secretary of Health and Human  
6 Services may require all home health agencies to submit  
7 additional information that the Secretary considers nec-  
8 essary for the development of a reliable case mix system.

9 **SEC. 10713. CLARIFICATION OF PART-TIME OR INTERMIT-**  
10 **TENT NURSING CARE.**

11 (a) IN GENERAL.—Section 1861(m) (42 U.S.C.  
12 1395x(m)) is amended by adding at the end the following:  
13 “For purposes of paragraphs (1) and (4), the term ‘part-  
14 time or intermittent services’ means skilled nursing and  
15 home health aide services furnished any number of days  
16 per week as long as they are furnished (combined) less  
17 than 8 hours each day and 28 or fewer hours each week  
18 (or, subject to review on a case-by-case basis as to the  
19 need for care, less than 8 hours each day and 35 or fewer  
20 hours per week). For purposes of sections 1814(a)(2)(C)  
21 and 1835(a)(2)(A), ‘intermittent’ means skilled nursing  
22 care that is either provided or needed on fewer than 7  
23 days each week, or less than 8 hours of each day for peri-  
24 ods of 21 days or less (with extensions in exceptional cir-

1 cumstances when the need for additional care is finite and  
2 predictable).”.

3 (b) EFFECTIVE DATE.—The amendment made by  
4 subsection (a) applies to services furnished on or after Oc-  
5 tober 1, 1997.

6 **SEC. 10714. STUDY ON DEFINITION OF HOMEBOUND.**

7 (a) STUDY.—The Secretary of Health and Human  
8 Services shall conduct a study of the criteria that should  
9 be applied, and the method of applying such criteria, in  
10 the determination of whether an individual is homebound  
11 for purposes of qualifying for receipt of benefits for home  
12 health services under the medicare program. Such criteria  
13 shall include the extent and circumstances under which  
14 a person may be absent from the home but nonetheless  
15 qualify.

16 (b) REPORT.—Not later than October 1, 1998, the  
17 Secretary shall submit a report to the Congress on the  
18 study conducted under subsection (a). The report shall in-  
19 clude specific recommendations on such criteria and meth-  
20 ods.

21 **SEC. 10715. PAYMENT BASED ON LOCATION WHERE HOME**  
22 **HEALTH SERVICE IS FURNISHED.**

23 (a) CONDITIONS OF PARTICIPATION.—Section 1891  
24 (42 U.S.C. 1395bbb) is amended by adding at the end  
25 the following:

1       “(g) PAYMENT ON BASIS OF LOCATION OF SERV-  
2 ICE.—A home health agency shall submit claims for pay-  
3 ment for home health services under this title only on the  
4 basis of the geographic location at which the service is fur-  
5 nished, as determined by the Secretary.”.

6       (b) WAGE ADJUSTMENT.—Section 1861(v)(1)(L)(iii)  
7 (42 U.S.C. 1395x(v)(1)(L)(iii)) is amended by striking  
8 “agency is located” and inserting “service is furnished”.

9       (c) EFFECTIVE DATE.—The amendments made by  
10 this section apply to cost reporting periods beginning on  
11 or after October 1, 1997.

12 **SEC. 10716. NORMATIVE STANDARDS FOR HOME HEALTH**  
13 **CLAIMS DENIALS,**

14       (a) IN GENERAL.—Section 1862(a)(1) (42 U.S.C.  
15 1395y(a)(1)), as amended by section 10616(c), is amend-  
16 ed—

17           (1) by striking “and” at the end of subpara-  
18 graph (G),

19           (2) by striking the semicolon at the end of sub-  
20 paragraph (H) and inserting “, and”, and

21           (3) by inserting after subparagraph (H) the fol-  
22 lowing new subparagraph:

23           “(I) the frequency and duration of home health  
24 services which are in excess of normative guidelines  
25 that the Secretary shall establish by regulation;”.

1 (b) NOTIFICATION.—The Secretary of Health and  
2 Human Services may establish a process for notifying a  
3 physician in cases in which the number of home health  
4 service visits furnished under the medicare program pur-  
5 suant to a prescription or certification of the physician sig-  
6 nificantly exceeds such threshold (or thresholds) as the  
7 Secretary specifies. The Secretary may adjust such thresh-  
8 old to reflect demonstrated differences in the need for  
9 home health services among different beneficiaries.

10 (c) EFFECTIVE DATE.—The amendments made by  
11 this section apply to services furnished on or after October  
12 1, 1997.

13 **SEC. 10717. NO HOME HEALTH BENEFITS BASED SOLELY**  
14 **ON DRAWING BLOOD.**

15 (a) IN GENERAL.—Sections 1814(a)(2)(C) and  
16 1835(a)(2)(A) (42 U.S.C. 1395f(a)(2)(C),  
17 1395n(a)(2)(A)) are each amended by inserting “(other  
18 than solely venipuncture for the purpose of obtaining a  
19 blood sample)” after “skilled nursing care”.

20 (b) EFFECTIVE DATE.—The amendments made by  
21 subsection (a) apply to home health services furnished  
22 after the 6-month period beginning after the date of en-  
23 actment of this Act.



1     **CHAPTER 3—BABY BOOM GENERATION**  
2                     **MEDICARE COMMISSION**

3     **SEC. 10721. BIPARTISAN COMMISSION ON THE EFFECT OF**  
4                     **THE BABY BOOM GENERATION ON THE MEDI-**  
5                     **CARE PROGRAM.**

6             (a) ESTABLISHMENT.—There is established a com-  
7 mission to be known as the Bipartisan Commission on the  
8 Effect of the Baby Boom Generation on the Medicare Pro-  
9 gram (in this section referred to as the “Commission”).

10            (b) DUTIES.—

11                (1) IN GENERAL.—The Commission shall—

12                    (A) examine the financial impact on the  
13 medicare program of the significant increase in  
14 the number of medicare eligible individuals  
15 which will occur beginning approximately dur-  
16 ing 2010 and lasting for approximately 25  
17 years,

18                    (B) make specific recommendations to the  
19 Congress respecting a comprehensive approach  
20 to preserve the medicare program for the period  
21 during which such individuals are eligible for  
22 medicare, and

23                    (C) study the feasibility and desirability of  
24 establishing—

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1 (i) an independent commission on  
2 medicare to make recommendations annu-  
3 ally on how best to match the structure of  
4 the medicare program to available funding  
5 for the program,

6 (ii) an expedited process for consider-  
7 ation of such recommendations by Con-  
8 gress, and

9 (iii) a default mechanism to enforce  
10 Congressional spending targets for the pro-  
11 gram if Congress fails to approve such rec-  
12 ommendations.

13 (2) CONSIDERATIONS IN MAKING REC-  
14 OMMENDATIONS.—In making its recommendations,  
15 the Commission shall consider the following:

16 (A) The amount and sources of Federal  
17 funds to finance the medicare program, includ-  
18 ing the potential use of innovative financing  
19 methods.

20 (B) Methods used by other nations to re-  
21 spond to comparable demographic patterns in  
22 eligibility for health care benefits for elderly  
23 and disabled individuals.

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1 (C) Modifying age-based eligibility to cor-  
2 respond to changes in age-based eligibility  
3 under the OASDI program.

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

7 (c) MEMBERSHIP.—

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

10 (A) The Majority Leader of the Senate  
11 shall appoint, after consultation with the minor-  
12 ity leader of the Senate, 6 members, of whom  
13 not more than 4 may be of the same political  
14 party.

15 (B) The Speaker of the House of Rep-  
16 resentatives shall appoint, after consultation  
17 with the minority leader of the House of Rep-  
18 resentatives, 6 members, of whom not more  
19 than 4 may be of the same political party.

20 (C) The 3 ex officio members of the Board  
21 of Trustees of the Federal Hospital Insurance  
22 Trust Fund and of the Federal Supplementary  
23 Medical Insurance Trust Fund who are Cabinet  
24 level officials.

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1           (2) CHAIRMAN AND VICE CHAIRMAN.—As the  
2 first item of business at the Commission’s first  
3 meeting (described in paragraph (5)(B)), the Com-  
4 mission shall elect a Chairman and Vice Chairman  
5 from among its members. The individuals elected as  
6 Chairman and Vice Chairman may not be of the  
7 same political party and may not have been ap-  
8 pointed to the Commission by the same appointing  
9 authority.

10           (3) VACANCIES.—Any vacancy in the member-  
11 ship of the Commission shall be filled in the manner  
12 in which the original appointment was made and  
13 shall not affect the power of the remaining members  
14 to execute the duties of the Commission.

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

18           (5) MEETINGS.—

19                 (A) The Commission shall meet at the call  
20 of its Chairman or a majority of its members.

21                 (B) The Commission shall hold its first  
22 meeting not later than February 1, 1998.

23           (6) COMPENSATION AND REIMBURSEMENT OF  
24 EXPENSES.—Members of the Commission are not  
25 entitled to receive compensation for service on the

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1 Commission. Members may be reimbursed for travel,  
2 subsistence, and other necessary expenses incurred  
3 in carrying out the duties of the Commission.

4 (d) ADVISORY PANEL.—

5 (1) IN GENERAL.—The Chairman, in consulta-  
6 tion with the Vice Chairman, may establish a panel  
7 (in this section referred to as the “Advisory Panel”)  
8 consisting of health care experts, consumers, provid-  
9 ers, and others to advise and assist the members of  
10 the Commission in carrying out the duties described  
11 in subsection (b). The panel shall have only those  
12 powers that the Chairman, in consultation with the  
13 Vice Chairman, determines are necessary and appro-  
14 priate to assist the Commission in carrying out such  
15 duties.

16 (2) COMPENSATION.—Members of the Advisory  
17 Panel are not entitled to receive compensation for  
18 service on the Advisory Panel. Subject to the ap-  
19 proval of the chairman of the Commission, members  
20 may be reimbursed for travel, subsistence, and other  
21 necessary expenses incurred in carrying out the du-  
22 ties of the Advisory Panel.

23 (e) STAFF AND CONSULTANTS.—

24 (1) STAFF.—The Commission may appoint and  
25 determine the compensation of such staff as may be

1 necessary to carry out the duties of the Commission.  
2 Such appointments and compensation may be made  
3 without regard to the provisions of title 5, United  
4 States Code, that govern appointments in the com-  
5 petitive services, and the provisions of chapter 51  
6 and subchapter III of chapter 53 of such title that  
7 relate to classifications and the General Schedule  
8 pay rates.

9 (2) CONSULTANTS.—The Commission may pro-  
10 cure such temporary and intermittent services of  
11 consultants under section 3109(b) of title 5, United  
12 States Code, as the Commission determines to be  
13 necessary to carry out the duties of the Commission.

14 (f) POWERS.—

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

20 (2) STUDIES BY GAO.—Upon the request of the  
21 Commission, the Comptroller General shall conduct  
22 such studies or investigations as the Commission de-  
23 termines to be necessary to carry out its duties.

24 (3) COST ESTIMATES BY CONGRESSIONAL  
25 BUDGET OFFICE.—

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1 (A) Upon the request of the Commission,  
2 the Director of the Congressional Budget Office  
3 shall provide to the Commission such cost esti-  
4 mates as the Commission determines to be nec-  
5 essary to carry out its duties.

6 (B) The Commission shall reimburse the  
7 Director of the Congressional Budget Office for  
8 expenses relating to the employment in the of-  
9 fice of the Director of such additional staff as  
10 may be necessary for the Director to comply  
11 with requests by the Commission under sub-  
12 paragraph (A).

13 (4) DETAIL OF FEDERAL EMPLOYEES.—Upon  
14 the request of the Commission, the head of any Fed-  
15 eral agency is authorized to detail, without reim-  
16 bursement, any of the personnel of such agency to  
17 the Commission to assist the Commission in carry-  
18 ing out its duties. Any such detail shall not interrupt  
19 or otherwise affect the civil service status or privi-  
20 leges of the Federal employee.

21 (5) TECHNICAL ASSISTANCE.—Upon the re-  
22 quest of the Commission, the head of a Federal  
23 agency shall provide such technical assistance to the  
24 Commission as the Commission determines to be  
25 necessary to carry out its duties.

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

7           (7) OBTAINING INFORMATION.—The Commis-  
8 sion may secure directly from any Federal agency  
9 information necessary to enable it to carry out its  
10 duties, if the information may be disclosed under  
11 section 552 of title 5, United States Code. Upon re-  
12 quest of the Chairman of the Commission, the head  
13 of such agency shall furnish such information to the  
14 Commission.

15           (8) ADMINISTRATIVE SUPPORT SERVICES.—  
16 Upon the request of the Commission, the Adminis-  
17 trator of General Services shall provide to the Com-  
18 mission on a reimbursable basis such administrative  
19 support services as the Commission may request.

20           (9) PRINTING.—For purposes of costs relating  
21 to printing and binding, including the cost of per-  
22 sonnel detailed from the Government Printing Of-  
23 fice, the Commission shall be deemed to be a com-  
24 mittee of the Congress.



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1 (g) REPORT.—(1) Not later than May 1, 1999, the  
2 Commission shall submit to Congress a report containing  
3 its findings and recommendations regarding how to pro-  
4 tect and preserve the medicare program in a financially  
5 solvent manner until 2030 (or, if later, throughout the pe-  
6 riod of projected solvency of the Federal Old-Age and Sur-  
7 vivors Insurance Trust Fund). The report shall include de-  
8 tailed recommendations for appropriate legislative initia-  
9 tives respecting how to accomplish this objective.

10 (2) Not later than 12 months after the date of the  
11 enactment of this Act, the Commission shall report to the  
12 Congress on the matters specified in subsection (b)(1)(C).  
13 If the Commission determines that it is feasible and desir-  
14 able to establish the processes described in such sub-  
15 section, the report under this paragraph shall include spe-  
16 cific recommendations on changes in law (such as changes  
17 in the Congressional Budget Act of 1974 and the Bal-  
18 anced Budget and Emergency Deficit Control Act of  
19 1985) as are needed to implement its recommendations.

20 (h) TERMINATION.—The Commission shall terminate  
21 30 days after the date of submission of the report required  
22 in subsection (g).

23 (i) AUTHORIZATION OF APPROPRIATIONS.—There  
24 are authorized to be appropriated \$1,500,000 to carry out  
25 this section. 60 percent of such appropriation shall be pay-

1 able from the Federal Hospital Insurance Trust Fund,  
2 and 40 percent of such appropriation shall be payable  
3 from the Federal Supplementary Medical Insurance Trust  
4 Fund under title XVIII of the Social Security Act (42  
5 U.S.C. 1395i, 1395t).

6 **CHAPTER 4—PROVISIONS RELATING TO**  
7 **DIRECT GRADUATE MEDICAL EDUCATION**  
8 **SEC. 10731. LIMITATION ON PAYMENT BASED ON NUMBER**  
9 **OF RESIDENTS AND IMPLEMENTATION OF**  
10 **ROLLING AVERAGE FTE COUNT.**

11 Section 1886(h)(4) (42 U.S.C. 1395ww(h)(4)) is  
12 amended by adding after subparagraph (E) the following:

13 “(F) LIMITATION ON NUMBER OF RESI-  
14 DENTS FOR CERTAIN FISCAL YEARS.—Such  
15 rules shall provide that for purposes of a cost  
16 reporting period beginning on or after October  
17 1, 1997, the total number of full-time equiva-  
18 lent residents before application of weighting  
19 factors (as determined under this paragraph)  
20 with respect to a hospital’s approved medical  
21 residency training program may not exceed the  
22 number of full-time equivalent residents with  
23 respect to the hospital’s most recent cost re-  
24 porting period ending on or before December  
25 31, 1996. The Secretary may establish rules,

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1 consistent with the policies in the previous sen-  
2 tence and paragraph (6), with respect to the  
3 application of the previous sentence in the case  
4 of medical residency training programs estab-  
5 lished on or after January 1, 1997.

6 “(G) COUNTING INTERNS AND RESIDENTS  
7 FOR FY 1998 AND SUBSEQUENT YEARS.—

8 “(i) FY 1998.—For the hospital’s first  
9 cost reporting period beginning during fis-  
10 cal year 1998, subject to the limit de-  
11 scribed in subparagraph (F), the total  
12 number of full-time equivalent residents,  
13 for determining the hospital’s graduate  
14 medical education payment, shall equal the  
15 average of the full-time equivalent resident  
16 counts for the cost reporting period and  
17 the preceding cost reporting period.

18 “(ii) SUBSEQUENT YEARS.—For each  
19 subsequent cost reporting period, subject  
20 to the limit described in subparagraph (F),  
21 the total number of full-time equivalent  
22 residents, for determining the hospital’s  
23 graduate medical education payment, shall  
24 equal the average of the actual full-time  
25 equivalent resident counts for the cost re-

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1 reporting period and preceding two cost re-  
2 porting periods.

3 “(iii) ADJUSTMENT FOR SHORT PERI-  
4 ODS.—If a hospital’s cost reporting period  
5 beginning on or after October 1, 1997, is  
6 not equal to twelve months, the Secretary  
7 shall make appropriate modifications to en-  
8 sure that the average full-time equivalent  
9 resident counts pursuant to clause (ii) are  
10 based on the equivalent of full 12-month  
11 cost reporting periods.”.

12 **SEC. 10732. PHASED-IN LIMITATION ON HOSPITAL OVER-**  
13 **HEAD AND SUPERVISORY PHYSICIAN COMPO-**  
14 **NENT OF DIRECT MEDICAL EDUCATION**  
15 **COSTS.**

16 (a) IN GENERAL.—Section 1886(h)(3) (42 U.S.C.  
17 1395ww(h)(3)) is amended—

18 (1) in subparagraph (B), by inserting “subject  
19 to subparagraph (D),” after “subparagraph (A)”,  
20 and

21 (2) by adding at the end the following:

22 “(D) PHASED-IN LIMITATION ON HOS-  
23 PITAL OVERHEAD AND SUPERVISORY PHYSICIAN  
24 COMPONENT.—

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1           “(i) IN GENERAL.—In the case of a  
2 hospital for which the overhead GME  
3 amount (as defined in clause (ii)) for the  
4 base period exceeds an amount equal to  
5 the 75th percentile of the overhead GME  
6 amounts in such period for all hospitals  
7 (weighted to reflect the full-time equivalent  
8 resident counts for all approved medical  
9 residency training programs), subject to  
10 clause (iv), the hospital’s approved FTE  
11 resident amount (for periods beginning on  
12 or after October 1, 1997) shall be reduced  
13 from the amount otherwise applicable (as  
14 previously reduced under this subpara-  
15 graph) by an overhead reduction amount.  
16 The overhead reduction amount is equal to  
17 the lesser of—

18                   “(I) 20 percent of the reference  
19 reduction amount (described in clause  
20 (iii)) for the period, or

21                   “(II) 15 percent of the hospital’s  
22 overhead GME amount for the period  
23 (as otherwise determined before the  
24 reduction provided under this sub-  
25 paragraph for the period involved).

**[HVAC Reconciliation]**

1237

1           “(ii) OVERHEAD GME AMOUNT.—For  
2 purposes of this subparagraph, the term  
3 ‘overhead GME amount’ means, for a hos-  
4 pital for a period, the product of—

5                   “(I) the percentage of the hos-  
6 pital’s approved FTE resident amount  
7 for the base period that is not attrib-  
8 utable to resident salaries and fringe  
9 benefits, and

10                   “(II) the hospital’s approved  
11 FTE resident amount for the period  
12 involved.

13           “(iii) REFERENCE REDUCTION  
14 AMOUNT.—

15                   “(I) IN GENERAL.—The ref-  
16 erence reduction amount described in  
17 this clause for a hospital for a cost re-  
18 porting period is the base difference  
19 (described in subclause (II)) updated,  
20 in a compounded manner for each pe-  
21 riod from the base period to the pe-  
22 riod involved, by the update applied  
23 for such period to the hospital’s ap-  
24 proved FTE resident amount.

**[HVAC Reconciliation]**

1238

1           “(II) BASE DIFFERENCE.—The  
2           base difference described in this sub-  
3           clause for a hospital is the amount by  
4           which the hospital’s overhead GME  
5           amount in the base period exceeded  
6           the 75th percentile of such amounts  
7           (as described in clause (i)).

8           “(iv) MAXIMUM REDUCTION TO 75TH  
9           PERCENTILE.—In no case shall the reduc-  
10          tion under this subparagraph effected for a  
11          hospital for a period (below the amount  
12          that would otherwise apply for the period  
13          if this subparagraph did not apply for any  
14          period) exceed the reference reduction  
15          amount for the hospital for the period.

16          “(v) BASE PERIOD.—For purposes of  
17          this subparagraph, the term ‘base period’  
18          means the cost reporting period beginning  
19          in fiscal year 1984 or the period used to  
20          establish the hospital’s approved FTE resi-  
21          dent amount for hospitals that did not  
22          have approved residency training programs  
23          in fiscal year 1984.

24          “(vi) RULES FOR HOSPITALS INITIAT-  
25          ING RESIDENCY TRAINING PROGRAMS.—

[HVAC Reconciliation]

1239

1           The Secretary shall establish rules for the  
2           application of this subparagraph in the  
3           case of a hospital that initiates medical  
4           residency training programs during or  
5           after the base period.”.

6           (b) EFFECTIVE DATE.—The amendments made by  
7           subsection (a) shall apply to per resident payment  
8           amounts attributable to periods beginning on or after Oc-  
9           tober 1, 1997.

10 **SEC. 10733. PERMITTING PAYMENT TO NON-HOSPITAL PRO-**  
11 **VIDERS.**

12           (a) IN GENERAL.— Section 1886 (42 U.S.C.  
13 1395ww) is amended by adding at the end the following:

14           “(k) PAYMENT TO NON-HOSPITAL PROVIDERS.—

15                 “(1) REPORT.—The Secretary shall submit to  
16           Congress, not later than 18 months after the date  
17           of the enactment of this subsection, a proposal for  
18           payment to qualified non-hospital providers for their  
19           direct costs of medical education, if those costs are  
20           incurred in the operation of an approved medical  
21           residency training program described in subsection  
22           (h). Such proposal shall specify the amounts, form,  
23           and manner in which such payments will be made  
24           and the portion of such payments that will be made  
25           from each of the trust funds under this title.



[HVAC Reconciliation]

1240

1           “(2) EFFECTIVENESS.—Except as otherwise  
2           provided in law, the Secretary may implement such  
3           proposal for residency years beginning not earlier  
4           than 6 months after the date of submittal of the re-  
5           port under paragraph (1).

6           “(3) QUALIFIED NON-HOSPITAL PROVIDERS.—  
7           For purposes of this subsection, the term ‘qualified  
8           non-hospital provider’ means—

9                   “(A) a Federally qualified health center, as  
10                  defined in section 1861(aa)(4);

11                  “(B) a rural health clinic, as defined in  
12                  section 1861(aa)(2);

13                  “(C) MedicarePlus organizations; and

14                  “(D) such other providers (other than hos-  
15                  pitals) as the Secretary determines to be appro-  
16                  priate.”.

17           (b) PROHIBITION ON DOUBLE PAYMENTS; BUDGET  
18           NEUTRALITY ADJUSTMENT.—Section 1886(h)(3)(B) (42  
19           U.S.C. 1395ww(h)(3)(B)) is amended by adding at the  
20           end the following:

21                   “The Secretary shall reduce the aggregate ap-  
22                   proved amount to the extent payment is made  
23                   under subsection (k) for residents included in  
24                   the hospital’s count of full-time equivalent resi-  
25                   dents and, in the case of residents not included

1 in any such count, the Secretary shall provide  
2 for such a reduction in aggregate approved  
3 amounts under this subsection as will assure  
4 that the application of subsection (k) does not  
5 result in any increase in expenditures under  
6 this title in excess of those that would have oc-  
7 curred if subsection (k) were not applicable.”.

8 **SEC. 10734. INCENTIVE PAYMENTS UNDER PLANS FOR VOL-**  
9 **UNTARY REDUCTION IN NUMBER OF RESI-**  
10 **DENTS.**

11 (a) IN GENERAL.—Section 1886(h) (42 U.S.C.  
12 1395ww(h)) is further amended by adding at the end the  
13 following new paragraph:

14 “(6) INCENTIVE PAYMENT UNDER PLANS FOR  
15 VOLUNTARY REDUCTION IN NUMBER OF RESI-  
16 DENTS.—

17 “(A) IN GENERAL.—In the case of a vol-  
18 untary residency reduction plan for which an  
19 application is approved under subparagraph  
20 (B), the qualifying entity submitting the plan  
21 shall be paid an applicable hold harmless per-  
22 centage (as specified in subparagraph (E)) of  
23 the sum of—

24 “(i) amount (if any) by which—

**[HVAC Reconciliation]**

1242

1           “(I) the amount of payment  
2           which would have been made under  
3           this subsection if there had been a 5  
4           percent reduction in the number of  
5           full-time equivalent residents in the  
6           approved medical education training  
7           programs of the qualifying entity as of  
8           June 30, 1997, exceeds

9           “(II) the amount of payment  
10          which is made under this subsection,  
11          taking into account the reduction in  
12          such number effected under the re-  
13          duction plan; and

14          “(ii) the amount of the reduction in  
15          payment under 1886(d)(5)(B) (for hos-  
16          pitals participating in the qualifying entity)  
17          that is attributable to the reduction in  
18          number of residents effected under the  
19          plan below 95 percent of the number of  
20          full-time equivalent residents in such pro-  
21          grams of such entity as of June 30, 1997.

22          “(B) APPROVAL OF PLAN APPLICA-  
23          TIONS.—The Secretary may not approve the ap-  
24          plication of an qualifying entity unless—

[HVAC Reconciliation]

1243

1 “(i) the application is submitted in a  
2 form and manner specified by the Sec-  
3 retary and by not later than March 1,  
4 2000,

5 “(ii) the application provides for the  
6 operation of a plan for the reduction in the  
7 number of full-time equivalent residents in  
8 the approved medical residency training  
9 programs of the entity consistent with the  
10 requirements of subparagraph (D);

11 “(iii) the entity elects in the applica-  
12 tion whether such reduction will occur  
13 over—

14 “(I) a period of not longer than  
15 5 residency training years, or

16 “(II) a period of 6 residency  
17 training years,

18 except that a qualifying entity described in  
19 subparagraph (C)(i)(III) may not make the  
20 election described in subclause (II); and

21 “(iv) the Secretary determines that  
22 the application and the entity and such  
23 plan meet such other requirements as the  
24 Secretary specifies in regulations.

25 “(C) QUALIFYING ENTITY.—

**[HVAC Reconciliation]**

1244

1           “(i) IN GENERAL.—For purposes of  
2 this paragraph, any of the following may  
3 be a qualifying entity:

4                   “(I) Individual hospitals operat-  
5 ing one or more approved medical  
6 residency training programs.

7                   “(II) Subject to clause (ii), two  
8 or more hospitals that operate such  
9 programs and apply for treatment  
10 under this paragraph as a single  
11 qualifying entity.

12                   “(III) Subject to clause (iii), a  
13 qualifying consortium (as described in  
14 section 10735 of the Balanced Budget  
15 Act of 1997).

16           “(ii) ADDITIONAL REQUIREMENT FOR  
17 JOINT PROGRAMS.—In the case of an ap-  
18 plication by a qualifying entity described in  
19 clause (i)(II), the Secretary may not ap-  
20 prove the application unless the application  
21 represents that the qualifying entity ei-  
22 ther—

23                   “(I) in the case of an entity that  
24 meets the requirements of clause (v)  
25 of subparagraph (D) will not reduce

**[HVAC Reconciliation]**

1245

1 the number of full-time equivalent  
2 residents in primary care during the  
3 period of the plan, or

4 “(II) in the case of another en-  
5 tity will not reduce the proportion of  
6 its residents in primary care (to the  
7 total number of residents) below such  
8 proportion as in effect as of the appli-  
9 cable time described in subparagraph  
10 (D)(vi).

11 “(iii) ADDITIONAL REQUIREMENT FOR  
12 CONSORTIA.—In the case of an application  
13 by a qualifying entity described in clause  
14 (i)(III), the Secretary may not approve the  
15 application unless the application rep-  
16 resents that the qualifying entity will not  
17 reduce the proportion of its residents in  
18 primary care (to the total number of resi-  
19 dents) below such proportion as in effect  
20 as of the applicable time described in sub-  
21 paragraph (D)(vi).

22 “(D) RESIDENCY REDUCTION REQUIRE-  
23 MENTS.—

24 “(i) INDIVIDUAL HOSPITAL APPLI-  
25 CANTS.—In the case of a qualifying entity

**[HVAC Reconciliation]**

1246

1 described in subparagraph (C)(i)(I), the  
2 number of full-time equivalent residents in  
3 all the approved medical residency training  
4 programs operated by or through the en-  
5 tity shall be reduced as follows:

6 “(I) If base number of residents  
7 exceeds 750 residents, by a number  
8 equal to at least 20 percent of such  
9 base number.

10 “(II) Subject to subclause (IV),  
11 if base number of residents exceeds  
12 500, but is less than 750, residents,  
13 by 150 residents.

14 “(III) Subject to subclause (IV),  
15 if base number of residents does not  
16 exceed 500 residents, by a number  
17 equal to at least 25 percent of such  
18 base number.

19 “(IV) In the case of a qualifying  
20 entity which is described in clause (v)  
21 and which elects treatment under this  
22 subclause, by a number equal to at  
23 least 20 percent of such base number.

24 “(ii) JOINT APPLICANTS.—In the case  
25 of a qualifying entity described in subpara-

[HVAC Reconciliation]

1247

1 graph (C)(i)(II), the number of full-time  
2 equivalent residents in all the approved  
3 medical residency training programs oper-  
4 ated by or through the entity shall be re-  
5 duced as follows:

6 “(I) Subject to subclause (II), by  
7 a number equal to at least 25 percent  
8 of such base number.

9 “(II) In the case of a qualifying  
10 entity which is described in clause (v)  
11 and which elects treatment under this  
12 subclause, by a number equal to at  
13 least 20 percent of such base number.

14 “(iii) CONSORTIA.—In the case of a  
15 qualifying entity described in subparagraph  
16 (C)(i)(III), the number of full-time equiva-  
17 lent residents in all the approved medical  
18 residency training programs operated by or  
19 through the entity shall be reduced by a  
20 number equal to at least 20 percent of  
21 such base number.

22 “(iv) MANNER OF REDUCTION.—The  
23 reductions specified under the preceding  
24 provisions of this subparagraph for a quali-  
25 fying entity shall be below the base number



**[HVAC Reconciliation]**

1248

1 of residents for that entity and shall be  
2 fully effective not later than—

3 “(I) the 5th residency training  
4 year in which the application under  
5 subparagraph (B) is effective, in the  
6 case of an entity making the election  
7 described in subparagraph (B)(iii)(I),  
8 or

9 “(II) the 6th such residency  
10 training year, in the case of an entity  
11 making the election described in sub-  
12 paragraph (B)(iii)(II).

13 “(v) ENTITIES PROVIDING ASSURANCE  
14 OF MAINTENANCE OF PRIMARY CARE RESI-  
15 DENTS.—An entity is described in this  
16 clause if—

17 “(I) the base number of residents  
18 for the entity is less than 750;

19 “(II) the number of full-time  
20 equivalent residents in primary care  
21 included in the base number of resi-  
22 dents for the entity is at least 10 per-  
23 cent of such base number; and

24 “(III) the entity represents in its  
25 application under subparagraph (B)

[HVAC Reconciliation]

1249

1 that there will be no reduction under  
2 the plan in the number of full-time  
3 equivalent residents in primary care.

4 If a qualifying entity fails to comply with  
5 the representation described in subclause  
6 (III), the entity shall be subject to repay-  
7 ment of all amounts paid under this para-  
8 graph, in accordance with procedures es-  
9 tablished to carry out subparagraph (F).

10 “(vi) BASE NUMBER OF RESIDENTS  
11 DEFINED.—For purposes of this para-  
12 graph, the term ‘base number of residents’  
13 means, with respect to a qualifying entity  
14 operating approved medical residency  
15 training programs, the number of full-time  
16 equivalent residents in such programs (be-  
17 fore application of weighting factors) of  
18 the entity as of the most recent cost re-  
19 porting period ending before June 30,  
20 1997, or, if less, for any subsequent cost  
21 reporting period that ends before the date  
22 the entity makes application under this  
23 paragraph.

24 “(E) APPLICABLE HOLD HARMLESS PER-  
25 CENTAGE.—

[HVAC Reconciliation]

1250

1           “(i) IN GENERAL.—For purposes of  
2           subparagraph (A), the ‘applicable hold  
3           harmless percentage’ is the percentages  
4           specified in clause (ii) or clause (iii), as  
5           elected by the qualifying entity in the ap-  
6           plication submitted under subparagraph  
7           (B).

8           “(ii) 5-YEAR REDUCTION PLAN.—In  
9           the case of an entity making the election  
10          described in subparagraph (B)(iii)(I), the  
11          percentages specified in this clause are, for  
12          the—

13                   “(I) first and second residency  
14                   training years in which the reduction  
15                   plan is in effect, 100 percent,

16                   “(II) third such year, 75 percent,

17                   “(III) fourth such year, 50 per-  
18                   cent, and

19                   “(IV) fifth such year, 25 percent.

20          “(iii) 6-YEAR REDUCTION PLAN.—In  
21          the case of an entity making the election  
22          described in subparagraph (B)(iii)(II), the  
23          percentages specified in this clause are, for  
24          the—

**[HVAC Reconciliation]**

1251

1           “(I) first residency training year  
2           in which the reduction plan is in ef-  
3           fect, 100 percent,

4           “(II) second such year, 95 per-  
5           cent,

6           “(III) third such year, 85 per-  
7           cent,

8           “(IV) fourth such year, 70 per-  
9           cent,

10           “(V) fifth such year, 50 percent,  
11           and

12           “(VI) sixth such year, 25 per-  
13           cent.

14           “(F) PENALTY FOR INCREASE IN NUMBER  
15           OF RESIDENTS IN SUBSEQUENT YEARS.—If  
16           payments are made under this paragraph to a  
17           qualifying entity, if the entity (or any hospital  
18           operating as part of the entity) increases the  
19           number of full-time equivalent residents above  
20           the number of such residents permitted under  
21           the reduction plan as of the completion of the  
22           plan, then, as specified by the Secretary, the  
23           entity is liable for repayment to the Secretary  
24           of the total amounts paid under this paragraph  
25           to the entity.

[HVAC Reconciliation]

1252

1           “(G) TREATMENT OF ROTATING RESI-  
2           DENTS.—In applying this paragraph, the Sec-  
3           retary shall establish rules regarding the count-  
4           ing of residents who are assigned to institutions  
5           the medical residency training programs in  
6           which are not covered under approved applica-  
7           tions under this paragraph.”.

8           (b) RELATION TO DEMONSTRATION PROJECTS AND  
9           AUTHORITY.—

10           (1) Section 1886(h)(6) of the Social Security  
11           Act, added by subsection (a), shall not apply to any  
12           residency training program with respect to which a  
13           demonstration project described in paragraph (3)  
14           has been approved by the Health Care Financing  
15           Administration as of May 27, 1997. The Secretary  
16           of Health and Human Services shall take such ac-  
17           tions as may be necessary to assure that (in the  
18           manner described in subparagraph (A) of such sec-  
19           tion) in no case shall payments be made under such  
20           a project with respect to the first 5 percent reduc-  
21           tion in the base number of full-time equivalent resi-  
22           dents otherwise used under the project.

23           (2) Effective May 27, 1997, the Secretary of  
24           Health and Human Services is not authorized to ap-  
25           prove any demonstration project described in para-

1 graph (3) for any residency training year beginning  
2 before July 1, 2006.

3 (3) A demonstration project described in this  
4 paragraph is a project that provides for additional  
5 payments under title XVIII of the Social Security  
6 Act in connection with reduction in the number of  
7 residents in a medical residency training program.

8 (c) INTERIM, FINAL REGULATIONS.—In order to  
9 carry out the amendment made by subsection (a) in a  
10 timely manner, the Secretary of Health and Human Serv-  
11 ices may first promulgate regulations, that take effect on  
12 an interim basis, after notice and pending opportunity for  
13 public comment, by not later than 6 months after the date  
14 of the enactment of this Act.

15 **SEC. 10735. DEMONSTRATION PROJECT ON USE OF CON-**  
16 **SORTIA.**

17 (a) IN GENERAL.—The Secretary of Health and  
18 Human Services (in this section referred to as the Sec-  
19 retary) shall establish a demonstration project under  
20 which, instead of making payments to teaching hospitals  
21 pursuant to section 1886(h) of the Social Security Act,  
22 the Secretary shall make payments under this section to  
23 each consortium that meets the requirements of subsection  
24 (b).

1 (b) QUALIFYING CONSORTIA.—For purposes of sub-  
2 section (a), a consortium meets the requirements of this  
3 subsection if the consortium is in compliance with the fol-  
4 lowing:

5 (1) The consortium consists of an approved  
6 medical residency training program in a teaching  
7 hospital and one or more of the following entities:

8 (A) A school of allopathic medicine or os-  
9 teopathic medicine.

10 (B) Another teaching hospital, which may  
11 be a children’s hospital.

12 (C) Another approved medical residency  
13 training program.

14 (D) A Federally qualified health center.

15 (E) A medical group practice.

16 (F) A managed care entity.

17 (G) An entity furnishing outpatient serv-  
18 ices.

19 (H) Such other entity as the Secretary de-  
20 termines to be appropriate.

21 (2) The members of the consortium have agreed  
22 to participate in the programs of graduate medical  
23 education that are operated by the entities in the  
24 consortium.

1           (3) With respect to the receipt by the consor-  
2           tium of payments made pursuant to this section, the  
3           members of the consortium have agreed on a method  
4           for allocating the payments among the members.

5           (4) The consortium meets such additional re-  
6           quirements as the Secretary may establish.

7           (c) AMOUNT AND SOURCE OF PAYMENT.—The total  
8           of payments to a qualifying consortium for a fiscal year  
9           pursuant to subsection (a) shall not exceed the amount  
10          that would have been paid under section 1886(h) of the  
11          Social Security Act for the teaching hospital (or hospitals)  
12          in the consortium. Such payments shall be made in such  
13          proportion from each of the trust funds established under  
14          title XVIII of such Act as the Secretary specifies.

15   **SEC. 10736. RECOMMENDATIONS ON LONG-TERM PAYMENT**  
16                           **POLICIES REGARDING FINANCING TEACHING**  
17                           **HOSPITALS AND GRADUATE MEDICAL EDU-**  
18                           **CATION.**

19          (a) IN GENERAL.—The Medicare Payment Advisory  
20          Commission (established under section 1805 of the Social  
21          Security Act and in this section referred to as the “Com-  
22          mission”) shall examine and develop recommendations on  
23          whether and to what extent medicare payment policies and  
24          other Federal policies regarding teaching hospitals and  
25          graduate medical education should be reformed. Such rec-



1 ommendations shall include recommendations regarding  
2 each of the following:

3 (1) The financing of graduate medical edu-  
4 cation, including consideration of alternative broad-  
5 based sources of funding for such education and  
6 models for the distribution of payments under any  
7 all-payer financing mechanism.

8 (2) The financing of teaching hospitals, includ-  
9 ing consideration of the difficulties encountered by  
10 such hospitals as competition among health care en-  
11 tities increases. Matters considered under this para-  
12 graph shall include consideration of the effects on  
13 teaching hospitals of the method of financing used  
14 for the MedicarePlus program under part C of title  
15 XVIII of the Social Security Act.

16 (3) Possible methodologies for making pay-  
17 ments for graduate medical education and the selec-  
18 tion of entities to receive such payments. Matters  
19 considered under this paragraph shall include—

20 (A) issues regarding children’s hospitals  
21 and approved medical residency training pro-  
22 grams in pediatrics, and

23 (B) whether and to what extent payments  
24 are being made (or should be made) for train-

1 ing in the various nonphysician health profes-  
2 sions.

3 (4) Federal policies regarding international  
4 medical graduates.

5 (5) The dependence of schools of medicine on  
6 service-generated income.

7 (6) Whether and to what extent the needs of  
8 the United States regarding the supply of physi-  
9 cians, in the aggregate and in different specialties,  
10 will change during the 10-year period beginning on  
11 October 1, 1997, and whether and to what extent  
12 any such changes will have significant financial ef-  
13 fects on teaching hospitals.

14 (7) Methods for promoting an appropriate num-  
15 ber, mix, and geographical distribution of health  
16 professionals.

17 (c) CONSULTATION.—In conducting the study under  
18 subsection (a), the Commission shall consult with the  
19 Council on Graduate Medical Education and individuals  
20 with expertise in the area of graduate medical education,  
21 including—

22 (1) deans from allopathic and osteopathic  
23 schools of medicine;

24 (2) chief executive officers (or equivalent ad-  
25 ministrative heads) from academic health centers,

1 integrated health care systems, approved medical  
2 residency training programs, and teaching hospitals  
3 that sponsor approved medical residency training  
4 programs;

5 (3) chairs of departments or divisions from  
6 allopathic and osteopathic schools of medicine,  
7 schools of dentistry, and approved medical residency  
8 training programs in oral surgery;

9 (4) individuals with leadership experience from  
10 representative fields of non-physician health profes-  
11 sionals;

12 (5) individuals with substantial experience in  
13 the study of issues regarding the composition of the  
14 health care workforce of the United States; and

15 (6) individuals with expertise on the financing  
16 of health care.

17 (d) REPORT.—Not later than 2 years after the date  
18 of the enactment of this Act, the Commission shall submit  
19 to the Congress a report providing its recommendations  
20 under this section and the reasons and justifications for  
21 such recommendations.

1 **SEC. 10737. MEDICARE SPECIAL REIMBURSEMENT RULE**  
2 **FOR CERTAIN COMBINED RESIDENCY PRO-**  
3 **GRAMS.**

4 (a) IN GENERAL.—Section 1886(h)(5)(G) (42 U.S.C.  
5 1395ww(h)(5)(G)) is amended—

6 (1) in clause (i), by striking “and (iii)” and in-  
7 serting “, (iii), and (iv)”; and

8 (2) by adding at the end the following:

9 “(iv) SPECIAL RULE FOR CERTAIN  
10 COMBINED RESIDENCY PROGRAMS.—(I) In  
11 the case of a resident enrolled in a com-  
12 bined medical residency training program  
13 in which all of the individual programs  
14 (that are combined) are for training a pri-  
15 mary care resident (as defined in subpara-  
16 graph (H)), the period of board eligibility  
17 shall be the minimum number of years of  
18 formal training required to satisfy the re-  
19 quirements for initial board eligibility in  
20 the longest of the individual programs plus  
21 one additional year.

22 “(II) A resident enrolled in a com-  
23 bined medical residency training program  
24 that includes an obstetrics and gynecology  
25 program shall qualify for the period of  
26 board eligibility under subclause (I) if the

1 other programs such resident combines  
2 with such obstetrics and gynecology pro-  
3 gram are for training a primary care resi-  
4 dent.”.

5 (b) EFFECTIVE DATE.—The amendments made by  
6 subsection (a) apply to combined medical residency pro-  
7 grams for residency years beginning on or after July 1,  
8 1998.

9 **CHAPTER 5—OTHER PROVISIONS**

10 **SEC. 10741. CENTERS OF EXCELLENCE.**

11 (a) IN GENERAL.—Title XVIII is amended by insert-  
12 ing after section 1888 the following:

13 “CENTERS OF EXCELLENCE

14 “SEC. 1889. (a) IN GENERAL.—The Secretary shall  
15 use a competitive process to contract with specific hos-  
16 pitals or other entities for furnishing services related to  
17 surgical procedures, and for furnishing services (unrelated  
18 to surgical procedures) to hospital inpatients that the Sec-  
19 retary determines to be appropriate. The services may in-  
20 clude any services covered under this title that the Sec-  
21 retary determines to be appropriate, including post-hos-  
22 pital services.

23 “(b) QUALITY STANDARDS.—Only entities that meet  
24 quality standards established by the Secretary shall be eli-  
25 gible to contract under this section. Contracting entities

1 shall implement a quality improvement plan approved by  
2 the Secretary.

3 “(c) PAYMENT.—Payment under this section shall be  
4 made on the basis of negotiated all-inclusive rates. The  
5 amount of payment made by the Secretary to an entity  
6 under this title for services covered under a contract shall  
7 be less than the aggregate amount of the payments that  
8 the Secretary would have otherwise made for the services.

9 “(d) CONTRACT PERIOD.—A contract period shall be  
10 3 years (subject to renewal), so long as the entity contin-  
11 ues to meet quality and other contractual standards.

12 “(e) INCENTIVES FOR USE OF CENTERS.—Entities  
13 under a contract under this section may furnish additional  
14 services (at no cost to an individual entitled to benefits  
15 under this title) or waive cost-sharing, subject to the ap-  
16 proval of the Secretary.

17 “(f) LIMIT ON NUMBER OF CENTERS.—The Sec-  
18 retary shall limit the number of centers in a geographic  
19 area to the number needed to meet projected demand for  
20 contracted services.”.

21 (b) EFFECTIVE DATE.—The amendment made by  
22 subsection (a) applies to services furnished on or after Oc-  
23 tober 1, 1997.

1 **SEC. 10742. MEDICARE PART B SPECIAL ENROLLMENT PE-**  
2 **RIOD AND WAIVER OF PART B LATE ENROLL-**  
3 **MENT PENALTY AND MEDIGAP SPECIAL**  
4 **OPEN ENROLLMENT PERIOD FOR CERTAIN**  
5 **MILITARY RETIREES AND DEPENDENTS.**

6 (a) MEDICARE PART B SPECIAL ENROLLMENT PE-  
7 RIOD; WAIVER OF PART B PENALTY FOR LATE ENROLL-  
8 MENT.—

9 (1) IN GENERAL.—In the case of any eligible  
10 individual (as defined in subsection (c)), the Sec-  
11 retary of Health and Human Services shall provide  
12 for a special enrollment period during which the in-  
13 dividual may enroll under part B of title XVIII of  
14 the Social Security Act. Such period shall be for a  
15 period of 6 months and shall begin with the first  
16 month that begins at least 45 days after the date of  
17 the enactment of this Act.

18 (2) COVERAGE PERIOD.—In the case of an eli-  
19 gible individual who enrolls during the special enroll-  
20 ment period provided under paragraph (1), the cov-  
21 erage period under part B of title XVIII of the So-  
22 cial Security Act shall begin on the first day of the  
23 month following the month in which the individual  
24 enrolls.

25 (3) WAIVER OF PART B LATE ENROLLMENT  
26 PENALTY.—In the case of an eligible individual who

1 enrolls during the special enrollment period provided  
2 under paragraph (1), there shall be no increase pur-  
3 suant to section 1839(b) of the Social Security Act  
4 in the monthly premium under part B of title XVIII  
5 of such Act.

6 (b) MEDIGAP SPECIAL OPEN ENROLLMENT PE-  
7 RIOD.—Notwithstanding any other provision of law, an is-  
8 suer of a medicare supplemental policy (as defined in sec-  
9 tion 1882(g) of the Social Security Act)—

10 (1) may not deny or condition the issuance or  
11 effectiveness of a medicare supplemental policy that  
12 has a benefit package classified as “A”, “B”, “C”,  
13 or “F” under the standards established under sec-  
14 tion 1882(p)(2) of the Social Security Act (42  
15 U.S.C. 1395rr(p)(2)); and

16 (2) may not discriminate in the pricing of the  
17 policy on the basis of the individual’s health status,  
18 medical condition (including both physical and men-  
19 tal illnesses), claims experience, receipt of health  
20 care, medical history, genetic information, evidence  
21 of insurability (including conditions arising out of  
22 acts of domestic violence), or disability;  
23 in the case of an eligible individual who seeks to enroll  
24 (and is enrolled) during the 6-month period described in  
25 subsection (a)(1).



1 (c) ELIGIBLE INDIVIDUAL DEFINED.—In this sec-  
2 tion, the term “eligible individual” means an individual—

3 (1) who, as of the date of the enactment of this  
4 Act, has attained 65 years of age and was eligible  
5 to enroll under part B of title XVIII of the Social  
6 Security Act, and

7 (2) who at the time the individual first satisfied  
8 paragraph (1) or (2) of section 1836 of the Social  
9 Security Act—

10 (A) was a covered beneficiary (as defined  
11 in section 1072(5) of title 10, United States  
12 Code), and

13 (B) did not elect to enroll (or to be deemed  
14 enrolled) under section 1837 of the Social Secu-  
15 rity Act during the individual’s initial enroll-  
16 ment period.

17 The Secretary of Health and Human Services shall con-  
18 sult with the Secretary of Defense in the identification of  
19 eligible individuals.

20 **SEC. 10743. PROTECTIONS UNDER THE MEDICARE PRO-**  
21 **GRAM FOR DISABLED WORKERS WHO LOSE**  
22 **BENEFITS UNDER A GROUP HEALTH PLAN.**

23 (a) NO PREMIUM PENALTY FOR LATE ENROLL-  
24 MENT.—The second sentence of section 1839(b) (42  
25 U.S.C. 1395r(b)) is amended by inserting “and not pursu-

1 ant to a special enrollment period under section  
2 1837(i)(4)” after “section 1837”.

3 (b) SPECIAL MEDICARE ENROLLMENT PERIOD.—

4 (1) IN GENERAL.—Section 1837(i) (42 U.S.C.  
5 1395p(i)) is amended by adding at the end the fol-  
6 lowing new paragraph:

7 “(4)(A) In the case of an individual who is entitled  
8 to benefits under part A pursuant to section 226(b) and—

9 “(i) who at the time the individual first satisfies  
10 paragraph (1) or (2) of section 1836—

11 “(I) is enrolled in a group health plan de-  
12 scribed in section 1862(b)(1)(A)(v) by reason of  
13 the individual’s (or the individual’s spouse’s)  
14 current employment or otherwise, and

15 “(II) has elected not to enroll (or to be  
16 deemed enrolled) under this section during the  
17 individual’s initial enrollment period; and

18 “(ii) whose continuous enrollment under such  
19 group health plan is involuntarily terminated at a  
20 time when the enrollment under the plan is not by  
21 reason of the individual’s (or the individual’s  
22 spouse’s) current employment,

23 there shall be a special enrollment period described in sub-  
24 paragraph (B).

1 “(B) The special enrollment period referred to in sub-  
2 paragraph (A) is the 6-month period beginning on the date  
3 of the enrollment termination described in subparagraph  
4 (A)(ii).”.

5 (2) COVERAGE PERIOD.—Section 1838(e) (42  
6 U.S.C. 1395q(e)) is amended—

7 (A) by inserting “or 1837(i)(4)(B)” after  
8 “1837(i)(3)” the first place it appears, and

9 (B) by inserting “or specified in section  
10 1837(i)(4)(A)(i)” after “1837(i)(3)” the second  
11 place it appears”.

12 (c) EFFECTIVE DATE.—The amendments made by  
13 this section shall apply to involuntary terminations of cov-  
14 erage under a group health plan occurring on or after the  
15 date of the enactment of this Act.

16 **SEC. 10744. PLACEMENT OF ADVANCE DIRECTIVE IN MEDI-**  
17 **CAL RECORD.**

18 (a) IN GENERAL.—Section 1866(f)(1)(B) (42 U.S.C.  
19 1395cc(f)(1)(B)) is amended by striking “in the individ-  
20 ual’s medical record” and inserting “in a prominent part  
21 of the individual’s current medical record”.

22 (b) EFFECTIVE DATE.—The amendment made by  
23 subsection (a) shall apply to provider agreements entered  
24 into, renewed, or extended on or after such date (not later

1 than 1 year after the date of the enactment of this Act)  
2 as the Secretary of Health and Human Services specifies.

3 **Subtitle I—Medical Liability**  
4 **Reform**

5 **CHAPTER 1—GENERAL PROVISIONS**

6 **SEC. 10801. FEDERAL REFORM OF HEALTH CARE LIABILITY**  
7 **ACTIONS.**

8 (a) **APPLICABILITY.**—This subtitle shall apply with  
9 respect to any health care liability action brought in any  
10 State or Federal court, except that this subtitle shall not  
11 apply to—

12 (1) an action for damages arising from a vac-  
13 cine-related injury or death to the extent that title  
14 XXI of the Public Health Service Act applies to the  
15 action, or

16 (2) an action under the Employee Retirement  
17 Income Security Act of 1974 (29 U.S.C. 1001 et  
18 seq.).

19 (b) **PREEMPTION.**—This subtitle shall preempt any  
20 State law to the extent such law is inconsistent with the  
21 limitations contained in this subtitle. This subtitle shall  
22 not preempt any State law that provides for defenses or  
23 places limitations on a person’s liability in addition to  
24 those contained in this subtitle or otherwise imposes great-  
25 er restrictions than those provided in this subtitle.

1 (c) EFFECT ON SOVEREIGN IMMUNITY AND CHOICE  
2 OF LAW OR VENUE.—Nothing in subsection (b) shall be  
3 construed to—

4 (1) waive or affect any defense of sovereign im-  
5 munity asserted by any State under any provision of  
6 law;

7 (2) waive or affect any defense of sovereign im-  
8 munity asserted by the United States;

9 (3) affect the applicability of any provision of  
10 the Foreign Sovereign Immunities Act of 1976;

11 (4) preempt State choice-of-law rules with re-  
12 spect to claims brought by a foreign nation or a citi-  
13 zen of a foreign nation; or

14 (5) affect the right of any court to transfer  
15 venue or to apply the law of a foreign nation or to  
16 dismiss a claim of a foreign nation or of a citizen  
17 of a foreign nation on the ground of inconvenient  
18 forum.

19 (d) AMOUNT IN CONTROVERSY.—In an action to  
20 which this subtitle applies and which is brought under sec-  
21 tion 1332 of title 28, United States Code, the amount of  
22 noneconomic damages or punitive damages, and attorneys’  
23 fees or costs, shall not be included in determining whether  
24 the matter in controversy exceeds the sum or value of  
25 \$50,000.

1 (e) FEDERAL COURT JURISDICTION NOT ESTAB-  
2 LISHED ON FEDERAL QUESTION GROUNDS.—Nothing in  
3 this subtitle shall be construed to establish any jurisdiction  
4 in the district courts of the United States over health care  
5 liability actions on the basis of section 1331 or 1337 of  
6 title 28, United States Code.

7 **SEC. 10802. DEFINITIONS.**

8 As used in this subtitle:

9 (1) ACTUAL DAMAGES.—The term “actual dam-  
10 ages” means damages awarded to pay for economic  
11 loss.

12 (2) ALTERNATIVE DISPUTE RESOLUTION SYS-  
13 TEM; ADR.—The term “alternative dispute resolution  
14 system” or “ADR” means a system established  
15 under Federal or State law that provides for the res-  
16 olution of health care liability claims in a manner  
17 other than through health care liability actions.

18 (3) CLAIMANT.—The term “claimant” means  
19 any person who brings a health care liability action  
20 and any person on whose behalf such an action is  
21 brought. If such action is brought through or on be-  
22 half of an estate, the term includes the claimant’s  
23 decedent. If such action is brought through or on be-  
24 half of a minor or incompetent, the term includes  
25 the claimant’s legal guardian.

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1 (4) CLEAR AND CONVINCING EVIDENCE.—The  
2 term “clear and convincing evidence” is that meas-  
3 ure or degree of proof that will produce in the mind  
4 of the trier of fact a firm belief or conviction as to  
5 the truth of the allegations sought to be established.  
6 Such measure or degree of proof is more than that  
7 required under preponderance of the evidence but  
8 less than that required for proof beyond a reason-  
9 able doubt.

10 (5) COLLATERAL SOURCE PAYMENTS.—The  
11 term “collateral source payments” means any  
12 amount paid or reasonably likely to be paid in the  
13 future to or on behalf of a claimant, or any service,  
14 product, or other benefit provided or reasonably like-  
15 ly to be provided in the future to or on behalf of a  
16 claimant, as a result of an injury or wrongful death,  
17 pursuant to—

18 (A) any State or Federal health, sickness,  
19 income-disability, accident or workers’ com-  
20 pensation Act;

21 (B) any health, sickness, income-disability,  
22 or accident insurance that provides health bene-  
23 fits or income-disability coverage;

24 (C) any contract or agreement of any  
25 group, organization, partnership, or corporation

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1 to provide, pay for, or reimburse the cost of  
2 medical, hospital, dental, or income disability  
3 benefits; and

4 (D) any other publicly or privately funded  
5 program.

6 (6) DRUG.—The term “drug” has the meaning  
7 given such term in section 201(g)(1) of the Federal  
8 Food, Drug, and Cosmetic Act (21 U.S.C.  
9 321(g)(1)).

10 (7) ECONOMIC LOSS.—The term “economic  
11 loss” means any pecuniary loss resulting from injury  
12 (including the loss of earnings or other benefits re-  
13 lated to employment, medical expense loss, replace-  
14 ment services loss, loss due to death, burial costs,  
15 and loss of business or employment opportunities),  
16 to the extent recovery for such loss is allowed under  
17 applicable State law.

18 (8) HARM.—The term “harm” means any le-  
19 gally cognizable wrong or injury for which punitive  
20 damages may be imposed.

21 (9) HEALTH BENEFIT PLAN.—The term  
22 “health benefit plan” means—

23 (A) a hospital or medical expense incurred  
24 policy or certificate,



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1 (B) a hospital or medical service plan con-  
2 tract,

3 (C) a health maintenance subscriber con-  
4 tract, or

5 (D) a MedicarePlus product (offered under  
6 part C of title XVIII of the Social Security  
7 Act),

8 that provides benefits with respect to health care  
9 services.

10 (10) HEALTH CARE LIABILITY ACTION.—The  
11 term “health care liability action” means a civil ac-  
12 tion brought in a State or Federal court against a  
13 health care provider, an entity which is obligated to  
14 provide or pay for health benefits under any health  
15 benefit plan (including any person or entity acting  
16 under a contract or arrangement to provide or ad-  
17 minister any health benefit), or the manufacturer,  
18 distributor, supplier, marketer, promoter, or seller of  
19 a medical product, in which the claimant alleges a  
20 claim (including third party claims, cross claims,  
21 counter claims, or distribution claims) based upon  
22 the provision of (or the failure to provide or pay for)  
23 health care services or the use of a medical product,  
24 regardless of the theory of liability on which the

1 claim is based on the number of plaintiffs, defend-  
2 ants, or causes of action.

3 (11) HEALTH CARE LIABILITY CLAIM.—The  
4 term “health care liability claim” means a claim in  
5 which the claimant alleges that injury was caused by  
6 the provision of (or the failure to provide) health  
7 care services.

8 (12) HEALTH CARE PROVIDER.—The term  
9 “health care provider” means any person that is en-  
10 gaged in the delivery of health care services in a  
11 State and that is required by the laws or regulations  
12 of the State to be licensed or certified by the State  
13 to engage in the delivery of such services in the  
14 State.

15 (13) HEALTH CARE SERVICE.—The term  
16 “health care service” means any service for which  
17 payment may be made under a health benefit plan  
18 including services related to the delivery or adminis-  
19 tration of such service.

20 (14) MEDICAL DEVICE.—The term “medical de-  
21 vice” has the meaning given such term in section  
22 201(h) of the Federal Food, Drug, and Cosmetic  
23 Act (21 U.S.C. 321(h)).

24 (15) NONECONOMIC DAMAGES.—The term  
25 “noneconomic damages” means damages paid to an

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1 individual for pain and suffering, inconvenience,  
2 emotional distress, mental anguish, loss of consor-  
3 tium, injury to reputation, humiliation, and other  
4 nonpecuniary losses.

5 (16) PERSON.—The term “person” means any  
6 individual, corporation, company, association, firm,  
7 partnership, society, joint stock company, or any  
8 other entity, including any governmental entity.

9 (17) PRODUCT SELLER.—

10 (A) IN GENERAL.—Subject to subpara-  
11 graph (B), the term “product seller” means a  
12 person who, in the course of a business con-  
13 ducted for that purpose—

14 (i) sells, distributes, rents, leases, pre-  
15 pares, blends, packages, labels, or is other-  
16 wise involved in placing, a product in the  
17 stream of commerce, or

18 (ii) installs, repairs, or maintains the  
19 harm-causing aspect of a product.

20 (B) EXCLUSION.—Such term does not in-  
21 clude—

22 (i) a seller or lessor of real property;

23 (ii) a provider of professional services  
24 in any case in which the sale or use of a  
25 product is incidental to the transaction and

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1 the essence of the transaction is the fur-  
2 nishing of judgment, skill, or services; or

3 (iii) any person who—

4 (I) acts in only a financial capac-  
5 ity with respect to the sale of a prod-  
6 uct; or

7 (II) leases a product under a  
8 lease arrangement in which the selec-  
9 tion, possession, maintenance, and op-  
10 eration of the product are controlled  
11 by a person other than the lessor.

12 (18) PUNITIVE DAMAGES.—The term “punitive  
13 damages” means damages awarded against any per-  
14 son not to compensate for actual injury suffered, but  
15 to punish or deter such person or others from en-  
16 gaging in similar behavior in the future.

17 (19) STATE.—The term “State” means each of  
18 the several States, the District of Columbia, Puerto  
19 Rico, the Virgin Islands, Guam, American Samoa,  
20 the Northern Mariana Islands, and any other terri-  
21 tory or possession of the United States.

22 **SEC. 10803. EFFECTIVE DATE.**

23 This subtitle will apply to any health care liability ac-  
24 tion brought in a Federal or State court and to any health  
25 care liability claim subject to an alternative dispute resolu-

1 tion system, that is initiated on or after the date of enact-  
2 ment of this subtitle, except that any health care liability  
3 claim or action arising from an injury occurring prior to  
4 the date of enactment of this subtitle shall be governed  
5 by the applicable statute of limitations provisions in effect  
6 at the time the injury occurred.

7 **CHAPTER 2—UNIFORM STANDARDS FOR**  
8 **HEALTH CARE LIABILITY ACTIONS**

9 **SEC. 10811. STATUTE OF LIMITATIONS.**

10 A health care liability action may not be brought  
11 after the expiration of the 2-year period that begins on  
12 the date on which the alleged injury that is the subject  
13 of the action was discovered or should reasonably have  
14 been discovered, but in no case after the expiration of the  
15 5-year period that begins on the date the alleged injury  
16 occurred.

17 **SEC. 10812. CALCULATION AND PAYMENT OF DAMAGES.**

18 (a) TREATMENT OF NONECONOMIC DAMAGES.—

19 (1) LIMITATION ON NONECONOMIC DAMAGES.—

20 The total amount of noneconomic damages that may  
21 be awarded to a claimant for losses resulting from  
22 the injury which is the subject of a health care liabil-  
23 ity action may not exceed \$250,000, regardless of  
24 the number of parties against whom the action is

1 brought or the number of actions brought with re-  
2 spect to the injury.

3 (2) JOINT AND SEVERAL LIABILITY.—In any  
4 health care liability action brought in State or Fed-  
5 eral court, a defendant shall be liable only for the  
6 amount of noneconomic damages attributable to  
7 such defendant in direct proportion to such defend-  
8 ant’s share of fault or responsibility for the claim-  
9 ant’s actual damages, as determined by the trier of  
10 fact. In all such cases, the liability of a defendant  
11 for noneconomic damages shall be several and not  
12 joint.

13 (b) TREATMENT OF PUNITIVE DAMAGES.—

14 (1) GENERAL RULE.—Punitive damages may,  
15 to the extent permitted by applicable State law, be  
16 awarded in any health care liability action for harm  
17 in any Federal or State court against a defendant if  
18 the claimant establishes by clear and convincing evi-  
19 dence that the harm suffered was the result of con-  
20 duct—

21 (A) specifically intended to cause harm, or

22 (B) conduct manifesting a conscious, fla-  
23 grant indifference to the rights or safety of oth-  
24 ers.

1           (2) PROPORTIONAL AWARDS.—The amount of  
2           punitive damages that may be awarded in any health  
3           care liability action subject to this subtitle shall not  
4           exceed 3 times the amount of damages awarded to  
5           the claimant for economic loss, or \$250,000, which-  
6           ever is greater. This paragraph shall be applied by  
7           the court and shall not be disclosed to the jury.

8           (3) APPLICABILITY.—This subsection shall  
9           apply to any health care liability action brought in  
10          any Federal or State court on any theory where pu-  
11          nitive damages are sought. This subsection does not  
12          create a cause of action for punitive damages. This  
13          subsection does not preempt or supersede any State  
14          or Federal law to the extent that such law would  
15          further limit the award of punitive damages.

16          (4) BIFURCATION.—At the request of any  
17          party, the trier of fact shall consider in a separate  
18          proceeding whether punitive damages are to be  
19          awarded and the amount of such award. If a sepa-  
20          rate proceeding is requested, evidence relevant only  
21          to the claim of punitive damages, as determined by  
22          applicable State law, shall be inadmissible in any  
23          proceeding to determine whether actual damages are  
24          to be awarded.

25          (5) DRUGS AND DEVICES.—

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1 (A) IN GENERAL.—(i) Punitive damages  
2 shall not be awarded against a manufacturer or  
3 product seller of a drug or medical device which  
4 caused the claimant’s harm where—

5 (I) such drug or device was subject to  
6 premarket approval by the Food and Drug  
7 Administration with respect to the safety  
8 of the formulation or performance of the  
9 aspect of such drug or device which caused  
10 the claimant’s harm, or the adequacy of  
11 the packaging or labeling of such drug or  
12 device which caused the harm, and such  
13 drug, device, packaging, or labeling was  
14 approved by the Food and Drug Adminis-  
15 tration; or

16 (II) the drug is generally recognized  
17 as safe and effective pursuant to conditions  
18 established by the Food and Drug Admin-  
19 istration and applicable regulations, includ-  
20 ing packaging and labeling regulations.

21 (ii) Clause (i) shall not apply in any case  
22 in which the defendant, before or after pre-  
23 market approval of a drug or device—

24 (I) intentionally and wrongfully with-  
25 held from or misrepresented to the Food



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1 and Drug Administration information con-  
2 cerning such drug or device required to be  
3 submitted under the Federal Food, Drug,  
4 and Cosmetic Act (21 U.S.C. 301 et seq.)  
5 or section 351 of the Public Health Service  
6 Act (42 U.S.C. 262) that is material and  
7 relevant to the harm suffered by the claim-  
8 ant, or

9 (II) made an illegal payment to an of-  
10 ficial or employee of the Food and Drug  
11 Administration for the purpose of securing  
12 or maintaining approval of such drug or  
13 device.

14 (B) PACKAGING.—In a health care liability  
15 action for harm which is alleged to relate to the  
16 adequacy of the packaging or labeling of a drug  
17 which is required to have tamper-resistant  
18 packaging under regulations of the Secretary of  
19 Health and Human Services (including labeling  
20 regulations related to such packaging), the  
21 manufacturer or product seller of the drug shall  
22 not be held liable for punitive damages unless  
23 such packaging or labeling is found by the court  
24 by clear and convincing evidence to be substan-  
25 tially out of compliance with such regulations.

1 (c) PERIODIC PAYMENTS FOR FUTURE LOSSES.—

2 (1) GENERAL RULE.—In any health care liabil-  
3 ity action in which the damages awarded for future  
4 economic and noneconomic loss exceeds \$50,000, a  
5 person shall not be required to pay such damages in  
6 a single, lump-sum payment, but shall be permitted  
7 to make such payments periodically based on when  
8 the damages are found likely to occur, as such pay-  
9 ments are determined by the court.

10 (2) FINALITY OF JUDGMENT.—The judgment  
11 of the court awarding periodic payments under this  
12 subsection may not, in the absence of fraud, be re-  
13 opened at any time to contest, amend, or modify the  
14 schedule or amount of the payments.

15 (3) LUMP-SUM SETTLEMENTS.—This sub-  
16 section shall not be construed to preclude a settle-  
17 ment providing for a single, lump-sum payment.

18 (d) TREATMENT OF COLLATERAL SOURCE PAY-  
19 MENTS.—

20 (1) INTRODUCTION INTO EVIDENCE.—In any  
21 health care liability action, any defendant may intro-  
22 duce evidence of collateral source payments. If any  
23 defendant elects to introduce such evidence, the  
24 claimant may introduce evidence of any amount paid  
25 or contributed or reasonably likely to be paid or con-

1 tributed in the future by or on behalf of the claim-  
2 ant to secure the right to such collateral source pay-  
3 ments.

4 (2) NO SUBROGATION.—No provider of collat-  
5 eral source payments shall recover any amount  
6 against the claimant or receive any lien or credit  
7 against the claimant’s recovery or be equitably or le-  
8 gally subrogated the right of the claimant in a  
9 health care liability action.

10 (3) APPLICATION TO SETTLEMENTS.—This sub-  
11 section shall apply to an action that is settled as well  
12 as an action that is resolved by a fact finder.

13 **SEC. 10813. ALTERNATIVE DISPUTE RESOLUTION.**

14 Any ADR used to resolve a health care liability action  
15 or claim shall contain provisions relating to statute of limi-  
16 tations, non-economic damages, joint and several liability,  
17 punitive damages, collateral source rule, and periodic pay-  
18 ments which are identical to the provisions relating to  
19 such matters in this subtitle.