other side of the aisle to oppose this ill-conceived Medicare plan. The Republican leadership proposal, as we know, will cut $270 billion out of Medicare to pay for $245 billion in tax cuts mostly for the wealthy.

It is not necessary to make these cuts in order to keep Medicare solvent. The Medicare trustees have told us that Speaker GINGRICH's cuts had three times any estimate of what is needed to make Medicare solvent. Mr. Chairman, seniors are going to be forced to pay more to get less under the Gingrich proposal. Part B premiums will double without a penny of that increase going back into the part A Medicare hospital trust fund.

Seniors will ultimately be forced into HMO's and have to give up their own doctors because the Republican proposal puts money into HMO's at the expense of the traditional Medicare system.

My colleagues, the Republican plan will destroy America's high quality health care system because hospitals and other health care providers will be so squeezed for Medicare dollars that they will be forced to close or significantly cut back on their services.

None of this would be necessary if Speaker GINGRICH were not insisting on a big tax break for the wealthy. I know that at least half of my Republican colleagues from the State of New Jersey have already indicated that they are voting no on this terrible bill. I would ask all of my colleagues on the other side to heed the words of three Republican State legislators from the Jersey Shore who wrote to my New Jersey colleagues in the House this week and urged support for the Gibbons-Dingell substitute.

They said, and I quote:

Alternative proposals have been offered that would maintain the solvency of the part A and part B trust funds until the year 2006. This $90 billion compromise package would provide a decade for Congress and the White House to achieve a well-planned and balanced proposal to resolve Medicare's financial problems.

We feel very strongly that a rush to judgment on this issue is bad public policy. America should not turn its back on our parents and grandparents.

Mr. Chairman, I include for the RECORD this letter from my fellow Republican State legislators in New Jersey urging opposition to this.

STATE OF NEW JERSEY,
9TH DISTRICT LEGISLATIVE OFFICES,
Forked River, NJ, October 13, 1995.

Re Medicare.

To: Hon. Christopher H. Smith, Hon. Robert E. Andrews, Hon. Marge Roukema, Hon. Robert D. Franks, Hon. Robert G. Torricelli, Hon. Rodney P. Frelinghuysen, Hon. Robert Menendez, Hon. H. James Saxton, Hon. Frank A. LoBiondo, Hon. Frank Pallone, Jr., Hon. William J. Martini, Hon. Donald M. Payne, and Hon. Richard A. Zimmer.

DEAR HOUSE MEMBERS: It is our understanding the House Ways and Means Committee has voted 22–14 to send the Medicare reform package to the House floor next week.

Our 9th District Delegation, which represents the largest Senior Citizen population in New Jersey in Ocean, Burlington and Atlantic counties, issued a letter on September 22, 1995 to House Speaker Newt Gingrich and Senate Majority Leader Bob Dole, urging them to scrap this plan.

Copies of our correspondence to Speaker Gingrich and Senator Dole were conveyed to New Jersey's Congressional Delegation. For your convenience, a second copy of this appeal is enclosed.

Please allow our Delegation this opportunity to reiterate our profound concerns about these cuts in Medicare services for our elderly.

As you are aware, alternative proposals have been offered that would maintain the solvency of the Part A and Part B trust funds until 2006. This $90 billion compromise package would provide a decade for Congress and the While House to achieve a well-planned and balanced proposal to resolve Medicare's financial problems. This compromise would also provide the opportunity for a bipartisan consensus.

Our Delegation is genuinely sensitive to the difficult decision you face and have had our own feet roasted by the hot coals of Leadership. We feel very strongly that a rush to judgment on this issue is bad public policy. America must never turn its back on our parents and grandparents.

We, respectfully, urge New Jersey's House Members to oppose this $270 billion Medicare cut. Your leadership, in targeting Medicare fraud, the staggering costs of health care and in building a bridge to the future with the alternative proposals set forth by Reps Sam Gibbons that will provide the chance for Congress to seek a consensus solution to preserve Medicare for our parents and grandparents.

Thank you for your thoughtful attention to this appeal on behalf of the Senior Citizens of Ocean, Burlington and Atlantic counties.

Sincerely,

LEONARD T. CONNORS, JR.,
Senator—9th District.
JEFFREY W. MORAN,
Assemblyman—9th District.
CHRISTOPHER J. CONNORS,
Assemblyman—9th District.

ANNOUNCEMENT BY THE CHAIRMAN

The CHAIRMAN. The Chair would like to take the time to remind Members that it is not appropriate to wear or display badges while engaging in debate.

Mr. ARCHER. Mr. Chairman, I yield 3 minutes to the gentleman from Louisiana [Mr. MCCRERY], a valuable member of the Subcommittee on Health.

Mr. MCCRERY. Mr. Chairman, as this chart shows, spending on the Medicare system has skyrocketed since 1970. Here we are today and Members can see, if nothing is done, it goes off the chart.

In 1970, Medicare spent about $8 billion; in 1994, Medicare spending was about $165 billion. That is an increase of almost 2,100 percent in just 14 years. In the part B side alone, growth rates have been so rapid that outlays of the program have increased 40 percent per enrollee just in the past 5 years. More alarming is that Medicare spending is projected to explode to over $350 billion in 2002. Clearly, this is an unsustainable trend and one that neither seniors nor younger Americans working to support themselves and their families can be asked to underwrite.

The financial crisis in the Medicare program is not a short-term cash flow problem, as the Democrats would like the American people to believe. The trustees of the Medicare trust fund, three of whom are President Clinton's own Cabinet members, said in their report on the HI, or part A, trust fund, ''The trust fund fails to meet the trustee's test of long range close actuarial balance by an extremely wide margin.'' Further, the same trustees said in their report on the SMI trust fund, the part B trust fund, ''while in balance on an annual basis, shows a rate of growth of costs which is clearly unsustainable.''

The public trustees of the Medicare program were very clear when they said, ''The Medicare Program is clearly unsustainable in its present form.''

The Democrats in the past have ignored the long-range spending problem of the Medicare Program. Their solution has been to continually raise taxes on working Americans, and that is still their solution.

In the years since the enactment of Medicare, the maximum taxable amount has been raised 23 times. Two years ago, the Congress, then controlled by Democrats, raised taxes, Medicare taxes again. All that did was just put another financial burden on the taxpayers and put off the financial crisis in the trust fund for just a few months. Clearly, raising taxes yet again on the American people is not the answer.

The Medicare Preservation Act, on the other hand, addresses the out-of-control spending in the Medicare Program by opening up the private health care market to the senior population. By harnessing some of the innovative cost effective and high quality private sector health care delivery options, Medicare beneficiaries will not only have a choice in their health care coverage for the first time, but the Government will also be able to rein in out-of-control Medicare spending. It is a win/win situation.

The Republican plan provides security for not only today's seniors but also lays the groundwork for the retirement of my generation, and it does it without increasing the tax burden on working people.

Mr. DINGELL. Mr. Chairman, I yield 1 minute to the distinguished gentleman from Pennsylvania [Mr. KLINK].

Mr. KLINK. Mr. Chairman, I thank the gentleman for yielding time to me.

I would like to begin by yielding to the gentleman from Ohio [Mr. BROWN].

Mr. BROWN of Ohio. Mr. Chairman, the previous speaker, under the Gingrich Medicare plan, the hospitals in and around the district of the gentleman from Louisiana [Mr. MCCRERY], will lose $158 million over the next 7 years under the Gingrich Medicare cut plan.

Mr. KLINK. Mr. Chairman, I thank the gentleman for that input. Here is the chart which actually shows the reduction in Medicare spending per beneficiary under the House Republican plan. I have to get this straight. When is a cut not a cut?

Last year when we were trying to do health care, every Republican on the Committee on Ways and Means signed a letter which said, ''the additional massive cuts in reimbursement to providers proposed in this bill''—the Clinton bill—''will reduce the quality of care for the Nation's elderly.'' That was $168 billion versus $70 billion now.

The current chairman of the Committee on Ways and Means made the statement, ''I just don't believe that the quality of care and availability of care can survive these additional cuts.'' Now they are saying that these are not cuts. It is cuts in the rate of growth. Were you lying to us now or are you lying to us then?

Mr. ARCHER. Mr. Chairman, I yield myself such time as I may consume.

I resent the fact that the gentleman implied that I have lied. No. 1, that does not belong on this floor. But the gentleman, as usual, has not given the factual information.

The plan that I made those comments on cut $490 billion out of Medicare and Medicaid. Without transforming Medicare, without giving other options, without including true savings in the cost drivers. That was a totally different time, a totally different program. But it cuts $490 billion out of Medicare and Medicaid.

Mr. Chairman, I reserve the balance of my time.

Mr. GIBBONS. Mr. Chairman, I yield such time as he may consume to the gentleman from Georgia [Mr. LEWIS].

Mr. LEWIS of Georgia. Mr. Chairman, I thank the gentleman for yielding time to me.

Mr. Chairman, I rise today in strong opposition to the Republican Medicare plan. I rise to tell you there is another way, a better way. We Democrats have a plan. We save the Medicare trust fund, and we do it without hurting the poor, the sick, and the elderly.

How can we do it? We can do it because we do not pay for tax breaks for the rich. There is only so much money—you can either use it to help the sick and the elderly or you can give it to the rich. My Republican colleagues may say whatever they wish, but the truth is that these very large—these huge Medicare cuts are needed to pay for their tax breaks for the rich.

The Republicans say they want to help Medicare. But what they do is different. Thirty years ago, the Democrats created Medicare and the Republicans voted against it.

Two years ago, Democrats passed a bill that helped the Medicare trust fund. Every Republican voted no.

Earlier this year. the Republicans took $87 billion from the Medicare trust fund. Today, they want to cut an additional $270 billion.

They voted against Medicare 30 years ago, and they are voting against it again today. My colleagues, actions speak louder than words, and the Republican actions are loud and clear.

The Republicans did not want Medicare 30 years ago and they want to dismantle it now.

I do not believe that we must destroy Medicare to save it. Democrats do not raise premiums for seniors. Democrats ensure that Medicare is there for our families, for our children, for our grandchildren, and their children.

Under their plan, the Republicans eliminate nursing home standards. Poor seniors lose help for copayments and deductibles.

Under the Republican plan, the rich get tax cuts, and our Nation's elderly and hard-working families get higher Medicare bills. It's a scam, a sham, and a shame. I know it. You know it. Now the American people know it.

Mr. Chairman, on this day, October 19, let the word go forth from this place into every State, every city, every town, every village, every hamlet that it was the Republicans who voted to cut Medicare—they voted to cut Medicare by $270 billion in order to give a $245 billion tax break to the wealthy. The Republican plan is too much, too radical, too extreme.

We have more than a legislative responsibility to oppose this Republican plan. We have a mandate, a mission, and a moral obligation to protect Medicare.

This vote—this debate is about something much bigger than one vote. It is bigger than one bill. It is about two contracts, the Republican contact with the rich, and the Democratic contract with the American people—Medicare. Medicare is a contract—a sacred trust with our Nation's seniors and our Nation's hard-working families.

My fellow Americans, remember—it was the Democrats who found the courage and the strength to provide health care to our seniors, and it is the Democrats who will preserve it for unborn generations.

We must not and will not break the contract with America's seniors and families. I urge my colleagues to support the Democratic alternative and oppose the Republican plan to cut Medicare.

Mr. ARCHER. Mr. Chairman, I yield myself such time as I may consume.

Mr. Chairman, the facts have already been presented to this committee. Medicare increases per beneficiary go from $4,800 to $6,700 per year. The total aggregate increase in medical expenditures increases $1.4 trillion under our plan over the next 7 years. But only in Washington can an increase be called a cut.

Mr. BLILEY. Mr. Chairman, I yield 1½ minutes to the gentleman from Pennsylvania [Mr. GREENWOOD].

Mr. GREENWOOD. Mr. Chairman, earlier this year we got some very bad news for Americans and senior citizens. The trustees of the Medicare funds told us that under all sets of assumptions the fund goes bankrupt, and it goes bankrupt in 7 years. Taking our responsibility very seriously, we Republicans went to work.

We gathered with senior citizens, with experts from around the country, and we said, what can we do? Is there any good news? Can we fix the situation? We found good news. We found that health insurance costs for working people, not retired people, were going down. Inflation rates at 10.5 percent in Medicare are killing it.

□ 1230

The private sector using intelligent new programs have brought the inflation rate down below to virtually zero. We said the good news is this. We can preserve Medicare, we can preserve fee-for-service options for everyone who wants to stay that way, but we have new and exciting options.

Mr. Chairman, my mother and father have chosen the managed-care option. They love it. They save $1,000 a year each because they no longer buy MediGap insurance. They have new prescription drug benefits. They get all of the referrals they want. They are delighted.

This plan is very straightforward. We preserve fee-for-service, we increase the per beneficiary expenditure from $4,800 a year to $6,700 a year, and for those seniors who want new choices, we have excellent new choices in managed care. This is a spectacular bill. Americans will be proud of it. Senior citizens love it. Vote ''yes.''

Mr. DINGELL. Mr. Chairman, I yield 2 minutes to the distinguished gentleman from Oregon [Mr. WYDEN].

(Mr. WYDEN asked and was given permission to revise and extend his remarks.)

Mr. WYDEN. Mr. Chairman, our Nation needs——

Mr. STARK. Mr. Chairman, will the gentleman yield?

Mr. WYDEN. I yield to the gentleman from California.

Mr. STARK. Mr. Chairman, I wish to inform the gentleman that in the district of the gentleman from Pennsylvania [Mr. GREENWOOD] there will be $128 cut from hospitals over the next 7 years.

Mr. WYDEN. Mr. Chairman, our Nation needs bipartisan reform of Medicare, but instead today's bill will deliver a nationwide Medicare migraine. Instead of listening to our seniors, and our families, and to the inspector general, this is a cut first, ask questions later Medicare initiative, and the fraud section is a metaphor for the whole bill. Instead of legislation to protect seniors and taxpayers, it protects the crooks and the thieves. Instead of improving access to health care, it provides a freeway to fraud, and, my colleagues, think of the words of the nonpartisan fraud-buster at the Office of the Inspector General who said that this bill will cripple, it will cripple, efforts to bring justice.

Let me tell my colleagues it is possible to develop 21st century Medicare that works for seniors and taxpayers. Reject this bill and come with me to Oregon because I will show each of you programs that protect seniors, hold down costs, and insure that we have a path to the 21st century. We can do this job right. We can do it in a bipartisan way. But let us listen to our seniors and our taxpayers.

Mr. DINGELL. Mr. Chairman, I yield 1 minute to the distinguished gentlewoman from Oregon [Ms. FURSE].

Ms. FURSE. Mr. Chairman, I thank the gentleman for yielding this time to me.

I have here a list of words that I am told the Republicans were asked to use in this debate, words like historic, successful, saves. Well, there was a historic event 30 years ago. The Democrats in this House passed Medicare. Not one Republican voted for it.

Successful? Well, yes. This bill successfully guts Medicare.

Saves? Well, yes. This bill saves the promised tax breaks for the rich.

Mr. Chairman, also on this list it says we should say the Democrats are scaring 85-year-olds. Mr. Chairman, as a member of the committee, I know that it was the Republicans who ordered the arrest of 85-year-olds who came to the committee. They came there. They came to ask the committee what is going to happen to our Medicare protection. They were Americans. It is a disgrace that they were arrested.

I think there is a word that is not on this list, Mr. Chairman, and that word is shame.

Mr. BLILEY. Mr. Chairman, I yield myself 30 seconds to respond.

Mr. Chairman, the rules of this House are explicit. The chairman of any committee is required to preserve order, and when citizens of any persuasion, any age, come in, refuse to obey the orders of this House, the chairman has no choice but to have them escorted out of the room.

Mr. Chairman, that is exactly what happened in the Committee on Commerce, and that is what we had to do regrettably, but that is the truth.

Mr. DINGELL. Mr. Chairman, I yield myself 15 seconds.

Mr. Chairman, I love my dear friend from Virginia, but I notice he did nothing when a bunch of people came in and dumped bags of mail from dead men, from people who were not supporting the legislation in question, and some of which were addressed ''contributor.'' Our Republican colleagues have a great sensitivity about the senior citizens, but none whatsoever about rascality by high-paid lobbyists.

Mr. BLILEY. Mr. Chairman, I yield myself such time as I may consume.

Mr. Chairman, the organization that disrupted that meeting, I would like the RECORD to show, 96 percent of those funds come from the public treasury. The person who was the ringleader was a paid staff person.

Mr. Chairman, I yield 2 minutes to the gentleman from Florida [Mr. BILIRAKIS].

(Mr. BILIRAKIS asked and was given permission to revise and extend his remarks.)

Mr. BILIRAKIS. Mr. Chairman, I will use the word ''shame.'' Shame on those politicians who over the years, not just now, use scare tactics and misinformation to frighten our senior citizens all in the interests of getting votes through fear. These actions are unconscionable.

Only the most affluent retirees are having their part B premiums raised substantially. We are not raising Medicare copayments or deductibles. We will not be reducing services or benefits—our legislation ensures that the core services in the current Medicare Program will be retained and must be offered to all beneficiaries.

I also want to make it clear that no one will be forced into HMO's. If Medicare beneficiaries wish to keep the current fee-for-service benefit where they have complete choice of their doctor, they will be permitted to do so. If beneficiaries want to enroll in an HMO which might include additional health benefits, or some other Medicare-plus plan, they can do so. It will be their choice. Under our proposal, coverage will be assured to all senior citizens, regardless of prior health history or age.

From the beginning of this effort, I have insisted that protecting beneficiaries was an essential part of any Medicare report effort. I represent a congressional district that has one of the highest percentages of senior citizens in the country. I also worked for years as an attorney and a community volunteer with many retirees. Recently, I myself, reached Medicare age.

This bill is the product of listening and learning. It is a product of many discussions with people who had real life, day to day experiences with the Medicare Program. It protects our current beneficiaries while ensuring that Medicare will exist for future beneficiaries.

In a recent Washington Post article, Robert Samuelson said it well when he stated that ''Republicans occupy the high moral ground and the low political ground. They have raised critical questions at the risk of political suicide.''

And, knowing that, Republicans still believe it is our responsibility to show pure guts and courage to save Medicare for our seniors, their children, and grandchildren. We have taken on the task of protecting and preserving Medicare because it is our moral responsibility, not because of political necessity. We have taken the higher ground and this is ground that I am proud to stand on.

Mr. WAXMAN. Mr. Chairman, I yield 2 minutes to the gentleman from Texas [Mr. BRYANT] and I ask him if he would yield back to me 15 seconds.

Mr. BRYANT of Texas. I yield to the gentleman from California.

Mr. WAXMAN. Mr. Chairman, I just want to comment on the statement made by the previous gentleman. He claimed we are not cutting benefits, we are not going to make people pay for benefits for their health care. How are we getting $270 billion in Medicare cuts and the AMA supports the bill? Something just does not add up.

Mr. BRYANT of Texas. Mr. Chairman, the gentleman's logic is impeccable. I would point out that the losses to hospitals in and around the district of the gentleman from Florida [Mr. BILIRAKIS] are going to be $210 million over the next 7 years, and my colleague says there are no cuts. His folks are going to feel them.

The fact of the matter is, Mr. BILIRAKIS, as chairman of the Subcommittee on Health, my colleague and his Republican friends ought to be working on the fact that health care costs are rising. Instead my colleague is working on cutting health care insurance that elderly people use to cope with health care costs. That is the problem.

The fact of the matter is it is not a secret that my colleague's party philosophically does not believe Medicare is the appropriate role of government, and yet he comes in here and tells us they are not cutting it. Mr. Chairman, my colleague has gotten power, and now he is cutting it. He boasts throughout the land he is cutting government, but today, as he takes $270 billion out of the program that insures the health needs of seniors, he says he is not cutting it.

Only in Washington would anybody believe that, Mr. ARCHER.

I would point out that with regard to these cuts, Mr. Chairman, the gentleman from Texas [Mr. ARCHER] and I are pretty much both in the same situation. In Harris County, TX, we are talking about $2.4 billion in cuts between 1996 and the year 2002 according to the Health Care Finance Administration.

Now my colleagues asked for facts, There is facts. Dallas County, $1.6 billion in cuts between 1996 and the year 2002. Why? To pay for tax cuts for wealthy people out of the hides of elderly people who are not going to be able to pay their medical bills because they have cut their insurance.

Mr. ARCHER. Mr. Chairman, I yield myself such times as I may consume very simply to say that once again we are back into the same rhetoric. There will be increases for hospitals across this country. Those increases have already been demonstrated by the facts.

Only in Washington can a Member of Congress stand up and call increases a cut.

Mr. Chairman, I yield 2 minutes to the gentleman from Michigan [Mr. CAMP], a respected member of the committee.

(Mr. CAMP asked and was given permission to revise and extend his remarks.)

Mr. CAMP. Mr. Chairman, I thank the distinguished gentleman from

Texas [Mr. ARCHER] for yielding this time to me, and I rise today in support of the Medicare Preservation Act because it officially ends the policy of just raise taxes.

Mr. Chairman, some who oppose our program have called it extreme. What is extreme is that year after year the Democrat's answer to the Medicare crisis has been to raise taxes. Almost every year, Democrats dug deeper into the pockets of working Americans just to get through the next election. And in 1993, they even raised taxes on seniors citizens.

Nine times, since 1965, the Medicare Board of Trustees has stated that Medicare was in severe financial trouble and needed reform. What was the Democrats answer? Raise taxes. Just throw more money at it to get through the next election.

Since 1965, Democrats raised the payroll tax on working Americans eight times, over 450 percent. They raised the earnings subject to tax for Medicare 10 times, an increase of over 2000 percent. Then they raised taxes on Federal and State employees, and, when they still needed more, in 1993, they raised taxes on American seniors who had already paid their fair share into the program. Now, a senior earning just $34,000 pays not half of their Social Security in taxes but 85 percent. And now even the President admits taxes were raised too much in 1993.

Mr. Chairman, that is extreme.

Could we put the Medicare crisis off a few years if we raise taxes again? Sure we could.

Could we avoid the vicious attacks by special interest groups if we didn't reform the system? Sure.

But we are not going to do that. We are going to preserve, protect and strengthen Medicare not to get through the next election, but for the next generation. We will ensure the solvency of this program. We will increase benefits. We will maintain the current premium rate and for the first time in the history of Medicare, we will give seniors the right to choose the health care plan that best suits their health needs.

Mr. BLILEY. Mr. Chairman, I yield 5 minutes to the gentleman from Florida [Mr. STEARNS].

Mr. STEARNS. Mr. Chairman, I would like to have a colloquy, if I could, with the gentleman from Pennsylvania. Both he and I have worked hard in our districts getting the message out how important it is to look at this program because it is going bankrupt, and we want to offer them choices, much like the choices that the gentleman and I have. Perhaps many Members do not know that a large number of the Federal employees are retired and they have choices, HMO's, PPO's, and all these other things. Let us talk, for example, about a widow whose $600-a-month pension is too low to pay for this expensive part C medigap insurance and whose biggest problem is that she cannot afford the deductible portion of her doctor's bill.

□ 1245

So what happens, she does not go to take care of herself. Now, what would we have under this program with our HMO's and PPO's and the PSN's? I mean, even a $5 doctor bill is something that she would be concerned about. You might want to amplify on that.

Mr. GREENWOOD. If the gentleman will yield, the option that would be very attractive for the constituent in your district that you just have described would be a managed care option. Most of the managed care companies have told us that, and they are already doing this in many areas of the country, that they will offer managed care plans in which there is no requirement whatsoever to pay Medigap insurance. So that $1,000 a year that she may be paying now toward her Medigap insurance would disappear. Suddenly she would gain new benefits. She would probably gain a prescription drug benefit. She may get an improved dental or vision benefit. She would no longer have that out-of-pocket cost at all and still be able to go to her doctors within her network whenever she chooses. She would, I think, would welcome this change very much and be far better off and have more money left over in her budget at the end of each month.

Mr. STEARNS. Is it not a point of fact that all the people in this room have the Federal employee health benefit program, and is it not a point of fact that people on this side are in HMO's, in fact, there are Members of Congress who have retired who are in health management organizations and they are not picketing and screaming and worried? Because actually what we are trying to do is develop a program for Medicare that is much like the First Lady and the President has and all of us have, which basically says that health management organizations might work for some people. It should be a choice, and surely if it is good enough for Members of Congress, these same choices should be available for the seniors. So I think that is what you are saying for this particular woman in Florida who is on a very small pension every month. This would be a possible choice for her. You might want to just amplify on that, because I know you have toured, like I have, many health maintenance organizations, talked to the seniors, and for some of them they are very happy.

There are people that have high monthly drug costs, and the HMO is paying for that, and it is paying for their deductible. So that surely that is an approach we should not rule out by keeping the one warehouse, one-size-fits-all program we now have. Surely moving it to what we have in the Federal employee health benefits program is a step forward.

Mr. GREENWOOD. The fact of the matter is 9 percent of seniors in this country already have chosen the option of receiving their Medicare benefits through managed care. That number is growing rapidly because you know how seniors will get together and talk and compare notes, and when one learns from the other that they have a new prescription drug program benefit, they say, ''How do I get that,'' and they make the choice.

One of the things about this debate that has been interesting to me is you and I and Members of this side of the aisle know our friends on the other side of the aisle will spend all day, as they have spent the last 6 or 7 months, scaring senior citizens that all of these terrible things are going to befall them.

The fact of the matter is that we are confident today, we are confident because we know when the political dust settles, when this plan is finally signed into law, that the senior citizens will then, beginning in January, have these new options. They will see, my goodness, their copays did not go up, deductibles did not go up, their Social Security check, even with part B deduction, is bigger than it was this year. They will then thank us. Once this debate is over, we think we will be able to say we told you so.

Mr. STEARNS. Is it not also true, if they want to remain in Medicare as it is right now, they can still do that? They still have that choice?

Mr. GREENWOOD. Absolutely. That is the beauty part. We have made certain from day one there is the fee-for-service option will always be available to every single senior citizen in America that wants to keep it. Those that may be a little too old for change, do not like to change, can keep their fee-for-service and enjoy the kind of Medicare that they have grown to enjoy these past years.

Mr. GIBBONS. Mr. Chairman, I yield myself 30 seconds.

I know the two gentlemen who just had this colloquy on the floor are sincere. But last year I checked all of the Medicare policies of every Member in Congress here. Ninety-nine percent of us have fee-for-service. Ninety-nine percent of us have fee-for-service, and all of those, all of those that have fee-for-service have abortion benefits in our medical care policies. You know, those are in the records of the House. Go check them.

PARLIAMENTARY INQUIRY

Mr. THOMAS. Mr. Chairman, I have a parliamentary inquiry.

The CHAIRMAN. The gentleman will state his parliamentary inquiry.

Mr. THOMAS. Mr. Chairman, is it against the rules to wear slogans, buttons, while addressing the Committee of the Whole, and did the Chairman not already indicate what the rules are?

The CHAIRMAN. The gentleman is correct.

Mr. STUPAK. Mr. Chairman, I yield 90 seconds to the gentleman from New York [Mr. MANTON].

Mr. MANTON. Mr. Chairman, at the outset, I yield to the gentleman from Michigan [Mr. STUPAK].

Mr. STUPAK. Mr. Chairman, I just wanted to point out the last speaker in

the well down here, the gentleman from Florida [Mr. STEARNS], his district will lose $154 million over the next 7 years if this Republican plan goes through, just to give a tax break to the rich.

I am more concerned about the State of Michigan where the gentleman from Michigan [Mr. CAMP] spoke in which in his district the hospitals will lose $125 million between now and 2002 just to pay for this tax break for the rich. Being from Michigan, I am very concerned about that.

Mr. MANTON. Mr. Chairman, I rise in strong opposition to this draconian plan to slash $270 billion from Medicare. This so-called Medicare preservation plan will seriously threaten the integrity of the program and inflict undue pain on America's elderly.

Under this bill, the elderly will suffer an increase in their premiums and a decrease in the quality of their health care services. Quite simply, you are asking seniors to pay a lot more, but expect a lot less.

And last night, Mr. Chairman, in one final act of cruelty, the majority included a provision to deny anti-nausea drugs for chemotherapy patients. How can you possibly justify denying basic dignity and comfort to those in the twilight of their life, who are fighting for that very life.

Speaking out against this outrageous proposal is not a matter of demagoguery, its a matter of duty. Duty to the senior citizens we represent.

Oppose this legislation.

Mr. ARCHER. Mr. Chairman, I yield 30 seconds to the gentleman from Louisiana [Mr. MCCRERY].

Mr. MCCRERY. Mr. Chairman, the gentleman stated something that is just incorrect, and it has been stated in the media some. We are not denying payments for anti-nausea drugs for cancer patients. The fact is that we will continue to pay for the intravenous drug that people, the cancer patients, use to fight nausea.

Mr. BLILEY. Mr. Chairman, I yield 4 minutes to the gentleman from Pennsylvania [Mr. GREENWOOD].

Mr. GREENWOOD. Mr. Chairman, I yield to the gentleman from New York [Mr. PAXON] for a question.

Mr. PAXON. Mr. Chairman, I have many constituents back in western New York, in the Buffalo and Rochester, Finger Lakes areas, that are concerned about catastrophic costs in health care. How would medical savings accounts help those with recurring health problems pay for these catastrophic expenses?

Mr. GREENWOOD. The medical savings account is a new component of Medicare that we have included in this reform. Those seniors who choose it would have deposited into their medical savings account a number of dollars that would average about $5,000 across the Nation; the first portion of that deposit would be used to buy catastrophic or major medical insurance that would cover them above he deductible. Then the senior gets to use what is left in the account for his or her medical benefits, go to whatever doctor or hospital he or she wants. Once the deductible is reached, then in a year in which that particular individual has high costs, then the medical, the catastrophic, coverage would kick in and they would have no more out-of-pocket costs whatsoever.

In a year in which she was particularly healthy, managed her costs and did not go to a doctor very often, she would be able to keep the balance in the medical savings account. It is a good opportunity for savings for those seniors.

Mr. PAXON. I would make a comment. My parents are both retired. Both have had catastrophic health care concerns. Of course, this would be very important to them.

I also want to make the point Medicare is important to them today, too. They want to see Medicare protected and strengthened. It is their health care needs. It concerns me deeply. If their Medicare is not safe and secure, they have to turn to the family to help. We want to make certain for them and all of the constituents this plan is preserved and protected for the coming years.

Mr. FRISA. Mr. Chairman, will the gentleman yield?

Mr. GREENWOOD. I yield to the gentleman from New York.

Mr. FRISA. Mr. Chairman, I just wanted to, if we could, because this is such a serious issue, it is an important one for our senior citizens. My folks are both retired and are counting on Medicare being there throughout their retirement, and they are happy that we are taking the opportunity to make Medicare safe and sound and better for all of us.

So I would like to ask the gentleman, are there going to be increased funds for seniors under the Republican plan?

Mr. GREENWOOD. Well, of course, there are. Despite all of the rhetoric to the contrary, we are actually taking, right now, we are spending on average $4,800 per each beneficiary in the Medicare Program. Our plan increases that about 5 percent each year for a 40-percent increase over the next 7 years. So 7 years from now we will be spending $6,700 for beneficiaries. It is a huge increase.

What we are doing is bringing down the unsustainable inflation rate which is bankrupting the system.

Mr. FRISA. In other words, and I think this is very important, despite the rhetoric, it is really not truthful. We are saying the average senior citizen will be getting an extra 100 $20-bills spent on their medical behalf. So there is more money being spent for senior citizens under the Republican plan.

It is absolutely incredible, I think you would agree, that my colleagues on the other side of the aisle are trying to say that 100 additional $20-bills for our senior citizens is a cut. It is absolutely incredible.

I thank the gentleman for explaining that and making it clear to the American people and, most importantly, to our senior citizens that the Republicans, by providing a $2,000-per-beneficiary increase is what is going to save Medicare for our seniors so they can feel that it is safe and sound and better for them.

Mr. DINGELL. Mr. Chairman, I yield 1 minute to the distinguished gentleman from Florida [Mr. DEUTSCH].

Mr. DEUTSCH. Mr. Chairman, you know, sometimes we can make complicated issues simple. If we are saving $270 billion and there are 37.6 million beneficiaries, this is what it is going to cost each Medicare beneficiary in America, whether in terms of direct out-of-pocket expenses or not.

There is another chart which I think is probably the best chart and the clearest and most factual, and if we can focus in on this so people watching can see, my Republican colleagues have said we have to do something, there is this incredible crisis, the trust fund is gong to go bankrupt in 7 years.

Well, the Medicare Program has existed for 30 years. Twelve of those thirty years there was a shorter life expectancy than 7 years that exists today, and we did incremental changes. We fixed it.

It is a flat-out lie that this is unprecedented. It is a flat-out lie that $270 billion needs to be cut. It is a flat-out lie that choice will be available for Medicare beneficiaries.

Mr. GIBBONS. Mr. Chairman, I yield such time as he may consume to the gentleman from Tennessee [Mr. CLEMENT].

(Mr. CLEMENT asked and was given permission to revise and extend his remarks.)

Mr. CLEMENT. Mr. Chairman, I rise in opposition to the Republican Medicare reform plan and ask my colleagues to support the Dingell-Gibbons substitute.

Mr. Chairman, when President Lyndon Johnson began the Medicare Program in 1965, less than half of all seniors had health insurance. It was understood that the elderly had declining resources, costly health care needs, and few insurers willing to sell them coverage. Since its creation, the Medicare Program has been a great success. Today, 99 percent of senior citizens and a substantial proportion of the disabled are covered by Medicare. It has contributed to reducing poverty among the elderly and causing the life expectancy rate in America to exceed that of every country in the world except Japan. Medicare is fulfilling its mission.

Let me review briefly the two areas of the Medicare Program. Part A of Medicare is financed by the hospital insurance trust fund, which comes primarily from the hospital insurance or Medicare payroll tax contributions paid by employers, employees, and self-employed individuals. Medicare part A will pay for inpatient hospital care, skilled nursing facilities, home health care, and hospice services. It is the trust fund of part A which the Medicare trustees say is ''severely out of financial balance'' and must receive ''prompt, effective,

and decisive action'' from Congress to restore the stability of the program.

The second aspect of the Medicare Program is part B, the supplementary medical insurance trust fund. Part B is optional, and primarily finances physician and hospital outpatient services. Part B is financed by premium payments from enrollees and by general revenue funds from the Federal Government. The part B premium is currently $46.10 monthly or 31.5 percent of total costs of Medicare, and the budget of 1993 would bring the premium down to 25 percent of total costs from 1996 to 1998. Beneficiaries are responsible for an annual deductible of $100 and coinsurance, usually a 20-percent copayment. The part B trust fund is not in financial crisis, though only because it is financed partially by the general fund which is experiencing runaway health care costs and driving up the deficit of the U.S. Government.

Let me be clear that I do not believe Medicare is out of control or too generous as some have stated. In truth, Medicare pays only 45 percent of the Nation's health care bill for the elderly, and it is less generous than 85 percent of private health insurance plans.

The problems we are facing with Medicare today are primarily external, not internal. Though some problems do exist internally such as fraud and abuse, most of the factors which bring us to the present crisis are external. Let me share a few with you.

First, the primary threat to Medicare is its rising costs which are consequently driving up the Federal deficit at alarming rates. The ability of any reform proposal must be measured by the following yardstick if we are to balance the budget and get our financial house in order: Does the reform measure control the costs of Medicare? Over the past 20 years the cost of the Medicare Program has increased an average of 15 percent a year. In this year alone, Medicare will account for 11.6 percent of all Federal spending. This will rise to 18.5 percent by 2005 if costs are not controlled.

Another factor which threatens the future of Medicare is the growing number of senior citizens in America. The Baby Boomers will begin retiring shortly after 2010, and recent years have seen a dramatic increase in life expectancy. During the 30-year period from 1990 to 2020, the growth rate of the senior citizen population will be double the growth rate of the total U.S. population. This means that those receiving Medicare benefits will outnumber those employees and employers paying into Medicare.

Among other contributors to the rising cost of Medicare are the high cost of advanced medical technologies, the rapid increase in procedures by doctors after a fee schedule was imposed by Medicare, the fee-for-service arrangement which gives no cost-saving incentives to providers or patients, and the rise of Medicare fraud and abuse. All these factors, some of which I applaud such as life expectancy and miraculous technology, have brought us to this present moment of crisis.

Before looking at the specific proposals to reform Medicare, I wish to suggest the values which I believe should drive any attempt at reform. I believe you will agree with me. These values are:

First, ensuring that every dollar saved from Medicare goes directly toward strengthening the part A trust fund and eliminating the Federal deficit;

Second, making the trust fund sound for the short term and the long term;

Third, protecting beneficiaries from dramatically increased costs and reduced access to care;

Fourth, improving patient choice without coercion or compromising the quality of care;

Fifth, reasonable sacrifice by all while ensuring the quality and viability of provider services for all Americans.

Let us now turn to a quick overview of the two major proposals now before the Congress, one from each party. First, let's look at the Republican plan to reform Medicare.

The Republicans, in their noble effort to balance the Federal budget and reduce the deficit, agreed to a fiscal year 1996 budget resolution which would reduce the rate of increase in Medicare spending by $270 billion by the year 2002, bringing its rate of growth down from its current 10 percent a year to about 6 percent a year.

The most important innovation in the Republican proposal is a feature which would allow Medicare beneficiaries to opt for a wide range of privately run health plans, with the Government paying the premium. The plan would provide an incentive for beneficiaries to choose an option that is less costly, such as managed care or preferred provider groups, while allowing those who want to stay in the traditional fee-for-service style Medicare Program to do so. However, the Republican plan would force many low-income seniors out of the traditional program because of the high cost of staying in the fee-for-service as compared to other options. The Dingell-Gibbons substitute, which I will support today, allows seniors to move into managed care and rewards this cost-saving sacrifice without punishing those who wish to stay in traditional fee-for-service programs.

Another set of cost-saving provisions in the Republican plan would reduce the growth of fees paid to hospitals, doctors, and other care providers by an estimated $110 billion over 7 years. The Democratic and Republican plans both rely heavily on reductions in the increase of payments to providers, but the Republican plan also contains a look back provision which I oppose that would balance the budget on the backs of providers if the projected cost savings are not realized. This will only mean that doctors and hospitals will begin turning down Medicare patients, leading to a national health care travesty.

Both Democratic and Republican plans also contain provisions to eliminate excessive fraud and abuse within the Medicare Program. The Congressional Budget Office estimates that at least $20 billion could be saved over 7 years by reducing fraud and abuse in the Medicare Program. I believe it is wrong to raise premiums for seniors until the cheats and ripoff artists are weeded out of Medicare. The Democratic plan makes significant headway toward reducing fraud, but the Republican plan will repeal existing statutes that keep doctors from preying on their patients for their own financial self-interests.

These measures, and others, are slated to ensure the viability of the Medicare part A trust fund. Let us turn to part B for a moment. I remind you that the primary reason to reform part B is to reduce the growth in the Federal deficit, not to build up the part A trust fund which receives its revenues from elsewhere. The Republicans choose to deal with the rising cost of part B by keeping the part B premium at 31.5 percent of total cost rather than at 25 percent as now planned. This means a doubling of Medicare part B premiums by 2002, increasing from $46.10 now to approximately $104 in 2002. While I do not oppose a sensible increase in premiums, I believe this increase is out of reach for many low-income seniors. I support the Democratic plan which would permanently maintain premiums at 25 percent of total cost.

As you can see, many of the aims and methods are the same in the two plans. But the details differ at significant points, particularly with regard to how much of the burden seniors are asked to bear.

I would like to sum up the Medicare debate as I see it. First, I support many of the reforms both sides support including incentives for entering managed care, slowing the increase in provider payments, and eliminating fraud and abuse. These are all contained in the Democratic substitute which I am supporting.

Let me share with you my disagreements with both plans, Democratic and Republican. Too often Democrats have sat on the sidelines this year while the Super Bowl is being played on the field—we have offered more critique than solutions. While this may be a good political stunt, it is not responsible nor respectful of our Nation's senior citizens or our children who will bear the cost of the Medicare Program if we do nothing. But I have not been content to sit on the sidelines. Before this debate even began, I stepped out in support of health care reform bill this year that would have made many of the adjustments we are now discussing. Even today, I would have preferred to have voted for the coalition substitute which would have dealt with part A and part B. But the Republicans in the Rules Committee would not allow this bill to come to the House floor for a vote. So, today I will choose between the better of two evils and support the Democratic substitute.

I sharply disagree with Republicans at one major point. Earlier this year, the Republicans voted for a $245 billion tax cut which gives over 50 percent of the cut to those who make over $100,000 a year. It is any wonder then that Republicans now need to save $270 billion from the Medicare Program to pay for these tax cuts. I believe a tax cut of this magnitude at this time is irresponsible, especially when the majority of the tax cut goes to wealthy Americans. This translates into the outrageous premium and deductible increases Republicans now propose.

The seniors in my district are telling me, ''Congressman, I don't mind sacrificing some benefits and bearing some of the financial burden of the Medicare Program to ensure the viability of the trust fund. But it seems to me that the Republicans are asking us to bear most of the burden for this reform, and it is not fair.'' I've been hearing a lot of people at home saying that they are beginning to think that GOP stands for Get the Old People party. I am not so sure they are wrong.

The Greek word for crisis is krisis. The Greeks used this word to point to a critical moment in time when the road ahead would either mean a time of devastation or a time of great opportunity. This is a time of krisis. The decisions Congress make at this time will mean a future of prosperity and health security for all Americans, or it will mean a bleak future

of prosperity and health care for only the privileged few. I believe this is the time of great opportunity, and together we will forge out a Medicare Program that will provide the best health care for our Nation's elderly for decades to come.

Mr. GIBBONS. Mr. Chairman, I yield 30 seconds to the gentleman from Wisconsin [Mr. KLECZKA].

Mr. KLECZKA. Mr. Chairman, the previous speaker indicated we are going to be giving all of this cash to senior citizens under the Republican plan.

What he did not tell the seniors that are watching today is we are going to double your premiums in part B; all right. The Senate provisions provides more copays, more out-of-pocket-expenses.

Seniors, this is what you are getting: Nothing.

Mr. GIBBONS. Mr. Chairman, I yield 2 minutes to the gentleman from Massachusetts [Mr. NEAL].

Mr. NEAL of Massachusetts. Mr. Chairman, the Massachusetts Hospital Association and the gentleman from Massachusetts [Mr. TORKILDSEN] have rejected the Republican Medicare bill. The MHA says the spending reductions in these proposals are too fast, too deep, and would jeopardize the ability of Massachusetts hospitals to provide quality health care to patients and communities.

Health care in Massachusetts is world-class. When Raisa Gorbachev and Elizabeth Dole, and as I learned yesterday, when Chairman SOLOMON, of the Committee on Rules, all were ill, they came to Massachusetts.

□ 1300

If the Medicare bill was a good bill, would not the Massachusetts teaching hospitals, with the renowned reputation that they have earned over many years, take the lead and endorse the bill? We trust these hospitals with our lives. We should also trust their assessment of the Republican Medicare bill.

The Gingrich Medicare cuts are simply too large for hospitals to absorb. Cuts of this magnitude will damage the quality of health care in America, especially for senior citizens and future generations. We should be investing, and not cutting research and education.

These outlandish cuts to hospitals will cause massive job loss across this country. The people hurt most by these cuts will be the hard working men and women of America, all so that a tax cut can be given to wealthy Americans who have not even asked for it. It is just not right.

Mr. DINGELL. Mr. Chairman, I yield 1½ minutes to the distinguished gentleman from New Mexico [Mr. RICHARDSON].

(Mr. RICHARDSON asked and was given permission to revise and extend his remarks.)

Mr. BROWN of Ohio. Mr. Chairman, will the gentleman yield?

Mr. RICHARDSON. I yield to the gentleman from Ohio.

Mr. BROWN of Ohio. Mr. Chairman, under the Gingrich Medicare plan, the hospitals in and around the district of the gentleman from New York [Mr. PAXON] will lose $64 million over the next several years to give tax breaks to the wealthy. Under the Gingrich Medicare plan, the district of the gentleman from New York [Mr. FRISA] will lose $262 million, again to give tax breaks to the wealthiest people in this country that do not need it.

Mr. RICHARDSON. Mr. Chairman, reclaiming my time, I want to talk about the effect of this plan on rural hospitals. That is what I represent. On Indian reservations throughout the State of New Mexico and many States in this country, rural health care will be devastated. Rural hospitals will close under this plan. In no way are they going to get more funds and resources.

Now, this is according to the American Hospital Association. The typical rural hospital will lose $5 million in Medicare funding over 7 years, and that means many of them are going to close. In my own district, the average senior lives on $800 a month, and paying $92 a month in premiums and unlimited out-of-pocket expenses is going to be devastating.

Rural Medicare patients are going to lose access to doctors. America's rural areas are going to need at least 5,000 more primary care physicians to have the same access to those that accept Medicare. The American Medical Association says cuts in Medicare are so severe they will unquestionably cause some rural physicians to leave Medicare.

Mr. DINGELL. Mr. Chairman, I yield 1 minute to the distinguished gentleman from Ohio [Mr. BROWN].

Mr. BROWN of Ohio. Mr. Chairman, I appreciate the gentleman yielding time.

Mr. Chairman, we have listened to the Republicans talk over and over about what a great plan this is, how it expands choice. The fact is senior citizens in this country now have full choice with Medicare. Yes, under the Gingrich plan seniors will have their choice of a plan, but they lose their choice of doctor.

The Gingrich plan gives physicians financial incentives, the New York Times calls it ''bribes for doctors,'' to move out of traditional fee-for-service into HMO's. Medicare beneficiaries therefore will be pushed out of traditional fee-for-service and forced into HMO's, forced into managed care.

This is purely and simply a political payoff to big insurance companies. We know it, NEWT GINGRICH knows it, the Republicans know it, and the American people know it.

Mr. ARCHER. Mr. Chairman, I yield 2 minutes to the gentleman from New York [Mr. HOUGHTON], a respected member of the Committee on Ways and Means.

(Mr. HOUGHTON asked and was given permission to revise and extend his remarks.)

Mr. HOUGHTON. Mr. Chairman, there is a lot of emotion in this issue, and I can understand it. It is a very important issue. I always think of what Wilbur Mills said, that there are probably more votes changed in the House Chapel than there are on the House floor.

I am not going to try to convince anybody, but I am just going to tell you where I am coming from. The gentleman from Ohio [Mr. BROWN] has thrown around a lot of numbers is terms of how many cuts will be in people's hospitals. I would question those numbers. I have seen those numbers myself as far as my own district is concerned and I question the authenticity of them.

Second, I think the issue is are we going to face up to this thing or not? Everybody agrees we should. The President agrees, the Democrats agree, the Republicans agree. How are we going to do it? It is a matter in terms of timing and numbers.

Also, there always is a better way. I can devise a better way. I am not sure this plan is exactly the way I want, but it is a good plan.

The next point is that there are no eternal fixes for the Medicare problem. We never can go asleep. We are always going to have to be on top of this thing. The question is are we going to have a short-term or longer term approach to this thing.

Let me talk a little bit about cuts. If I spend $1 today and I spend 90 cents 7 years from now, that is a cut. If I spend $1 today and I spend $1.45 7 years from now, that is not a cut. Those are the relationships we are talking about.

Let me talk a little bit about taxes. I did not vote for a tax cut. I did not think it was appropriate, I did not think it was the right timing. However, the Republican Party has felt that is important, the President has felt that is important, the gentleman from Missouri [Mr. GEPHARDT], the minority leader, has felt that is important. It is a fact we deal with everyday. Why can we not get together; why can we not, if our philosophy is the same, do something which is important as far as this overall Medicare issue is concerned?

Mr. GIBBONS. Mr. Chairman, I yield 1½ minutes to the gentleman from Indiana [Mr. JACOBS].

Mr. BROWN of Ohio. Mr. Chairman, will the gentleman yield?

Mr. JACOBS. I yield to the gentleman from Ohio.

Mr. BROWN of Ohio. Mr. Chairman, the gentleman from New York [Mr. HOUGHTON] mentioned he has other figures and he did not believe these figures. Under the Gingrich Medicare plan, the hospitals in and around the gentleman's district, my friend from New York, will lose $167 million over the next 7 years.

I would ask if he would come back in the well and perhaps tell us what the numbers he has that are different from

the numbers that we have been recounting, because we have heard no debate or no questioning of those numbers.

Mr. JACOBS. Mr. Chairman, reclaiming my time, speaking of numbers, the proponents of this measure cite approvingly the trustees' report that there will be a shortfall in the next 7 years in Medicare part A, and that is the truth. But it is not all the truth.

The rest of the trustees' report states how much that shortfall is, $90 billion. So if you accept approvingly the one part, you should accept approvingly the other; $90 billion is considerably less than $270 billion. I wonder anyone remembers the city of Bentre in Vietnam. That is the one that was wiped out, every lock, stock, horse carriage, human being, and building, the Army major declaring it became necessary to destroy it in order to save it.

My father used to say that in politics you can get people to eat the pudding, but you cannot get them to read the recipe. Today we are talking the recipe. We will see how the pudding tastes.

Mr. DINGELL. Mr. Chairman, I yield 2 minutes to the distinguished gentlewoman from California [Ms. ESHOO].

Ms. ESHOO. Mr. Chairman, today the Gingrich Republicans are being encouraged to use certain words, probably put together by some PR agency or PR person, to describe their Medicare plan, words like ''historic, serious, and long-term.''

Well, in some ways, I could not agree with them more. Their plan is historic because it marks the end of a 30-year commitment to provide our seniors with health care. It is serious. It is radical surgery, because it places the lives and well-being of 37 million Americans at risk. And it is long-term because it will tear holes in our social safety net that will remain for many years to come.

It ''saves, preserves, and protects,'' not Medicare, but $245 billion in tax breaks that no one is asking for. It ''protects the right to stay with your doctor,'' but only if you are able to pay more for the privilege. It ''protects the right to choose,'' only if your choices are slim and none. It is ''responsible,'' but only if you are a member of the AMA. It is ''innovative and bold,'' inasmuch as it breaks new ground for being cruel to seniors. It is ''the right thing to do,'' but only if your parents did not raise you to know any better.

Mr. Chairman, the Republican Medicare plan is all these words and one more, disgraceful, and I urge my colleagues to defeat it so that we can go on and make America a stronger, better, and more gentle Nation.

Mr. GIBBONS. Mr. Chairman, I yield 3 minutes to the gentleman from Washington [Mr. MCDERMOTT].

Mr. MCDERMOTT. Mr. Chairman, like the gentleman from New York [Mr. HOUGHTON], I wish that this debate would be about substance and we could actually talk about what is going to happen. We can argue about $90 billion or $270 billion, but the real issue here is what is happening to the health security of senior citizens.

Right now, senior citizens in this country get enough money to buy a program that covers what they need. And the Republicans are saying that in the first year, 1996, in the dark bar, we are going to give them enough to buy exactly what they have today. By the year 2000, you can see that the dark bar does not go as high as the CBO says an equivalent health plan is going to cost. The difference is $1,100. That is the national average.

Now, if you are from California and watching this, you are going to need another $1,200. If you are from New York, you are going to need another $1,100. If you are from Texas, you are only going to need $994. Ask yourself where those senior citizens are going to come up with that extra $1,100 to buy the same thing they have today.

Every time the Republicans use the word, ''choice,'' listen to that and say to yourself ''voucher.'' They are putting my father and my mother, my father 90, my mother 86, and everybody else's grandparents and parents, out on the street with a voucher. They call it choice. We are going to let you choose anything you want. But if you do not have the money, if that voucher only buys 75 percent of what it buys today, who will make it up? The kids will make it up.

This is the hidden agenda here. They are shoving that $1,000, they will not say it is cuts and I will not say it is cuts, they are shoving that additional $1,000 into their kids.

If you happen to be out there watching this or if Members are on this floor and happen to have a kid in college, you know what tuition does to you. To have your parents show up at the same time and say, ''well, I cannot afford it. It is not paid for by my health insurance,'' for the first time in 30 years, people my age, 58 and down, are going to have to think about how they make up that difference for their parents.

One can talk about $90 billion and actuarials and all the rest of this stuff. There is 96 pages of things where they give away to doctors. As a doctor, I am ashamed by the kind of deal they came in and cut. When we are cutting money from senior citizens and putting them at risk like this, for doctors to come in and negotiate for another $500 million, is a shame. There is no reason to do that.

Mr. BLILEY. Mr. Chairman, I yield 1½ minutes to the gentleman from Washington [Mr. WHITE].

Mr. WHITE. Mr. Chairman, I would like to say, first of all, that the explanation we just heard from my colleague from the Seattle area, who I have a great deal of affection and respect for, is exactly the kind of thinking that got us in this mess in the first place. We have been doing this for 30 years, and the fact is it is a self-fulfilling prophecy.

If the Government tells you the cost of medical care is going to go up 10 percent every year, you can be sure that it will, because people who are buying health care or selling health care to the Government are going to spend every nickel their customer tells them they are going to spend the next year.

The fact is we have to exercise some control at the Federal Government level to control these costs. Otherwise, they will be out of control forever and that is the reason we find ourselves in this situation. We have to fix this program. Otherwise, it is going to go bankrupt.

□ 1315

I want to say one other word about the Seattle area because it is very important. Seattle is an urban community and yet it is one of the healthiest communities in the Nation. It is also one where we have one of the most efficient health care systems in the Nation.

Why is that, Mr. Chairman? It is because in Seattle we essentially invented the managed care program. Under managed care individuals get to sign up in a program that looks out for your health over the long-term basis. Instead of trying to cure diseases as they come up, it actually prevents individuals from getting sick in the first place. A lot of people in the Seattle area have found that to be a good idea.

One of the great things about this bill is that it tries to do for the rest of the Nation what we have done very successfully in Seattle by having the option to take managed care instead of the fee-for-service program. We have been able to keep the costs down across the board, and that is what this bill will do for the entire country.

Mr. ARCHER. Mr. Chairman, I yield 2 minutes and 30 seconds to the gentleman from Ohio [Mr. PORTMAN], another respected member of the Committee on Ways and Means.

Mr. PORTMAN. Mr. Chairman, I thank the gentleman for yielding time to me.

We have heard a lot today from the other side of the aisle about how the increases in spending in our Medicare plan will not keep up with the private sector growth. We just heard from the gentleman from Washington [Mr. MCDERMOTT]. I wish his chart were still up. Maybe it can be put up again. It might be useful to have it. It is just not accurate. It is not accurate.

The charts we just saw from the gentleman compares apples to oranges. It is full of unknowns. It is full of false assumptions. Let me give Members a couple.

First of all, the Medicare figures are per beneficiary. The private sector figures are not per beneficiary. How can we compare those two? The private sector figures are, thus, inflated.

Second, the Medicare figures the Democrats use do not include a lot of other costs, including administrative costs. It is comparing apples to oranges.

Here is a better chart that illustrates clearly what the gentleman from New

York [Mr. HOUGHTON] and others have been trying to explain, which is that under this bill before us Medicare spending actually goes up. Guess what? It actually keeps pace with the private sector. It will be higher than the private sector 7 years from now as it is today.

This chart compares apples to apples. It compares what employers will pay per employee for health care in the private sector to what the government will pay per beneficiary under the Medicare Preservation Act. It clearly shows that, even when we assume a growth rate of 7 percent, as the gentleman from Washington did, Medicare will still pay more in each year through the year 2002 than we pay in the private sector. In fact, that 7 percent private sector health care figure is inflated.

I will give Members a couple of reasons it is. First, the private health care cost increases have been far lower over recent years than 7 percent. The administration's own Department of Labor tells us last year health care costs were nationally at about 4.5 percent.

Mr. Chairman, we have seen reports recently, including a story in the Washington Post of just a couple weeks ago, which indicates that recent surveys, comprehensive surveys have shown us that for the first time in 10 years health care costs nationally are below inflation.

All this, incidentally, was included in a recent CBO report that I would encourage everyone to read. The point is that the private sector numbers are nowhere near that 7 percent. But even when we include the 7 percent numbers, the Medicare spending continues to be higher than the private sector spending.

This is a generous program, folks. What we have come up with is a very generous plan. It is a responsible approach to a very real problem. I would encourage all Members to support the Republican plan.

Mr. BLILEY. Mr. Chairman, I yield 1½ minutes to the gentleman from Illinois [Mr. HASTERT].

(Mr. HASTERT asked and was given permission to revise and extend his remarks.)

Mr. HASTERT. Mr. Chairman, the question before us today is simple. Do we give seniors more choices or do we choose, do we choose, to let Medicare go bankrupt without any choices for anybody at all?

Under the Republican plan to save Medicare, seniors get more choices. One new choice, for instance, that is not offered today is preferred provider organizations. Many Americans are familiar with this option. In fact, it is available under the congressional medical insurance plan.

Mr. Chairman, under a preferred provider organization or PPO, seniors are part of a managed care plan but they can see any doctor they want, even a doctor outside the network through a point of service arrangement. That means if my father, who lives in Illinois, wants to see a cataract specialist at the Mayo Clinic, he would be able to do that and still receive his health care coverage.

All I want to emphasize is one important point; that under the Republican plan PPO's are required to take any senior who wants to sign up. If an individual happens to be diagnosed with cancer and wants to enroll in a PPO offered in their area, they have that option under this bill. Nobody can keep them out. They have to accept all comers.

Under the current Medicare system, PPO's are not available. Under the Medicare reform plan, PPO's are an option under this plan.

Mr. GIBBONS. Mr. Chairman, I yield 30 seconds to the gentleman from Maryland [Mr. CARDIN].

Mr. CARDIN. Mr. Chairman, we seem to have a debate over what is a cut. My constituents define it this way. If they are asked to pay more to get the same benefits, it is a cut. If they are receiving moneys that will not buy the same amount of service 7 years from now, and they are expected to put more money in their pocket in order to pay for those services, it is a cut.

The chart shown by the gentleman from Ohio [Mr. PORTMAN] shows what the per cost is per person. Yes, it costs less to provide for people under 65 than over 65, because people over 65 use more health care. This bill is a cut.

Mr. DINGELL. Mr. Chairman, I yield 30 seconds to the distinguished gentleman from Ohio [Mr. BROWN].

Mr. BROWN of Ohio. Mr. Chairman, I thank my friend for yielding me time, and I offer my condolences to my friend from Washington State about the Seattle Mariners.

More importantly, Mr. Chairman, I offer my condolences to the elderly in his district who will suffer some $31 million in cuts in services to them; and to the gentleman from Ohio [Mr. PORTMAN], in his district, $67 million in the next 7 years will be taken from the elderly in the Cincinnati area; and the gentleman from Illinois [Mr. HASTERT], in his district, some $143 million will be taken from the elderly in that area.

Mr. DINGELL. Mr. Chairman, I yield such time as he may consume to the gentleman from West Virginia [Mr. RAHALL].

(Mr. RAHALL asked and was given permission to revise and extend his remarks.)

Mr. RAHALL. Mr. Chairman, I rise in opposition to the so-called Republican Medicare plan.

Mr. Chairman, I rise today in total opposition to the so-called Medicare Reform bill before the House.

Mr. Chairman, H.R. 2425 is a little bit like topsy—it grows, and grows and grows. The bill before us is nearly 1,000 pages long—and few of us have had a chance to read it, much less understand it. But from what we've heard since the secrecy on details of the Republican plan was lifted, it's enough to put fear and trembling in the hearts of every senior citizen in the United States for decades to come.

Mr. Chairman, 380,239 of Americans on Medicare live in the State of West Virginia—my State. How many of them will be disenfranchised, when they lose $1.5 billion and more in Medicare payments under this bill? How many will become more seriously ill, or even die, as a result of denied health services under Medicare? The Republicans say: They don't know, and they don't care—all they know is they need to find $245 billion in a hurry, and Medicare is one of the biggest piggy banks around.

Mostly, what we don't understand is why it is necessary to take these drastic actions in a program that is not insolvent, and according to the trustees report, wasn't in danger of becoming insolvent for another 7 years? This 7-year window gives us plenty of time to work out ways in which to keep the program solvent as we have done since 1970 when the first trustees report came out—giving us only a 2-year window in which to bring solvency back to Medicare. For every year since, Congress has responded to the trustees report, and has never failed to assure continued solvency for Medicare.

The Medicare actuaries have stated, over and over again, that in order to bring solvency back to the Medicare Program now, we need only cut $89 billion from the Program. Why then the unprecedented, frightening cut of three times that amount?

H.R. 2425 calls for a cut of $270 billion in the program, supposedly in order to save it. Save it for whom? We believe, based on the evidence before us, that this $270 billion is necessary so that Republicans can award tax cuts for those who don't need it—and most wouldn't even want it if it disenfranchised the elderly.

This bill, if allowed to pass, will increase senior's Medicare premiums from today's $46 a month to more than $90 a month by 2002. It will force seniors off their current fee for service plan into managed care plans, where they will have no choice of physician or hospital. Under managed care, seniors will be unable to call 911 for an ambulance in an emergency—not unless someone somewhere in a new managed care bureaucracy preapproves the emergency.

Emergencies don't often happen during office hours where the preapproval comes from—and in my experience, when a person has an emergency, they are not inclined to call a business office for preapproval—they are more than prone to calling 911. Not allowed under this Medicare reform proposal. If a senior goes to the emergency room or calls an ambulance without managed care preapproval—even if it turns out to be a costly heart attack—that senior will be presented a bill for those costs—and required to pay them out of their own pockets.

If a senior needs home care which, today, costs seniors nothing in copayments under Medicare, that senior will in the future be forced to pay 20 percent of home care costs. Pretty tough on seniors on low, fixed incomes who are already struggling with decisions about whether to heat, or eat—or whether they can pay for their prescription drugs and still buy groceries.

And for those seniors not yet old enough for Medicare coverage—not yet 65 years of age—it gets worse—for in future they will have to wait a little longer—until they are age 67.

Mr. Chairman, let me repeat that, the Medicare cuts for my State of West Virginia will be more than $1.5 billion. Currently, West Virginia's 380,239 seniors who are enrolled in Medicare live predominantly in rural areas—54 percent of them. By living in rural areas, they are already limited with respect to access to health care providers of facilities. Cuts in Medicare reimbursement to hospitals located in rural areas is expected to cause many of them to close—further limiting rural West Virginia seniors' access to hospital care.

Seniors in West Virginia can expect to pay from $535 to over $1,000 in additional out of pocket expenses for less coverage and fewer services than they get from Medicare today. The current deductible is expected to go from the current $100 to $150 next year, and above $150 between now and 2002.

My West Virginia seniors can't afford additional premiums, additional deductibles, additional costs of 20 percent for home care, or to lose access to their own physician, hospital, and emergency response ambulances.

I am appalled at the mean-spiritedness of H.R. 2425, Mr. Chairman. I am appalled that anyone would treat our seniors as tiresome old people not important enough for their Government to champion their health care needs. These seniors have lived and worked long, hard lives, giving to society at large, to their own communities, end up being tossed out of their health care system—too poor and too disenfranchised to have their Government look after their health needs.

Mr. Chairman, we may not have the votes to defeat this measure, but we can and we will continue to tell our seniors that the $270 billion cut wasn't necessary—because the Medicare trustees stated plainly that only about $89 billion would be necessary to ensure its solvency for the next decade—at least to 2006.

Mr. DINGELL. Mr. Chairman, I yield 1½ minutes to the distinguished gentleman from Illinois [Mr. RUSH].

Mr. RUSH. Mr. Chairman, I want to thank the gentleman for yielding me time.

Mr. Chairman, it was bad enough that Republicans last year voted unanimously to reject legislation providing Americans with the health security that every other advanced Nation in the world provides to its citizens, leaving 41 million of our fellow citizens without health care. This year the Republicans want to cut $182 billion out of Medicaid with a big, big chunk of those savings coming from disproportionate share payments under that program. And now Republicans want to cut Medicare so that hospitals cannot keep their doors open.

Mr. Chairman, let me ask the Republicans how on Earth they expect these hospitals to survive. On air? How do they think they will be able to continue to provide services to 41 million uninsured Americans if they cut off all sources of support for them. These hospitals are already in serious financial trouble before all of these additional costs even hit them. They have the lowest margins of revenue over costs of any type of hospital, a full 25 percent below the average. They have the highest number of hospitals of any type with overall negative margins. They have physical plants which average more than 25 years in asset age as compared to 7 years for other hospitals.

Mr. Chairman, cutting these hospitals is the last place we should consider rather than the first place we should consider.

Mr. ARCHER. Mr. Chairman, I yield 2 minutes to the gentlewoman from the State of Washington [Ms. DUNN], a respected member of the Committee on Ways and Means.

Ms. DUNN of Washington. Mr. Chairman, like many seniors in my district, my own parents sometimes have been frightened by the rhetoric that has been generated in this debate. I rise today to clear away some of that emotionalism, perhaps to set the record straight, and to reassure my parents in Bellevue, WA, and seniors around the country.

Mr. Chairman, if I we able to speak to them for a few minutes today this is what I would tell them:

> Mother and Dad, our Medicare plan will preserve your right to stay in the current Medicare. You can stay in the system just as it is, if you want to. That is a fact. You can also choose one of the new options, every one of which will be very clearly explained to you. But the truth is that nobody will be forced out of traditional Medicare. If you wish to remain in traditional Medicare, fee-for-service, traditional service, if you want to keep your current doctor with no change to a doctor you do not know or do not want, you can do that. That is a guarantee, and the Federal Government will continue to provide two-thirds of your part B premiums. There will be no increase in your copayments, there will be no increase in your deductibles and there will be no decrease in your benefits.

Mr. Chairman. I also want to assure seniors that nobody will be forced into HMOs or forced to go to a doctor that they do not know. Managed care is just one of several options we provide in our Medicare Preservation Act.

Over the past several months, I have talked to constituents who deal with the Medicare system every single day. Throughout those talks I have been guided by several principles that my folks and seniors around the country are looking for in Medicare reform. They want Medicare saved for their children and for their grandchildren. They want the problem solved, not just postponed, and they want to choose for themselves among the plans and the doctors they know. This is my promise, my commitment to the seniors of today.

Mr. GIBBONS. Mr. Chairman, I yield such time as he may consume to the gentleman from California [Mr. LANTOS].

(Mr. LANTOS asked and was given permission to revise and extend his remarks.)

Mr. LANTOS. Mr. Chairman, I strongly oppose this economically bankrupt proposal that will damage seniors and children.

Today, the House is considering the so-called Medicare Preservation Act. Naming it does not make it so. We could just as well call this legislation the End of Medicare as We Know It Act.

One of my favorite stories about Joseph Stalin relates to his manipulative use of labels. He designated the Soviet satellites of Eastern Europe ''People's Democracies.'' The label did not make these enslaved countries either democratic or popular.

When the Soviet-dominated international Communist movement wanted a snappy title for its newspaper, Stalin came up with a real show-stopper. The newspaper was called: For a Lasting Peace, For a People's Democracy. The strategy was simple—make capitalists mouth a Communist political slogan when they quoted the newspaper. The Soviet Union and its affiliated Communist parties were hardly committed to peace or democracy, but the slogan got considerable mileage.

Today, Mr. Chairman, we have the same type of subterfuge being carried out by the majority in this body. They have given this economic monstrosity a politically correct title, ''The Medicare Preservation Act of 1995''. This legislation will neither preserve nor protect Medicare. It will simply strip away benefits to America's most vulnerable and voiceless citizens of our country in order to pay for an outrageously large tax break for the wealthiest individuals.

I have several names to propose for the legislation that we are considering today, Mr. Chairman.

First of all, this could be called ''The Robin Hood in Reverse Act of 1995.'' It clearly deserves that title. It robs the poor to give to the rich. A $270 billion cut is unnecessary to save Medicare. Democratic alternatives—the one we are permitted to consider today as well as others that should be considered—would keep Medicare solvent without imposing a huge burden on our senior citizens. The reason we have this economically irresponsible legislation is so the Republicans can offer a $245 billion tax cut to the wealthy.

Second, we could call this legislation Bash the Seniors Act of 1995. Premiums for our senior citizens will increase by some $400. Since a third of all seniors barely get by on their monthly Social Security checks, this Republican legislation will force seniors to choose between health care and food, or between health care and heat, or between health care and rent.

Third, we could logically call this The Them That Has Gets Even More Act of 1995. While our low-income seniors—those in the sunset of their lives—will be forced to dig deeper in their meager resources. Meanwhile, those earning over $100,000 a year will receive half of the Republican tax break. Furthermore the wealthiest 1 percent of Americans will get an average tax break of $19,000. Those who need this tax break least are the ones who get the most, while costs for our seniors are increased.

Mr. Chairman, I could continue with a number of other titles for this legislation, all of which would more accurately describe the impact of this ill-named, ill-conceived, ill-considered sell out of our senior citizens for the benefit of special interests.

My point is clear. This is poor legislation. It should be rejected. I urge my colleagues to repudiate this ill-named bill.

Mr. GIBBONS. Mr. Chairman, I yield 3 minutes and 30 seconds to the gentleman from Michigan [Mr. LEVIN].

(Mr. LEVIN asked and was given permission to revise and extend his remarks.)

Mr. LEVIN. Mr. Chairman, I just want to explain, so that everybody understands, why this is such an extreme proposal.

The gentleman from Washington [Mr. MCDERMOTT] referred to this chart. And what it does is to show how the projected or the capped expenditures on Medicare are below the projected rate of inflation. Now, those numbers do not come from the gentleman from Washington. They do not come from Democrats. They come from CBO, which is essentially controlled by the Republicans. And there is nothing that the gentleman from Ohio [Mr. PORTMAN], or anybody else can say that changes that.

Mr. Chairman, this resolution assumes an inflation rate under 4.9 percent. Under 5 percent—4.9. The CBO figure is 7.1. And that is why, as the gentleman from Washington [Mr. MCDERMOTT] says, we end up with this gap of $1,000 per beneficiary in the year 2002.

The gentlewoman from Connecticut [Mrs. JOHNSON] asked where are the changes in benefits? The answer is, as the gentleman from Washington [Mr. MCDERMOTT] said, when we have a $1,000 shortfall, something has to give. And who is going to give are hospitals who are underfunded, who are, in turn, going to either shift it to the private sector, or are going to close emergency rooms, or who will have to cut benefits. That is the problem.

Now, Mr. Chairman, I want us to refer to history. My friend, the gentleman from Texas [Mr. ARCHER], does not like me to quote his previous statement. I understand that. ''Make no mistake about it,'' he said just a year ago, ''for the elderly in this country, these cuts are going to devastate their program under Medicare.''

Our Medicare cuts in the resolution about which he was talking were $168 billion, and most of that was plowed back into the Medicare System. Here we have a proposal for $270 billion, and what they are saying is it is going to save Medicare. We need to save Medicare from the Republican majority of the House of Representatives.

Mr. Chairman, I want to read from the gentleman's minority views, if the gentleman does not like my reference to his words.

□ 1330

This is the minority views about our Medicare proposal, which is much less and most of it plowed back into the system. And I quote,

> For more than a decade, Congress has cut back on payments to doctors and hospitals until they no longer cover the costs for Medicare patients, and the additional massive cuts in reimbursement to providers proposed in this bill will reduce the quality of care for the Nation's elderly.

Mr. Chairman, will reduce the quality of care, the gentleman was saying, for the Nation's elderly. There will be no place else to shift.

I do not expect the Republicans to eat their words in public, but we are not going to let them gobble up Medicare on this day, October 1995.

Mr. ARCHER. Mr. Chairman, it is sad that we have to replow this ground. The gentleman from Michigan [Mr. LEVIN] misspoke. The gentleman knows it.

Mr. Chairman, we were not dealing with a Government takeover of the entire health care system in this country. My remarks, and our minority views, were directed toward that. But as a part of that overall health care program, CBO scored the cuts in Medicare and Medicaid at $490 billion. That was intolerable. It was intolerable, particularly independent of any transformation of Medicare to make it more efficient.

So once again, Mr. Chairman, the gentleman has taken this completely out of context.

Mr. GIBBONS. Mr. Chairman, I yield 30 seconds to the gentleman from Michigan [Mr. LEVIN].

Mr. LEVIN. Mr. Chairman, let me read some of the gentleman's specific words a year ago. ''Make no mistake about it. For the elderly in this country, these cuts are going to devastate their program under Medicare.''

Mr. Chairman, the gentleman from Texas [Mr. ARCHER] is moving in a 180-degree different direction. The reason for it is because my colleagues on the other side have got a $245 billion tax cut for very wealthy families, and they have to find a way to pay for it, and it is on the backs of the seniors of this country. That is not fair.

Mr. BLILEY. Mr. Chairman, I yield 1½ minutes to the gentleman from Georgia, [Mr. NORWOOD].

Mr. NORWOOD. Mr. Chairman, I know this debate must be very difficult on our seniors trying to determine what is fact and what is not. It is particularly difficult with so much misinformation coming out on this floor. But before the gentleman from Ohio [Mr. BROWN] has an opportunity to talk about the hospitals in the 10th District of Georgia, I want the gentleman to know that those hospitals are having increased funding each year over the next 7 years. I would like for the gentleman to also know that for the first time in history of this government, we are giving the hospitals the opportunity to lower their cots by repealing very, very difficult and expensive rules and regulations, tort reform, and antitrust legislation.

Mr. Chairman, giving senior Americans the option to choose from among the many new health care plans is the absolute key to saving Medicare. I want to talk just about one of those options: Provider Sponsored Networks, PSN's.

Mr. Chairman, I have a message to my mother-in-law: If you like traditional Medicare, you can continue to choose it just like you have it today. Part A, part B, Medigap; can you keep it just like you have got it, if you would like to do that. But, I would like for you to consider one of these excellent choices known as Provider Sponsored Networks.

Mr. Chairman, they are locally organized care networks formed by doctors and hospitals. They will provide coordinated care that allow the providers to achieve the efficiencies and cost controls that have been forbidden by laws in years past.

Mr. DINGELL. Mr. Chairman, I yield 15 seconds to the gentleman from Florida [Mr. DEUTSCH].

Mr. DEUTSCH. Mr. Chairman, let me just point out that under the Gingrich Medicare plan, the hospitals in and around the district of the gentleman from Georgia [Mr. NORWOOD] would lose $232 million over the next 7 years to pay for the program and tax cuts for the very rich in this country.

Mr. GIBBONS. Mr. Chairman, I would yield myself 30 seconds to respond to the gentleman.

Mr. Chairman, I would respond to the gentleman that he better tell his mother-in-law the whole truth. There will not be any fee-for-service, because under the Archer bill, the Gingrich bill, it will be abolished, because the Secretary of Health and Human Services must take all the cuts in this bill out of fee-for-service. So, she may look for it, but it just will not be there.

Mr. DINGELL. Mr. Chairman, I yield 2 minutes to the distinguished gentleman from Massachusetts [Mr. MARKEY].

Mr. MARKEY. Mr. Chairman, not since the feudal days of lords and serfs has such an effective system of transfer of wealth from the poor and giving it to the rich been enacted.

Mr. Chairman, the trustees of Medicare said that part A is $90 billion in arrears over the next 10 years. The Democratic substitute solves that problem. The Republican substitute solves that problem and then takes out an additional $180 billion more than is needed.

Now, listen to this. Of the 37 million Americans on Medicare, 11 million of them are widows living on an income of $8,000 a year or less. Under the Republican proposal, those 11 million widows, by the year 2002, each year will have their Medicare part B premiums go up $300 to $400 a year.

Mr. Chairman, in that same year, those who make more than $350,000 a

year will get a $19,000 tax break. It takes 60 widows paying $300 to $400 a year more to give a tax break into the pockets of the wealthy making $350,000 a year.

Mr. Chairman, under the Republican plan, the rich get rich and the poor get poorer, and that is wrong. Just plain wrong. We have a better country than that.

There is no uniform sacrifice here. The contract with the country club that the Republicans signed a year ago on the steps of the Capitol requires the poor in this country to be tipped upside down. GOP used to stand for ''Grand Old Party.'' Today, it stands for ''Get Old People.''

Mr. BLILEY. Mr. Chairman, I yield 1 minute to the gentleman from Ohio [Mr. OXLEY].

(Mr. OXLEY asked and was given permission to revise and extend his remarks.)

Mr. OXLEY. Mr. Chairman, we have heard today about many of the improvements that this bill makes to the Medicare Program. Foremost among these is what we call the seamless web. Today, millions of retirees are forced by rigid and antiquated Medicare rules to disenroll from their employer's health plan—even if the coverage they receive was better than that provided by Medicare. Just because you retire shouldn't mean that you have to give up the coverage you're used to—but today, that's the case. Under the bill, your 65th birthday doesn't have to be the day you give up your association or employer coverage. This bill frees retirees from this unreasonable and counterproductive requirement. Under our plan, retirees can remain in their preretirement health plan, so long as it meets important Medicare standards. In fact, this bill allows members of associations and labor unions to maintain their current coverage even after they retire. Why do we feel it is so important to create this seamless web? Because Medicare should create opportunities—not obstacles—to better health care coverage and greater senior satisfaction.

Mr. DINGELL. Mr. Chairman, I yield 15 seconds to the gentleman from New Jersey [Mr. PALLONE].

Mr. PALLONE. Mr. Chairman, I wanted to point out that under the Gingrich Medicare plan, the hospitals in and around the district of the gentleman from Ohio [Mr. OXLEY] will lose $144 million over the next 7 years.

Mr. DINGELL. Mr. Chairman, I yield 1 minute to the distinguished gentleman from Texas [Mr. DOGGETT].

Mr. DOGGETT. Mr. Chairman, today if an elderly American wants quality health care, all they need is this. Even if they are not an American hero, like the gentleman from Florida [Mr. GIBBONS] who has this Medicare card, they are going to get quality health care the way seniors have for the last three decades.

But, Mr. Chairman, after Speaker GINGRICH and his cohorts finish today paying for their tax cut to the rich, this is the plan that they will have. This is the new Medicare maze that our Republican colleagues present. They have got one bureaucracy after another.

Mr. Chairman, we have a lot of new commissions. A baby boom commission. We have got boxes. We have got arrows. We have got quite a new organization of the health care system that for those seniors who could not decide today whether they were getting a cut or increase are going to need to go back from their retirement to get a doctorate to figure out how they are going to get health care.

Mr. Chairman, there is one thing that is certain: These red arrows coming from the plan to pay for a tax cut for the wealthy, out of the hide of the seniors of this country.

Mr. ARCHER. Mr. Chairman, I yield 2 minutes to the gentleman from Texas, Mr. SAM JOHNSON, a true American hero, a respected member of the Committee on Ways and Means.

Mr. SAM JOHNSON of Texas. Mr. Chairman, unlike my friend, the gentleman from Texas [Mr. DOGGETT], we are not interested in the next election; we are interested in the future of America.

Mr. Chairman, Republicans have faced the challenge head on. We have addressed a broken system. Instead of scaring seniors and ignoring the problem, we have worked with seniors and produced a solution. Most importantly, we have not allowed Democrat scare tactics and politics as usual to keep us from doing what is right for America.

Mr. Chairman, I plan to choose a medical savings account. I just turned 65, and now I do have a Medicare card. I am thankful that this bill will allow me to get out of the inefficient system of 1965 and into a program and choose an option that is better suited for me 30 years later in 1995.

Mr. Chairman, with a medical savings option, I will get a high-deductible insurance policy and a cash deposit in a medical savings account to cover a significant portion of the deductible. There are no copayments. I am empowered to make my own decisions concerning my health care without the interference of a middle man. I can be a cost-conscious consumer and, with others, fundamentally empower and change the health care delivery systems in America.

The accounts are available for all qualified medical expenses; a great advantage over the current system. There are many other options, but no one is going to be forced into any particular plan. In the true American spirit, we know that people want different choices and this bill makes those choices available.

Mr. Chairman, this is a vote to save Medicare and give seniors a choice.

Mr. BILIRAKIS. Mr. Chairman, I yield 1 minute to the gentleman from Ohio [Mr. GILLMOR].

Mr. GILLMOR. Mr. Chairman, I wanted to take a few moments to highlight one of the innovative additions to the Medicare system in H.R. 2425: the incentive it provides for citizens to expose and attack Medicare fraud and abuse. I am also pleased by the legislation's measures that implement stiff new criminal penalties. For those convicted of Federal health care fraud, embezzlement or false billings, the legislation provides for up to 10 years in prison. There is no limit placed on the penalty's prison term if such a criminal violation should result in bodily injury.

Until now, Medicare beneficiaries have participated in a system that simply did not provide adequate enforcement mechanisms or adequate civil or criminal penalties. Without these, we have lacked an effective deterrent to waste. Fraud and abuse continues to rob the system and the taxpayers that finance it.

The Medicare Preservation Act, through innovative and focused task forces, financial incentives that empower seniors, and stronger criminal and civil penalties, unequivocally acknowledges and addresses these problems. The current Medicare system is losing 10 cents on the dollar to waste, fraud, and abuse—$50 million every day that could have and should be used for patient care. Let the word go out to those who would bilk the Medicare system—once this bill is passed, enforcement is innovative and it is real. Barney Fife has his walking papers, and the terminator is on the job.

□ 1345

Mr. DINGELL. Mr. Chairman, could we have a recapitulation of the time?

The CHAIRMAN. The gentleman from Texas [Mr. ARCHER] has 17 minutes remaining, the gentleman from Florida [Mr. GIBBONS] has 17 minutes remaining, the gentleman from Florida [Mr. BILIRAKIS] for the gentleman from Virginia [Mr. BLILEY] has 18 minutes remaining, and the gentleman from Michigan [Mr. DINGELL] has 18½ minutes remaining.

Mr. DINGELL. Mr. Chairman, I yield 1 minute to the distinguished gentlewoman from Arkansas [Mrs. LINCOLN].

(Mrs. LINCOLN asked and was given permission to revise and extend his remarks.)

Mrs. LINCOLN. Mr. Chairman, I thank the gentleman for yielding time to me.

The people of the First District of Arkansas sent me here to put people above politics. Unfortunately, here today we have got both sides who really seem more interested in making campaign commercials rather than good policy. One cuts too much and the other does not do enough.

What the American people do not know is that there is a proposal out there that we have not been allowed to bring to the floor that actually makes good common sense, reasonable policy. The Republican bill will close the doors of rural hospitals. The Republican bill will penalize the rural areas by cutting

fee-for-service, when we cannot afford managed care without infrastructure. The Republican bill will dig into the pockets of senior citizens. The Democratic bill has missed the opportunities to restore complete dignity and solvency of Medicare while balancing the budget.

I came here to preserve the dignity of senior citizens who depend on Medicare and to restore the faith of the young people who are paying now into the system but will not use this program for decades. This is not the democratic process that I learned in civics class, and it is no wonder that the American people are frustrated.

Mr. ARCHER. Mr. Chairman, I yield such time as he may consume to the gentleman from Pennsylvania [Mr. CLINGER].

(Mr. CLINGER asked and was given permission to revise and extend his remarks.)

Mr. CLINGER. Mr. Chairman, I rise in strong support of this bill.

Mr. Chairman, I rise in support of H.R. 2425, the Medicare Preservation Act. I did not, however, arrive at my decision to support the bill easily or without hesitation. As someone who represents a very rural district with an aged population, I am keenly aware of the importance of Medicare in meeting the health care needs of older Americans.

Last spring, the Board of Trustees for the Medicare Trust Fund warned in its 1995 annual report that the hospital insurance, part A portion of the Medicare Trust Fund will start going bankrupt beginning as early as next year and will run out of money by 2002. The Board of Trustees for the Medicare Trust Fund, which is a bi-partisan panel that includes three of President Clinton's Cabinet secretaries, state clearly in the report that the Federal Government has no authority to pay hospital bills if funds in the part A trust fund are depleted. What is more, the Medicare part B trust fund, which pays for physician and outpatient services, is also in financial trouble and needs to be addressed. Without significant reform, part B expenses are projected to double by 2002.

The reason for the imbalance between what Medicare takes in and what it pays out is that the Medicare Program is growing at an unsustainable rate of 10.5 percent, more than twice the rate of increase for private health care spending, which is 4.4 percent. Controlling this excessive growth rate is the necessary, responsible, and moral thing to do.

When I learned of Medicare's financial outlook, I conducted a survey of the Pennsylvanians I represent. By an overwhelming number, my constituents agree that Congress should act promptly to preserve and protect this vital insurance program, which serves nearly 36 million Americans, but should do so in a responsible manner that goes after fraud and abuse and addresses rural concerns. Mr. Chairman, I believe that this legislation, though it is not any easy fix, achieves these crucial goals while ensuring that Medicare will be preserved for future generations.

First, I want to clarify the impact this legislation will have on seniors. Beneficiaries will see no increase in their copayments or deductibles and will continue to pay 31.5 percent of the part B premium, as they do today. In fact, out-of-pocket costs for seniors will be just $4 more each month in 2002 than under President Clinton's plan. And Medicare will be preserved for the next generation, not just for the next election.

Despite all the rhetoric during this debate that Republicans are cutting Medicare, spending per beneficiary will increase from $4,800 next year to $6,700 in 2002 under H.R. 2425. Furthermore, we have spent $844 billion on Medicare over the past 7 years, and under this legislation we will spend $1.6 trillion over the next 7 years—an increase of $742 billion. Only in Washington can a spending increase be called a cut.

What is more, seniors will be offered more choices of health care plans, in addition to traditional Medicare. Under the bill, a MedicarePlus program will be established to allow beneficiaries to enroll in a range of private or employer-based health plans, including managed-care plans, traditional fee-for-service plans, high deductible insurance/medical savings accounts, or so-called provider-sponsored networks [PSN's] formed by health care providers. In some cases, these plans could mean more or better benefits for seniors, such as free eyeglasses or prescription drug benefits. However, none will be forced to change plans or change doctors under the bill. These fundamental reforms will not only provide beneficiaries with a broader range of health care choices but will also strengthen the existing Medicare Program.

I am very encouraged by other provisions in the bill as well. H.R. 2425 will reform medical malpractice law by establishing uniform standards for health care liability actions and capping non-economic damages at $250,000 in a particular case. The bill also establishes a commission to recommend long-term structural changes to preserve and protect Medicare when the Baby Boom generation begins retiring in 2010. Finally, this legislation contains a lock-box mechanism that places all savings from part B into a Medicare preservation trust fund and prohibits any transfers to pay for future tax cuts.

Throughout the debate, I have heard a lot of misinformation that Republicans are trying to push Medicare reforms through Congress without sufficient hearings. That is simply not true. The Medicare Preservation Act is the culmination of months of hearings by the House Committees on Ways and Means and Commerce, who have jurisdiction over the Medicare Program. Altogether, these committees held nearly 30 hearings throughout the summer and into the fall to find ways to control Medicare's unsustainable growth rate, make the program more efficient, and offer seniors more choices in the type of coverage they receive.

During that time, I, too, have been studying this issue and actively seeking feedback from my constituents. In addition to the thousands of survey forms, letters and phone calls on Medicare I have received from constituents, I have visited senior centers and met with hospital administrators in my area of Pennsylvania to discuss proposals to preserve and protect the Medicare Program. Here in Washington, I have met with the House Rural Health Care Task Force to discuss the impact of Medicare reform proposals on rural areas, and I have heard regularly from such organizations as the Hospital Association of Pennsylvania, the American Association of Retired Persons [AARP], and the Seniors Coalition.

One key aspect of the Medicare Preservation Act that I particularly want to make note of is the bill's provisions combating fraud and abuse. The Government Reform and Oversight Committee, which I chair, has held a series of hearings to examine the problem of waste and fraud in the Medicare and Medicaid programs. As I learned at the hearings, the General Accounting Office [GAO] estimates that these programs will lose approximately $26 billion this year alone to fraudulent activities. Without question, waste, fraud, and abuse drive up the cost of these programs and make it increasingly difficult not only for Medicare beneficiaries, but for all individuals to afford quality health care.

As a result of these hearings, I helped introduce legislation to crack down on the problem of waste and fraud in the Medicare and Medicaid programs. This legislation, the Health Care Fraud and Abuse Prevention Act, H.R. 2326, contains substantive measures that will serve as a valuable deterrent against health care fraud.

The Medicare Preservation Act strengthens Federal efforts to combat fraud and abuse in the Medicare program by creating new criminal penalties for those who fraudulently abuse the Medicare program, providing monetary incentives for individuals who report a violation that results in savings in the program, doubling sanctions for filing false claims or committing fraud, and authorizing funding to bolster the Health and Human Services Inspector General's anti-fraud efforts and payment safeguard activities.

I am very pleased that the Medicare Preservation Act addresses this serious issue and incorporates some of the tough, anti-fraud provisions contained in the Health Care Fraud and Abuse Prevention Act. Indeed, these anti-fraud measures are long overdue and will create significant savings in the Medicare program. Furthermore, I pledge to continue working with my colleagues on the Government Reform and Oversight Committee to carry on the effort to crack down on health care fraud and abuse.

Another area of the legislation that has been of particular concern to me throughout this process—along with my colleagues on the Rural Health Care Task Force—is Medicare's payment rate to Medicare contractors, known as the average adjusted per capita cost [AAPCC] rate. One of the primary structural reforms contained in the Medicare Preservation Act is the establishment of Medicare-plus organizations.

The AAPCC is based on a complex formula which determines Medicare's payment rate to certain types of plans that will be offered under the Medicare-plus program, specifically, health maintenance organizations [HMOs], provider-sponsored networks, and medical savings accounts. However, because the AAPCC formula is tied to Medicare utilization, which is typically lower in rural areas, wide geographic disparities have arisen between rural and urban communities. This variation makes it economically impossible for Medicare to offer choices to beneficiaries in many rural areas.

Five counties in my part of Pennsylvania have payment rates that are below the national average, which directly impacts the ability of HMOs and PSNs to operate in these

counties. Although the bill, as originally drafted, made adjustments that began to correct the disparity, the changes did not go far enough and would have failed to lift payment rates to a sufficient level.

Fortunately, after much deliberation with the Republican leadership and the drafters of the bill, my colleagues on the Rural Health Care Task Force and I were successful in negotiating substantive improvements to the AAPCC formula. I feel confident these changes will put my district on a more level playing field with urban areas and will ensure that rural America won't be left behind. Rural America should be allowed to participate in the new range of choices that will be created under the Medicare Preservation Act and be part of the 21st Century Government.

Despite this positive change, there are still areas in the bill that I feel could be improved, including the level of hospital reimbursements—namely the Prospective Payment System update factor, disproportionate share payments, and inpatient capital, the timing of Graduate Medical Education Trust Fund payments to academic health centers, and the treatment of ancillary services provided in skilled nursing facilities, which, under the bill, will be subject to routine service costs.

In the end, I remain strongly supportive of the fundamental goal of saving Medicare for current and future beneficiaries; we simply cannot afford to do nothing. The Medicare Preservation Act ensures the solvency of the Medicare system without jeopardizing the medical coverage seniors need and addresses Medicare's long-term solvency by putting the structural changes in place that will enable Congress to address the ''Baby Boom'' generation's entrance into retirement. I firmly believe that the Medicare Preservation Act is the only plan that will accomplish these goals.

Mr. ARCHER. Mr. Chairman, I yield 2 minutes to the gentleman from Minnesota [Mr. RAMSTAD], another respected member of the Committee on Way and Means.

Mr. RAMSTAD. Mr. Chairman, I rise today in strong support of freedom of choice for America's seniors in their health plans. Why should not America's seniors have the same choice in health care plans as every other American? All of us know that most Americans secure their health care coverage through their employers. They have a vast variety of health plans from which to choose. How many choices do America's seniors have under Medicare? Only two: fee-for-service and traditional HMOs.

Now, with all respect to my friends from Massachusetts, no Sate is more advanced in their innovative health care, quality of health care and innovative health care choices than the good State of Minnesota. Minnesotans have a vast array of health care choices, ranging from traditional indemnity plans, to points of service plans, to HMOs. It is reasonable to expect then that seniors in Minnesota would have a similar range of choices. But how many choices to Minnesota's seniors have under Medicare? Only two: fee-for-service or traditional HMOs.

I have heard from countless seniors who want the opportunity to choose their own health plan. These seniors are fully capable of choosing from a variety of health plans to get the coverage that best fits their needs. Mr. Chairman, the seniors of America deserve nothing less than freedom of choice. We have heard today from opponents of saving Medicare, of this legislation here today to give seniors choices, that seniors will be forced to join HMOs. Nonsense. Under our bill, what happens to seniors is they can remain in the current fee-for-service system.

Mr. Chairman, we have also heard that benefits offered to enrollees in Medicare Plus plans would not compare favorably to those in traditional fee-for-service plans. That is also nonsense. The same benefits or better benefits will be available for seniors.

Vote for freedom of choice. Vote for the Medicare Preservation Act.

Mr. GIBBONS. Mr. Chairman, I yield such time as he may consume to the gentleman from Pennsylvania [Mr. COYNE].

(Mr. COYNE asked and was given permission to revise and extend his remarks.)

Mr. COYNE. Mr. Chairman, I rise in opposition to the Republican plan.

Mr. Chairman, I rise to oppose this legislation. The Republican Medicare reform bill will undoubtedly be adopted by this body today, but I strongly believe that the policy decisions that are reflected in this legislation are unnecessarily harsh, unprincipled, and unwise.

The $270 billion in Medicare cuts contained in this legislation are not necessary to keep the Medicare trust fund solvent for the next 10 years. In fact, less than $100 billion in cuts are needed to meet that goal. Significant long-term changes will be necessary in order to address the impact that the baby boom generation will have on the Medicare system, but such major changes should be addressed in a more thorough, thoughtful manner than that which has characterized the process by which this legislation was developed.

I believe that the so-called Medicare Preservation Act is unprincipled because its primary goal is not, in fact, the preservation of the Medicare system. The real objective of this legislation is clearly to produce savings in order to balance the budget and finance the Republican tax cut. If anyone doubts that, they should carefully consider the fact that the proposal to cut $370 billion out of Medicare grew out of Republican efforts to pay for the Contract With America's tax cuts—not the Republicans' concern over the future of this vital program.

I believe that this legislation is unwise because it ignores much of our past experience with the Nation's health care system. For example this legislation would repeal Federal nursing home standards that were enacted in 1987. These standards were not established on some whim; they were adopted in response to reports of unacceptable conditions in nursing homes across the country. It is reasonable to assume that absent these standards, such conditions will return. Another example is the repeal of the ban on physician referrals to labs in which they have financial interests. Such referrals increased Medicare costs unnecessarily prior to the imposition of the ban, and there is little reason to believe that lifting the ban now will have some other effect. Finally, while the legislation contains a useful provision that allows physicians to establish organizations to compete for business with HMOs, the bill exempts these physician-sponsored organizations from the State licensing requirements that other health care providers have to meet, and it exempts them from the balance billing restrictions that apply to other providers. State licensing protects the quality of care that patients receive, and balance bill restrictions ensure that patients benefit from the purchasing power wielded by the Federal Government. Exempting physician-sponsored organizations from these requirements is unwise because it creates an uneven playing field for different competing providers—and because it could allow inadequate regulation of an industry with tremendous potential for fraud and abuse.

Every member of Congress understands that Medicare must be reformed in order to keep program costs under control. Where Democrats disagree with the Republican majority is on what reforms are necessary to keep Medicare solvent, and on whether Medicare beneficiaries should be forced to bear the triple burden of Medicare reform, balancing the Federal budget, and paying for a tax cut for the affluent as well. I urge my colleagues to vote this proposal down, and to work on a bipartisan solution to the problems confronting Medicare.

Mr. DINGELL. Mr. Chairman, I yield such time as she may consume to the distinguished gentlewoman from Ohio [Ms. KAPTUR].

(Ms. KAPTUR asked and was given permission to revise and extend her remarks.)

Ms. KAPTUR. Mr. Chairman, I thank the gentleman and rise in opposition to this Republican plan under which the seniors in our community alone will lose over $377 million over the next 7 years.

I rise today in opposition to the bill before us and to raise serious concerns with the manner in which H.R. 2425, the Medicare Preservation Act, has been railroaded through the House of Representatives. Literally millions of citizens in our country depend on Medicare as their lifeline. These 36 million older and disabled people receive medical insurance through this program. Congress must proceed carefully before taking any action that will affect the lives and futures of millions of our families and their loved ones. Cutting $270 billion from Medicare and then transferring that money for tax cuts to the rich is absolutely wrong.

TIMING

On Friday, September 29, legislation was officially introduced to reform Medicare. What did the leadership of the House do next? Did it hold comprehensive hearings on the most sweeping changes to Medicare since its inception 30 years ago? No—they allowed only 1 day of hearings before their bill was distributed to Members and left town, only to return on October 9 and proceed with marking up the bill. No senior citizens were even invited to testify.

The committees marked up around the clock until Wednesday October 11. Mr. Chairman, the legislative process used to move this bill has been a disgrace. This Congress has spent 48 days holding hearings on

Whitewater, Ruby Ridge—we even spent an afternoon debating snails—but they could not manage to hold more than 1 day of hearings on Medicare.

The very people who will be most affected by these cuts, our Nation's seniors, have been subject to arrest and silenced as the leadership rushed this bill through committees. Could we not have allowed just 1 day to hear their concerns? With $136 billion in the current Medicare part A trust fund there are funds to meet obligations for 7 years. We know we must act, but why the rush?

Members, especially those not on the committees of jurisdiction such as myself, have been given very little time to review these sweeping changes. This is not the way to legislate. We have disenfranchised the American public by not allowing their elected representatives to do their job—to analyze and make an informed vote on Medicare reform. And the American people have been barred from testifying, and senior citizens in the hearing room were even arrested.

REPUBLICAN PLAN AND TAX CUTS

Mr. Chairman, this past weekend I met with our community's health advisory group, a bipartisan group of citizens from my district representing health professions, businesses, labor, retirees, insurance, hospitals, and all health professions. The group was charged with analyzing the Medicare trustees report and the Medicare Preservation Act.

The consensus of the group was that these Medicare cuts are draconian. Any changes in Medicare should be used only for the preservation of Medicare and should not be used to provide a tax cut for the wealthy. Our health advisory group stated that they would not operate a business the way this bill has been considered and that the Congress is making too many changes too fast. The members of the group also stated emphatically that this is absolutely the wrong time to be discussing a tax cut whose beneficiaries are primarily the wealthier among us, with those in upper incomes emphasizing that it is right that they pay their fair share.

Our health advisory group suggests a short-term solution must address waste, fraud, and abuse, spiraling health costs of prescription drugs, labs, equipment, doctor and hospital fees, home health care, vision and dental care, and durable medical equipment. New ways to fix the long-term financing of Medicare must also be explored including the high cost of pharmaceuticals and private insurance. Research and development of drugs is a cost of doing business and should not be passed on the consumers in the form of higher prescription drug prices. A national commission must be set up for this purpose of developing a long-term solvency plan for the Medicare Program beyond 2010.

The trustees report has been cited as the reason reform is needed. I agree. Medicare is facing a short-term financing crisis in the part A hospital insurance [HI] trust fund which we must solve this year and a long-term crisis which needs much more careful consideration. However the plan before us cuts $270 billion from Medicare when the trustees only call for $90 billion in savings. In addition, the plan before us doubles part B premiums and we all know that not one dime of that money will go to the HI trust fund cited in the trustees report. Where is all this money going? To a balanced budget? No. It is being used to pay for a $245 billion tax cut for the privileged few in our society.

I cannot and will not vote for a bill which provides a tax cut to the wealthy on the backs of our senior citizens.

FRAUD AND ABUSE

As I visit the senior centers of my district one message resonates. It is time to cut fraud and abuse. Find your savings by hiring more investigators to crack down on the crooks in the system, do not make cuts at the expense of seniors. Isn't it ironic that the majority passed legislation earlier this year that would eliminate 72 fraud and abuse inspectors at HHS Office of the Inspector General. The plan before us actually weakens the ability of HHS to detect waste, fraud, and abuse. In fact, the HHS Inspector General June Gibbs Brown states that this bill would:

Make the existing civil monetary penalty and antikickback laws considerably more lenient and place an insurmountable burden of proof on the Government to punish illegal kickbacks;

Relieve providers of the legal duty to use reasonable diligence for insuring that the claims they submit to Medicare and Medicaid are true and accurate;

Create new exemptions to the law which could be exploited by those who wish to pay rewards or incentives to physicians for the referral of patients; and divert to private contractors scare resources currently devoted to law enforcement against fraud and abuse.

In conclusion, let us take our time and truly study the changes that are needed to provide both long-and short-term solutions to our system of Medicare financing. Let me quote from the book ''Intensive Care'', ''The health care system in the U.S. is far too complicated for anyone or any group to claim that a single reform plan is the solution to the crisis. Rather than taking a huge first step with a new untested system, wouldn't it make sense to pilot test a number of proposals? This is the only reasonable method to determine what works and what doesn't work. The danger with scrapping any old system of any kind is that a new system may not be any better.''

Mr. Chairman, let us heed this advice. Send this bill back to the committees of jurisdiction and let us do this reform in a reasoned, bipartisan manner.

Mr. GIBBONS. Mr. Chairman, I yield 2 minutes to the gentleman from Michigan [Mr. CONYERS] who is the ranking Democrat on the Committee on the Judiciary, which, unfortunately, waived all chances of participating in this debate today through its chairman's actions.

(Mr. CONYERS asked and was given permission to revise and extend his remarks.)

Mr. CONYERS. Mr. Chairman, before I talk about the antifraud and antitrust provisions, let me point out that the medical malpractice provisions in this bill for the first time tells the States that the Big Brother Federal Government is going to preempt them in the area of medical malpractice, and the provisions are a gift for the irresponsible and the reckless.

Take the case of Mr. King, who recently lost the wrong leg in an amputation in one of the worst medical malpractice cases in recent times. He would have been forced to face an absolute cap on pain and suffering at $250,000 even though he could face excruciating pain and suffering for every day for the remainder of his life. Yet a CEO who could not perform his job because of the same exact injury would face no such cap.

Similarly, with this bill the House Republican leadership is saying that the woman who loses her reproductive capacity as a result of medical malpractice would have her damages capped at $250,000. Does anyone here believe that a woman's reproductive capacity is worth a mere $250,000?

Now, on antitrust and fraud, there is more. Under the False Claims Act that allowed whistleblowers to sue for those who defraud taxpayers, we gutted, it has been taken out by the Republicans. That provision has returned $1 billion to the Government in savings from fraud, waste, and abuse, $1 billion. This bill will gut that law.

I am saying to my colleagues, do not be fooled by this phony new health care. The Committee on the Judiciary has not had a second's worth of hearings on any of these antitrust, antifraud provisions.

Mr. BLILEY. Mr. Chairman, I yield 1 minute to the gentleman from Georgia [Mr. DEAL].

Mr. DEAL of Georgia. Mr. Chairman, like many of my colleagues, I held meetings with my constituents this summer about Medicare. The No. 1 complaint that most senior citizens had was the amount of money that was being spent for services that were not rendered, for overcharges for drugs and supplies, and for general waste. They are angry, and well they should be, when they see Medicare paying $2 for an aspirin, $12 for a box of Kleenex, and thousands of dollars for services that were unnecessary or never delivered.

We must stop these abuses of the status quo. They are costing at least 10 cents out of every Medicare dollar, $50 million a day, that will amount to $1.3 trillion over the next 7 years.

Can we do better than that? Of course we can, if we let our senior citizens have a part in pointing out these abuses. They know better than a government bureaucrat what services and supplies they receive. They are tired of being told not to worry about the fraud since Medicare is paying for it. They know, even if some in government don't, that it is their tax money that is being wasted.

This bill gives Medicare recipients a voice in the process. These are men and women who lived through the Depression, fought in the World Wars, and built this Nation by hard work and sacrifice. If they are empowered rather than victimized, they will help eliminate the thieves and con artists who cheat Medicare out of $50 million every day.

Let us pass this bill and stop this outrage.

Mr. GIBBONS. Mr. Chairman, I yield myself such time as I may consume.

The gentleman just does not know what he is talking about. We pay hospitals based on a capitated basis. We do not pay hospitals for all that foolishness that the gentleman just read off. I do not know where he got that information.

Mr. BLILEY. Mr. Chairman, I yield such time as he may consume to the gentleman from Georgia [Mr. DEAL].

Mr. DEAL of Georgia. Mr. Chairman, it is very clear that there are those who wish to try to defend the status quo. We are here to change the status quo and do something about these problems.

Mr. DINGELL. Mr. Chairman, I yield 30 seconds to the distinguished gentleman from Illinois [Mr. RUSH].

Mr. RUSH. Mr. Chairman, under the Gingrich Medicare plan, the hospitals in and around the district of the gentleman from Georgia [Mr. DEAL] will lose approximately $159 million over the next 7 years.

Last week, in the Committee on Commerce, the Republicans delivered thousands of bogus letters. The seniors of my district and my State requested that I deliver a symbol of their true feelings regarding the Republican Medicare plan, a cut of pure grade bologna.

Mr. BLILEY. Mr. Chairman, I yield 1 minute to the gentleman from Colorado [Mr. SCHAEFER].

(Mr. SCHAEFER asked and was given permission to revise and extend his remarks.)

Mr. SCHAEFER. Mr. Chairman, I rise in strong support of the Medicare Preservation Act. This well thought-out package takes an important step towards ensuring the solvency of Medicare for today's beneficiaries and for generations to come.

In addition to the numerous hearings the Ways and Means and Commerce Committees held on saving Medicare, we all got an earful of advice during our respective town meetings. At my town meetings, many good suggestions were put forward. However, more than anything else, seniors asked that we vigorously attack the waste, fraud, and abuse that now plagues the system.

Senior citizens I have talked with routinely witness overbilling and needless tests. ''Don't worry,'' some say. ''Medicare will pay it.'' Unfortunately, seniors know it is they, their children and grandchildren who really foot the bill.

There are many steps the Medicare Preservation Act takes to combat waste, fraud, and abuse. None is more basic and makes more sense than simply doubling the monetary fines for defrauding the system. The money collected through these fines will be immediately recommitted to pursue additional anti-fraud efforts.

Mr. Chairman, this legislation will literally save Medicare from ruin. Rooting out the waste, fraud, and abuse is an important piece of the overall package. I urge all of my colleagues to join this important effort.

Mr. DINGELL. Mr. Chairman, I yield 2 minutes to the distinguished gentlewoman from Illinois [Mrs. COLLINS].

(Mrs. COLLINS of Illinois asked and was given permission to revise and extend her remarks.)

Mrs. COLLINS of Illinois. Mr. Chairman, I rise in opposition to H.R. 2425, the ''Get Old People, Gingrich Republican, Put The Hurt on Seniors, Medicare Destruction Act of 1995.'' This bill is nothing more than a mean-spirited attempt by the majority to destroy the basic health care rights all older Americans now enjoy in order to give tax breaks to their wealthy, big business, special interest buddies. Never in all my time in Congress have I witnessed a greater legislative travesty than the ill-conceived proposal we have before us today.

To begin with, the rule we just considered stifles any amount of reasonable debate on this legislation. For instance, with the exception of pap smear testing, this bill eliminates quality assurance guarantees that are now in place for patients who have diagnostic or other types of testing done in their doctor's office laboratories.

It probably should not be surprising that the Republican Medicare proposal—which bends so close to special interests and tilts so far from the best interests of America's senior citizens—would eliminate requirements for quality and accuracy of laboratory tests. This, like the Republicans' blatant and cruel elimination of national standards for nursing homes, is one more way of saying to the ill, the infirmed and the aged: you're on your own—good luck!

Where is the rationale for eliminating quality standards for cholesterol tests, colon and prostate cancer screening, needle biopsies to detect precancerous conditions, glucose monitoring and so on? There isn't any!

Equally disturbing is the fact that this Republican bill places a seven-year freeze on Medicare payments to providers of durable medical equipment such as wheel chairs, electric beds, walkers and, yes, even oxygen. Now this freeze is at a time when more and more Americans are aging and the need will be greater.

This freeze will cause severe disruptions in the health care and quality of life for sick and/or infirmed Americans who need their wheelchairs and walkers to get around more easily, electrical beds to rest comfortably and oxygen to breath effectively. By putting a freeze on oxygen, the Republicans are literally taking the breath of life out of the bodies of old folk. Only God has that right.

Mr. Chairman, I heard a Member a few minutes ago say that he was glad that he had made 65 and qualifies for Medicare. A lot of people qualify for Medicare who do not make $133,000 a year, as he does. And not only that, people who use facilities like wheelchairs and the like were among those who are thrown out of the committee by the Republican side in the Committee on Commerce: Julia Searles, 75; Joseph Rourke, 90 years old; Theresa McKenna, 68 years old; Bert Seidman, Loretta Adkins, Cecelia Banks, Doretha Beverly, Barbara Greenwell, Gladys Lyles, Roberta Saxton, Annie Earl, Marie Roots, Lilly Valentine, Gertrude Snead, Ruth Thorn, Edna Custis, all over age 69 who do not make $133,000 a year.

Mr. Chairman, the 7-year freeze on DME payments once again demonstrates the lengths to which the Republicans have been driven by adopting an arbitrary cut of $270 billion in Medicare so that they finance a tax cut for the rich.

In an attempt to protect these Medicare beneficiaries, I attempted to offer amendments to restore these provisions. Unfortunately, the Republicans would not let me.

Let me also address the blatantly undemocratic process by which this proposal, which will directly impact the health and well-being of 37 million older Americans and nearly every family in the Nation, has been brought forth. Not one public hearing has been held in which the legislative specifics of the drastic Medicare changes we are about to act on were in plain view. This is appalling and flies in the face of the legislative process.

After flagrantly spending the taxpayer's time and money without a second thought to conduct 28 days of hearings on Whitewater, 10 days of hearings on Waco, and 8 days of hearings on Ruby Ridge, it is crystal clear that the Republican party has put partisan politics above the public interest.

The fact that Democrats had to convene hearings on the lawn of the Capitol in order to provide a public forum to examine the GOP plan is compelling evidence, in and of itself, that the Speaker and his troops know that their proposals cannot stand up to public scrutiny. Moreover, it speaks volumes to the enormous disconnect that exists between the Republican party and the rights and needs of older Americans today.

Such a disconnect became extremely apparent on October 11, when 13 seniors, some of whom were over 90 years old and relegated to wheel chairs, came to ask questions about the Republican Medicare proposal prior to markup by the Commerce Committee. They were promptly arrested and hauled off to jail at the direction of the committee chairman!

During the Democratic ''lawn'' hearings, however, we helped answer the question, just what does the Republican Medicare proposal do? It charges seniors more for medical care, medicine, wheelchairs and medical devices. It forces seniors to abandon their own doctors for some uncharted course through the HMO system. It takes $270 billion in Medicare funding away from seniors, doctors, and hospitals all to pay for tax cuts for the wealthy. In short, it devastates the health care program upon which so many millions of Americans have come to rely.

Among the many witnesses were several of my constituents from Chicago who testified about the devastating consequences of the GOP so-called reforms.

Dr. William Troyer, director of External Services for the University of Illinois at Chicago Medical Center, an academic health center which houses the Nation's largest medical school and serves thousands of 7th District residents, gave a bleak view of the future under Republican Medicare changes. To quote Dr. Troyer, ''a gradual weakening and eventual demise'' of UIC Medical Center will

result from the more than $7 billion in cuts to direct and indirect medical education funding proposed by the GOP.

Following Dr. Troyer, Mr. Lacy Thomas, chief financial officer of the Cook County Bureau of Health Services, was equally dismal in his predictions. As a safety net provider for the disadvantaged and underserved in Chicago, the Bureau will be unable to deliver basic care for this population due to the total elimination of assistance to non-U.S. medical graduates—graduates which comprise nearly 40 percent of Chicago Medical Society physicians. In addition, $8 billion in reductions for disproportionate share payments to hospitals serving the indigent, such as Cook County, will only serve to exacerbate the pain felt by these patients.

Yet, I believe the most compelling testimony came from Ms. Irene Nelson, a senior from Chicago, who spoke eloquently regarding her fears of the Republican Medicare cuts. She stated,

> It is obvious to me that the people who are making these decisions are completely out of touch with the daily struggles of senior citizens like me. I wonder if any of these people have ever been forced to decide between eating, heating, and paying that outstanding medical. I doubt it very much! But that is what I, and many other seniors out there, will be forced to do if the Republicans are allowed to cut Medicare.

Mr. Chairman, it is of extreme importance that the American people are provided with this information on the Republican plan to gut Medicare in the dark of night and leave our Nation's seniors holding the bag.

After promising to balance the Federal budget in 7 years, increase military spending, and provide hefty tax cuts to the richest Americans in the country, the GOP is looking for a magic potion to fund these big promises.

Unfortunately, the Republicans seem to think Medicare is going to be the cure-all. In pushing a package of the deepest Medicare cuts in the program's 30-year history, $270 billion, the GOP wants to immediately increase the cost of Medicare to the average senior citizen by nearly $1,000, and force many to give up their own doctors.

This is bad policymaking and bad medicine for senior citizens.

In my State of Illinois, the proposed cuts will eliminate health care coverage outright for more than 58,000 individuals with disabilities over the next 7 years. In addition, 23,000 senior citizens will lose coverage.

Out-of-pocket costs will increase by an average of $3,500 over the next 7 years for each of Illinois' 1.62 million Medicare recipients. Further, Illinois will be denied $6.2 billion in Federal health care assistance over the next 7 years.

I am outraged at the efforts of the GOP to gut this essential program for no reason other than to pay for $245 billion in tax cuts for the rich. It is unnecessary, it is outrageous, it is wrong.

As the saying goes, ''You can fool some people some of the time, but you can't fool all the people all of the time.'' The vast majority of the American people are not fooled Mr. Chairman. Pass these Medicare cuts and you will discover that cold, hard fact pretty darn quick.

I urge my colleagues to vote ''no'' on H.R. 2425. Let's not take the ''care'' out of Medicare.

Mr. ARCHER. Mr. Chairman, I yield 2 minutes to the gentleman from Florida [Mr. SHAW], a respected member of the Committee on Ways and Means, the chairman of the Subcommittee on Human Resources.

(Mr. SHAW asked and was given permission to revise and extend his remarks.)

Mr. SHAW. Mr. Chairman, I rise today in support of the Medicare Preservation Act, and to deliver to this legislative body a message from my senior constituents in south Florida. Stop the fraudulent and abusive practices against the Medicare system. Do something about it, and just stop it.

On September 6, I mailed a letter to all of my constituents who qualify for Medicare which explained the problems that face the Medicare program. In this letter I asked for their input on how to preserve the system. To my surprise, over 90 percent of those who responded said that Congress must stop the fraud and abuse that they feel is widespread. Just listen to what is going on out there.

On September 22, I received a letter from Mrs. Jack Barnett, whose husband at one time was the chief of surgery at his hospital in New Jersey. Today Dr. Barnett is an invalid living with his wife in Hollywood, FL. Mrs. Barnett noticed last year that they were receiving billing statements for feeding tubes which Dr. Barnett never used. The company charging for these services received $2,765, $3,870, and $4,411 from Medicare. Mrs. Barnett asked her husband's nurse if she had ever seen anything like this before, and when the nurse saw the name of the company, she stated that two of her other patients were billed for the same thing by the same company.

Mrs. Audrey Vitolo of Deerfield Beach, FL was charged $600 for a simple blood test. Medicare paid the bill. She told me she felt victimized.

Mr. Ted Murphy of Fort Lauderdale, FL, was charged $10,000 for a simple operation on his eye lid. Even though this was an outpatient procedure, Medicare paid the bill. He told me that he complained to the hospital, but no action was taken.

Mr. Chairman, I want my constituents to know that their message came through loud and clear, and that Congress today is taking serious steps to stop fraud and abuse.

This Medicare bill will make it a Federal offense to engage in fraud, theft, embezzlement, false statement, bribery, graft, and illegal remunerations, including kickbacks. Civil penalties have been doubled and incentives have been added to encourage people to report cases of fraud and abuse.

First, the Secretary of the Department of Health and Human Services will be required to alert beneficiaries of instances of fraud and abuse against the program. A toll-free number will be established to report cases of fraud and abuse. Also, at the request of any person, the Secretary will publish a special fraud alert, which notifies the public of practices that are suspect.

Second, a beneficiary incentive program will be established where individuals who report cases of fraud and abuse can share the amount collected against those who are fined. Just think of the power of this provision, Mr. Chairman. There are currently 37 million Americans in the Medicare program. This means there are 37 million potential private attorney generals to help stop fraudulent and abusive practices. I know this will please many of my constituents, especially the Simons of Hallandale, FL, who wrote to me recently to inform me that they saved Medicare $4,000 by reporting suspect billing practices of their doctor.

Third, under this legislation, direct spending for Medicare-related activities of the inspector general of the Department of Health and Human Services will significantly increase. These activities include: First, prosecuting Medicare-related matters through criminal, civil, and administrative proceeding; second, conducting investigations relating to the Medicare program; third, performing financial and performance audits of programs and operations relating to the Medicare program; fourth, performing inspections and other evaluations relating to the Medicare program; and fifth, conducting provider and consumer education activities regarding Medicare fraud and abuse.

I want to stress to my constituents that this legislation is not a paper tiger. This bill provides serious money to stop fraud and abuse: At least $430 million in 1996; $490 million in 1997; $550 million in 1998; $620 million in 1999; $670 million in the year 2000; $690 million in 2001; and $710 million in 2002. This is a serious financial commitment that the Congressional Budget Office said will save Medicare money.

Finally, this bill establishes a health care anti-fraud task force. This task force will be a coordinated effort by the Department of Justice to prosecute health care fraud offenses.

Mr. Chairman, the Medicare Preservation Act is the toughest, most serious attempt this Congress has ever taken to stop fraud and abuse in the Medicare program. I am proud to have contributed to the effort to address the issue of fraud and abuse, and I know when my constituents learn of their new rights under the Medicare program, they will be proud of this Congress too. I urge my colleagues to vote for this most important legislation. Vote to preserve and strengthen Medicare.

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Mr. GIBBONS. Mr. Chairman, I yield such time as he may consume to the gentleman from Ohio [Mr. SAWYER].

(Mr. SAWYER asked and was given permission to revise and extend his remarks.)

Mr. SAWYER. Mr. Chairman, today, Congress is debating cuts to the Medicare program.

As the post-war generation ages and their parents outlive all previous generations, we

are facing the largest elderly population in our Nation's history and, therefore, the largest Medicare beneficiary population. Our national policies must reflect this changing reality. As we seek ways to balance the Federal budget, we must also continue investing in our Nation's future—including ensuring that both current and future retirees will have the resources they need to survive.

However, the Republican Medicare proposal would cut benefits for current retirees, those who no longer have the opportunity to prepare for their retirement, in order to increase discretionary spending for current working age people. This type of policy perpetuates the generation battle for my pot of money. Instead, we need to work together to find ways to reduce the deficit, ensure the stability of Medicare, and invest in the future.

We also have to learn from our history. As a nation, America cannot afford to return to the bad old days before the Medicare program was created. Medicare has helped secure our Nation's seniors against the threat of poverty and has limited the high costs of emergency and non-insured health care. Medicare has allowed our Nation's elderly to take care of their own health needs, regain self-respect, and, in turn, remain active members of society.

I support efforts that enable us to extend the life of the Medicare program which has been so important to the health of many older Americans. That is why I have supported the Democratic alternative which ensures the solvency of the Medicare trust fund through 2006—the same as the Republican proposal—without making harmful and excessive cuts to the Medicare program.

The American health care system, despite its shortcomings, is the envy of the world. Medicare has opened the door for many Americans to quality health care. The Republican proposal will undermine the graduate medical education program, and hurt urban and rural hospitals which are already struggling to remain open. Finally, the Republican proposal will mean that premiums will double in 7 years, meaning that for the poorest of the elderly, health care will continue to absorb more and more of their living costs.

The Republican Medicare bill is simply bad policy. It pits one generation against another, rich against poor, Democrats against Republicans. The Republican Medicare bill does not invest in our future, nor does it help current retirees.

I urge my colleagues to vote against this bill.

Mr. GIBBONS. Mr. Chairman, I yield such time as he may consume to the gentleman from New Mexico [Mr. PASTOR].

(Mr. PASTOR asked and was given permission to revise and extend his remarks.)

Mr. PASTOR. Mr. Chairman, as we consider this sweeping piece of legislation today, let us at least make an attempt to honestly describe what is being proposed. To begin, we are reducing Medicare payments to hospitals and doctors. Secondly, we are increasing the premiums paid by beneficiaries. And, although we are considering some modest changes in how health services will be provided, the fact that Medicare payments are being cut and premiums are being increased remain the most salient features of the legislation. This is what most alarms me about this proposal.

While the public is being told we need to make these changes in order to save the system, the fact of the matter is that the proposed cuts far exceed the amount needed. It is part A of Medicare which is scheduled to become insolvent by the year 2002 and its $90 billion which is needed to avoid this catastrophe. Yet, the combined cuts in payments to doctors and hospitals surpasses this figure. More startling is the fact the premium increases, which have nothing to do with keeping part A of Medicare solvent, will further reduce Medicare costs. The combined cuts, premium increases, and other changes to the system will reduce Medicare by $270 billion over 7 years. This leaves a large gap of $180 billion.

Even a simple examination of this proposal yields numerous questions. Why are we proposing to wreck havoc in rural America by jeopardizing the delivery of health care there; Why are we proposing to increase premiums for beneficiaries, many of whom will only be able to make these payments through great personal sacrifice; and, why are we moving to undermine public hospitals?

There are only two answers that are readily discernible. One is that excessive Medicare cuts facilitate a cut in taxes further down the road; the other is that these cuts could allow the budget deficit to be reduced by some factor. While I could support both tax and budget reductions, I cannot support such an effort under these circumstances. Why would we want to jeopardize the welfare of our senior citizens to either give more money to wealthier individuals or to reduce a budget deficit? Are there not more equitable approaches we could follow to achieve these goals?

I would propose that, foremost, we consider sacrosanct the welfare of those who have made significant, lifetime contributions to this nation. Whatever approach we use to stimulate investment in this country should not be done on the backs of our senior citizens. Our budget deficit is real. Yet how can we in good conscience engage in this wholesale attack against senior citizens when other, more measured alternatives remain at our disposal? Let us make an honest effort to address our budget deficit problem without strangling our most vulnerable citizens. And, let us consider policies which stimulate economic activity without exacerbating our deficit.

Mr. GIBBONS. Mr. Chairman, I yield such time as he may consume to the gentleman from Illinois [Mr. POSHARD].

(Mr. POSHARD asked and was given permission to revise and extend his remarks.)

Mr. POSHARD. Mr. Chairman, due to the concerns I have regarding the future of our rural health care system and the people who depend on those facilities, I rise in strong opposition to the bill, H.R. 2425.

It is difficult to misread the conclusions contained in the report of the Entitlement Reform Commission, which states that without fundamental change, our entire Federal budget will be consumed by entitlements and interest on the debt by the year 2012. That means none of the tax money sent to Washington will be available for national defense, our transportation system, education, law enforcement, science or space, national parks or any of the other functions of government which operate with discretionary funds. It will all be committed to interest on the debt and entitlement spending.

Doing nothing is not an option. But doing the wrong thing is no better. Today we face a trio of choices concerning the future of Medicare and our prospects for balancing the budget.

The Board of Trustees of the Medicare Hospital Insurance Trust Fund indicate that we have traditionally maintained a 10- to 12-year balance in the fund, and, currently, we are only 6 years from going broke. We are obligated to take action to ensure the solvency of the fund.

By most estimates, we could control the growth of Medicare spending over the next 7 years by about $90 billion and protect the integrity of the fund by extending its balance to 10 years solvency. But that course ignores the fundamental problem that entitlement spending must be further contained if we are going to meet our balanced budget goal.

Our second option, which I have voted for and will continue to support, is to control Medicare growth by $170 billion over the next 7 years. That would secure the trust fund and contribute the necessary cost controls which, when combined with the rest of the coalition budget, would bring us to balance in 7 years. We must do both of those things—preserve Medicare for our seniors, and balance the budget on behalf of future generations of our sons and daughters.

The third option, which is before us today, takes $270 billion out of the Medicare Program. It will stabilize the trust fund and put us on a 7-year path toward a balanced budget. But it also takes $100 billion more out of Medicare than is necessary to achieve financial solvency of the Medicare trust fund and to balance the budget. This additional $100 billion, coming directly from Medicare, will be used to help finance a $245 billion tax cut for some of the wealthiest people in America.

As Cochair of the Rural Health Care Coalition, I have long been concerned with preserving an adequate and affordable health care system for people in rural areas such as the 19th district of Illinois, which I am privileged to represent. The approach being advanced today encourages health maintenance organizations to provide Medicare services, an approach which may work well in urban areas but will never adequately serve the rural people of this country. Why would a health care provider establish a system in a rural area where the monthly payment is approximately $300 when it receives nearly $500 for providing similar services in a more urban area?

This week, the Illinois Hospital and HealthSystems Association wrote me a letter which states:

> IHHA continues to be strongly opposed to the magnitude of Medicare reductions that are contained in this proposal. The House measure calls for approximately $76 billion in Medicare reductions to be achieved by reducing payments to hospitals. Of this total, reductions to Illinois hospitals would be $3.5 billion. For the hospitals in your district, the reductions amount to $119 million.

As the specifics of this proposal became clear, I traveled my district to listen to the people who run the hospitals and clinics and the patients who depend on them to maintain their quality of life. One after another, hospital administrators in my district told me of the hundreds of thousands of dollars they would lose under this plan. Rural hospitals are valuable not only for their vital health care services, but for providing some of the best paying jobs in

our communities. They cannot be allowed to dry up and blow away, leaving people wanting for medical care.

Mr. Chairman, we cannot continue the Medicare System as it presently exists which today stands near bankruptcy. We should and must consider asking seniors who are financially secure to pay more for their share of the Medicare Program. I am on record supporting a bill which would means test Medicare premiums for higher income individuals to make the system more fair.

We cannot simply make the short term fix to sustain the trust fund. It is equally irresponsible to cut the Medicare Program to pay for a tax cut which Republican analysts admit will add $95 billion to the national debt. Both courses of action are wrong.

Let us come together as a deliberative body to secure the trust fund, balance the budget, and put our country in a position to care for its people and compete in the international marketplace in the coming century. We can do better for all generations of Americans, and I stand ready to work with anyone of any party to make better choices than the one before us today.

It is unfortunate that the leadership of both parties will not allow the moderate Democrat proposal to come forward on this floor for a vote. This proposal is the best option available because it accomplishes both a balanced budget and a fiscally sound Medicare trust fund, but does not overreach by downsizing Medicare another $100 billion for fund a tax cut which is unnecessary.

My hope will be that this sensible approach to fiscal responsibility will be allowed next week in the reconciliation bill and that eventually this Congress will achieve the middle ground that is necessary to solve these problems.

Mr. GIBBONS. Mr. Chairman, I yield 30 seconds to the gentleman from Wisconsin [Mr. KLECZKA].

Mr. KLECZAK. Mr. Chairman, last year the Democrats had a proposal to extend the solvency of Medicare by cutting $168 billion in the program. The speaker who just addressed us from Florida indicated to the committee at that time, ''We have here in this bill the seeds of destruction of Medicare. Let's not destroy a health care program in this country that we know works well and that our seniors are depending on it.'' Now he comes to the floor supporting a bill cutting $270 billion.

Mr. Chairman, I guess those seeds have germinated.

Mr. DINGELL. Mr. Chairman, I yield 30 seconds to the distinguished gentleman from Pennsylvania [Mr. KLINK].

Mr. KLINK. Mr. Chairman, we are hearing about this bill cutting waste, fraud, and abuse. It is odd that the GAO, the Department of Justice, and the HHS Office of Inspector General all have very grave concerns about what this bill does to provisions in the Medicare bill that would allow them to do law enforcement. In fact, if my colleagues like waste, fraud, and abuse, which we all agree now account for about 10 percent of all that is spent on Medicare and Medicaid, my colleagues are going to love this bill because it makes the health care waste fraud a growth industry and a new way of life for a lot of Willie Suttons.

Mr. BLILEY. Mr. Chairman, I yield 3 minutes to the gentleman from Illinois [Mr. HYDE], chairman of the Committee on the Judiciary.

(Mr. HYDE asked and was given permission to revise and extend his remarks.)

Mr. HYDE. Mr. Chairman, I rise in strong support of H.R. 2425, the Medicare Preservation Act of 1995.

Mr. Chairman, there is no question that reform of the Medicare Program is imperative if it is to survive. But its mere survival is not the goal of this legislation: What we seek is to preserve Medicare by keeping it solvent while strengthening and improving the coverage and options it provides to this Nation's elderly. We must not squander this opportunity to deal comprehensively with the multitude of issues which bear on the efficient delivery of health care in this country.

As the chairman of the Committee on the Judiciary, I would like to point out some particularly important provisions contained in this bill that fall within our Committee's jurisdiction. Specifically, the bill contains provisions designed to facilitate the operation of the revised Medicare Program—notably, health care liability reform, antitrust relief for provider service networks, and an antitrust exemption for medical self-policing entities. The combined effect of these changes will provide a fertile environment for the delivery of Medicare services in a manner which maximizes consumer choice. Liability reform will generally decrease the cost of providing health care services, and eliminate many of the frivolous lawsuits which are clogging our courts. Antitrust relief for provider service networks, or PSN's, will increase competition for contracts under the Medicare system, thereby increasing choice and decreasing costs. Providing an antitrust exemption to medical self-regulatory entities will encourage physicians and hospitals to police themselves, and will contribute to a reduction in malpractice, fraud, and abuse.

HEALTH CARE LIABILITY REFORM

Our health care system is clearly being burdened by a number of cost-based pressures. One of these costs is the threat of liability suits facing medical practitioners and health care providers and the large dollar amounts they are forced to spend to protect themselves against these legal actions.

The average physician has a 40-percent chance of being sued at some time in his or her career. This increases to 52 percent for surgeons and to 78 percent obstetricians. The estimate is that medical malpractice premiums now total $10 billion annually. The average annual medical premium for a doctor specializing in obstetrics in some urban areas now exceeds $100,000 a year.

Many liability cases brought against doctors are frivolous. In fact, two out of three medical liability claims are closed without any payment to the claimant, but only after large legal and administrative fees have already been incurred.

Further, the increasing insurance premiums for malpractice coverage represent only a part of this problem. The estimates are that the costs of defensive medicine run from $20 to $25 billion a year.

Numerous other entities in addition to doctors and hospitals such as pharmaceutical manufacturers and those that manufacture medical devices or provide blood or tissue services are also impacted by the same liability concerns. Finally, as we move more and more into a managed care system, the scope of third-party liability is also a matter of increasing concern.

There is no question but that our health care system is seriously burdened by both the threat, and the reality, of liability suits facing medical practitioners and health care providers. The Health Care Liability Reform legislation that is included in this bill will solve this serious national problem.

EASING OF ANTITRUST BARRIERS FOR PHYSICIAN SERVICE NETWORKS

Provider service networks—those composed of doctors, hospitals, and other entities who actually deliver health care services—are potentially vigorous competitors for Medicare beneficiaries. The benefits to the Medicare Program of their participation would be lower costs and higher quality of care than in nonprovider sponsored health plans. Costs would be lower because contracting with a PSN instead of an insurer could eliminate a layer of profit and overhead. Quality would be higher because providers, and particularly physicians, would have direct control over medical decision-making. Arguably, physicians and other providers are better qualified than insurers to strike the balance between conserving costs and meeting the needs of the patient.

There are obstacles, however, to the formation of PSN's. One of the most serious is the application of the antitrust laws to such groups in a manner which does not allow the network to engage in joint pricing agreements, regardless of whether its effect on competition is positive rather than negative.

Antitrust law prohibits agreements among competitors that fix prices or allocate markets. Such agreements are per se illegal. Where competitors economically integrate in a joint venture, however, agreements on prices or other terms of competition that are reasonably necessary to accomplish to procompetitive benefits of the integration are not necessarily unlawful. Price setting conduct by these joint ventures should be evaluated under the rule of reason, that is, on the basis of its reasonableness, taking into account all relevant factors affecting competition.

Current Department of Justice-Federal Trade Commission guidelines require that a physician group share substantial financial risk before being considered a joint venture and thus eligible for rule of reason analysis. Their definition of substantial financial risk is too rigid, thereby eliminating from the market PSN's which would provide an expanded set of consumer choices and increase competition in the market for health care services.

The proposed legislation overcomes this barrier by mandating that the conduct of an organization meeting the criteria of a provider service network be judged under the rule of reason. The result will be to permit a case by case determination as to whether the conduct of that PSN would be procompetitive, and thus permissible under the antitrust laws. It is important to understand, however, that this is not an exemption from the antitrust laws. In no event would providers be allowed to set prices or control markets so as to injure competition.

Only an organization meeting specified criteria would qualify for this more liberal, rule of reason consideration. The network must have in place written programs for quality assurance, utilization review, coordination of care, and resolution of patient grievances and complaints. It must contract as a group, and mandate that all providers forming part of the group be accountable for provision of the services for which the organization has contracted.

ANTITRUST EXEMPTION FOR MEDICAL SELF-REGULATORY ENTITIES

Standard setting is a cooperative activity engaged in by the providers of health care services in this country. Those entities have a long history of protecting the public with standards for medical education, professional ethics, and specialty certification. These activities have increasingly been challenged under the antitrust laws in recent years, typically by those who fail to meet the standards. Congress attempted to address this problem with the Health Care Quality Improvement Act of 1986, 42 U.S.C. §11101 et seq., which provided antitrust protection for peer review actions conducted in good faith. While beneficial, this law shifted the debate in antitrust litigation over peer review to whether the participants acted in good faith and has not served to stem the tide of antitrust law suits.

The medical self-regulatory entity exemption included in our legislation would bar antitrust suits against medical self-regulatory entities that develop or enforce medical standards. This would include activities such as accreditation of health care providers and medical education programs and institutions, technology assessment and risk management, development and implementation of practice guidelines and parameters, and official peer review proceedings. The exemption would cover suits against individual members of the groups which undertake these activities as well as the organizational entity on whose behalf they act.

The scope of this antitrust protection is not absolute, however, Activities by a medical self-regulatory body that are conducted for purposes of financial gain or which would interfere with the provision of health care services of a provider who is not a member of the profession that sets the standard would not be covered or exempted by this legislation.

Mr. Chairman, H.R. 2425 represents a historic step forward in improving the delivery of health care in America. It deserves the support of every Member of this body.

Mr. DINGELL. Mr. Chairman, I yield 30 seconds to the gentleman from Michigan [Mr. CONYERS].

Mr. CONYERS. Mr. Chairman, I say to the gentleman, great statement. The gentleman's district loses in hospital fees $260 million. The legal news points out doctors mop up on medical malpractice reform, and you have not had 1 minute's hearing on medical malpractice reform. The Judiciary Committee was cut out.

Mr. DINGELL. Mr. Chairman, I yield 1 minute to the distinguished gentleman from New York [Mr. TOWNS].

Mr. TOWNS. Mr. Chairman, make no mistake about it. What we are doing here today is applying a $270 billion meat-ax approach to a $90 billion problem merely to pay for a $245 billion tax cut for the wealthy.

Let me say that I know my colleagues want to help their rich friends, but let me say to the Republicans, Please find another way to help your friends. Do not do it on the backs of senior citizens, those that have worked all their lives to come to this point now and to be told we are going to cut, cut, cut, cut.

Let me just talk about two lies here very quickly. No. 1 is that we are going to go after fraud and abuse. My colleagues are not going after fraud and abuse; they are cutting half of the people that is supposed to go find fraud and abuse. How are they going after it if they eliminate half of the people that are supposed to look for it? And the last one is choice. The biggest lie of all is choice. If they do not have the resources, they have no choice.

Mr. GIBBONS. Mr. Chairman, I yield 3 minutes to the gentleman from New York [Mr. RANGEL].

(Mr. RANGEL asked and was given permission to revise and extend his remarks.)

Mr. RANGEL. Like so many of my friends here, Mr. Chairman, I am sick and tired of these Republicans being beat up on really. Most of the chairmen and certainly the committee people have nothing to do with this. Someone told them that they had to find a $245 billion tax cut. Do my colleagues think these people, kind and gentle as they are, will be going after housing, and job training, and lunch programs? No, it is not their fault.

And let us get another thing straight about this $270 billion cut. It is a savings; do my colleagues not get it? What it means is that, as we find U.S. population growing and people getting older, and becoming more ill, and having to see more doctors and more hospitals, we are going to give them some more money. So who the heck is saying that they are not giving more? What they are not doing is taking care of those older people the way they should be taken care of because they have decided to legislate the rate of inflation.

Now another thing which we have to understand is that we want to save money by taking these old folks off of this fee-for-service, seeing their own doctor business. Cannot my colleagues not understand that? We have these private organizations. They meet every month. Most of them are Republican, but what has that got to do with it? When they are there, they do not have meetings asking how many lives did we save. They want to know many bucks did we make. Now the quicker we get people off of these expensive doctors, because now it is costing us $3 billion more, these doctors are a lot of money, as my colleagues know; ask them, they can tell us how much they want; and get them on these programs where we can ration the care, then it is not really cutting services. It is not really cutting money, it is cutting the services, and so do not call that a cut.

Now some may say, Well, how are these old people going to shop around, feeble as they are in wheelchairs, and find one of these for-profit organizations to give them care? My Democratic friends, I want them to know they can stay in the program they are in. They can stay there, and it is discriminatory if one of these for-profits do not let them in.

Now there is a problem. There is nothing in the law that says these for-profits have to go in communities where there is sick people. There is nothing in here that says they have to go to the rural areas, there is nothing in here that says they have to go to the inner city, and why should they? They are in the business of making money. There are sick people in these communities, and we have to avoid it, but the meanest thing of all, my Republican friends, and I wish they could help me to explain this, is that for years we have known when one works and they have no insurance, when someone is poor and they have no coverage, they go to the public hospitals. I ask, why did you hit them so hard? Mr. Chairman, that is where people have no place else to go.

Mr. ARCHER. Mr. Chairman, I yield 3 minutes to the gentlewoman from Connecticut [Mrs. JOHNSON], chairman of the Subcommittee on Oversight of the Committee on Ways and Means who has given so much of her time and her knowledge in developing this plan.

Mrs. JOHNSON of Connecticut. Mr. Chairman, the goal of this bill is very simple. It is to preserve Medicare for current retirees and for future retirees. Why do we want to do this? Because the twin pillars of retirement security for American seniors are Social Security and Medicare, and believe me, when the Trustees of Medicare say next year they are going to pay out more money than they are going to take in and in 5 years after that they are going to use up all their savings and be broke, I think that is a crisis. I think that is a problem. I think delaying addressing that problem is going to make it harder, not easier.

So I am proud to support a bill that says simply we have a crisis, that to preserve Medicare we have to fix it, and we can do it. It is actually not very hard. It means reducing the rate of growth in Medicare from 10 percent down to 6.5 percent.

Why do we think we can do this? Because the private sector has already reduced the rate of health care cost growth to 3 percent. We can preserve Medicare by reducing its growth rate to twice that of the private sector. We

can do that, and we can do that in a way that opens up new opportunities for seniors because Medicare is an old-fashioned program that does not provide prescription drugs nor cover prevention, all of which can save money.

Right in Boston today we have two plans open to Medicare seniors offering all Medicare services, prescription drugs, and a number of other services, for zero premium. That is a zero-premium choice.

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That means for the same dollar we are investing into Medicare, these folks in Boston, our senior citizens, are going to get choices that buy better than Medicare benefits. That is what this is all about. It is about controlling costs in Medicare by opening up to seniors the kinds of plans that in the private sector have preserved benefits and reduce the rate of medical inflation in this country.

And how do we get the $270 billion? This is how we get it. We reduce the rate of growth in hospital reimbursement rates and doctor reimbursement rates so they go up 6.5 percent instead of 10 percent. You Democrats keep jumping up and saying ''We are cutting funding to hospitals''. Mr. Chairman, I ask Members to ask their kids if they can pay more than the 19 percent of payroll that they are now paying for Social Security and Medicare so we can let those hospitals grow at 10 percent instead of 6.5 percent. Ask them that. They will tell us they cannot afford it.

Yes, we can guarantee Medicare to our seniors by slowing the rate of growth in reimbursements to hospitals and physicians, and by getting tough on fraud and abuse. Incidentally, if the Members on that side of the aisle do not like our fraud and abuse provisions, why didn't they propose tougher laws when they were in the majority for 40 years?

We get $2 billion more in revenues from our fraud and abuse provisions because we are tougher than we have been in the past. So, the $270 billion comes from slowing the rate of growth in reimbursements to doctors and hospitals, cracking down on fraud and abuse and, yes, requiring seniors to continue paying premiums to cover 31 percent, just what they are paying today, and, though the Members on that side never mentioned it, in our plan requiring rich seniors to pay more. We are proud of our plan. It preserves Medicare and protects seniors.

Mr. GIBBONS. Mr. Chairman, I yield 1 minute and 30 seconds to the gentlewoman from Florida [Mrs. MEEK].

(Mrs. MEEK of Florida asked and was given permission to revise and extend her remarks.)

Mrs. MEEK of Florida. Mr. Chairman, who do the Republicans think they are, the Oracle of Adelphi? They have just put a bill together where they arbitrarily set interest? They look forward to the year 2002, and they have said how much money people are going to make. They have set the inflationary rate. Who are they, the Oracle? They cannot do that.

What they have done here by setting those unofficial rates, they have cheated the senior citizens of this country. My Medicare card is shivering in my pocket when I sit here and listen to some of this, because what they are doing is fooling the senior citizens. They say to me, ''Don't scare them.'' I need to scare them and say, ''Look out, it is coming.'' I ask the Members, would they know a hurricane is coming and not do anything about it?

I am saying, and all over this country I will continue to say that they are not telling the full truth to these senior citizens. Mr. Chairman, the honorable gentleman from Pennsylvania [Mr. GREENWOOD] this morning said, and also my sister here who is a health care expert, bringing down the inflation rate. Who told them they can do that? They do not know what is going to happen. I rebut that stand very much, because they cannot do that.

I can tell Members how many of them are going to be hurting when they get back home. People back home do not know they are up here pontificating. They do not know that. But when they get back there and they look at how their hospitals are going broke, they are going to come to them and say, ''What gives here? How can you be the Oracle at Delphi?''

Mr. UPTON. Mr. Chairman, I yield 2 minutes to the gentleman from Oklahoma [Mr. COBURN].

(Mr. COBURN asked and was given permission to revise and extend his remarks.)

Mr. COBURN. Mr. Chairman, many of the people of this country sent new representatives to this Congress, representatives that have a basis of experience.

As a practicing physician who continues to care for Medicare patients and Medicaid patients, whose practice was made of a majority of Medicaid and Medicare patients, I have truthfully and honestly looked at this bill. This bill is going to save Medicare. It is not perfect, but it does the things that we need to do to preserve this program. To do otherwise, to put a band-aid on it, is wrong.

I want to share with the Members for a moment what happened and what we have done by changing some of the system. Not long ago, in the late 1980s, a program called the Clinical Laboratory Improvement Act was introduced. The effect of the act is that you can have a pregnancy test at home using technology today that the Federal Government says your doctor is not capable of using unless approved by the Government.

As a result of that, what we see is that 30 percent of the doctors, and mainly in rural America, are still testing, 54 percent of the doctors stopped some form of testing because of this law. Seven percent dropped tests for other reasons, and 9 percent of the rural doctors in this country quit testing completely.

The fact is we had a well-intentioned plan. There were problems with pap smears in this country, but there were not that kind of problems. Now what we do is we have patients paying two and three times for the same testing, waiting 2 and 3 days to get the same results back. CLIA was well-intended. It has now been changed. We will have quality because we are going to trust our caregivers to give us quality.

Mr. GIBBONS. Mr. Chairman, I yield myself such time as I may consume.

Mr. Chairman, I would ask the gentleman, how many 65-year-old older women in his district were pregnant last year? How many 65-year-old women, older women, were pregnant in his district last year?

Mr. DINGELL. Mr. Chairman, I yield 30 seconds to the distinguished gentleman from Pennsylvania [Mr. KLINK].

Mr. KLINK. Mr. Chairman, I thank the gentleman for yielding time to me.

Mr. Chairman, I just wanted to say that under the Gingrich Medicare plan, medical providers and hospitals around the district of the gentlewomen from Connecticut [Mrs. JOHNSON], and she spoke just a few moments ago, are going to lose $129 million over the next 7 years. That is what I call choice under the Gingrich Medicare programs. The doctors and hospitals are going to lose $152 million. That is choice.

Janis Joplin, if she were alive, would say freedom is just another word for being forced to choose between your doctor, who will leave the traditional Medicare plan, and whatever else you are going to do.

Mr. DINGELL. Mr. Chairman, I yield 1½ minutes to the distinguished gentleman from Maryland [Mr. HOYER].

Mr. GIBBONS. Mr. Chairman, I yield 30 seconds to the gentleman from Maryland.

The CHAIRMAN. The gentleman from Maryland [Mr. HOYER] is recognized for 2 minutes.

(Mr. HOYER asked and was given permission to revise and extend his remarks.)

Mr. HOYER. Mr. Chairman, we had the opportunity to see a tape from a consultant to a Republican meeting. The consultant said ''Use soothing words for your radical change. Tell them you are saving Medicare. Tell them you are giving them choices. Express moderation in your radicalism and swear that the $270 billion cut in Medicare has nothing to do with the $245 billion cut in taxes,'' and hope that the public is lulled into apathy.

So we hear on this floor talk by our Republican colleagues of preserving and reforming a health care system that 93 percent of them opposed in 1965. Beware, the wolf in sheep's clothing. Beware those who want to save that which they eschew. Beware those who want to come from the majority party in Washington and help you.

Mr. Chairman, if we pass this bill today, before too long Medicare for

millions and millions of Americans will become Medigone. Oppose this Republican medical killing proposal.

Mr. BLIILEY. Mr. Chairman, I yield 1 minute to the gentleman from California [Mr. BILBRAY].

Mr. BILBRAY. Mr. Chairman, not too long ago I got a call from a senior citizen in my county about the fact that she was billed for two mammograms. When she confronted the billing agent on it, they assured her that she was wrong and she was just a senior, just a senior and did not understand. The mistake is the seniors understand. This women pointed out that it was physically impossible for her to have two mammograms, because she had had surgery 2 years before, and when this billing agent found out about their mistake, the comment was ''Well, it is not your money, ma'am. Why are you worried about it?''

For too long, people have been saying to the seniors ''It is not your money, do not worry about it.'' The seniors care. In this bill, we are going to fight fraud by creating a neighborhood watch strategy for fighting Medicare fraud. We are going to allow the seniors to participate, not only in choosing their program for their health care, but also participate in fighting fraud.

Mr. Chairman, I strongly support this concept, because I think if we really want to be serious about fighting fraud, then have the guts to allow the seniors to participate in these programs and approve this bill.

Mr. Chairman, I rise in opposition to the Medicare package before us today.

The Republicans have proposed cutting $270 billion out of the Medicare system.

They did not choose $270 billion because it is needed to save the trust fund, or because there is $270 billion worth of waste, fraud, and abuse in the system, or because cutting $270 billion will improve seniors' health.

They chose $270 billion because they have a huge fiscal hole to fill—a hole created by an unnecessary and irresponsible tax cut for the wealthy.

The Republicans have committed to balancing the budget, increasing spending on defense, and cutting taxes.

If revenues are going down by $245 billion, and you're going to balance the budget, you've got to raid the bank somewhere else.

That somewhere else is Medicare.

The Republican plan is not driven by a desire to save Medicare.

Ninety-three percent of Republicans voted against the Medicare Program at its creation.

Ninety-nine percent of House Republicans voted to cut more than $280 billion out of the program in 1995.

This Republican plan is a stake in the heart of the medical insurance program 37 million seniors from all walks of life rely on for their health security.

The Republican plan will increase charges to seniors with an average income of $13,000 per year so that people with incomes of $350,000 per year can get a $20,000 dollar tax cut.

I don't think that's fair, and I don't believe it's right.

The Republican plan will undermine Medicare in other ways as well.

Medicare-plus Programs will be allowed to cherry-pick low risk seniors, leaving traditional Medicare subject to the higher costs of adverse selection.

The plan creates incentives for doctors and hospitals to leave traditional Medicare for Medicare-plus options that permit them to charge seniors higher fees—creating the probability that seniors who cannot afford higher Medicare-plus charges will be unable to find doctors and hospitals willing to treat them.

And, the plan actually weakened sanctions against waste, fraud and abuse.

I believe that we need to take steps to fix what's broken with Medicare.

We must crack down on the waste, fraud, and abuse.

I know that seniors are willing to bear their fair share of the costs of balancing the Federal budget for our children and grandchildren.

But this debate is not about fixing what's wrong.

It's not about changing the parts of Medicare that don't make sense.

It's about charging seniors more for health care.

It's about giving seniors less for their Medicare dollars.

And it's about filling the tax cut hole.

I urge my colleagues to vote ''no'' on the Republican Medicare plan.

PARLIAMENTARY INQUIRY

Mr. THOMAS. Mr. Chairman, I would ask the Chair, what are the rules in terms of sloganeering, buttons worn on the floor when participating in debate?

The CHAIRMAN. The Chair has already stated that wearing badges on the floor while participating in debate is against the rules of the House.

Mr. DINGELL. Mr. Chairman, I will take it off, and I will be delighted to give it to the gentleman from California. It will benefit him highly.

Mr. Chairman, I yield 15 seconds to the distinguished gentleman from New Jersey [Mr. PALLONE].

Mr. PALLONE. Mr. Chairman, I thank the gentleman for yielding time to me.

Mr. Chairman, I just wanted to point out that under the Gingrich Medicare plan, the hospitals in and around the district of the gentleman from California, [Mr. BILBRAY] will lose $345 million over the next 7 years in order to pay for a tax cut for the rich.

Mr. DINGELL. Mr. Chairman, I yield such time as she may consume to the gentlewoman from California [Ms. LOFGREN].

(Ms. LOFGREN asked and was given permission to revise and extend her remarks.)

Ms. LOFGREN. Mr. Chairman, I oppose the bill.

Mr. Chairman, I rise today on the behalf of the thousands of senior citizens, parents, children, women, hospitals, doctors, nurses, health-care providers and workers who live in my district and have written to me, talked to me and pleaded with Congress to stop these ill-conceived cuts to Medicare.

Thirty years ago the Congress made a promise to the American people. That promise was a bold commitment to entitle older Americans, poor children, families, and the disabled to health coverage through the Medicaid and Medicare Programs. Today, our new Republican leaders are turning their backs on that promise.

Why? The facts are that they cut Medicare so deep to pay for their tax breaks. American seniors will be forced to pay more out of their pockets, will have less choice in selecting their own doctor and will receive a lower quality of service, so that the Republicans can use savings for a tax cut.

None of the $270 billion that the Republicans are cutting out of the Medicare Program will go back into the Medicare trust fund—not one cent. It will all go back into the general Treasury. The Republican lockbox is a gimmick. It does not change the fact that the cuts are there to be counted in determining whether the budget is balanced and you can't give those tax breaks, and balance the budget—not without cuts. Did the Republicans cut defense to pay for their tax break? No, they cut Medicare and Medicaid.

The Medicare trustees say that the proposed cuts are more than three times greater than the $89 billion recommended to keep the Medicare trust fund solvent. I doesn't take a Ph.D. in mathematics to figure out that the $270 billion in Medicare cuts will cover the cost of the $245 billion tax break.

When I came to Congress in January as a freshman Member of Congress, I expected Congress to take care in passing laws. Not in this Congress. The Medicare cuts that are before the House today got 1 day of hearings—1 day. And, the committee members didn't even have the real bill in front of them before the hearing started. Today we have 1 day of debate, with no amendments allowed, on the basic health care program relied on by millions of Americans. We spent all of yesterday on the floor of the House talking about fish—seems to me we could have waited to deal with fish and used at least part of that time to deliberate on the fate of American's seniors.

The impact on the State of California will be large. California will lose $27.5 billion in Medicare funding over 7 years. California will lose $816 million next year alone and the losses will only increase as each year passes. The combined potential loss in Federal health care spending in California over 7 years will be at least $44.1 billion. In 1996 California will lose $1.5 billion in Federal health care spending and the loss per year will increase every year after 1996 reaching a whopping loss of $12.1 billion in 2002. To put this in perspective, the State of California's entire budget for this fiscal year was $42 billion. The personal cost for Seniors in my State will be high. They can expect their premiums to double by the year 2002. Let me repeat that: California seniors will pay double what they are paying now in just 6 short years. And Medicare spending per beneficiary will be cut by $1,700 by the year 2002.

In my district in Santa Clara County, CA the effects of these cuts will be profound. By the year 2002, Santa Clara County's Medicare

loss will be $1.2 billion. Next year alone, Santa Clara will loss $33.4 million in Federal Medicare money. I was a Santa Clara County supervisor for 14 years and I can tell you from experience the ramifications of these cuts will be far-reaching. Counties and hospitals will be forced to thin the health care soup. Costs will be shifted and care will jeopardized. Patients in other insurance programs will feel it—their costs are likely to go up or coverage down.

I have received letters from both private and public hospitals in my district that tell me they do not know how they will be able to cover the Medicare losses. Public hospitals form the backbone of the safety net in most counties. They provide substantial amounts of care to low-income populations and the uninsured. They rely heavily on Medicaid and Medicare to pay for that care. These hospitals also provide wide range of regional and community services that are often not otherwise available, such as trauma care, children's specialty services, spinal cord injury rehabilitation and burn care. Medicaid and Medicare ensure that these hospitals remain financially viable to provide these much needed services. In California the number of people who rely on public hospitals is growing. And, growing along with it at an even more alarming rate is the number of uninsured people.

While the financial side of these cuts is important, the human question of serving people in need is paramount. On behalf of all of those people who live in the 16th district of California who have taken the time to write, to call and to speak up against these cuts, I ask my colleagues here in Congress, not to turn your back on this American promise. Don't turn your back on America's seniors and uninsured. It isn't too late to say: "this goes too far."

Mr. DINGELL. Mr. Chairman, I yield 1 minute to the distinguished gentleman from Virginia [Mr. SISISKY].

(Mr. SISISKY asked and was given permission to revise and extend his remarks.)

Mr. SISISKY. Mr. Chairman, I have just completed, 7 weeks ago, an operation for rectal cancer. I was able to afford the prescreening of that, even though I am on Medicare, but I found out today that it is not even included in this bill. How can we be uncompassionate for people who cannot afford to get these examinations? It just seems to me that that is one of the things that should be included. Mr. Chairman, I do not need 30 seconds more to say that I do not believe in attacking, and doing this from the Democrats or Republicans, but just from utter compassion for people, I promise the Members, to get that examination, they do not have to worry about fraud and abuse then. Nobody will ask and beg for that examination, I promise that. But for goodness sakes, care about people who do need that examination.

Mr. ARCHER. Mr. Chairman, I yield 2 minutes to the distinguished gentleman from Illinois [Mr. CRANE], chairman of the Subcommittee on Trade of the the Committee on Ways and Means.

Mr. CRANE. Mr. Chairman, there was an interesting cartoon in yesterday's newspaper that perhaps not everybody in our listening or viewing audience saw. It had this patient lying in bed in a hospital on a life support system, and at the foot of the bed he was identified as Medicare, and there were two Republican elephants there that were dressed in doctor's attire and they said, "He needs immediate surgery to survive," and the nurse was behind the two elephants and she was standing in front of the Jackass and a man who occupies the other end of Pennsylvania Avenue, and said "No, no, the family insists, no surgery. They believe in faith healing." I think it pretty well describes so much of the rhetoric that has been going on here in this debate. We got from the administration's trustees the death sentence. They handed down the death sentence on the fate of Medicare.

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It required some kind of immediate attention. Now, to be sure, we could have enacted blood transfusions out of my children and my grandchildren by tripling their taxes as a way of addressing this problem. But there are more efficient ways and ways that employ certain options that have been prevalent in the private sector all along, and that is guaranteeing people more choice and more control over their own medical coverage.

The fact of the matter is I am confident that the Republican approach can address this problem and simultaneously hold those escalating costs on an annual basis to just a little more than 2 percent than the escalating costs in the private sector. That is not too much to expect.

The fact of the matter is this is long overdue legislation. It is a shame we waited until the 11th hour to finally take a look at it, but I support H.R. 2425. I urge all of you too.

Mr. GIBBONS. Mr. Chairman, I yield such time as he may consume to the gentleman from Massachusetts [Mr. OLVER].

(Mr. OLVER asked and was given permission to revise and extend his remarks.)

Mr. OLVER. Mr. Chairman, I rise in opposition to this legislation.,

Mr. Chairman, today the Republican Party takes on the onus for dismantling Medicare, the health care guarantee within Social Security.

And you can bet the Republican Party has its sights on dismantling Social Security as well.

And to what end? To create a comprehensive health care system which 80 percent of Americans want? No.

To serve extremists in the Republican Party.

To serve the insurance companies and the American Medical Association.

The Republican Party in cutting $270 billion from health care for American retirees to give $245 billion in tax cuts.

More than half of the tax cut goes to fat cats already making over $100,000 per year—while 75 percent of the people taking Medicare cuts to pay for that tax cut live on less than $20,000 per year.

The Republican Party is taking health care dollars from low- and middle-income retired Americans to give billions to insurance companies and the already wealthy.

You can bet Americans will remember next November.

Mr. GIBBONS. Mr. Chairman, I yield such time as he may consume to the gentleman from North Carolina [Mr. WATT].

(Mr. WATT of North Carolina asked and was given permission to revise and extend his remarks.)

Mr. WATT of North Carolina. Mr. Chairman, I rise in strong opposition to the scam on the senior citizens of America.

Mr. GIBBONS. Mr. Chairman, I yield such time as he may consume to the gentleman from California [Mr. DIXON].

(Mr. DIXON asked and was given permission to revise and extend his remarks.)

Mr. DIXON. Mr. Chairman, I rise in opposition to this bill.

Mr. Chairman, I rise today in strong opposition to the Medicare Preservation Act of 1995 (H.R. 2425), a bill which cuts $270 billion from the Medicare Program over the next 7 years. This bill would make these cuts by substantially increasing out-of-pocket costs for beneficiaries and reducing the payments to health care providers, which has serious implications for the quality of care our seniors deserve.

Under this bill, beneficiaries face a retirement plagued by higher health costs. The bill permanently increases the beneficiary's portion of the Medicare part B premium to 31.5 percent, resulting in a $48 billion increase in costs over 7 years.

Hospitals and other health care institutions, already facing severe budget constraints, would face a $70 billion cut in Medicare payments. Roughly half would come from a reduction in the inflation adjustment received by hospitals. Skilled nursing facilities would find themselves $10 billion poorer. Hospitals which treat a disproportionate share of low-income beneficiaries get their funding cut twice. One cut will come from the inflation adjustment and another cut will come from a reduction in funds from the disproportionate share program [DSH] by $9 billion.

Health care providers participating in traditional Medicare would face an extra hit from the so-called failsafe provision. This provision would require the Secretary of Health and Human Services to further reduce payments to doctors and hospitals if Medicare spending exceeds the targets for a given year.

These reductions would apply only to traditional Medicare and are estimated to result in an additional $31 billion in cuts. The failsafe provisions clearly demonstrate the bias against the traditional Medicare fee-for-service system, on which the vast majority of beneficiaries now rely.

Until very recently, doctors would have faced nearly $55 billion in cuts. However, the Republicans made a last minute change in calculating payments to physicians to secure the endorsement of their bill from the American Medical Association [AMA].

Another enticement for doctors is the bill's arbitrary limits on the recovery of damages in malpractice suits. Such a provision has nothing to do with Medicare and does not belong in the measure. It is shameful that the GOP would commingle the cost of delivering health care with tort reform.

We know that Medicare's insolvency must be addressed. We also know that it is not necessary to do so by cutting $270 billion from the program. Treasury Secretary Robert Rubin—one of the Medicare trustees—wrote to Speaker GINGRICH to let him know that $270 billion in cuts are not necessary to keep the program solvent. Also, the Republicans have admitted that their bill will only keep Medicare solvent until 2006. That is the same length of time that the Democratic alternative, which cuts only $90 billion, would keep Medicare solvent.

Why are the Republicans recommending these Medicare cuts? Because they need to find $245 billion to pay for their tax cut proposal—most of which benefits corporations and higher income Americans.

The American people want a different approach—one which ensures Medicare's solvency but without jeopardizing the quality of care that Medicare beneficiaries currently receive. The alternative offered by Democrats on the Ways and Means Committee would make smaller reductions in the Medicare Program without raising premiums. However, the alternative was rejected by the Ways and Means Committee Republicans.

It is ironic that the Republicans named their bill the Medicare Preservation Act. It should be renamed the Medicare Devastation Act. This bill jeopardizes the health care of beneficiaries and places a heavy burden on health care providers. We should not be making deep cuts in Medicare to pay for tax cuts. America's seniors deserve better.

Vote ''no'' on the Medicare Preservation Act.

Mr. GIBBONS. Mr. Chairman, I yield 1 minute to the gentleman from Tennessee [Mr. FORD].

Mr. FORD. Mr. Chairman, under the Gingrich Medicare plan, the hospitals in and around the district of the gentleman from Illinois [Mr. CRANE], who spoke earlier, will lose about $67 million over the next 7 years.

Mr. Chairman, I have been receiving calls all afternoon in my office with this debate being heard throughout America. People are saying: ''Please, do not vote for the Gingrich Medicare plan.''

I am not going to vote for that plan today. I want my constituents to know that.

In my district alone, I say to the gentleman from Texas [Mr. ARCHER], hospitals in my area will lose $457 million over the next 7 years. There are clear winners and losers in this Gingrich Medicare plan. The losers are the elderly and the hospitals throughout America.

Those winners are the health insurance industry, and naturally we know those who will receive the huge tax breaks.

There will be a substitute that will come soon to this bill that Democrats will being solvency to the Medicare plan only with $90 billion, and not the $270 billion under the Gingrich plan.

Mr. BLILEY. Mr. Chairman, could I inquire how much time remains?

The CHAIRMAN. The gentleman from Texas has 8 minutes remaining, the gentleman from Florida has 8½ minutes remaining, the gentleman from Virginia [Mr. BLILEY] has 10 minutes remaining, and the gentleman from Michigan [Mr. DINGELL] has 9¼ minutes remaining.

Mr. BLILEY. Mr. Chairman, do I have the right to close for the Committee on Commerce?

The CHAIRMAN. The gentleman from Virginia is reserving the right to close.

Mr. BLILEY. Mr. Chairman, I yield 2 minutes to the gentleman from Connecticut [Mr. FRANKS].

Mr. FRANKS of Connecticut. Mr. Chairman, in the 103d Congress, all parties involved in the delivery of health care services as well as those receiving care recognized that change was in order. However, the public said ''no'' to the radical government takeover Clinton plan and ''yes'' to a market-driven system.

Now in the 104th Congress, we are attempting to address the unacceptable double-digit growth of Medicare which would lead to its bankruptcy. Our plan provides health care security for today and tomorrow's seniors. It does so without increasing the tax burden on families and without increasing copays or deductibles for seniors.

Like in the general population, Mr. Chairman, Medicare-plus will allow seniors to choose from a variety of plans. If seniors would like to stay in the traditional Medicare plan, they can. Our plan will help end waste, fraud, and abuse in our current system. It offers regulatory relief to help curb the growth of health care costs.

We also protect the quality of health care for the future by protecting and strengthening our teaching hospitals. It should be noted, Mr. Chairman, that better managing the services would not mean lesser services. It would mean doing things better and smarter.

We have incentives in our plan to encourage all involved in Medicare to play a role in better managing each dollar spent on health care.

The Democrats would like to give the public the impression that they have the market cornered on compassion. Oh, how wrong. Oh, how wrong.

A variety of plans will give us competition and will thus increase the likelihood of a more efficient system.

Mr. DINGELL. Mr. Chairman, I yield myself 15 seconds.

I note for the record that, under the Gingrich Medicare plan, hospitals in and around the district of my good friend, the gentleman from Connecticut [Mr. FRANKS], in Waterbury, CT, will lose $211.8 million over the next 7 years so the rich can get a tax cut.

Mr. Chairman, I yield 1 minute to the distinguished gentlewoman from Colorado [Mrs. SCHROEDER].

Mrs. SCHROEDER. Mr. Chairman, I just came to say we now know what this is all about. The Speaker said the crown jewel is going to be the tax cut, the tax cut for the parade of millionaires we have seen going in and out of his office recouping what they have invested in GOPAC and everything else.

As I hear people from this side of the aisle coming down and saying, ''Trust us, we are so compassionate,'' the reason we do not trust you is that you were not for this program to begin with. You waved the trustees' report around as to why you had to cut this, not the tax cut, but the trustees. But you will not wave your 961-page bill past the trustees to see if they fixed it. No; no; no.

We fix it as much as you fix it. We do what they do about fixing. You go on to raid it. You do not really like that. You do not really like people pointing that out.

You also turn on the fraud faucet, as the Attorney General said. That is why we do not trust you, and that is why this is a tragic day because you are unraveling social Medicare as we know it and Medicaid as we know it, and you know it.

Mr. ARCHER. Mr. Chairman, I yield 2 minutes to the gentleman from Nebraska [Mr. CHRISTENSEN], another respected member of the Committee on Ways and Means.

Mr. CHRISTENSEN. Mr. Chairman, 30 years ago Medicare, when it was started, was estimated to cost, in 1995, $9 billion. The people who were operating the Government back then miscalculated a little bit. Today it costs $178 billion, a $169 billion miscalculation, a miscalculation that has caused an incredible stress upon the system, a miscalculation that the Medicare trustees said would bankrupt the system in the year 2002, and that we were given the choice of whether we should let it go bankrupt or whether we should try to save it.

Since working on this plan for the last 8 months, I am proud to say this plan is going to offer a lot of choices. It is going to offer choices to my 84-year-old grandmother. It is going to offer choices to my soon-to-be 65-year-old father. It is going to give him the opportunity, as he lives in rural America, to get into a medical savings account. It is also going to give him the opportunity and choice to get into a provider-sponsored network.

He thinks he can manage his money better than the Federal Government can.

I am proud this plan is going to save Medicare for whose who want to remain in the current Medicare system and offer choices for those who want to get into new Medicare, Medicare-plus. This is a good plan.

I urge strong support for passage of the Medicare Preservation Act.

Mr. GIBBONS. Mr. Chairman, I yield 30 seconds to the gentleman from New York [Mr. ENGEL].

Mr. ENGEL. Mr. Chairman, this sign says it all. Shame on NEWT GINGRICH and the Republicans for what they are doing to senior citizens in this country. Shame on them for what they are doing to people who have worked hard all of their lives.

At least our Republican colleagues have been somewhat consistent. This

bill came out of the Committee on Ways and Means. They certainly found many ways to be mean to senior citizens in this country.

Our colleagues talk about choice, our Republican colleagues. The only choice senior citizens are going to have under this legislation is whether or not to buy dog food to eat because that is all they will be able to afford after they get through paying for health care under this bill.

Shame, this bill ought to be rejected.

Mr. BLILEY. Mr. Chairman, I yield 1½ minutes to the gentleman from Texas [Mr. FIELDS].

(Mr. FIELDS of Texas asked and was given permission to revise and extend his remarks.)

Mr. FIELDS of Texas. Mr. Chairman, facts should be important in this debate.

Mr. Chairman, when most Americans who are in managed care plans go to the doctor, it costs $10. However, Medicare recipients, such as my mother and grandmother, pay the first $100 and then 20 percent of the remainder. When most Americans go to the hospital, they pay $35 a day. Seniors, on the other hand, pay a $716 deductible for the first 60 days and then $179 for every day afterwards. That is because while most Americans have a choice, seniors, choices are made for them by Washington bureaucrats.

So after months of hearings and careful study, we will vote today on legislation that will not only ensure the long-term fiscal health of Medicare, but also create choice by providing options for senior citizens. This bill moves the decision-making down the Potomac River, outside of the beltway and into the hands of people like my mother and my grandmother.

The Medicare Preservation Act of 1995 offers seniors the opportunity to continue participating in the existing ''fee for service'' system, if they want to. However, it will give them much greater choice. Seniors will have the chance to opt into HMO's or to buy private health insurance policies.

They will be able to select the medical system that best suits their needs; that saves them money; that provides the most benefits for the lowest cost.

This bill creates tax-free ''medisave'' accounts that provide seniors incentives to shop around for the most cost-effective care and to reward seniors who maintain healthy habits. This bill will also help retirees maintain previously held employer-provided health coverage.

Finally, according to one study, if Medicare is not reformed soon, the average increase in cost per household, in my district alone, initially will be $1,541. Therefore, I urge my colleagues to pass H.R. 2425 because under this bill, seniors, like my mother and grandmother, are winners.

Mr. DINGELL. Mr. Chairman, I yield 1 minute to the distinguished gentleman from California [Mr. MILLER].

Mr. MILLER of California. Mr. Chairman, Members of the House, it is a good thing my colleague, the gentleman from Texas [Mr. FIELDS], has hospitals that charge $35 a day, because they are going to lose $102 million, and so that is about all they are going to be able to provide is $35 worth of service.

Mr. Chairman, and Members of the House, today the Gingrich Republicans snatched from the elderly of this country the finest health care system in the world, the most comprehensive health care system in the world, that gives the finest quality of health care in the world, and they do so not to strengthen that system, not to preserve that system, they do so simply to snatch over $200 million in excess cuts to provide a tax cut to the wealthiest.

This day is the day that a system that has been built up to provide security and protection for America's elderly, for the people who built this Nation and fought its wars, this is the day we start to shred that system, and in a matter of years it will not be whether they force you out of the system, there will be no system that people have come to expect in this country.

Mr. GIBBONS. Mr. Chairman, I yield 30 seconds to the gentleman from New Jersey [Mr. MENENDEZ].

(Mr. MENENDEZ asked and was given permission to revise and extend his remarks.)

Mr. MENENDEZ. Mr. Chairman, I hope my New Jersey Republican colleagues will remember that not only will we be hurting New Jersey senior citizens who will pay $1,000 for the privilege of getting less but we will lose $14 billion, $7 billion from Medicare, $7 billion from Medicaid. That is not right. It is wrong. It is not necessary, and there is not one New Jersey Representative who can stand on this floor and in good conscience vote for this package. This is not the Medicare Preservation Act. It is the Medicare Destruction Act, and New Jersey is one of the prime targets.

Mr. Chairman, I rise today in strong opposition to devastating Medicare. Common sense dictates that taking $270 billion out of your account—and telling you that you will be better off—just does not make sense. If this bill passes, it will hurt Americans of all ages. Seniors will be hurt because they will have less choice in their health care. They will be hurt because they will pay over $1,000 more by the year 2002. To remain in Medicare as they know it, they will be forced to pay substantially higher prices than they do today. Their children will be hurt because they will be expected to step in and help their older parents meet these rising Medicare and nursing home expenses, at the same time they're trying to send their kids to school.

If this bill passes, our hospitals will be severely impacted. I hope my New Jersey colleagues remember that Medicare provides 45 percent of all hospital revenues—76 of our New Jersey hospitals will be on a critical list.

Many of those hospitals receive over 65 percent of their revenue from Medicare; and, if this bill passes, they may be forced to consolidate, offer fewer services, or even close. Any of those options adversely impact everyone in the community; not just seniors. And everyone will suffer because of the reduced health care delivery systems available to them.

This bill is not a Medicare Preservation Act. It's the Medicare Destruction Act. Thirty years ago, 93 percent of all Republicans voted against Medicare—trying to kill it before it was born—now they're trying to kill it again. The $452 billion savings attained at the expense of our older Americans, our poor women and children and even the working children of senior citizens will be used to pay for a $245 billion tax cut which benefits a minority of wealthy Americans. It is not fair, it is not right, it is not necessary. We should vote ''no.''

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Mr. GIBBONS. Mr. Chairman, I yield 2 minutes to the gentleman from Massachusetts [Mr. NEAL].

Mr. NEAL of Massachusetts. Mr. Chairman, this Republican Medicare bill is a direct assault upon hospitals across America. The bill includes the largest cuts in the history of Medicare, and do not kid yourself, they are aimed at our hospitals.

Do not be fooled by this rhetoric. The Gingrich Medicare bill does much more than tinker around the edges with the way hospitals are reimbursed. These Republican Medicare cuts jeopardize the ability of hospitals to continue to provide quality care.

Republicans say that the cuts to hospitals included within this bill are just reductions in growth. This is simply not true. The Republican Medicare bill will bring real pain to many hospitals across America. This bill could include outright cuts to many hospitals, hospitals that are already vulnerable and in difficult financial situations.

We have the luxury in this Congress today of looking at Medicare in a vacuum. Hospitals do not have this luxury. When drastic cuts to Medicare disproportionate share and teaching hospitals are coupled with outlandish Medicaid cuts that are coming, our Nation's hospitals are going to be left out to dry. Public hospitals, community hospitals, and old urban hospitals, disproportionate share hospitals and teaching hospitals, they simply cannot absorb the cuts of this magnitude, as Republicans naively suggest.

The Medicare bill will damage the quality of care that our hospitals enjoy. It is that simple. Vote against this ill-conceived, unwarranted, and unwise attack.

Mr. ARCHER. Mr. Chairman, I yield myself 1 minute.

Mr. Chairman, a great deal of information has been presented today. Some numbers have been called cuts, some have been called increases. I think it is important that we focus on why this difference occurs.

The hospitals will get an increase in every year under our plan, compared to the previous year, but the Democrats call those cuts, because they are using the CBO projections that assume that health care costs are going to go up at over 10 percent per year. That projection is unsustainable. We all know that.

But if we take anything off of that unsustainable increase, they call it a cut. If we increase above today's level of expenditure and above the rate of inflation, they still call that a cut. As I have said earlier, only in Washington is an increase, because of this phony projection, called a cut. We are not cutting hospitals, we are increasing them at a slower rate.

Mr. DINGELL. Mr. Chairman, I yield 1 minute to the gentleman from Texas, Mr. GENE GREEN.

(Mr. GENE GREEN of Texas asked and was given permission to revise and extend his remarks.)

Mr. GENE GREEN of Texas. Mr. Chairman, it is a sad day that the House is about to pass this crown jewel of the contract which slashes a $270 billion from Medicare in order to pay for a budget busting $245 billion tax cut.

The bill that is about to be passed by Speaker GINGRICH and the Republican majority will add hundreds of dollars every year to seniors' out-of-pocket medical costs and force seniors to give up their life-long doctors, without saving Medicare past the year 2006 and without cutting, in fact increasing the problems, of fraud, abuse, and waste.

This bill is about as much designed to save Medicare as the grim reap is designed to bring happiness to our lives.

Mr. Chairman, I urge everyone to continue this fight. The decision today is just round one. The Democrats will continue to fight this extreme bill if it is enacted. The senior citizens in my district and around our country deserve better. I hope the Senate will change it. If not, I pray the President will veto it.

Mr. BLILEY. Mr. Chairman, I yield 1½ minutes to the gentleman from Michigan [Mr. UPTON] who was so helpful in helping us revise the AAPC formula.

Mr. UPTON. Mr. Chairman, days like today we need to think about the reasons why we are here. Are we here to talk about problems or are we here to solve them? The current Medicare Program today is going bankrupt. You know that, and we know that. Can you imagine the answer to the question in the next decade if today we shirk our responsibility from saving Medicare from going bankrupt, what seniors will say about this Congress? ''What the hell happened when you all saw the writing on the wall? What did you do?''

Two years ago there was a lot of talk about the Clinton health care plan, and the more that folks heard about it, the more they did not like it, and it never even came up for a vote. Today, as I have met with hundreds and hundreds of seniors and many of my providers, I realize that the more folks understand this bill, knowing that the alternative is either doubling the FICA tax or letting Medicare go belly up, the more they like the idea of themselves choosing the plan that fits their needs best. The right to choose, with knowledge that they can keep Medicare the way they have it now, without a reduction in benefits, will always remain as an option.

Mr. Chairman, I do not ever want to look in the eyes of one of my seniors and say ''Medicare went bankrupt on my watch.''

Mr. DINGELL. Mr. Chairman, I yield myself 15 seconds to note that the hospitals of my friend, the gentleman from Michigan [Mr. UPTON], under the Republican bill will lose $211 million over the next 7 years so we can give a tax cut to the rich.

Mr. GIBBONS. Mr. Chairman, I yield myself 30 seconds.

Mr. Chairman, I sat through a number of hearings with the gentleman from Texas [Mr. ARCHER] and heard him make the same speech. I have listened to him all day make the same speech. He says there are not any cuts in his bill. I do not know which one it is in, the one he introduced the other day of the one he introduced last night, but the CBO just gave a scoring table on his bill, whichever one it is, and says it cuts $270 billion. Now, somebody is stretching the truth.

Mr. BLILEY. Mr. Chairman, I yield 2 minutes to the gentleman from Iowa [Mr. GANSKE].

Mr. GANSKE. Mr. Chairman, everybody in this Chamber cares deeply about the health care of our senior citizens. Prior to last November, I was a doctor taking care of Medicare patients, and I too am especially concerned about this issue. Which is why I am going to support the Medicare Preservation Act.

Mr. Chairman, for many years the Health Care Financing Administration has been tightening the tourniquet on health care by price controls, and bureaucratic paperwork, and regulations. If we do nothing substantive and structural, then you will see much more of the same, and no longterm solution to explosive costs. A tourniquet too tight can cause gangrene.

This bill makes an honest effort to provide structural changes that will allow seniors to choose options in which they will be able to make decisions, in consultation with their doctor, about their health care, rather than having that decision made by a faceless Government bureaucrat.

The question, Mr. Chairman, is not whether decisions are going to have to be made, the question is who is going to make that choice—the Government or the patient?

I have devoted a great deal of thought to this bill and I have studied and read it. This bill is not exactly the way I would have written it, but many thoughtful people have worked on this bill and I hasten to add that I am under no illusion that my solutions are the only way to achieve a good end.

However this bill does have provisions in it for patient protections that I have worked with many Members on, it does start to address the inequity in geographic variations of reimbursement that exist under the current system, it does offer choices to Medicare recipients that they don't currently have, and it is much better than the fiscal band-aid that has been proposed by my Democratic colleagues across the aisle.

Mr. Chairman, I want my former patients and, now my senior citizen constituents, to have good health care. Our final vote on this measure will probably be after a Presidential veto and then an agreement between the President and Congress. If at that time, I am not happy with a plan that protects our senior citizens' health care than I will vote accordingly. Unfortunately, I don't have a crystal ball. For today, I vote for the bill because it is moving in the right direction.

Mr. GIBBONS. Mr. Chairman, I yield 30 seconds to the gentleman from California [Mr. WAXMAN].

Mr. WAXMAN. Mr. Chairman, the preceding speaker talked about the decisions that have to be made and who will make those decisions. I would submit if people are herded into HMO's because they really have no other choice, because they cannot afford anything else, the decisions will be made by a bureaucrat in an HMO that wants to maximize the profit for the HMO. That is not the way the decisions for health care should be made in this country.

Mr. DINGELL. Mr. Chairman, I yield 15 seconds to the distinguished gentleman from Ohio [Mr. BROWN].

Mr. BROWN of Ohio. Mr. Chairman, the previous speaker, the gentleman from Iowa [Mr. GANSKE], my friend on the Committee on Commerce, his hospitals in and around his district will lose $241 million over the next 7 years because of the Gingrich Medicare cuts.

Mr. DINGELL. Mr. Chairman, I yield 1 minute to the distinguished gentlewoman from Connecticut [Ms. DELAURO].

Ms. DELAURO. Mr. Chairman, Hubert Humphrey remarked in 1977:

> It was once said that the moral test of government is how that government treats those who are in the dawn of life, the children, those who are in the twilight of life, the elderly, and those who are in the shadows of life, the sick, the needy, and the handicapped.

Mr. Chairman, this Republican controlled House miserably fails that moral test. I stand here in this Chamber ashamed, ashamed that my Republican colleagues are trading, trading the health security of our Nation's elderly for a tax break for the rich.

They talk about attacking fraud and abuse in the system, but it is bogus, for the Republican plan turns back the clock on statutes to combat fraud and abuse. They repeal the laws that prohibits fraudulent practices, like prohibitions on doctors who refer patients to providers that they or a family member personally profit from.

The Washington Post says it best, ''Gingrich Places Low Priority on Medicare Crooks.''

Mr. GIBBONS. Mr. Chairman, I yield myself 15 seconds.

Mr. Chairman, I know since there are no cuts in this bill and everything is an

increase, I know the gentleman from Texas [Mr. ARCHER], will be sad to learn that the Texas Medical Center in Houston will lose $500 million, $500 million.

Mr. Chairman, I yield 1 minute to the gentleman from Maryland [Mr. CARDIN].

Mr. CARDIN. Mr. Chairman, let me correct some of the misstatements that have been made by my colleagues on the other side of the aisle.

First, it has been said that our beneficiaries will not have to pay anymore because we are just continuing the current law. That is not correct. According to the Congressional Budget Office, ''It would increase the portion of costs borne by beneficiaries through premiums relative to current law.''

Under the bill before us, the premium increase goes up to $87 a month for part B. Under the bill that we will be bringing forward as a substitute, it is $30 a month less. That is $360 a year. For seniors who on average have a modest income, that is a lot of money.

Second, CBO has estimated seniors will have to pay an extra $1,000 a year in order to be able to maintain the same benefits. When it costs you more to maintain the same benefits, it is a cut.

Let me quote finally from the Washington Post. You have quoted the Washington Post before the plan was unveiled. The Washington Post said, ''It is not clear that Government contributions would any longer even pay for basic insurance.''

Mr. DINGELL. Mr. Chairman, I yield such time as he may consume to the distinguished gentleman from Texas [Mr. EDWARDS].

(Mr. EDWARDS asked and was given permission to revise and extend his remarks.)

Mr. EDWARDS. Mr. Chairman, I rise in opposition to this unfair, hastily put together legislation.

Mr. DINGELL. Mr. Chairman, I yield such time as he may consume to the gentleman from Rhode Island [Mr. REED].

(Mr. REED asked and was given permission to revise and extend his remarks.)

Mr. REED. Mr. Chairman, I rise in opposition to the Republican proposal.

For more than 30 years, the Medicare and Medicaid programs have exemplified our national commitment to care for seniors, disabled Americans, and low-income Americans. In essence, it is the tangible evidence that, in the most affluent and productive country in the world, we would not let millions of Americans suffer because they were too old, too poor, or too ill to fend for themselves, Because of our investments in Medicare and Medicaid, we have also created the most sophisticated and highest quality health care system in the world.

But today, Republicans will begin their all-out assault on these programs by cutting the Medicare program by $270 billion. These cuts represent the most sweeping changes in the Medicare program since its establishment in 1965. And let me be clear, these cuts are not about reforming the Medicare program—it is about tax cuts for wealthy Americans and an arbitrary march to a seven year deficit reduction target. These cuts are three times more than any estimate of what is necessary to make Medicare solvent.

Treasury Secretary Robert Rubin, managing trustee of the Medicare Trust Fund, has recently stated that ''no member of Congress should vote for the $270 billion in cuts believing that reductions of this size have been recommended by the Medicare trustees or that such reductions are needed now to prevent an imminent funding crisis. That would be factually incorrect''.

Here is why the Republican cuts in Medicare are not about reforming the system and are about paying for a tax cut for the rich and a forced march to deficit reduction. The Medicare Part A Trust Fund is not faced with an unprecedented and immediate crisis. The trustees are required by law to report each year on the status of the Part A Trust. The trustees have on eight previous occasions warned that the Trust Fund would be insolvent within seven years. On each of these occasions, the Congress and the president—without alarmist predictions of collapse—took appropriate action to protect the fund.

Republican proposals go far beyond the Part A Trust Fund and also reach into the Part B Trust Fund. Their plan calls for about $170 billion in cuts to Part A of Medicare, which funds hospitalization, and about $100 billion in cuts to Part B, which pays for doctor visits and ancillary services. The Part A Trust is financed by employer and employee contributions, and ''savings'' will be retained by the Trust. However, since the federal deficit is calculated by including the surplus of the Part A Trust, these savings will be used to fund the tax cut and mask deficits in other public accounts. Part B is funded by premiums paid by the elderly and the Treasury. Savings here will directly rebound to tax cuts and deficit reduction.

And the cuts we will vote on today are not only about senior citizens paying more for less health care; the cuts are also about straining the intergenerational benefit of the Medicare program. When Congress passed the Medicare program in 1965, we assured working families that they would not have to choose between investing in their children and caring for their elderly parents when they became old and frail. I have heard from many middle-aged working parents in my district who are afraid of what these Medicare cuts will mean for their families—How will they find the means to ensure that their parents receive quality health care in their old age? How will they choose between their parents and their children? Surely this is not reform.

This bill also repeals the current prohibition against physician self-referral. These laws provide vital protections for consumers. It has been well documented that physician self-referral leads to excessive utilization, fraud and abuse, and drives up the cost of health care. The Congressional Budget Office estimates that these changes to the physician self-referral laws will cost Medicare an additional $400 million over the next 7 years—$400 million in patient abuse in over-testing and over-referring!

Republicans claim that this bill will give seniors more choices. However, the real truth is that the Republicans will squeeze down so hard on payments to health plans that beneficiaries are likely to pay higher premiums to get the same or fewer benefits. That is not what I would characterize as more choices.

This bill also represents the possible dismantling of my state's medical education infrastructure. As a result of the proposed cuts in the Medicare program, Rhode Island alone will lose $20 million (10%) of its medical education budget each year. This bill does nothing to rationalize the graduate medication education system financed through Medicare; rather, it simply guts GME which will translate into a reduction in the quality of health care and reduced access for many citizens as teaching hospitals close and downsize.

The Republican proposal that this House will vote on today will increase costs for health coverage for seniors, reduce quality and access, and burden working parents. But most importantly, this bill represents nothing less than a betrayal of the trust of the people of this country and a reversal of a generation of guaranteed health care for the elderly.

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Mr. DINGELL. Mr. Chairman, I yield 1 minute to the gentleman from Pennsylvania [Mr. HOLDEN].

Mr. HOLDEN. Mr. Chairman, the Gingrich Medicare plan will have a devastating effect on health care for citizens in Pennsylvania. I spent the summer talking to my hospital administrators and they tell me that currently they are reimbursed $1.01 for every dollar of services they provide to a Medicare patient. Under the Gingrich plan they will be reimbursed $.88 for every dollar of services they provide.

There are two choices that our hospitals are going to be left with: Cost shift on to employers and working families who are paying premiums, or reduce services for senior citizens. This plan is unacceptable.

Mr. Chairman, the American people cannot be fooled. The American people know that the Medicare trustees have called for $90 billion to make the system solvent to the year 2006. The Democratic plan does that. And the American people also know that the Republican plan only puts in $90 billion to make the plan solvent to 2006, and the rest of the money is being used for a tax break and to balance the budget on the backs of senior citizens. That is wrong.

Mr. GIBBONS. Mr. Chairman, I yield myself 1 minute.

Mr. Chairman, I apologize to everyone that this debate has been so hurried, but it is not my fault. Mr. GINGRICH prescribed the time we would have on this debate. Yesterday he gave the House 4 hours to talk about shrimp. Yesterday, Mr. GINGRICH gave the House 4 hours to talk about shrimp. Today he gave us 3 hours to talk about the benefits of 40 million Americans, the most fragile of our Americans, too, by the way. So much for Republican priorities and for Mr. GINGRICH's concern about people versus shrimp.

Mr. Chairman, this is a horrible piece of legislation. We know most of the Medicare people are not sick. Ninety percent of them are not sick. We only

spend about $1,300 apiece on them. The Republican bill takes all that money, gives it to the insurance companies, the medical savings accounts, and leaves Medicare with all of the sick people. It will ruin Medicare as it now is.

Mr. DINGELL. Mr. Chairman, may I discuss how many speakers we have remaining. I know the gentleman from Texas has said he has one, the gentleman from Virginia has indicated he has one, and I am not certain how many my good friend from Florida has.

Mr. GIBBONS. I have one more, Mr. Chairman; it is for the minority leader, and I will yield him the balance of my time.

Mr. DINGELL. Mr. Chairman, I have a similar situation.

Mr. Chairman, I yield such time as he may consume to the gentleman from Illinois [Mr. COSTELLO].

(Mr. COSTELLO asked and was given permission to revise and extend his remarks.)

Mr. COSTELLO. Mr. Chairman, I rise in opposition to the bill.

Mr. Chairman, I rise today in opposition to the Medicare Preservation Act. For the 30 years since it was signed into law, Medicare has been the primary source of health care coverage for Americans 65 and older. Today, I fear, we are going to put the security of our seniors' health care in jeopardy.

This bill cuts $270 billion out of the Medicare Program over 7 years. Two hundred and seventy billion dollars can only come from one of two places: Cuts to seniors or cuts to providers. Either way, my district loses. People lose. Mr. Chairman, I held Medicare forums with each of the hospitals in my district. All of them, without exception, said $270 billion cuts would be disastrous to their facilities. At least two hospitals will close. A hospital in East St. Louis is the only health facility in the area that provides obstetric care. What will happen if there is no where in the city to deliver babies? The hospitals in the 12th District of Illinois have already streamlined operations. They have cut staff and services. They feel additional cuts will be so detrimental to services, they would rather close than compromise quality of care. Is this what we've come to—forcing hospitals to close and threatening the health and safety of entire communities to pay for a tax cut?

If $270 billion does not come from providers, seniors are going to feel the burden of "slowing the growth in Medicare spending." Haven't we asked enough of our senior citizens? Mr. Chairman, I support a balanced budget. In fact, I voted for the balanced budget constitutional amendment. However, if we are serious about balancing our budget, we should not be talking about a huge tax cut which clearly is going to benefit the very wealthy in our society.

If we are serious about reforming Medicare, we should be engaging in open debate about how to keep Medicare solvent into the next century. It is hypocrisy to call for a $245 billion tax break while cutting Medicare by $270 billion. Granted, there are major problems with the Medicare Program. However, Medicare is no closer to going broke than it has been the nine times in the past that we have faced similar solvency issues. Medicare will be at a zero balance in 2002, with a debt the following year, if adjustments are not made. However, the President's Medicare Board of Trustees shows that only $79 billion is needed to keep the trust fund solvent. That means we are looking at $181 billion in unnecessary cuts. That $181 billion could go a long way in protecting seniors from increased premiums or cuts in services.

Mr. DINGELL. Mr. Chairman, I yield 1 minute to the distinguished gentleman from California [Mr. WAXMAN].

Mr. WAXMAN. Mr. Chairman, today we are discussing only the Medicare bill. We talked about it in terms of the relationship to the tax bill that is coming up next week. I want to mention the relationship between Medicare and Medicaid, which is coming up next week.

Mr. Chairman, we have no program to protect seniors when they become so frail that they require nursing home care. We have relied on Medicaid to take care of that. But next week the Medicaid program is going to be repealed and there will be no guarantee of a person in a nursing home getting coverage after they spend every cent they own. There will be no protection for the spouse of that nursing home resident or the children of that nursing home resident or the lien to be put on the home.

There will be no protection in the standards of care that will be given in that nursing home because all of that law has been repealed under the bill passed out of the Committee on Commerce.

Mr. Chairman, we should not think of Medicare alone, we should think of it in the context of the tax cut the money from Medicare will pay for and the other undercutting of services for the elderly under Medicaid.

Mr. GIBBONS. Mr. Chairman, may I inquire of the Chair how much time I have officially remaining?

The CHAIRMAN. The gentleman from Florida [Mr. GIBBONS] has 2¼ minutes remaining, the gentleman from Texas [Mr. ARCHER] has 5 minutes remaining, the gentleman from Virginia [Mr. BLILEY] has 3 minutes remaining, and the gentleman from Michigan [Mr. DINGELL] has 2½ minutes remaining.

Mr. DINGELL. Mr. Chairman, I note we have, I think on this side, about 2½ minutes each, something like about 4, 4½ minutes, but my good friends over there have 8 minutes.

Mr. ARCHER. Mr. Chairman, my understanding of the agreement is they will reduce their time to one speaker, we will then use our last speaker, their speaker will then speak, and then the gentleman from Virginia [Mr. BLILEY] will close.

The CHAIRMAN. Is that the understanding of the gentleman from Michigan?

Mr. DINGELL. Mr. Chairman, I am not quite sure I understand what was said. I note they have 8 minutes over there and we have something like 4.

The CHAIRMAN. My understanding is the gentleman from Texas [Mr. ARCHER] will yield his 5 minutes to his speaker, then the gentleman from Michigan [Mr. DINGELL] and the gentleman from Florida [Mr. GIBBONS] will each yield their 2-plus minutes to the minority leader, and then the closing debate will be by the gentleman from Virginia [Mr. BLILEY].

The CHAIRMAN. The gentleman from Texas [Mr. ARCHER] is recognized.

Mr. ARCHER. Mr. Chairman, I yield 5 minutes to the gentleman from California [Mr. THOMAS], chairman of the Health Subcommittee of the Committee on Ways and Means, a gentleman who has contributed massively in the development of this plan.

(Mr. THOMAS asked and was given permission to revise and extend his remarks.)

Mr. THOMAS. First of all, I want to thank my colleagues, Mr. Chairman, for allowing me to be part of a majority that has rejected politics as usual. What we have heard today from the minority was a lot of sloganeering, figurative and literal baloney, and that what we propose to do is, in fact, bold and innovative. And I think those are appropriate words, but I also believe it is radical.

Mr. Chairman, what we propose to do is to not follow the politics as usual solution. What is the politics as usual solution? Fix Medicare until the next election.

When the Democrats were in the majority that is exactly what they did. In the last 10 years, between 1985 and today, the Democrats fixed Medicare over and over again. Six times the Democrats either raised the payroll tax or raised wages subject to the payroll tax. That is how they fixed Medicare. And in 1993, they even blew the lid off of wages. There is no limit to the payroll tax being applied to wages today thanks to the solutions offered by the former majority. This new majority will not buy that approach. Quick fixes are out. Real solutions are in.

Mr. Chairman, this is a quote from President Clinton, and it is up there because I, frankly, admire that he had the guts to say it. I counted over 100 times the Democrats went to the well and said cut. Is it because they just do not get it or is it because this is more of the demagoguery and the sloganeering? Even the President of the United States admits that when we slow the growth of Medicare, we do not cut it, we slow the growth of Medicare.

Mr. Chairman, what we do is slow the growth of Medicare. That is how we make the savings. We do not stay at a 10½ percent increase because it will go bankrupt if we do. Hospital spending goes up under our program. It does not go up as fast as it was going to go up, but $652 billion will be spent between now and 2002 on hospitals.

Physicians: Payments to physicians go up every year. Not a cut, but a reduction in growth. In fact, over those 7 years, more than $315 billion will be paid for physician services under the

Medicare program proposed by the Republicans, and every year those payments grow larger.

Mr. Chairman, in home health care, the same thing. Every year the payments go up. More than $150 billion over the next 7 years. And every year the payment to the home health care industry will go up. We are not making cuts, folks, we are slowing the growth.

Mr. Chairman, there has been a lot said about changes, and frankly, this is one of the more exciting parts about the Republican program. What we are doing is opening up the Medicare program to the choices available to more and more Americans today. The Medicare savings accounts, the provider sponsored organizations, the seamless coverage that has been discussed will be available so that individuals can go from the workplace to the rocking chair and not have to change or look for a new kind of a health care program. The coordinated health care programs will be expanded and improved.

This is what we will get under the Republican program to preserve Medicare. This is what is offered now. This is what seniors will have available: Prescription drugs, routine physicals, the cancer physical that was discussed. Seniors will have available eye exams, lenses, ear exams, hearing aids, and dental coverage. That is available today and it will be available under the new program.

Mr. Chairman, let us talk about eliminating fraud and abuse. We find it. We double the civil penalties. We establish new criminal penalties, and, more important, we have already passed medical malpractice. We did that in March.

Here is the bottom line. What do we get for the money out of the Republican program? A sound program until 2010. We are in the black, or the blue, if you will, until 2010. The Republican program gets us clear to the baby boomer generation. The Democratic program has a $300 billion deficit in the same time.

Mr. Chairman, let us focus on seniors, but let us remember people who are paying their taxes now want a program as well. The Republican program preserves, protects, and makes sure that Medicare is available for those who pay the bills today.

Mr. DINGELL. Mr. Chairman, I yield the balance of my time to the distinguished gentleman from Missouri, [Mr. GEPHARDT], the minority leader.

Mr. GIBBONS. Mr. Chairman, I yield the balance of my time to the gentleman from Missouri [Mr. GEPHARDT], and say that he has, for years, toiled on this problem. He was a member of the Health Subcommittee of the Committee on Ways and Means, and I can personally remember his long and effective work on this program.

Mr. GEPHARDT. Mr. Chairman, I want to first congratulate the ranking member of the Committee on Ways and Means and of the Committee on Commerce and their colleagues on the committees for the great work that they have done in working on this issue. But I rise today with sadness and almost disbelief of what I am afraid is about to happen to what I believe to be the most important program, the most important help that the people of our country have enjoyed now for over 30 years.

I say to the Members that this is the kind of vote that comes once in a generation, maybe once in a career, about the very future of one of the most important efforts that our country has ever made.

Mr. Chairman, the cuts, the changes, the modifications that are called for in Medicare, and Medicaid next week, are the largest changes in these great health care programs that have ever been called for, by far. If they were being made because they were necessary to balance the budget, that would be one thing; if they were being made to save Medicare, that would be another thing; but, in my opinion, if we look at these changes and then we look at the amounts of money that are projected to be saved and then we look at the tax break, which is included in the very same budget, no matter how people may try to separate the issues, we will see that the reason for these deep, severe, damaging cuts in Medicare are to pay for a tax break for the wealthiest Americans.

Mr. Chairman, I would ask us to just imagine, just think in our minds of two individuals, two families, if you will. Think first of a frail 85-year-old woman, who, undoubtedly, lives in your district, and I know lives in mine.

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Think of an 85-year-old who today lives on their Social Security, maybe $7,000, $8,000, $9,000 a year. That is all the income they have. My colleagues on the other side may not think that $45 a month is a big deal out of their Social Security check to pay the increased premium, but to them, they are already counting every penny, every month, in order to get by.

Mr. Chairman, I have met seniors who have a $3,000 prescription drug bill now that comes out of that $9,000 a year. They are counting every penny every month. The change that is being called for here will ask them to pay $40 or $45 additional a month that will come out of their Social Security check. Tell them that this is not a big deal.

It would be one thing if that were to balance the budget or to save Medicare. But think about the other person. The family making $500,000 a year that, for the Republican tax break, will get over $19,000 a year in the tax break. It is wrong by anybody's light to take $400 a year from somebody who is 85 and frail and living on 9 grand a year and give it to somebody who is making a half a million dollars a year. That is precisely what this budget is calling for.

Mr. Chairman, that is not all. When we make cuts this deep in Medicare and Medicaid, we close 25 percent of the health facilities in this country. The ones that will be closed are the ones we can least afford to close; the ones in the inner city, the ones in the rural areas where people already have a lack of health care facilities.

Yes, medical education will be affected. Medicare and Medicaid now pay over 60 percent of the costs of medical education. In an intensely competitive world, private health insurance will pay less and less and less of medical education. So, the Government is the only entity that will do this.

Mr. Chairman, I have told this story many times. My son was diagnosed with terminal cancer in 1972 at the age of 2. We were devastated. The next morning, a young resident showed up bright-eyed and bushy-tailed at 7 o'clock in the morning. He met my wife and I, and he said:

> I know you are devastated, but I stayed up half the night on the computer and I found a therapy that I think might, do not get your hopes up, but it might save his life. We are going to try.

Let me tell my colleagues something. That day we needed that doctor and we needed those ideas. We needed good medical education. We needed the quality of this health care system. And I am telling my colleagues today, if these cuts are made this deeply, the medical education that has been the bright light of this health care system through our entire lives will be ripped apart.

Mr. Chairman, I say to the ladies and the gentleman of the House, this vote is a vote of conscience. It is a vote of values. It is a vote of what is right and wrong. And I ask my colleagues before they deliver this vote today, to examine their consequences, because if we do what is wrong instead of what is right, in the days ahead every time you face a senior citizen who is trying to scrape it out on $8,000 or $9,000 a year, my colleagues are going to know that they voted to make life harder for them.

Every time my colleagues pass a health clinic or a rural hospital that has been closed, they are going to turn their back on that. And every time they meet somebody's family who had somebody who died because of the lack of medical education, they will know we did the wrong thing.

Mr. Chairman, I say to my colleagues, do the right thing today and refuse to go along with this program which is not being done for the right reasons, but for the wrong.

Mr. BLILEY. Mr. Chairman, I yield such time as he may consume to the gentleman from Virginia [Mr. GOODLATTE].

(Mr. GOODLATTE asked and was given permission to revise and extend his remarks.)

Mr. GOODLATTE. Mr. Chairman, I rise in strong support of the Medicare Preservation Act of 1995.

This historic legislation will preserve, protect, and strengthen this vital lifeline to our senior citizens.

Mr. Chairman, today we are voting on a realistic solution to a crisis situation. America's seniors, families, doctors, and employers all agree that Medicare is broken and this legislation fixes it.

By saving Medicare from bankruptcy, we ensure that the program will be there to serve the health needs of seniors. We are giving seniors the choice in selecting the best health care plan for their needs, including the right to keep the same Medicare coverage and doctors they have now. Finally, we are guaranteeing Medicare's solvency well into the next century so that the program can serve future generations of seniors.

Contrary to all of the talk about cuts in Medicare, spending per person will actually increase by nearly $2,000—from $4,800 today to $6,700 in 2002. Total Medicare spending increases by 54 percent from $178 billion this year to $274 billion in 2002. Leave it to the big spenders here in Washington to call such increases cuts.

Choice is a key part of this Medicare legislation. Those who want to stay with their current Medicare plan can do so. No one will be forced to change coverage or doctors.

Seniors will have the option to choose from additional health care plans under Medicare-plus. Options will include coordinated care plans, a physician service organization, or a MediSave account.

These plans are required to offer at least as good a benefit package as Medicare does now. Some of these new plans actually offer more benefits, such as prescription drug and eyeglass coverage which are not available under Medicare. They also can reduce out-of-pocket costs and eliminate the need for MediGap insurance that costs $750 to $1,200 a year.

Today, seniors pay 31.5 percent of part B costs and taxpayers pay the remaining 68.5 percent. That rate will not change. Premiums, therefore, will go up only because the cost of the program rises. The only exception will be for affluent seniors who will be asked to pay more.

By 2002, part B premiums will be $87 per month instead of the $46.10 per month today. Under President Clinton's budget, which does not offer a plan to preserve Medicare, monthly premiums would increase to $83 per month. That is only a $4 a month difference—which is not too much to pay to help save the Medicare Program.

The bill provides fair but limited increases in spending on hospital and doctor services. Health care providers will have to manage under funding limits and compete in the marketplace on the basis of price and quality.

There will be a Medicare preservation trust fund created within the part B Medicare Program to ensure that senior's premiums go to save Medicare and are not used for other purposes such as tax cuts.

Mr. Chairman, we must not miss this opportunity to offer security for seniors and save Medicare for the next generation. I urge my colleagues to vote in favor of the Medicare Preservation Act.

Mr. BLILEY. Mr. Chairman, I yield myself the balance of my time.

Mr. Chairman, for the 6 months that have followed the Medicare trustee's report, we have held a national debate on the question of how best to save Medicare from bankruptcy. We took the trustee's report to the American people and we asked them for their best advice. We listened. We listened to our friends and neighbors in thousands of town hall meetings from coast to coast.

We listened in 40 congressional hearings this summer, 10 of them in my committee alone; more hearings in my committee on Medicare than the other side held in the last 6 years combined. We heard 70 witnesses who gave thousands of pages of testimony. We listened to the views of Americans of every political stripe.

We did a computerized search of articles on Medicare, just since the beginning of the year. There were more than 11,000 articles on Medicare this year in the major newspapers alone.

We listened and we learned. We learned that as good a program as Medicare is, as important as this program has become to America's seniors, there is still plenty of room for improvement.

We learned from health care managers in the private sector how new managed care options can help hold down costs and give beneficiaries better quality care. We learned from experts in health planning about the value of medical savings accounts.

Throughout the process, there emerged a national consensus that Medicare can indeed be preserved. In fact, that it can be improved considerably in the process. But, something else happened as well, because during this 6 months, America has seen the difference between the two major political parties.

Mr. Chairman, while we were risking our careers to save Medicare, our opponents were frightening senior citizens. We developed a plan to save Medicare. They pulled neckties and broke glasses and stormed out of congressional hearings.

Last week in my committee, they used senior citizens as props to disrupt a plan to save Medicare for 37 million Americans. Today, as we discussed our plan, they have given us 3 hours of excuses, 3 hours of politics, 3 hours of hysterics.

Mr. Chairman, I would say: There you have it, America. In 3 very revealing hours, the crystallization of the differences between us. On the one hand, political courage, accountability, leadership in solving a crisis. On the other hand, excuses, distortions, overstatements, misstatements, fear.

Mr. Chairman, I used to be a Democrat. It is sad for me to see a once-great political party reduced to this.

Mr. EVANS. Mr. Chairman, do not let anyone fool you. This proposal is not about saving Medicare, it is about giving tax breaks to businesses and wealthy Americans.

It pays for a $245 billion tax break for the rich by breaking seniors backs. It makes health care less accessible and more expensive. It will close hospitals and other health facilities. And it will cost thousands of Americans their jobs.

The Republican proposal cuts $270 billion from Medicare and deprives millions of seniors health care when they need it the most.

It will force our parents and grandparents to choose between medical care, food, and shelter. It will force hospitals and providers around the Nation to curtail services or close for good.

It will roll back efforts to crack down on waste, fraud, and abuse. It will lead to lower the quality of care, increase patient abuse, and cost the Medicare program over $1 billion.

These cuts are cruel. The deficit should not be lowered at the expense of the elderly. Seniors should not have to suffer in order to give tax breaks to the rich.

For over 30 years, Medicare has protected the health and financial security of millions of Americans. These men and women did not work for decades and pay their taxes just to have the rug pulled out from under them as they prepared to retire. The Republican proposal would do just that. It would decrease the value of seniors' savings and seriously drop their quality of life.

Seniors deserve more respect than this. They should be able to enjoy their later years. They should not worry about whether they can afford health care.

Thousands of my constituents have told me to oppose the Republican proposal. They do not want to pay more for less. They do not want to give a $245 billion tax cut to wealthy Americans. They know that this proposal will hurt them, their families, and the country.

I oppose this bill and ask you to do so as well.

Mr. DICKS. Mr. Chairman, I strongly oppose H.R. 2425, Medicare legislation which I fear will hurt far too many Americans—literally making senior citizens less healthy and less financially well off than they are today under the current Medicare program.

Over the years here in the House, I have found that it is necessary to put major legislation like this into better focus by concentrating on how it will impact those people who will be affected. By cutting $270 billion from Medicare, this bill will hurt many of the people I have come to know representing the 6th District of Washington State.

And like most Americans, this drastic cut in Medicare spending will affect my family. My parents have been retired for years, still living in my hometown of Bremerton. And like most Americans their age, they depend on Medicare to live a healthy and productive retirement. But because they are middle class—like most people in the district I represent and throughout America—the large increase in out-of-pocket costs will lower their living standard, I cannot help but take it personally that the Republican majorities in Congress want to lower my parents living standard in order to pay for a huge tax cut that is really not necessary.

Over and over today we have heard the false charge that those of us who vote against this legislation are against Medicare reform. That is not true. I support the Democratic alternative plan, which shores up Medicare's financial health without increasing costs for beneficiaries. This Democratic alternative cuts Medicare spending by just one-third of the GOP's $270 billion of cuts. The simple fact is that the House leadership needs the whole $270 billion in Medicare cuts in order to pay for their huge tax cut.

As we here in Congress ask the American people to roll up their sleeves for deficit reduction, it is absolutely unfair to make middle-class retirees on Medicare pay for this tax cut. For that reason, I oppose this Medicare legislation.

Mr. STOKES. Mr. Chairman, today, the House is debating H.R. 2425, the Medicare Preservation Act of 1995. I am strongly opposed to H.R. 2425, and I plan to vote for its defeat. In my opinion, the legislation represents a full attack on the health of our Nation's elderly population.

H.R. 2425 slashes $270 billion from health care services for the elderly. We know that to achieve this enormous reduction, health care premiums for seniors will double. Also removed from the bill are limitations on the amount that doctors and hospitals can charge patients. I am also opposed to the bill because it opens the door for fraud and abuse. Current provisions that are designed to prevent kickbacks and provide accurate billing are repealed. This provision alone will cost American citizens over $1 billion.

Mr. Speaker, the enactment of H.R. 2425, the Medicare Preservation Act of 1995, would be devastating to seniors throughout America. In my home State of Ohio, 1.6 million Medicare beneficiaries would suffer from reduced benefits and a lower quality of life. Earlier today, while our Republican colleagues were pushing to gut the Medicare program, a nonprofit research organization, Speak Out! USA, sponsored a special Medicare hearing with testimony from all 50 States. I was honored to attend this important hearing where Medicare beneficiaries and their families testified about their experience with Medicare and concerns about proposed cuts in the program.

Mr. Chairman, I applaud Speak Out! USA for putting a human face on the Medicare debate. It would be impossible to hear from senior citizens who have real life experience with Medicare and then enter this Chamber and vote to demolish the program. One of the witnesses at the Speak Out! USA hearing was Bishop Marvin Johnson, a resident of my congressional district. Bishop Johnson is a minister of the Good Sheppard Divine Spiritual Temple in Cleveland. He is confined to a wheelchair and began receiving Medicare disability payments for diabetic ulcers on his feet in 1992. Bishop Johnson's testimony was very moving and to the point. It served as an important reminder of the people we are pledged to represent as Members of this body. As we debate the Medicare issue, I want to share his testimony with my colleagues.

TESTIMONY OF BISHOP MARVIN JOHNSON, GOOD SHEPARD DIVINE SPIRITUAL TEMPLE

SPEAK OUT! USA SPECIAL HEARING ON MEDICARE

I would be on the streets if it were not for Medicare. I pay for my own medication from my Social Security check. I don't have family to help me. My diabetic condition keeps me from working and I am forced to live on full-time disability. I came to Washington to tell our elected officials to save the Medicare Program. If the Nation's poor don't have Medicare, many people will not be able to go to the hospital when they are sick. Without Medicare, I would not be able to buy insurance for myself.

Through the Medicare Program, I receive quality care from the Visiting Nurse Association. If the Medicare Program is gutted, I have nowhere to turn for health care.

Mr. ACKERMAN. Mr. Chairman, it is not quite Halloween but the majority is already playing trick or trick.

In the spirit of the season, the Republicans are about to commit the Medicare massacre. My colleagues on the other side would have us believe that Medicare is in some unprecedented state of crisis and that without their meat cleavers and chain saws the program will cease to exist.

In fact, most of their bill's Medicare cuts will not be dedicated to the so-called trust fund crisis, not one penny of the cuts the bill makes in Medicare part B, and not one penny of the increases in part B premiums paid by beneficiaries will go into the trust fund—the only part of Medicare that needs propping up.

The trick, Mr. Chairman, is that the bill will force seniors and doctors out of fee-for-service medicine by arbitrarily limiting the growth in Medicare, as people live longer, not for reasons of health care policy, but simply to meet budget targets. In addition, the bill's failsafe mechanism, this gimmick that automatically reduces payments if the targets are not met, only cuts from the fee-for-service portion of Medicare, not from the HMO's.

The bill also allows doctors, for the first time, to ''balance bill'' senior citizens for the difference between what Medicare pays and the providers' actual costs.

The other trick, according to our Republican colleagues, is that they are protecting the solvency of Medicare for future generations. But as we all know, the bill cuts three times the amount the Medicare trustees say is necessary.

In reality, the Republican bill extends the solvency of the trust fund until 2006. Precisely where we would be if we adopted the trustees', and not the Republicans' level of cuts.

Mr. Chairman, the trick under the Republican Medicare plan is that seniors will pay more and get less. The treat—I guess will have to wait until next year.

Mr. VENTO. Mr. Chairman, I rise today in opposition to H.R. 2425, a bill which will radically change the nature of health care in the United States, decimating seniors' health care security.

Medicare is one of our Nation's most successful programs. It was established over 30 years ago as a national commitment to assuring seniors health care coverage. Before it was enacted in 1965, only 46 percent of seniors had health coverage. Today 99 percent of seniors are assured of access to health care. Medicare is an intergenerational contract between working Americans and seniors, and it represents a commitment from our Federal Government that seniors should not have to choose between buying food or going to the doctor.

Medicare has served America's senior citizens well for 30 years. Most seniors are not well off. Under Medicare, seniors have complete freedom to select the health care plan of their choice, with guaranteed coverage. Now Republicans want to slash Medicare. They say that they are doing this to save the Medicare trust fund. Well, Medicare is in danger, because the Republicans are in control. The changes they are proposing are going to cost Medicare three times what is needed to extend the trust fund solvency to the year 2006. The trustees of the Medicare trust fund have stated that it would take approximately $90 billion to shore up the Medicare system for 10 years, but Republicans want to cut $270 billion to achieve the same objective. Ironically, the Democratic plan offered during Committee consideration of this bill actually extends the trust fund solvency to the same year, 2006, as the Republican plan, while only cutting about $90 billion. The truth is that Republicans are searching for a way to finance their budget priorities, and are using Medicare cuts as a cash honey pot to pay for a $245 billion tax break for wealthier people and increased military spending, not for helping the Medicare trust fund or the American health care system.

We all know that some improvements need to be made in the Medicare Program. After all, the health care laws have been constantly evolving for decades. For instance, I hear from seniors all of the time about the high cost of prescription drugs. A sound outpatient prescription drug benefit should be part of Medicare. Certainly we need to crack down on fraud and abuse within the system so that crucial health care dollars aren't going down the drain. Ironically, however, the Republicans cut money for inspectors of waste, fraud and abuse in the fiscal year 1996 appropriations bill, and this Medicare bill will make it more difficult to curb fraud and abuse by changing the standard for making sure Medicare claims are accurate, and repealing the 1987 laws governing nursing homes.

In the process of bleeding the Medicare trust fund, the Republican scheme is going to destroy seniors' health care security. Under this bill, overall Medicare spending will be cut by $6,795 per senior over the next 7 years, meaning that in 2002 there will be $1,747 less in Medicare dollars per senior in that year itself.

This Republican Medicare cut scheme will increase seniors' monthly premiums by $53.5 billion over 7 years—this means an individual senior will pay approximately $490 more per year in premiums by 2002. This amount will be doubled for married couples. This is a lot of money considering that 80 percent of Medicare beneficiaries earn less than $25,000 a year, and none of the premiums go into the Medicare trust fund, but are a part of the general revenue bottom line instead. Once again this illustrates the true impact of the GOP efforts—financing their priority which is a tax break for the wealthy.

The Republicans are going to cut $150 billion from payments to providers. There is not one hospital in this country that won't be affected by this drastic cut. This, combined with the proposed Medicaid cuts in the GOP budget plan, mean that hospitals will be forced to shut down, or try to make up the difference in cost by increasing and shifting health care costs onto Americans of all ages. Hospitals may well start to turn away Medicare and Medicaid patients, just as some physicians do already today.

Another disturbing part of the Republican proposal is the ''look back'' proposal where Republicans say they will make unspecified cuts in the future. When Republicans say ''look back'' seniors should ''look out.'' The GOP's so-called safety valve provides compliance with their scheme to cut Medicare, but no safety, no security, and no health care for Medicare recipients.

Provisions of the Republican scheme will fundamentally restructure Medicare, shifting seniors out of fee-for-service care by putting resources into other untried and untested

forms of care such as medical savings accounts and provider-sponsored organizations, therefore making traditional fee-for-service care so prohibitively expensive for most seniors as to eliminate the option. Ironically, the new medical savings accounts will actually cost Medicare money, with estimates ranging to $15 billion over 7 years, as more trust funds are passed out to healthy seniors who may not even need medical care, draining the funds which cost taxpayers billions. Provider-sponsored organizations will be exempt from State financial and consumer protection requirements, which insurers and HMOs have to comply with, meaning that provider-sponsored organizations will not be put on a level playing field with these other providers. This is a prescription for problems, not health care policy.

We also need to look at what Republicans are doing for Medicaid, the companion health care program which helps so many seniors get access to nursing home care. They are going to turn over complete control of this program to the States, stripping away mandates that guarantee coverage to children, the elderly, and the disabled. The Republican Medicaid scheme cuts the program by $182 billion in 7 years, a 20-percent reduction, and abolishes the entitlement status and State maintenance of effort. Minnesota was one of the biggest losers in the restructuring of the House Medicaid formula and is going to lose $3.4 billion over the next 7 years under the House plan. This is a cut of over 21 percent.

These changes will affect every person in this Nation, whether indirectly through their health care costs increases due to the rising number of uninsured people, or directly if they have to deal with the cutbacks in their coverage or their parents', spouse's or child's coverage.

The problems we face with health care demand a response, but a long term solution requires more than slashing health care coverage. The need remains not to consider Medicare and Medicaid in a vacuum, but to address the health care system as a whole. The trustees of the Medicare trust fund strongly oppose the Republican plan because the extensive cuts go far beyond program reform or deficit reduction.

What a difference a year makes. Last fall 1994, the Congress was struggling to expand health care to those without Medicare, Medicaid or private coverage. There were over 40 million uninsured Americans from working families then and the number has risen by 1.4 million more in the past year. Today Congress isn't even addressing the issue of those without health care, but pulling back and punching holes in the American health care programs, Medicare and Medicaid, that help people. What a shame and what a disgrace that the modest programs that provide dignity to the elderly and the disabled, and compassion and empathy for those without means, in fact 16 million children, are being bled for priorities that place tax breaks for the wealthy ahead of health care for the needy.

At the Democrats' hearings on the Capitol lawn and at public meetings in Minnesota, I've learned anew from a broad spectrum of people who will be hurt by the GOP policy path. Not only from doctors and hospitals, but from seniors who rely on them for their health care security. One senior at the hearing gave these words of wisdom, ''Seniors weren't born yesterday. They know what before you sign any policy, you read the fine print.'' Well, I urge my colleagues to look at the fine print of the Republican plan and see the bottom line which is that seniors and Americans of all ages are going to pay more for less.

Medicare represents our Nation at it's best. It represents the desire on the part of the people to pull together and care for those who otherwise might not have enough resources to have access to health care. Instead of building upon this success, by responsibility managing Medicare and expanding health care coverage to all Americans, this Republican bill rolls back the progress that has been made. I urge my colleagues to vote against the Republican plan.

Mr. SKAGGS. Mr. Chairman, this Republican Medicare bill is tragic almost any way you look at it. It's tragic because it will make life harder for many older Americans in order to make life easier for a few who are already financially comfortable. And it's tragic because we're missing an opportunity for genuine reform.

Medicare is in need of corrective surgery. This bill instead prescribes amputation.

By any reasonable assessment, Medicare has been a resounding success. Since it was signed into law by President Johnson in 1965, the system has dramatically improved the lives of millions and millions of older Americans and their families.

Before the system was created, over half of all seniors had no health insurance at all, and largely because of that problem, one-third lived in poverty. Today, thanks to Medicare, virtually all seniors have insurance, and less than 13 percent live below the poverty line.

That's hardly the outcome Republicans predicted. In 1965, 93 percent of Republicans in Congress voted against creating the system in the first place, because it was, they said, socialized medicine.

Thirty years later, the Medicare system remains essentially a private, market-oriented system. It's substantially less bureaucratic than the private sector system of health insurance—about 2 percent of Medicare goes toward administrative costs versus anywhere from 6 to 25 percent in the private health insurance market. Every American agrees Medicare must be maintained and must be put on a sound financial footing.

Medicare does face some serious actuarial problems. Medicare costs have been rising along with the skyrocketing cost of all health care. Those cost increases have outpaced revenue increases, so that the part A trust fund, which pays primarily for hospital coverage, needs to be shored up.

According to the Medicare trustees, the Part A trust fund faces a shortfall over the next several years of about $90 billion. Other more pessimistic analyses range up to $130 billion. So, we need to find $90 billion in savings or additional revenue to keep part A solvent.

But it is clear this is not the problem the Republican majority is trying to solve.

No, the Republicans set out to reach two other goals; first, to cut taxes, mostly for the wealthy; and second, to balanced the budget in 7 years. To make this math work, and given other priorities, they close to reduce Medicare spending by $270 billion, or two to three times what's necessary to deal with the Part A trust fund problem.

In other words, the size of the Medicare reductions wasn't driven by the health-care needs of seniors or the fiscal needs of the Medicare trust fund, but by the political agenda of the Republican majority.

In fact, the first Medicare action taken by the Republicans was last spring, in the $354 billion tax cut bull they pushed through. And ironically, it was designed to make Medicare's financial problems worse. How? By draining $36 billion in revenue out of the Medicare Part A trust fund. To offset that action, Republicans now have to make larger cuts in the hospital insurance program than otherwise necessary. These additional cuts will, inevitably, result in a lower quality of care for seniors.

The Republican plan also raises the premiums that help fund Part B of Medicare, which primarily pays doctors' bills. They're also trying hard to get seniors to opt out of the Medicare program altogether. By reducing spending on part B, which is paid for by general tax revenue, the GOP frees more money to funnel into tax breaks for people making over $100,000. And, of course, the savings from those moves won't do a thing for the insolvency problem in part A, which is the illness they're purporting to treat.

It's perfectly clear what's happening. The Republicans need to squeeze money out of the Medicare program to provide a promised $245 billion tax break—the crown jewel of the so- called Contract With America—to some of the wealthiest people and corporations in the country. And, to add insult to injury, the Speaker of the House has been busy cutting backroom deals in a desperate attempt to get this travesty to pass.

First, he bought the AMA's endorsement with concessions they wanted. Then, astoundingly, he decided to loosen the rules on Medicare fraud. Rather than making things tougher on those who cheat the system, and drive up costs, the Speaker will make fraud and abuse easier—just to win the support of powerful interest groups.

Let me stipulate: much more needs to be done to assure the long-term sustainability of Medicare than just fixing the part A trust fund shortfall. We need to ask those beneficiaries who can pay more for their care to do so. We need to tackle the systemic failings in the overall health insurance and to rein in costs.

But these matters ought to be addressed on their merits, and in the context of health care reform generally, not as mere mans to the end of a tax cut we can't now afford.

So it is, as my Republican colleagues have claimed, a historic day. Thirty years ago, Republicans voted in large numbers against Medicare. They will do so again today.

Older Americans, who have worked hard, and played by the rules, and paid into the system for a generation, deserve better from us. I urge my colleagues to vote against the bill.

Mr. SERRANO. Mr. Chairman, I rise in strong and determined opposition to H.R. 2425, the Medicare so-called Preservation Act of 1995.

H.R. 2425 is a very bad bill. It comes to the floor after a very flawed process and under artificial time limits imposed by the Republicans to prevent full and free discussion of the issues.

H.R. 2425 is driven by the Republicans' draconian budget, which means it is based on very bad numbers, not on any understanding of health care in this country. It will have far-reaching, negative impacts on most Americans.

H.R. 2425 would cut $270 billion in future Medicare spending. That is three times the size of any previous provision to address the Hospital Insurance Trust Fund's solvency. Yet it will extend the HI Trust Fund's year of exhaustion only to 2006—the same year the Democrats' much more modest proposal, based on the Medicare trustees' recommendations would.

The balance of the $270 billion does nothing to shore up the HI Trust Fund, but, instead, makes possible $245 Billion in unnecessary tax cuts aimed at the wealthiest—more than half the tax break goes to people making over $100 thousands a year.

Seniors would pay twice the current part B premium in 2002, as well as higher deductible and copayments.

Cost growth would be held below the growth in private sector health spending. Seniors who have greater health needs than the working population, would be forced to pay much more, particularly as fewer providers would be willing to accept rock-bottom Medicare reimbursement rates, and protections from balance billing would be repealed. Otherwise, seniors would have to give up their choice of doctors and accept second-class health care in underfunded managed care plans.

Hospitals are already reeling from changes in the health care industry; the hits they would take in reduced payments for graduate medical education, bad debt, disproportionate low-income patient load, and the like, would put many hospitals, particularly the public hospitals that serve the poorest populations and our great teaching hospitals, at great risk of closing.

Special deals for various portions of the health care industry would weaken consumer protections and make it much harder to combat Medicare fraud and abuse, kickbacks, and other anticompetitive behavior.

Meanwhile, medical research and the care provided by specialized institutions such as our children's hospitals are very much at risk.

The process, too, is very bad. Medicare is being rushed to the floor without full consideration by all the committees with jurisdiction. The Judiciary Committee majority actually waived—just gave away—its jurisdiction over crucial changes in medical malpractice, antitrust rules, the False Claims Act, and antikickback penalties. That is just not right.

Nor should the House consider Medicare apart from the rest of reconciliation, just so the Republicans can try to convince the American people that there is no relationship between Medicare cuts and tax cuts for the wealthy.

Under a fair and open process, this House would consider and amend all parts of reconciliation—the inexplicable tax increases on the working poor, the unnecessary tax cuts for the wealthy, the dangerous attack on workers' pension funds, the reckless spending cuts across the budget, as well as the excessive cuts and changes in Medicare and Medicaid—together.

The House should be able to consider the cumulative impacts of all the changes and make necessary adjustments. American's so-called sandwich generation, for instance, as a result of reconciliation, will find themselves pressed harder and harder, helping their parents with higher Medicare premiums and other health care costs while dealing with cuts in their children's student aid.

Because of the close relationship between Medicare and Medicaid, the House should be able to consider—and, where necessary, do something about—the impacts on each of changes in the other as well as the cumulative effects of changes to both.

What will be the combined impact of Medicare and Medicaid cuts on our health system?

A report by Barents Group LLC prepared for the Greater New York Hospital Association estimates that, over 7 years, New York City residents will pay $2 billion in excess part B premiums; and hospitals and long-term-care facilities together will lose more than $24 billion. By 2002, job loss will total 140,000, of which 112,000 will be in health care sector.

The Healthcare Association of New York State estimates that the 16th district will lose over $2 billion and nearly 11,000 health care jobs. Individual hospitals will lose hundreds of millions of dollars.

And what would be the impact on Medicare if a State, given authority to set Medicaid eligibility and coverage and a shrinking pot of Medicaid dollars, decides it cannot afford to fund long-term care? Under the proposed caps on Medicare spending, how will Medicare cover the much more expensive hospitalization that will surely result?

What recourse will seniors have if a State decides not to fully cover the Medicare premiums, deductibles, and copayments of the elderly poor? Their coverage would effectively be ended, and it is unlikely that managed care plans will have sufficient enrollment capacity soon enough or in enough places to meet the needs of all seniors who need low-cost health care.

I believe the House ought to be able to consider situations like this, but separating consideration of Medicare from Medicaid by nearly a week will make it impossible.

Mr. Chairman, there is much more I could say in opposition to this bill, but I will not go on. I simply urge my Republican colleagues to come to their senses and support the Democratic alternative, which extends Medicare's life just as long as H.R. 2425 without all the other harmful baggage. At a minimum, I urge all my colleagues to oppose this dangerous, ill-considered bill.

Mr. EVERETT. Mr. Chairman, I rise today in strong support of the Medicare Preservation Act. Yes, reforming Medicare is intimidating. Yes, maintaining the status quo is easier. Well, my constituents did not send me up here to take the easy way out, but to make hard choices in the best interest of the second district of Alabama and for this country's future.

I believe that there is nothing more abhorrent than using the power of this institution to terrify the elderly, the disabled, and the poor. But, the House Democrats are doing just that. While they are well aware that the Medicare Program is in a state of crisis, they continue to spout fear rhetoric. We all know, and even Democrats cannot deny, that Medicare is growing at over 10 percent every year. In order to sustain this rate of growth. Congress would be forced to cripple working Americans by raising the payroll tax by 44 percent. The only other alternative would be to allow Medicare outlays to reach 100 percent of Federal revenues by the year 2030 and bankrupt the entire country.

The Republican Party has a plan to save, preserve, and improve Medicare for today's beneficiaries and for future generations. The Medicare Preservation Act offers seniors the same cost effective choices for quality health care available to younger Americans, but develops innovative ways to save health care dollars; all while still delivering the best health care to all Americans without cutting a single dollar to beneficiaries. Let me make that clear, regardless of Democrat's demagoguery, there are no cuts in this legislation, Mr. Speaker.

Medicare payments will increase at a high rate of 6.5 percent allowing for a $2,000 increase from the current $4,800 today to $6,700 in 2002, for every single beneficiary. Correct me if I am wrong, but a $2,000 increase is not a cut in any teacher's math class. Currently, Medicare recipients pay 31.5 percent of their Medicare part B premium. Under the MPA, traditional Medicare recipients will continue to pay 31.5 percent of their Medicare part B premium. The MPA does not include changes to the deductible or the co-payment. Again, how can this mean that seniors pay more? The truth of the matter is that because the Medicare Program is a 30-year-old dinosaur, seniors actually pay more money in traditional Medicare for fewer services than their children and grandchildren do in the health care open market.

This historic legislation empowers seniors by offering choices through MedicarePlus coverage which includes coordinated care preferred provider organizations, local union or association policies, HMO's, private fee-for-service, medical saving's accounts, or continuing traditional Medicare. Most of these choices are currently available for every other American. Why should senior citizens continue to get the short end of the stick? The MPA goes a step further and opens the health care playing field to hospital and doctor coordinated organizations who can network to offer direct medical care to beneficiaries saving the cost of a middleman. Since hospitals are burdened with a large portion of the Medicare payment reimbursement savings, creating provider service organizations [PSO's] will allay some of their burden while opening up a whole new choice for direct medical care.

Medical savings account [MSA's] will allow seniors who choose this option to completely control how their Medicare contribution and out-of-pocket money is spent. They will receive their Medicare contribution each year in one sum which will be deposited into their medical savings account. They can then choose a high deductible policy which best fits their needs, maintaining at least 60 percent of the cost of the deductible in their MSA at all times. They can then use the balance of their MSA for doctor's visits, prescription drugs, eyeglasses or other medical-related expenses. If they are hospitalized the MSA pays for the

deductible and then insurance pays for the rest. If money is left over in the MSA at the end of the year, the money belongs to the senior and can be used for any purpose or can be rolled over into the next year's MSA.

MPA not only keeps the Medicare Program healthy into the 21st century, but finally gives seniors the power and choices they deserve. The legislation also includes long awaited liability reforms, strong incentives for combating fraud and abuse, and many other reforms which will only improve the Medicare health care delivery program. The amazing thing about this is that the MPA does not cut a single dollar from a beneficiary check, nor does it ask seniors to pay a single dollar more than they now pay. Again, in simple language, there are not cuts to beneficiaries in this bill, Mr. Speaker.

Mr. Chairman, we must all take the responsibility for protecting and caring for our grandparents and parents and of those disabled either physically, emotionally, or financially. But, we also have a responsibility to our younger taxpayers who are not only future beneficiaries of Medicare, but the future of this country. At this point they are paying 68.5 percent of the Medicare part B premium. Like most seniors, they simply cannot afford to pay more. Private health care organizations have been successful in the last several years at finding savings by actively seeking new and innovative ways to deliver the quality health care that Americans expect and deserve. The Republican Medicare Preservation Act accomplishes this same goal for America's seniors.

In support of the Medicare Preservation Act, I challenge Democrats to quit their scare tactics and join Republicans as we get down to the business of saving Medicare today and protecting and preserving the program into the 21st century.

Mr. GEJDENSEN. Mr. Chairman, I rise today to express my strong opposition to Newt Gingrich's bill to cut the Medicare Program by $270 billion in order to pay for a tax break to the wealthy.

Contrary to their recent pronouncements that the cuts in H.R. 2425 are necessary to save Medicare, it is clear that the Republicans do not want to save the Medicare system. They want to eliminate it. In fact, they have a longstanding record of opposing the program. In 1965, 93 percent of Republicans voted against the bill which established Medicare.

Throughout the years, the trustees have predicted imminent bankruptcy for the program. And, every time, Democrats have taken the steps necessary to keep this pay-as-you-go system solvent. In 1970, the trust fund was supposed to go broke in 1972. In 1972, it was to be bankrupt in 1976. In 1993, the trustees reported that the trust fund would go broke in 1999. However, thanks to reforms in the system enacted as part of the Omnibus Budget Reconciliation Act of 1993 [OBRA #93], the life of Medicare was extended until 2002. OBRA 93 passed the House of Representatives without one Republican vote. Where were Newt Gingrich and his friends then?

Earlier this year, the Medicare trustees reported that the Medicare part A trust fund needed $90 billion in cuts to remain solvent for the next decade. For that reason, I will vote for the Democratic alternative which saves exactly that amount. Nevertheless, Newt Gringrich and his loyal followers in Congress have crafted a bill to cut the program by almost three times the amount necessary. Why?—to pay for tax cut for wealthy Americans.

The Republican plan reduces Medicare spending by $270 billion, but increases beneficiary cost-sharing by $55 billion by raising monthly premiums. Under the proposal, the premium will rise from the current $46.10 to $87 in 2002. These figures are in direct contrast to the alternatives. Under the Democratic alternative, the premium will increase to only $58 in the same year. If current law were continued, the premium would increase to $61.

In addition, the majority's ill-advised proposal will result in seniors losing the ability to choose their own doctors. Proponents of this measure contend that beneficiaries will have unlimited choice, but the bill provides financial and other incentives to entice physicians to accept only MedicarePlus enrollees. Therefore, if a doctor decides to stop participating in the traditional fee-for-service Medicare, his or her patients are essentially left with no choice at all.

IN short, the Republicans' priorities are reversed. Their Medicare plan helps the greedy at the expense of the needy. That is simply wrong and I will vote against this shortsighted and punitive legislation. I urge my colleagues to do the same.

Mr. COLLINS of Georgia. Mr. Chairman, over the past several months I have held many townhall meetings for the purpose of listening and learning about Medicare from the people of Georgia's Third Congressional District. I have met with groups of senior citizens, physicians, and hospital administrators to better understand their concerns about the current Medicare insurance program.

I have learned from senior citizens of their fear of losing their Medicare insurance. They have shared with me their concerns about excessive fees charged by doctors and hospitals. They have brought me copies of complicated doctor and hospital bills they have received. They are frustrated with these billing procedures. Our seniors are concerned over excessive charges and fraudulent use of their Medicare insurance money.

I learned of the frustrations of doctors and hospitals that try to provide health care to Medicare patients under intrusive regulations and complicated reimbursement rules that have been forced onto them by past Congresses. They also shared their concerns about excessive testing and the overpracticing of health care due to the fear of lawsuits. Doctors and hospitals are frustrated because they are not allowed to legally discuss the delivery of health care within a community because of antitrust laws.

Mr. Chairman, in simple terms, the people of Georgia's Third District know and understand this Congress must address the problems within the Medicare insurance program such as overcharging, waste, and fraud. They also understand that in 1996, the Medicare insurance trust fund will begin paying out more money than the trust fund collects from payroll taxes deducted from each and every paycheck earned by the working people of this country.

But, Mr. Chairman, I am not the only Member of Congress who has listened and learned. The message I heard from the people of my district can be repeated by almost every Member of this House of Representatives who heard the same concerns in meetings held throughout their districts and out across our great Nation.

As a result of these meetings, the Republican Members of the House of Representatives have written, and now passed, the Medicare Preservation Act [MPA]. The MPA saves Medicare by addressing the very areas of concern voiced by those who depend on Medicare to pay for the cost of their health care.

Mr. Chairman, I read a speech not long ago which was given by the CEO of the Chrysler Corp., Mr. Eaton. In his speech he referred to a period of time some 15 years ago when the Japanese were taking over a large portion of the American automobile market.

The Japanese were beating the domestic automakers in the area of quality and price, very similar to the way the private health care industry is beating today's Government-run Medicare Program in quality and price.

What did the big three U.S. automakers do? They looked at the process of how they were manufacturing cars. They pulled together supervisors, union leaders, consumer groups, dealers, and anyone who they thought might have valuable input in how to change the process of manufacturing.

As a direct result of changing the process, the quality of their products has increased two and one-half times and they are building the same number of cars with half the work force.

Mr. Chairman, the process of Medicare is what the MPA changes.

Let's look first at who will be covered by Medicare under the MPA. Everyone. That's right everyone who receives Medicare today. I will say it again—everyone—each and every individual who is eligible for Medicare today will remain in the Medicare insurance program. Each and every individual who will become eligible for Medicare in the future will be covered under Medicare when they reach the Medicare age. No one—not one senior or disabled person will be mandated to leave the current Medicare insurance program.

Mr. Chairman, the American people are now hearing a great deal of rhetoric about how the Republicans are ending Medicare. Some special interest groups, and even some of our own colleagues in Congress, are engaging in scare tactics and giving false, misleading information about our plan. Well that is just what it is: Rhetoric. The truth is—the Medicare Preservation Act does not and will not end Medicare. In fact Mr. Speaker, the MPA does not cut—I repeat—does not cut Medicare benefits.

Well, if MPA does not cut Medicare, how do we plan to save $270 billion over 7 years at an average of $36.5 billion per year? The answer is we are making the changes our senior citizens requested to make. And by making those changes the taxpayers will spend $270 billion less than will be necessary under the current Medicare insurance program.

Mr. Chairman, we have a choice—either we correct the major problems within the Medicare process or we raise taxes on every working person in the Nation. In the past, raising taxes has been Congress' answer to fixing Medicare. In fact, the payroll tax and the income base have been raised 23 times over the past 31 years to fund runaway cost in the Medicare system.

But raising taxes decreases a family's income, increases the cost of consumer goods and services, and increases the cost of living for everyone, including seniors, who are on Medicare and a fixed income. Rather than raising taxes again, Republicans have chosen

to fix Medicare, according to what our senior citizens have requested. Let's take a quick look at some of the changes our seniors have suggested.

First, we are reducing the growth of excessive payments to doctors and hospitals. The Medicare Preservation Act consolidates a clumsy multiple layer reimbursement process which is unfair to general practitioners and very favorable to specialized medicine practitioners. It also simplifies the reimbursement process in a more fair and equitable manner.

The Medicare Preservation Act will simplify hospital bills so those insured by Medicare will better understand the billing process while at the same time reducing the growth of reimbursements for hospital care. One of the real problems with many hospitals is the lack of utilization of the entire facility or low occupancy rates. Yet many hospitals continue to build and add on to their hospital.

Have you ever wondered why? One reason is a part of the Medicare reimbursement for hospital care is based on the capital investment of the hospital. In other words the more the hospital makes capital investment, the more reimbursement they get from Medicare. Well the Medicare Preservation Act will slow down the unnecessary building by reducing the reimbursement based on capital investment. This should have been done many years ago.

Mr. Chairman, back during the late 1970's I served as chairman of the board of commissioners for a rural county in Georgia. The county has a Hill-Burton Hospital and the local government was responsible for keeping the doors open. Our hospital was losing money and had a high account receivable owed to it by Medicare.

As one who was responsible for the people's tax dollars, I paid a visit to the Blue Cross-Blue Shield insurance company and asked why they had not fully reimbursed the hospital for the bills submitted. They looked in the file and said, ''we are discounting your bills because you are not charging us enough.'' I could not believe what I had heard. Our hospital was being penalized by Medicare rules because we were not charging enough for our hospital care. It is no wonder Medicare has had money problems for a long time.

Mr. Chairman, if we are reducing doctor and hospital reimbursements, we also must help them reduce their cost of operation or we may discourage them from serving the Medicare insured. We are reducing their costs by including in the Medicare Preservation Act a provision commonly known as malpractice reform.

Today, doctors and hospitals pay ridiculously high premiums for malpractice insurance and most feel they have to practice defensive medicine to avoid lawsuits. Both the cost of the insurance and the overpracticing of medicine have led to higher costs for health care.

Additionally, the Medicare Preservation Act includes an antitrust provision so doctors and hospitals can legally discuss better ways to deliver health care to a community. It is just plain common sense to allow providers this flexibility.

Another good idea included in the Medicare Preservation Act is to purchase the necessary equipment to better track how much we pay doctors and hospitals for health care delivered to each Medicare insured beneficiary. You would think this would have already been done—it only makes good business sense to keep up with your accounts payable. But at this point nothing surprises me about how the current Medicare insurance program is operated.

Next we heard what folks were saying about waste, fraud, and abuse. Therefore the Medicare Preservation Act includes several provisions to eliminate waste, fraud, and abuse. Provisions such as:

One, requiring the Secretary of Health and Human Services to alert individuals entitled to Medicare of scams aimed at ripping off Medicare and providing a tollfree number to report such scams.

Two, rewarding beneficiaries who report huge illegal charges and rewarding them for good ideas which save Medicare dollars and improves the program. This will be a good incentive for those who are covered by Medicare to help keep down program costs and report fraud and abuse.

Three, a voluntary disclosure program for doctors who may have unintentionally overcharged for Medicare services. There is no such provision in current law.

Fourth, heavy fines on doctors who commit fraud against Medicare.

Five, a Medicare integrity program whereby the Secretary can contract with private concerns to review activities of doctors, audit the cost reports, determine whether Medicare should or should not have paid for services charged, and gives the Secretary the authority to collect overcharges.

Six, establish within the Department of Justice an antifraud task force.

Third, the Medicare Preservation Act establishes a trust fund for medical education. Currently teaching hospitals receive additional reimbursement money to help pay for medical education; again increasing the cost of Medicare.

Fourth, the Medicare Preservation Act establishes a baby boomer commission. This commission will begin now to look ahead for ideas of how to best ensure that Medicare will be there for those Americans born during or after World War II. In the past Congress has waited until a crisis occurs before taking an action. This commission will change that precedent. It is a very needed provision because when the baby boomers reach Medicare age there will only be 2.5 workers per Medicare insured, compared to today where there are 3.3 workers per Medicare recipient.

Fifth, there is a provision requiring a lookback commission to review the Medicare Preservation Act changes and how they are working. This will give Congress an idea of just what affect Medicare reform has on the cost of Medicare and recommendations for any necessary corrections needed to protect benefits.

Mr. Chairman, many of our seniors are worried about whether copayments or their hospital deductible will be increased under the Medicare Preservation Act. The answer is no. I will repeat the answer, no—capital NO—no.

The question has also been asked, will my part B premium increase? The answer is: The part B premium deducted from Social Security checks will remain at the current 31.5-percent level. This is different from the Democrats substitute which would have dropped the part B premium deduction to 25 percent. Under the Medicare Preservation Act, those individuals insured by Medicare who have an annual income of $75,000; and for those couples that earn $125,000, their part B premium will increase gradually to a point they could pay for the whole premium.

Mr. Chairman, there are a lot of misleading comments about what happens to the money saved by passing the Medicare Preservation Act. What will happen to those dollars? First of all the hospital trust fund, which pays for part A Medicare insurance, will continue to collect the payroll taxes needed to sustain itself. Second, the fewer dollars needed to subsidize the part B insurance, less general fund dollars, will be needed to pay for Medicare. Of course, Mr. Speaker, as you know the general fund is already overdrawn by some $5 trillion.

There are the changes to the current Medicare insurance program. However, there are other options for health care which will be available under the Medicare Preservation Act known as MedicarePlus plans. These new MedicarePlus options include: One, provider-sponsored organizations; two, medical savings accounts; and three, health maintenance organizations.

Each new option is a marketplace program. Each option will be completely voluntary. No one insured by Medicare will be required to select one of these options. The success of these options will be determined by the marketplace according to the quality of care provided, and the fees charged for the care provided. If an individual is not satisfied with either the quality of care or the price charged, they will have the ability to go back to the current Medicare system.

Mr. Chairman, the Medicare Preservation Act is a good idea. It is a plan which I fully believe will ensure that Medicare will be there for me 14 years from now when I become eligible for Medicare insurance.

Mr. HORN. Mr. Chairman, we have endured a great deal of campaign rhetoric regarding the Republican tax cut proposal and its alleged affects on the reforms we offer today to Medicare. I would like to refute the well-choreographed Democratic attempt to sideline a valiant effort to save Medicare.

The Republican plan to strengthen and save Medicare has nothing to do with the tax cut proposed for working families. When we passed the revenue bill in the House we had already made the spending cuts to permit a tax reduction. And they know that. There is a gap as wide as the Grand Canyon between what they know and what they say.

Even if the budget were balanced, Medicare would still have to be saved from bankruptcy. The President claims that, ''not 1 red cent of the money being paid by seniors will go to the trust fund. It will go to fund a tax cut that is too big.'' The President is wrong. He ought to read the law. Under current law, premiums and payroll taxes paid into the Medicare trust funds can only be used for the Medicare program. This is true for both the trust fund that pays hospital expenses, part A, and the trust fund that pays physician and other expenses, part B. As the Medicare trustees stated in their April 1995 report: ''The assets of the trust fund may not be used for any other purpose.''

Now let us address the so-called tax cuts for the rich. The House Budget Committee estimated that 74 percent of the $500-per-child family tax credit will go to families making less than $75,000 per year. The 4.7 million working families earning $25,000 a year and below will no longer pay any Federal income taxes; families earning between $25,000 and $30,000 will

have 48 percent of their Federal tax liability wiped out; although families with incomes of $100,000 will only have their Federal taxes reduced by 5 percent.

President Clinton penalized seniors with a retirement income above $34,000 by imposing higher taxes on them in his 1993 tax bill. The Republican Contract with American legislation provides tax relief to senior citizens by phasing out the President's 1993 Social Security benefits tax. We also help seniors who continue to work after turning 65 by raising the earnings limit. If you continue to work and earn more than $11,280 after turning 65, you currently are hit with a tax on your Social Security benefits. I think seniors who desire to work should be encouraged to work, not punished with lost benefits. Our revenue proposal raised this earnings limit from $11,280 to $30,000. Is a senior earning $30,000 rich? I do not think so.

Mr. Chairman, what the naysayers do not want to admit is that the Republican proposal to save Medicare is a viable plan not only for those who currently depend on its services but also for the generations to follow.

Mr. Chairman, 30 years ago as the legislative assistant to Senator Thomas H. Kuchel, the Republican Whip/deputy leader of the Senate, I was part of the working group that met with key Members of the Johnson administration to put together what became known as Medicare. I have been a strong supporter of Medicare over the three decades since that time.

Today, we are preserving, strengthening, and saving Medicare from bankruptcy. We have provided much improved choices for all senior citizens. The result is a much improved Medicare which will meet the needs of the current and future generations of older Americans.

Vote for the Medicare Preservation Act of 1995. History will prove we did the right thing.

Mr. FAZIO of California. Mr. Chairman, we are not talking today about Medicare preservation—we are talking about Medicare decimation. The Republican Medicare proposal flunks the test by which we judge sensible health policy. On all counts, it fails to measure up to the standards that the American people demand and deserve. It reflects not the informed consensus of the millions of seniors who depend on Medicare, but the arbitrary will of a handful of Republican leaders.

Health policy experts agree that this plan will actually end up hurting seniors, not helping them. At the expense of Medicare beneficiaries, primarily seniors on fixed incomes, this Medicare plan lines the pockets of special interests. And the scope of the plan—far exceeding what is necessary to shore-up the Medicare trust fund well into the next century—is a dead-giveaway that the cuts are, in fact, simply a vehicle to finance tax cuts for people who don't need them.

This so-called Medicare Preservation Act isn't about making Medicare more efficient. It's not about working with seniors and health policy experts to craft sensible reforms that guarantee our seniors the safety and security they deserve.

This plan is about one thing. It is about squeezing the people in the middle, and the people who have worked hard and paid into Medicare all their lives, in order to give the people at the top a $19,000 tax break.

The New York Times, in a recent article, explained exactly how the GOP decided to cut $270 billion out of Medicare. It's not pretty. In fact, it's more bad math and good government. Essentially, they set themselves a 7 year timeline for reaching a balanced budget. An admirable goal. But, then they insisted on a $245 billion tax cut. What NEWT GINGRICH called the crown jewel of the Republican agenda, turns out to be a combination of tax credits and tax cuts that help the richest 1 percent. Then, they turned their sights on discretionary spending, squeezing as much as they could out of programs that help kids, families, and the underprivileged.

Left with a $270 billion shortfall, they devised a last-minute plan to squeeze exactly that amount out of Medicare.

Coincidence, conspiracy, or incompetence? Regardless, the true losers are the 37 million seniors who depend on Medicare—the real crown jewel of our 30 year commitment to quality health care.

Just over 3 weeks ago, Democrats here in Congress decided we'd had enough Enough bad math, enough bad policy, enough disregard, on the GOP's part, for open debate and free discussion.

We staged our own series of hearings to evaluate the elements of the Republican proposal. We invited health care providers, Medicare beneficiaries, and health policy experts to present their views in the court of public opinion, right here in the shadow of the Capitol. In some ways, I regret that we had to step outside the convention and custom of the House, and away from a committee system that I respect, to conduct these hearings.

But, as I listened to these witnesses, I felt, at last, that we had begun the real public dialog. In some cases, we heard the views of people who had been shut out of the official debate—shut out of the single day of Republican-led hearings in the Ways and Means Committee.

I have also been listening to seniors in my district, hearing about how this Medicare decimation proposal would be devastating to them. It is estimated that this plan will cost seniors $400 a year more in premiums costs. This may not sound like much to the people who are benefiting from the tax breaks in the overall budget package. But keep in mind that more than half our seniors have no pension income other than a Social Security check and half of these seniors get less than $7,000 a year.

These are not just faceless statistics. Listen to the words of Mary Hopkins, a Medicare recipient who lives in my district in Carmichael, CA.

> My husband's employer went bankrupt, wiping out all his benefits. He now works part time at McDonald's to make ends meet.
>
> I suffer from arthritis, asthma, and a heart condition, so I am taking a lot of medication and see my doctor at least every 3 months.
>
> I am very concerned about how I would pay for any increase in my copayments for Medicare service. There is no room in our budget for any further medical expenses, so we would have to go on welfare. Where are the savings there?

While I believe this plan to cut Medicare will be bad for hundreds of thousands of people like Mary Hopkins, I know it will be even worse for rural residents. My district in northern California encompasses many rural areas and small towns. The fragile economies of rural areas often mean many residents have little or no insurance, making it difficult for these communities to attract and keep doctors and maintain local hospitals.

There is no question that there is an excess of hospital beds in some communities and that some hospitals could be closed. The problem with this plan is that, as a result of these drastic cuts, the wrong hospitals will end up closing. Hospitals in many of the smaller communities in my district are in precarious financial situations, and if they close, there may not be another facility for 75 miles.

When I visited with the head of one of these hospitals in my district his message was clear. Ed Bland of Colusa Hospital said simply, ''When you put everyone on a starvation diet, the small and the weak die first.''

This Medicare plan, combined with the unprecedented Medicaid cuts that are also proposed, will be a one-two punch to rural residents. Out of the patients the hospitals in my area serve, approximately 43 percent receive Medicare reimbursed service and 17 percent Medicaid reimbursed service. On the average, this means a full 60 percent of the care these hospitals provide is federally financed care.

If these Medicare reductions go into effect, hospitals in my district alone would have $175 million taken out of their budgets over the next 7 years. There is no way you could take that much out of our hospital budgets without harming the quality of patient care these facilities could offer.

What we have before us is a Medicare decimation act—put Medicare on a starvation diet, raise premiums for seniors, drive up their out-of-pocket costs, bankrupt rural hospitals. All of this to give the wealthiest in this country a tax break.

The alternative to today's Medicare decimation act is a sensible, equitable reform plan that does not jeopardize the health and security of millions of seniors and their families.

The Democratic alternative has no premium increases for Medicare beneficiaries, expands choices of providers and plans, adds new preventive benefits, and implements tougher fraud and abuse standards. It reduces Medicare spending by two-thirds less than the Republican plan, only $90 billion, but extends the solvency of the trust fund to the same year as the Republican plan—2006.

Let me reinforce this point—the Democratic alternative would preserve the Medicare trust fund for until 2006. This is the same exact time frame as the Republican's proposal to save Medicare.

Mr. Chairman, I will not support a plan which claims to save Medicare by taking $270 billion out of the program in order to fund $245 billion in tax breaks for the wealthy. I urge my colleagues to join me in rejecting this Medicare decimation act.

Mr. MURTHA. Mr. Chairman, we simply cannot solve Medicare in a partisan manner, and that's why this is the wrong bill, at the wrong time, for the wrong reasons. It's the wrong bill because it increases premiums, reduces coverage and reduces choices for older Americans while closing rural hospitals—as many as half the hospitals in our area would close, according to the Pennsylvania Hospital Association. It's the wrong time because we're not in a crisis situation that demands the drastic steps contained in this legislation—we have time to study the alternatives and develop a bipartisan consensus. And it's the wrong reasons because the savings won't go to the Medicare trust fund, but instead would go toward a tax cut slanted toward the wealthy.

Let's separate Medicare from the budget-tax cut issue, and work for legislation which guarantees that older Americans will continue to have access to affordable, quality health care of their choice.

For the last 30 years, Medicare has worked very well—it's enabled senior citizens to get the health care they need without facing financial disaster. The backers of this legislation claim we're in a crisis situation which demands the drastic steps contained in this legislation, but that's simply not true.

This bill does everything senior citizens don't want—it makes health care more expensive, it forces them to go to doctors they don't want, and if they need to go to a hospital, it may risk their lives by forcing them to travel farther, because according to the Pennsylvania Hospital Association, half the hospitals in western Pennsylvania may close if this bill is signed into law. And the legislation doesn't do what everyone, including seniors, feels is necessary—to guarantee the stability of Medicare for more than 10 years.

The supporters of this legislation should stop worrying so much about reaching a certain number for savings and start paying attention to the needs of senior citizens. We should take our time and come up with a bipartisan solution which starts with addressing the waste, fraud, and high administrative costs in the Medicare system. The savings we could get from those areas are enough to stabilize Medicare and avoid the premium increases and limits on care which are going to penalize older Americans.

Medicare is too important to too many people to be lost in political rhetoric. Seniors should feel confident they're receiving the best possible care at a cost they can afford. So let's not throw 30 years of success away in a panic—let's protect Medicare, and not make it a program where only the wealthy can get the best care.

Ms. WOOLSEY. Mr. Chairman, now is the time to stand up for seniors by voting down this plan to raid Medicare to provide tax breaks for wealthy special interests. Instead of continued partisan bickering, we need a bipartisan effort to save Medicare by eliminating the waste and fraud that cost billions each year.

I come to this floor today as the Representative for Sonoma and Marin Counties in California. As I always say to my colleagues, I am so fortunate to represent such a concerned and caring constituency.

For the last several months, I have been speaking to the people in my Congressional District. I have been speaking with senior citizens, with hospital administrators, with physicians, and with working families. Seniors are scared to death because they will have to pay more for less at a time when so many are struggling to get by. And families are scared to death because they do not understand how they will support aging parents and send their kids to college at the same time. The people of Sonoma and Marin Counties have spoken loud and clear: they do not support $270 billion in Medicare cuts in order to pay for $245 billion in tax breaks for wealthy special interests.

The new majority is making the argument that these massive cuts in Medicare are needed to save the system. I agree that Medicare and Medicaid can be improved, and that Congress should vigorously support efforts to make this system better. But I disagree with Speaker GINGRICH that the way to keep Medicare solvent is to operate on it with an axe, instead of a scalpel.

Speaker GINGRICH would like to convince the American public that Medicare is in a sudden crisis. However, concerns about the Medicare Trust Fund are not new. The Medicare Trustees have on eight previous occasions warned that the Trust Fund would be insolvent within 7 years. Each time, Congress responded immediately in a bipartisan way to make the changes necessary to keep Medicare solvent. However, the cuts proposed by Speaker GINGRICH go far beyond what is needed to protect the Medicare Trust Fund. What is more, since the proposed premium increases do not even contribute to the Medicare Trust Fund, it is clear that the new majority is increasing premiums only to pay for a special interest tax giveaway, not to strengthen Medicare.

In other words, the Gingrich Medicare plan is a major cut. According to the non-partisan Congressional Budget Office, the rate of growth in health care spending per person in the private sector over the next 7 years will be 7.9 percent. The Gingrich Medicare plan, however, brings the rate of growth of Medicare spending down to 4.9 percent per beneficiary. This means that the Gingrich plan will not keep up with the pace of inflation and the growing population of older and disabled Americans. As a result, there will be major increases in costs: by the year 2002, seniors will spend $400 more in Medicare premiums. Moreover, seniors may lose their choice of doctor because they will be forced into a Government-mandated managed care plan. In addition, hospitals and emergency rooms will be forced to reduce care and many will close. Some health care experts predict that up to 25 percent of all hospitals could close if Speaker GINGRICH's assault on Medicare becomes law.

But I do support making Medicare stronger. That is why I voted for the Democratic substitute to reform Medicare, and am a cosponsor of H.R. 2476, the Common Sense Medicare Reform Act.

The Democratic substitute saves $90 billion over the next 7 years. It reduces seniors' premiums, while providing coverage for new benefits such as more frequent mammograms, colorectal screenings, Pap smears and diabetes screening. The Democratic substitute increases seniors' choice of health care coverage, but does not force them to give up their own doctors. Under the Democratic substitute, the Medicare program will be strong and solvent, and seniors will continue to receive high quality care from doctors they know and trust.

I also support the approach taken in the Common Sense Medicare Reform Act, which strengthens Medicare by eliminating real waste, fraud, and abuse in the Medicare system. It will also save the amount needed to keep Medicare solvent for years to come. This bill will give law enforcement more tools to fight Medicare fraud, a crime which harms Medicare and the American taxpayer. And this bill, unlike the new majority's plan, will require that any funds recovered through cuts or savings from waste, fraud, and abuse will be automatically returned to the Medicare Trust Fund—not used to pay for a special interest tax giveaway.

In addition, I would also like to raise my objection to the way that Speaker GINGRICH has conducted the debate on his massive changes to Medicare. As someone who believes in the democratic process, I am outraged that the new majority only allowed for one day of public hearings on this assault on Medicare. As a former Petaluma City Council member, I remember that we talked longer and harder about sidewalk repairs than the House of Representatives has about an issue which affects the health of millions of Americans. This is unfair and undemocratic.

So, I am here to speak out for the people who have been shut out of the democratic process by this new majority. These people should not be silenced, and they should not see their concerns ignored by a Congress bent on pursuing a partisan agenda.

We would all do better if we listened carefully to those we represent. As one man in my district said, ''I worked hard all my life, raised ten kids and fought in two wars to live my life in peace. Living on only $801 a month, I need all the help I can get.''

To my colleagues on both sides of the aisle, I would like you to remember these words. Think about this man, and the millions of seniors just like him all over America who do not deserve second rate medical care and who do not deserve to have their pockets picked for a special interest tax giveaway. I call on my colleagues to reject this bill, take the tax giveaways off the table, and get on with the bipartisan job of restoring Medicare's solvency by eliminating rampant waste and fraud. Stand up for seniors by voting down this bill.

Mr. BORSKI. Mr. Chairman, I rise today to denounce the majority's plan to cut $270 billion from Medicare and $182 billion from Medicaid over the next 7 years in order to pay for $245 billion in tax breaks for the wealthy. These excessive cuts are unnecessary and harmful to America's senior citizens, working families, and the health care industry.

It is my honor to represent the Third congressional district in Pennsylvania, the twentieth oldest congressional district in the country. Pennsylvania is the second oldest State in the Nation where one out of six residents is a Medicare recipient and one out of seven is a Medicaid recipient. In the Third Congressional District, approximately 100,000 residents rely on Medicare. Approximately 400,000 people in Philadelphia rely on Medicaid.

Not only will the senior citizens in my district suffer, but all citizens, our health care system, and the entire Philadelphia economy will be endangered by these insidious cuts. Let me give you an example. At the Episcopal Hospital in Philadelphia, 88 percent of the people who enter the hospital are Medicare or Medicaid beneficiaries. If these cuts are approved, I don't know how the Episcopal Hospital will survive. Several other hospitals in my district, in other parts of Philadelphia, and across the State of Pennsylvania, are on the critical list as well. Health care workers—as many as 25,000 in Philadelphia and up to 6,000 in the Third District alone, will be at risk of losing their jobs. Communities will lose their local hospitals when these devastating cuts force them to close their doors. In addition, working families will pay more for their own health care as a result of the cost shifting which will follow these cuts.

But none of this deep, human pain seems to matter to this majority. In Washington, these days, a chill wind blows over our Nation's senior citizens. A lack of compassion fills the air.

The senior citizens in the Third District, and across the Nation, will pay more for their

health care, have less choice regarding their doctor, and receive a lower quality of care. Balance billing protection, which prohibits health care providers from charging seniors more than 15 percent above the Medicare reimbursement rate, will be eliminated. Seniors who enroll in HMO's because it has become financially impossible to remain with their family doctor will have no protection against additional charges once they are locked into an HMO. That's the bad news. There is no good news in this Republican plan.

Now, let me tell you the worst news. Everyone knows that Medicare is for our senior citizens and Medicaid is for those who are less fortunate. But, what people across America don't realize is that Medicaid also pays for the long term care costs of senior citizens. In Pennsylvania, 65 percent of all long term care costs are paid for by Medicaid. After our seniors have exhausted the savings they have worked so hard to accumulate over their lifetime, they go on Medicaid to receive the nursing home care they so desperately need. With the costs for a modest nursing home averaging about $4,000 a month, it is easy to understand how typical Philadelphia seniors could easily drain their savings in a short time. After these savings are depleted, Medicaid provides seniors with a safety net. As a result of these cuts, this safety net is now gone. The guarantee that Medicaid will cover Medicare costs for poor senior citizens is now gone. Some laws that enable the Government to stop fraud, waste, and abuse are now gone.

These exorbitant and heartless cuts are not designed to fix or save Medicare. They are being enacted in order to give $245 billion in tax breaks to the country's wealthiest individuals. Despite all the rhetoric from the majority, one fact is clear: The savings from the Medicare cuts will not go back into the Medicare trust fund. They will pay for tax breaks for the wealthy. Our senior citizens on fixed incomes cannot afford these increased costs. The Medicare system can not afford these excessive cuts.

I have traveled my district and asked hundreds and hundreds of my constituents if they support $270 billion in Medicare cuts and $182 billion in Medicaid cuts in order to provide $245 billion in tax breaks for the wealthiest in our country. The answer is always the same—no.

I will vote against this mean-spirited legislation and I urge my colleagues to do the same.

Ms. HARMAN. Mr. Chairman, on behalf of hundreds of seniors in the 36th District of California with whom I met over the course of this debate, I rise in strong opposition to this bill that would decimate Medicare, our most successful Federal program.

For more than 30 years, Medicare has guaranteed health care coverage for seniors—99 percent of whom are now covered—and it has dramatically reduced poverty among seniors, from 33 percent in 1965 before Medicare's creation to 13 percent today.

I have carefully read the Medicare trustees report. I agree that Medicare must be reformed. We must extend the solvency of the part A trust fund and take steps to control Medicare's high rate of growth—10 percent a year—to save Medicare for today's seniors and for generations to come.

Unfortunately, Washington is at it again playing politics. Members from both sides of the aisle have been more concerned with pointing fingers at the other rather than engaging in substantive discussion of real solutions to address the rapidly rising costs of Medicare.

I would like to share with my colleagues what I have learned from my constituents, and tell you some of their personal stories. I have been greatly impressed by their understanding of the changes being proposed and their ideas about how to reform Medicare.

The plan before us is not Medicare reform—it is Medicare destruction. The bill cuts Medicare by $270 billion over 7 years even though the Medicare trustees have stated that cuts of about $90 billion will extend the life of the part A trust fund to 2006.

My constituents have asked: ''why does the Gingrich plan cut Medicare by $180 billion more than what the trustees say is necessary?'' To them, the reason is clear: To pay for an ill-timed tax cut. They want the focus on saving Medicare and balancing the budget—not on cutting taxes. ''We can't afford a tax cut now,'' wrote Glenda Masek. ''And I'm a registered Republican,'' she added.

Many seniors recognize the financial problems facing Medicare and express a fervent desire for reforms. Some seniors told me they are willing to pay slightly higher premiums and deductibles, as long as the increases are fair. ''Some of us can afford to pay a little more,'' Irwin Gerst acknowledges. ''But many seniors are on fixed incomes and so any increases should be minimal and gradual and not used to offset tax cuts.''

Like these individuals, I cannot support a proposal that will take money out of the pockets of Medicare beneficiaries who have an average income of $13,000 a year. Under the bill before us beneficiaries' monthly premiums will rise to $87 by 2002, as compared to $61 under current law, and $1,700 less will be spent per beneficiary. These figures translate into higher costs for less care.

Not all my constituents can afford the increases:

One San Pedro senior, Katie Brazerich, pleads: ''Please don't cut my Medicare benefits and raise my premiums. Every single dollar is needed to help with my living expenses. There isn't any extra left for me to cut.''

''Don't bankrupt us just because we are living longer,'' comments her neighbor.

''These cuts are cruel,'' Lillian Watson observes.

Joyce Short, a 75-year-old Westchester resident told me, ''I paid into it [Medicare] all my life, and now I need it.''

Another, 71-year-old Mary Ford, fears she will be put out in the street. ''I have been diagnosed with Lupus and probably will be completely bankrupt if these cutbacks go through. We are the same Americans who went through the Depression.''

I support expanding choices for Medicare beneficiaries. While the bill purports to do this, a choice is not a choice when it becomes too expensive and when doctors move elsewhere. What supporters of the so-called choices in this bill do not mention is that under their plan, beneficiaries will no longer have extra billing protection. This means health care providers can charge seniors above what Medicare reimburses for the same services they receive without additional charge under Medicare today. Fear of extra billing will drive seniors out of fee-for-service arrangements.

''I don't want to be forced into an HMO,'' Virginia Balesteri told me. ''And I don't want my children to have to take care of us.''

These Americans want the right to choose their doctors. If premiums are such that they cannot afford fee-for-service plans, that choice is effectively taken away.

I have also heard countless stories of waste, fraud, and abuse within the Medicare system. Seniors have told me about receiving bills for services they did not receive. When they questioned the bills, they were told by Medicare administrators that it was easier and cheaper to just pay. ''If I ran my business like those Medicare folks,'' one told me, ''I'd be going broke, too.''

To counter fraud, one group of seniors in my district has suggested an incentive program for reporting abuses. Others suggested making Medicare billing easier for consumers to understand. They explained that people need to know exactly what the doctors and hospital are charging to make sure that those tests and services were received—and necessary. I agree that legislative change is necessary to crack down on waste, fraud, and abuse, and a bipartisan approach is essential.

Health care reform is essential. But the reform must help seniors, one of our most vulnerable populations. I strongly believe that we can make reforms to Medicare that attack fraud and abuse and which lower costs.

I urge my colleagues to vote against the Medicare Preservation Act, an oxymoron if there ever was one.

Mr. BARCIA. Mr. Chairman, when people reach the age of senior citizens, their biggest concern is their ability to maintain their quality of life. They have worked all their lives. They have sacrificed. Many have served in our Nation's Armed Forces. They are owed a great debt for their years of contribution.

I agree that we need to make responsible reductions in the cost of the Medicare Program. But we also need to make sure that we maintain a viable health care system that provides hospitals, doctors, nurses, and the other support mechanisms that people need when their health demands it. The bill before today just does not do this.

The ability to have access to health care is vital for the elderly. Last year, many of us heard from our senior citizens who were concerned that proposed changes to the health care system would leave them without access to their own doctor, would drive up their premiums, would force them into managed care systems when they did not want them. In my own district, in response to a questionnaire that I sent out last year, 43 percent said the choice of their own doctor was the most important element of health care. This year, nearly 60 percent of my constituents said that they did not want to see HMO's instead of being able to choose any doctor. And by a 2-to-1 margin they said that we should maintain spending on Medicare and Medicaid, not cut it.

The Michigan Health and Hospital Association has written to me claiming that these anticipated cuts in Medicare and Medicaid will probably result in many rural hospitals closing. I have several rural counties. How can I go back to my constituents and say I supported a proposal that meant that their local hospital was likely to close? Where would these people go for treatment, especially in an emergency, when the hospital closed? How many doctors would locate in rural areas where it would be difficult to get to hospitals where they could adequately treat their patients?

Some will say that doctors and patients can go to hospitals in the nearest city. Bay Medical Center in Bay City, one place that would be a likely alternative, tells me that the cuts in Medicare proposed by this bill would mean a loss of $70 million in revenue between now and 2002. That is before we add in the impact of the Medicaid proposals we will consider next week. Bay Medical Center could be in serious jeopardy if these proposals pass. if this hospital were to close, where would my constituents who need assistance go?

Yesterday we spent 4 hours debating shrimp and lobsters. Today we get only 3 hours to debate the future of a health care system for millions of senior citizens and for millions more who will need to make use of that system in the future. We were able to debate thirteen amendments for shrimp and lobsters. Today senior citizens will be restricted to only one. Earlier this year I celebrated passage of new House rules requiring a three-fifths vote to impose any tax increase. If this bill does not raise fees—taxes—for our seniors, why must we waive this provision? We were sent here to do the people's business, not to give greater consideration to shrimp and lobsters, nor to go back on the reforms we made at the first available opportunity.

Mr. Chairman, I cannot support this bill. It jeopardizes health care for our seniors. It does not give them the kind of system they want and deserve. It is being forced through without adequate review, and it breaks our word. Our seniors deserve better. We can and should do better.

Mr. JOHNSON of South Dakota. Mr. Chairman, I rise in strong opposition to H.R. 2425, legislation designed to reduce Medicare funding by $270 billion over the next 7 years. While I support constructive efforts to stabilize the Medicare part A trust fund and other efforts to promote administrative efficiencies and simplification, the plain fact is that this bill does little to strengthen Medicare and is primarily designed to free up $270 billion in order to finance the cost of the $245 billion tax cut and $60 billion defense pork provisions contained in Speaker GINGRICH's budget reconciliation bill.

Seniors in South Dakota have always been willing to make some adjustments to assist with Federal budget deficit reduction and they realize the need for some health care reforms that will slow down the growth of health care inflation—but they are also wise and experienced enough to know when someone is trying to sell them the Brooklyn Bridge. I have been holding town meetings on the Medicare and Medicaid issue all around South Dakota, and the bipartisan opposition to H.R. 2425 is overwhelming. Seniors want Medicare reforms, but they absolutely do not want wealthy special interests laughing at them all the way to the bank at their expense.

Mr. Chairman, I support alternative legislation which is designed to stabilize the Medicare part A trust fund and does so in a manner which does not raise premiums or reduce benefits to seniors. I cannot and I will not, however, support this misdirected, ''Reverse Robin Hood'' attack on Medicare and Medicaid.

Mr. FAWELL. Mr. Chairman, I rise in support of H.R. 2425, the Medicare Preservation Act of 1995. In April, the Medicare Board of Trustees concluded in their annual report that ''* * * prompt, effective and decisive action is necessary'' to avert the projected bankruptcy of Medicare by the year 2002. I am pleased that today House Republicans are fulfilling their commitment to saving Medicare by adopting this legislation.

The Medicare Preservation Act represents a major overhaul of Medicare. The proposal is aimed at preserving, protecting, and strengthening Medicare, while empowering seniors to choose the health care plan that best suits their needs.

The principle behind this legislation is choice. The Medicare Preservation Act contains an important and innovative feature that will give seniors more choice as well as introduce a truly competitive framework, called Medicare-plus. Medicare-plus will give beneficiaries new options to select from a broader array of privately offered plans, with the Government paying the premiums. These plans could include private traditional insurance, HMO's, new physician-hospital network—provider-sponsored organizations—coordinated care, Medisave plans, and limited enrollment plans sponsored by unions or trade associations. Under Medicare-plus, standard Medicare benefits will be retained so that future beneficiaries will be assured that their benefits will not be reduced. Moreover, if a health plan can provide Medicare benefits at less than the Government contribution, the plan can either provide additional benefits or provide a rebate to beneficiaries.

I want to stress the significance of the provider-sponsored organization [PSO] portion of the bill. This area gives recognition to the important competitive aspects of having PSO's as a choice option for Medicare recipients while also according these entities certain Federal protections. In my view, the ability of providers—doctors and hospitals—to offer health services directly to Medicare recipients adds an extremely important new aspect to the pulsating revolution already taking place in the private health care market. In fact, these providers are already offering health services to employees covered under the Employee Retirement Income Security Act [ERISA] covered plans sponsored by employers and unions. Under the PSO option, Medicare enrollees also will have the freedom to choose the doctors and hospitals they think will provide them the best care at the lowest cost. PSO's and similar entities, which continue to drive down the cost of private health care, will be an important element of the solution to containing Medicare health costs and preserving quality health care.

The extension of choice of coverage to members of qualified associations and Taft-Hartley multiemployer plans is also another key element for expanding the choice of Medicare-plus coverage and allowing seniors to continue their care under organizations that they looked to while working. Moreover, I want to stress that the PSO, qualified association, and multiemployer plan options under the bill does not amend or modify the Federal preemption framework under ERISA.

While providing choice in new options for beneficiaries, the bill simultaneously allows any Medicare beneficiary to remain in or return to the current fee-for-service system where they choose their own doctor or hospital. Other priorities of the Medicare Preservation Act include: combating Medicare fraud and abuse by rewarding seniors who discover and report fraud and abuse; increasing the punishment for those engaged in fraud; curtailing malpractice abuse; and, providing regulatory relief to improve efficiency and help stem the growth in health care costs.

Mr. Chairman, I urge my colleagues to recognize the Medicare crisis, and to support the Medicare Preservation Act. Only by acting now, can we preserve, protect, and strengthen Medicare for generations to come.

Mr. WELDON of Pennsylvania. Mr. Chairman, we have heard in this debate on the floor today and over the past few months an unrelenting barrage of denial, disinformation, distortion, and demagoguery from the Democratic Party on the subject of Medicare. That's why it is no wonder so many senior citizens have expressed concerns about this bill.

Denial, because the nonpartisan Medicare Board of Trustees, which includes three members of President Clinton's own Cabinet, issued a report in April stating that the Hospital Insurance trust fund will be able to pay benefits for only about 7 more years. The trustees said that even under the best estimates, if nothing is done, the trust fund will be exhausted by 2002. Yet the Democrats deny there is a problem and say do nothing.

Disinformation, because the Democrats speak falsely of massive cuts in Medicare, when it can plainly be demonstrated that Medicare spending goes up each year under the Medicare Preservation Act, that we will spend almost $2,000 more per Medicare beneficiary by 2002 under this plan, and that there are no cuts.

Distortion, because the Democrats want you to believe that these supposed cuts, which don't exist, will pay for Republican tax cuts for the rich, another figment of the Democrats' imaginations. Yet this bill contains a lock-box provision that puts all savings back into Medicare. Furthermore, the Republican tax cuts for the middle class—including a $500 a year credit per child for working families—has already been paid for by other savings in the Republican budget. We did that months ago. The Democrats choose to ignore that inconvenient fact.

Demagoguery, because Democrats have engaged in a conscious effort to frighten senior citizens, to scare them into thinking someone is trying to take away their benefits. It is absolutely outrageous. They are sending videos to senior centers claiming that this bill will ''destroy Medicare, not save it.'' This prompted the dean of the University of Pennsylvania's Annenberg School of Communications, Kathleen Hall Jamieson, quoted in the Philadelphia Inquirer, to state, ''It's inappropriate to target a vulnerable population with that kind of information.''

It's far worse than inappropriate. It's offensive to suggest that Republicans don't care about seniors, that we want to harm seniors. My 85-year-old mother relies on Medicare and Medicaid and Social Security and I resent having anyone on the other side suggest that I don't care about my mother. That my party doesn't care about seniors.

Despite the distortions, despite the demagogues, despite the bitterly partisan rhetoric, it is Republicans who are facing up to the problem and taking action to save Medicare. The Medicare Preservation Act does just what its name says. It preserves Medicare for seniors. It saves Medicare for the next generations. It strengthens Medicare for all of us. This bill will attack waste, fraud, and abuse. It will give

seniors more health care choices. It does not raise copayments, deductibles, or premium rates. The Medicare Preservation Act ensures that Medicare will be there well into the future.

Mr. Chairman, I urge all my colleagues to join in support of this bill. It is our responsibility to act. We have to step up to the plate. No one else can. We must have the courage to act. Let us do the right thing and save Medicare.

Mrs. CHENOWETH. Mr. Chairman, I rise today to once again remind the American people of who has a plan to save Medicare and who doesn't.

My constituents are understandably concerned over what might happen to Medicare. Instead of putting legislation where their mouths are, opponents of Republican Medicare reforms have done nothing but use inflamed rhetoric to frighten and confuse people. In fact, I've seen some newspapers describe it as ''MediScare.''

I am happy to point out, however, that one of the newspapers in my district—the Idaho Statesman out of Boise—recently endorsed the Republican Medicare proposal. To quote the Statesman ''GOP-sponsored reforms in Congress make a modest beginning at getting Medicare costs under control * * * Without their passage, senior citizens won't have a viable health-care system.'' I am submitting the Stateman's editorial for the RECORD.

The problem we are facing is this: If we don't act to strengthen Medicare, the benefits available now just won't be there in the future. We must not let politics as usual get in the way of protecting the security that all Americans should have when they retire. We need to keep our eyes on the facts.

I know I couldn't bear to look at my grandchildren and explain to them we had the chance to fix the system in 1995 but didn't.

Let's stop the bickering and pass Medicare reform now.

[From the Idaho Statesman, Oct. 11, 1995]

CONGRESS CAN TRIM MEDICARE

Public health assistance for billionaires is hardly what Americans had in mind for Medicare when it was created 30 years ago. But such unintended consequences are one of the reasons the massive health insurance program is going broke.

GOP-sponsored reforms in Congress make a modest beginning at getting Medicare costs under control. Lawmakers can also set income limits for recipients or have high-income recipients chip in more for their coverage. They also need to allow recipients to pick private plans as an alternative to the traditional Medicare program.

Such reforms are necessary because the current program covers virtually every American, not just the needy. For example, when Boise billionaire J.R. Simplot had hip-replacement surgery last spring, Medicare covered some of the costs. That simply makes no sense to Simplot or anyone else.

Congress also needs to get the paperwork under control. Look at what Vice President Al Gore discovered about just one rule of the Health Care Financing Administration, the agency that directs Medicare and Medicaid.

That one rule generated 11 million forms. Each hospital spend about $22,500 a year filling out those forms—and Medicare is governed by 3,200 pages of federal regulations.

GOP Medicare reforms are scheduled for a vote next week in the House. A similar bill is pending in the Senate. Without their passage, senior citizens won't have a viable health-care system.

Mrs. COLLINS of Illinois. Mr. Chairman, I rise in opposition to this rule and in opposition to the underlying bill, H.R. 2425.

Democratic Members of Congress and seniors across this Nation continue to ask for free and open debate on the extreme and unnecessary Medicare cuts that are before this body today. They have yet to be heard, let alone answered.

There were 10 hours of debate on the legislation that established the Medicare Program 30 years ago. Today we have half that time on a bill to dismantle it. There were 20 hours of debate earlier this year on legislation to send U.S. aid overseas. Today we have one-fourth of that time to consider ripping $270 billion in health care away from older Americans. Where is the logic?

Last week during markup of H.R. 2425, 13 senior and elderly citizens were led out of the Commerce Committee and arrested just because the committee chairman and his GOP colleagues were unwilling to answer the most basic questions about the consequences of passing the Republican Medicare bill. The rule we have before us on this bill continues this gag order by denying Members on both sides of the aisle the opportunity to participate in a fair and democratic review of H.R. 2425 and to offer amendments to this drastic legislation.

As members of the National Council of Senior Citizens testified before Democrats on the Government Reform and Oversight Committee yesterday, the flame of democracy continues to be smothered by the Gingrich Republicans.

Yesterday I presented testimony on two amendments before the Rules Committee that I believe would improve certain deficiencies of H.R. 2425. My amendments were not made in order. The Rules Committee didn't bother to listen to me, and therefore didn't bother to listen to my senior constituents and hundreds of thousands like them around this country.

My amendments are designed to restore current protections for seniors who have diagnostic tests performed in a doctors' office and to ensure that our elderly continue to have access to durable medical equipment such as wheelchairs, electrical beds, walkers, and oxygen.

My Clinical Laboratory Improvement Act [CLIA] amendment would reinstate quality assurance guarantees for patients who have testing done in physician office laboratories by striking the provision in the bill that eliminates the requirements of CLIA for labs in doctors' offices.

It probably should not be surprising that the Republican Medicare proposal—which bends so close to special interests and tilts so far from the best interests of America's senior citizens—would eliminate requirements for quality and accuracy of laboratory tests. This like the Republicans' blatant and cruel elimination of national standards for nursing homes, is one more way of saying to Medicare beneficiaries: You're on your own—good luck.

What is the rationale for exempting office labs? What is the rationale for exempting one specific test—pap smears—from such labs? If it is critically important for doctors' offices to meet quality standards for pap smears, why shouldn't those same quality standards be met when it comes to cholesterol tests, colon and prostate cancer screening, needle biopsies to detect precancerous conditions, and glucose monitoring?

My second amendment would remove the 7-year freeze on payments for durable medical equipment [DME].

H.R. 2425 will cause severe disruptions for seniors and the elderly who need their oxygen to breathe, electrical beds, wheelchairs and walkers to move about. Without these needed and essential items, seniors and the disabled could be forced into potentially life threatening situations.

Unfortunately Mr. Chairman, the Republican leadership just doesn't care.

I urge all my colleagues to vote ''no'' on this rule and ''no'' on the bill.

Mr. KOLBE. Mr. Chairman, today, Congress has a historic opportunity to pass legislation that will allow recipients of Medicare—both present and future—the freedom to choose their doctors, their health plans, and the health care services they decide are appropriate for them. It is time we allow Medicare recipients access to the same choices in health care that the rest of us have. That is the heart and soul of this legislation.

It's become abundantly clear in the last several months that Medicare faces a very real threat of bankruptcy. It is this looming bankruptcy of the trust fund that first alerted the country to the need for extensive changes if we were to save the Medicare system. What won't work is another Band-Aid. Yet, for decades that has been the Democrats' only answer to ensure solvency of the Medicare trust fund. The trustees themselves have told us it needs a systemic fix to be real. This year, once again, the Democrats have proposed the same quick fix solution and have failed to deal honestly with the underlying structural problems of the Medicare system. By simply reducing payments to hospitals and physicians, the Democrats Band-Aid staves off bankruptcy for another 2 or 3 years. This is simply irresponsible; it's what we've done for too long on too many other issues. It's why Medicare faces such a bleak future today.

H.R. 2425 doesn't wait for disaster to wash over us; it takes action now to assure the future security of Medicare for seniors. By providing fundamental changes to the structure of the program, the Medicare Preservation Act will keep Medicare solvent for at least 15 years, until the baby boomer generation begins retiring. We freely acknowledge that another deeper fix will be required then, but this legislation gives us time to see how well free market solutions can work to retain health care costs.

The heart of this legislation is the expansion of Medicare beneficiaries choice of health care options. The private health care market has demonstrated that health care services can be provided in a cost-effective way while maintaining the patient's quality of care. Such care is found in alternative health care systems, such as managed care system, health maintenance organizations, preferred providers organizations and medical savings accounts. Currently, Medicare recipients have not had wide access to these options. With passing of H.R. 2425 Medicare recipients will not have to rely on a system that is a relic of 1965 medicine.

It is unfortunate that my colleagues across the aisle, do not recognize the need for comprehensive reform. Their bill provides no security for seniors who rely on Medicare today, because it extends its life by only a year or two. It provides even less assurances for future seniors who are counting on Medicare to be there for their retirement.

Even if the Medicare trust fund were not facing bankruptcy, this legislation would make sense. It allows Medicare recipients access to the same range of choices in health care that other Americans have. Similar to the Federal Employees Health Benefit Plan, Medicare recipients would receive information each year about different health care providers and plans in their area. And like other Americans, they will be able to choose who provides their health care.

Arizona has been on the forefront in developing a successful managed care market. Over a decade ago, the Arizona Medicaid program, AHCCCS, was established as a managed care system. Now, with an extensive network of HMO's seniors are enrolling in the same system in increasing numbers. They are, by and large, very satisfied with the health care services offered by the competing health plans and have found that some plans offer services outside the required Medicare services, such as eye glasses, lower or no copays for visits and lower prescription drug prices. They can compete on these added services because they hold costs down on basic services.

Then there are medical saving accounts—an option not available now to any Medicare recipient. This option will allow seniors to buy a high deductible, catastrophic policy and pay for out of pocket expenses with the cash from their Medicare payment. If they use health care services prudently, they can even pocket the excess as income. It turns health care consumers into cost-conscious health care purchasers.

Will these options—and there are others—save money and prevent Medicare from going bankrupt? Yes, because private health care is more efficient and consumer driven choices more cost effective than a government administered one-size-fits-all health care program. Medicare costs grew at about 10.5 percent last year. But, in the private sector, large employers actually saw their cost decrease by 1.1 percent. The marketplace can work in health care.

The Medicare Preservation Act addresses another concern of seniors and taxpayers alike by putting in place a systematic program to combat fraud and abuse. As Medicare is designed right now, doctors are paid for procedures whether or not the patient needs it. That means the taxpayer gets ripped off, and the Medicare patient often doesn't get the proper care. By allowing providers and hospitals and insurers to compete for your business, the system will root our fraud and abuse, and will squeeze out waste. Furthermore, seniors who find fraud in their bills will be rewarded with a percentage of the money recovered.

Mr. Chairman, this legislation provides our seniors with health care they can trust and believe in. It is not riddled with burdensome Federal mandates on providers. As a consequence, it allows physicians to do what they do best—provide top quality care for their patients. It is about time we allow seniors to have the same type of health care as the rest of us have. Let's pass this real Medicare reform.

Mr. EDWARDS. I come to the well today because, like many Americans, I am concerned about fate of the Medicare Program.

I cannot support NEWT GINGRICH's plan to cut $270 billion from Medicare while offering a hefty tax break to people making over $200,000. The Gingrich plan cuts Medicare too deeply and hurts senior citizens without really strengthening the program.

I am not willing to sacrifice the quality of health care for senior citizens to pay for NEWT GINGRICH's $20,000 tax break for individuals making over $200,000 a year.

Seniors will pay more and get less. The cost of health care will climb and Medicare benefits won't keep up. Seven years from now seniors citizens and health care providers will find themselves in a hole because of a tax cut for the wealthy.

For senior citizens the plan means up to $1,200 in extra out-of-pocket expenses, limits on their choice of doctors and decreases in future benefits.

Central Texas rural hospital administrators have told me their hospitals could close as Medicare payments drop dramatically. Rural hospitals in central Texas have a high percentage of Medicare patients because of our large population of senior citizens. Some hospitals can't keep their doors open with the low level of reimbursement that the Gingrich plan offers.

I oppose the Gingrich Medicare plan because no one really knows what is in it. The 968 page Medicare bill landed on my desk Wednesday night and was being revised today, the same day I am forced to vote on it. Central Texas senior citizens, medical professionals, and taxpayers have no idea what is in the bill.

To railroad legislation through the House that directly affects 37 million senior citizens and their families is absolutely unfair. To pass such legislation before my constituents and American citizens have a chance to review it and express their views is irresponsible.

There is no question that we must reform Medicare to preserve it for future senior citizens. I'm willing to make the tough choices to cut spending, preserving the program, and balance the budget. However, Newt's Medicare plan simply does not pass the fairness test.

Mr. ALLARD. Mr. Chairman, this year Medicare turned 30, and while it has served the country well, it is still running on a 1965 engine.

In the last 30 years, medical procedures and technology have made tremendous advances. Medicare has not. It is out of touch with today's health care system. Medicare is like a 1965 car—it looks nice and elicits nostalgia, but it gets terrible gas mileage and you're never sure how long it will run. Without any reforms, Medicare can run cruise control only until the year 2002 before sputtering out of gas.

Major reforms are needed if Medicare is going to last. First, we have to slow the rate of growth in Medicare spending from 10.5 to 6.5 percent a year. Even with these changes, the average Medicare yearly benefits per person will increase from $4,800 this year to $6,700 by 2002.

The second step calls for major changes that gives senior Americans more flexibility and choices of medical plans to replace the outdated, bureaucratic one-size-fits-all plan designed by Congress 30 years ago.

Medicare recipients should have the same opportunities as other Americans to select the health care options that are best for them. The Federal Government should stop interfering with the relationship between patients and their doctors.

Unlike President Clinton's 1994 health care reform plan, the Medicare Preservation Act will not force anyone to leave the current system, nor will it force seniors into mandatory health alliances. Proposed reforms will offer Medicare beneficiaries more choices and better benefits than they enjoy now.

Let me review carefully the proposed reforms. First, Medicare would continue to be available to any beneficiary, and seniors could keep their current coverage. There would be no change in copayments or deductibles. Premium rates for Medicare part B would remain at 31.5 percent of total costs, which would mean an increase of only $4 a month above what is scheduled to occur under current law.

The only exception would be for wealthy seniors: single seniors making $75,000 a year or senior couples making $125,000 a year would be asked to pay higher part B premiums.

Average spending per beneficiary would increase by $1,900 over the next 7 years. If seniors don't like their current plan, or if they are unable to change plans, they would have options. Seniors who do not make a choice would be enrolled automatically in the traditional Medicare system.

Second, the Medicare Preservation Act would allow beneficiaries to choose several private sector options in a new Medicare Plus plan. Every year, beneficiaries would receive information about the approved plans available in their area. All they would have to do is check off their plan of choice.

Health plans under this MediChoice option would be selected by the seniors, not the Government. Seniors would choose a complete plan with its medical providers in return for more benefits. Unlike the traditional Medicare, they could choose less out-of-pocket expenses for coinsurance and deductibles, outpatient prescriptions drugs, eyeglasses and hearing aids.

A third option would allow seniors to take complete control of their health care with MediSave, a kind of medical savings account. The Government would pay for a catastrophic illness policy. Seniors would draw the remaining balance of their benefits from an account to pay a significant portion of their deductible. The high deductible policy would have no copayments, limiting seniors' out-of-pocket costs.

No one would be denied coverage due to illness or preexisting conditions. Every plan participating in Medicare must take all applicants and allow everyone to stay in a plan as long as they want. Seniors would not only keep their health care, but it would be better and stable for years.

I've heard countless horror stories about waste, fraud, and abuse in the Medicare system. The act would remedy that in part by rewarding recipients who report misuse of traditional Medicare. It also would require private Medicare plans to set up a toll-free phoneline to receive billing complaints. And it would impose strict penalties on anyone who defrauds Medicare. Furthermore, it would compel facilities to give patients cost estimates to guard against later bill padding.

Giving seniors more flexibility and control of their health care is critical. Our seniors' future should be controlled by them, not the Federal Government. Simply fretting about the system

will not help Medicare survive into the next century.

When we are engaged in the predictable political wrangling over this important issue, we must never lose sight of our ultimate goal: A health care system that delivers the best possible service to our seniors.

Mrs. FOWLER. Mr. Chairman, in emergency rooms, medical teams frequently have to use what are called heroic measures to resuscitate someone who's dying. This week in Congress, we are trying to rescue our desperately ill Medicare system, and H.R. 2425 is the heroic measure that will save the patient.

H.R. 2425 clamps down on overpayments, fraud, and abuse. It provides new choices for seniors, like medical savings accounts, provider service networks, and private health insurance, but not force them into change.

Some have said that Republicans are cutting Medicare to pay for a tax cut for the rich. Wrong on both counts. The tax cut was paid for long ago—and we are not cutting Medicare. Spending per beneficiary will continue to increase by nearly $2,000 per beneficiary over the next 7 years.

Scare tactics and lies will not save the Medicare system, but working together and passing the Medicare Preservation Act will keep Medicare strong and healthy for us and our children.

Mr. GILMAN. Mr. Chairman, I rise today in support of H.R. 2425, the Medicare Preservation Act. I would like to commend the gentleman from Texas [Mr. ARCHER] for introducing this important measure.

Over the past months, I have heard from many of my constituents concerned about cutting the Medicare program. Unfortunately, there have been a number of mediscare critics misrepresenting the current Medicare reform proposals.

H.R. 2425 overhauls the current Medicare system and slows its growth to achieve a projected $270 billion in savings over 7 years. It limits increases in payments to hospitals—except for rural hospitals—to save over $130 billion to keep the Medicare part A hospital insurance [HI] trust fund solvent until fiscal year 2010. It freezes the part B premium at 31.4 percent of program costs and restructures payments to providers. Additionally, the bill contains a lock-box mechanism that places all savings from part B into a Medicare preservation trust fund and prohibits any transfers to pay for future tax cuts.

In order to clear the record, please bear in mind that H.R. 2425 contains a number of fundamental reforms to provide beneficiaries with a broader range of health care choices and strengthens the existing program.

Specifically, the Medicare reform bill: First, establishes a Medicare plus program that allows beneficiaries to enroll in a range of private or employer-based health plans, including managed care plans, traditional fee-for-service plans, or high deductible insurance/medical savings accounts; second, allows health care providers to establish provider-sponsored organizations that can offer Medicare plus products; third, establishes a Commission to recommend long-term structural changes to preserve and protect Medicare when the baby boom generation begins retiring in 2010; fourth, strengthens Federal efforts to combat fraud and abuse in the Medicare program; fifth, eases or eliminates regulations banning physician self-referrals; sixth, reforms medical malpractice law; seventh, establishes a prospective payment system for home health services; eighth, creates a separate new trust fund, funded from both Medicare and the Federal Treasury, to finance teaching hospitals and graduate medical education programs; and ninth, creates a fail-save budget sequestration mechanism to reduce Medicare fee-for-service spending if budget targets are not met.

It is urgent for Congress to address the Medicare crisis. The administration's Medicare board of trustees reported on April 3 that under current policies, the hospital insurance trust fund—Medicare part A—which pays for inpatient hospital care and other related care for those age 65 and over as well as the long-term disabled, will be bankrupt by the year 2002, unless the system is reformed.

It is, therefore, critically important that Congress and the President take immediate action to preserve, protect, and improve Medicare not only for those who rely on the program now, but for those of us who expect to begin receiving benefits in the years ahead. One thing is certain: doing nothing will guarantee the bankruptcy of the program and will lead to a major health care crisis for millions of senior citizens.

Regrettably, practitioners are promoting mediscare rather than trying to work with the Congress to preserve, protect, and improve Medicare, using the Medicare reform debate as a tool to scare our seniors into believing that Medicare spending will be severely cut. On the contrary, payments made to help seniors will go up, not down. Medicare spending per beneficiary will increase by almost $2,000 from $4,800 to $6,700 over the next 7 years.

Although I support H.R. 2425, I do have reservations about the bill. I feel that this bill does not help my district hospitals from experiencing financial hardship. I hope that as we progress through our efforts to reform the ailing Medicare system, we will further look to find ways to help hospitals that have received unfair reimbursements under the current geographic reclassification regulations.

Mr. Chairman, whenever Americans have faced a crisis, we have come together as a nation to solve our problems. The problems facing Medicare are serious, but can be resolved if we keep an open mind and are all willing to do our part to protect, preserve, and improve Medicare. We must do it for our current recipients and for future generations.

Accordingly, I support H.R. 2425, and urge my colleagues to vote in favor of it.

Mrs. MINK. Mr. Chairman, 30 years ago I had the great privilege of voting for the Medicare program. It has changed the character and quality of life for all seniors over 65 years of age, and has allowed their children to build their lives without the fear of costly illnesses of their parents which could consume all their earnings and savings. The Medicare program has liberated families and allowed the elderly and their children the freedom of knowing that the best health care would be made available. It placed the cost of hospital care in part A on all the working people and their employers by assessing a payroll tax of 1.45 percent on the worker and on the employer. This part A is what the trustees report indicated will be in financial trouble in the year 2002.

Let us understand that the Medicare trustees have reported previously, eight times in fact, that part A hospital care was in fiscal difficulty. And each time the Congress responded and fixed the payment structure for the providers. This trustee's report is no different. The Congress should not rush to a ''fix'' which will jeopardize the health security that has been guaranteed these past 30 years.

I say ''rush to a fix'', because that is exactly what has been the process followed by the Republican majority. Without a single day of hearings by either Committees of jurisdiction this bill is being rammed through. No one has read this bill. They could not have, because it was only put into final form late last night.

For all the declamation that the Republicans seek only to ''save'' Medicare from bankruptcy, why do we have to vote on a bill that has not been read, has not been published for the public to read and comment on, and has not been analyzed? The fine print has been written in secret with various special interest groups, like the American Medical Association.

The process is outrageous. I could not possibly vote for a bill that has not seen the sunshine of public scrutiny.

The Republican strategy is to seize upon the trustees report as though it justifies this radical reversal of guarantees for medical care without even one day of hearings. If the Republican majority truly believe the course of action they are pursuing is good for the system, then they should be willing to allow it to be reviewed, analyzed and objectively studied by all parties affected, and not only a select few.

Second, one of the most serious concerns that I have about the estimated cuts of $270 billion is that it will penalize the poorest and the sickest of our seniors. These brutal cuts are not needed. They are proposed because the Republicans had to come up with ''savings'' in Federal spending to balance the budget which they are committed to do by the year 2002.

The reason they had to come up with this large cut in spending in Medicare is because the deficit is $245 billion larger than when you started. The increase in the deficit by $245 billion is due to your tax cuts by this amount. If you cut taxes by $245 billion, obviously you have that much less revenues, that much more deficit, and that much more red ink.

In order to cover this loss of revenue the Republican majority had to find programs that they could cut in order to have a balanced budget by the year 2002. They cut here, and they cut there, but nowhere were there funds to cover this enormous tax revenue giveaway. And so their budget ax turned to Medicare. It was not to save the solvency of Medicare. It was to meet the goal of balancing the budget by the year 2002. Let no one fool you into thinking that this cut of $270 billion in Medicare is needed to ''save'' Medicare from bankruptcy. This Medicare cut is to balance the budget deficit because of tax giveaways of $245 billion, more than half of which go to persons who have taxable incomes in excess of $100,000.

If the Republican tax plan did not have these $245 billion of tax cuts, the budget would have a $245 billion surplus. If the budget had a $245 billion surplus there would not be any need to cut Medicare.

The connection between the tax cut for the very wealthy people and the cuts in Medicare funding are directly related. Without the former, there would not need to be the latter.

Third, last year when we were debating the Universal Health Care plan for all Americans,

we all knew that with rising health care costs it was imperative that we act to rein in these costs. This was the central motivation for the President's initiative. We held months of hearings in three committees on these proposals. It was fully debated. It failed to pass. No one can say that Democrats were blind to the need for reform, the need for change, and the need to cut costs of medical care. We are recorded in favor of health care reform. But not a reform bill that was written in the dark, in secret, without any of us really knowing what the impact will be on our elderly, on our existing health care providers, and on the quality of health care.

Fourth, the real cost savings in Medicare is in routing out fraud and abuse. This is the place for the Federal Government to move in and crack down on the abuse. It has been noted that we could save $80 billion over a 7-year period if we installed tougher rules and regulations to rout out fraud and abuse. Instead we are now advised by the Justice Department that indeed the Republican bill will make it easier to commit fraud and get away with it. How do we know? No one saw the bill to read it until last night. Most of us only saw the bill this morning.

Why are the majority Members of this House afraid to have their ideas aired in the open and subject to public scrutiny?

Fifth, I am very concerned that the rural hospitals and clinics in my district will be forced to close. Why can't we have full hearings before this catastrophe occurs? I represent rural communities for whom life and death depends on the ability of these health facilities to survive.

Sixth, in 1993 the Congress passed a law that said that the cost of Medicare part B, doctors and laboratory services, would be paid by enrollees at the rate of 25 percent of the costs of the program. The Federal Government paid 75 percent of the cost of part B. The Republican bill before us today raises this premium charge paid by the enrollee to 31.5 percent of the total cost. Without cost controls, this means that the amount of money that the enrollee has to pay will rise astronomically. If the cost of doctor's care rises, the 31.5 percent that has to be paid by the enrollee must also rise. The failure of the Republican plan is that it does nothing to curb the rising costs of health care.

Seventh, the Republicans like to argue that they are not cutting funding only reducing the percentage of increase. In point of fact the Republican plan restricts the growth rate to 4.9 percent whereas the private sector estimates the growth rate of costs of health care at 7.1 percent. That is the major source of cuts. Any time your family budget has a 2.2-percent shortfall of earnings you know that you will have to cut how you spend. Accordingly under the restrictions of only 4.9 percent growth in Medicare costs, there is no other conclusion to be reached than that benefits will have to be cut and that the restrictions will shrink the reimbursements to providers and many Medicare beneficiaries will find themselves without any provider at all. This unrealistic restriction of the rate of growth is the real culprit. More people are going to reach 65 years of age. Health care costs are going to rise. A cap on the costs means benefits will have to be cut.

Eighth, as these changes are being made, the possibility that the quality of health care will be lowered is great. There will be less safeguards. Even under this cloud, the Republican plan enacts limits of liability for negligent and faulty medical care. Remember that patient who went into the operating room expecting that his left leg would be amputated, and woke up in his room with his good right leg gone. His left leg was so badly infected that it too had to be amputated, leaving him without any legs at all. Do you honestly think that having this doctor and hospital pay him $250,000 is adequate compensation for his loss? He is elderly and has no economic losses which could be used to treble his award. This bill has a $250,000 liability limit. This is unfair to the public. It is another reason I cannot vote for this bill.

From the mail I have received, there are a myriad of other provisions in this bill, that require further review. I cannot answer the question posed. No one can. It would be irresponsible to vote for this bill.

This is a day the Republican majority will have to answer for in the years ahead. As the tragic consequences enfold over the next 7 years, seniors will die before their time, and as rural hospitals close all persons living in those areas will die before their time. This is not a historic day. It is a sad day in the history of America.

Mr. EMERSON. Mr. Chairman, the choice before Congress today is clear. We can act now to preserve and strengthen Medicare as the President's own Medicare Trustees recommend, or we can do nothing and let Medicare go bankrupt in less than 7 years. Clearly, it would be the height of irresponsibility to let Medicare go broke. We have an absolute obligation to America's senior citizens to save Medicare, and I am pleased that Congress is working to do just that.

The Medicare Preservation Act will save Medicare without cutting benefits or increasing seniors' out-of-pocket costs. This year, Medicare per beneficiary spending averages about $4,800. This amount will increase to $6,700 per beneficiary under our plan.

Much has been made in this debate about process. I believe the Medicare Preservation Act is a good example of what the legislative process is all about—taking a bill and making it better.

For example, after meetings and discussions with the leadership, we have secured important rural funding changes to better serve rural citizens. As a senior member of the Rural Health Care Coalition, I am pleased that this Medicare reform package will significantly boost Medicare reimbursement rates to rural counties, like those in Southern Missouri. We all know that rural America faces unique health care challenges, and our plan responds by changing a Medicare reimbursement formula to attract more doctors and health care provider options to rural areas. Much work remains to be done to improve health care quality and access in rural regions, and our Medicare preservation plan is a leap in the right direction. I look forward to working with the Senate to see that the legislative process continues to move the plan to save Medicare forward.

The Medicare Prevention Act also gets tough on abuse, fraud and waste in the Medicare program. Seniors who report a verifiable incident of abuse, fraud or waste will receive a financial reward. Criminal and civil penalties will also be strengthened for anyone caught defrauding Medicare. Cleaning up the program is one of the best ways to save Medicare without cutting benefits.

The Medicare Preservation Act lives up to the obligation we in Congress owe to America's seniors. We have a non-negotiable responsibility to ensure that Medicare meets the health care needs of seniors who have worked hard all of their lives and contributed their share for health security. Our plan preserves, protects and strengthens Medicare for the next generation, as opposed to the President and his liberal allies in Congress, who offer a disingenuous press release to Band-Aid Medicare until the next election.

Mr. OWENS. Mr. Chairman, this bill takes us back to a time when the elderly expected to live in poverty sooner or later because of mounting health care bills they could ill afford to pay. Thirty years ago, with the swipe of a pen, President Johnson erased such fears of impoverishment, working with a Democratic Congress to overcome a hostile Republican minority. Our Government made a solemn promise to our senior citizens back then, but now the new Republican majority is proposing to break that contract with our seniors and make them live in fear once again.

The $270 billion that the Republicans propose to cut from Medicare will buy them their $245 billion tax cut for the rich, $51 billion of which will go directly into the coffers of large corporations. It is sad that the Republicans' priorities are so upside down. If they were to reduce corporate subsidies by the same percentage as the budget as a whole, as called for in the budget resolution, they would need to take $122 billion over 7 years from the pockets of the Fortune 500 fat cats freeloaders. Obviously, that won't happen.

Instead, America's seniors will pay $400 more in premiums each year by the year 2002. My home State of New York will lose $25 billion—$650 million from my district alone. And these figures don't even begin to tell the horror story that will result from the Medicaid cuts the Republicans will inflict upon the American people next week. Those cuts will be neatly buried in the budget reconciliation package, as the Grand Old Party removes the final shreds of dignity that the poorest of the poor have left.

Deep cuts in Medicare will expel seniors out of nursing homes or bankrupt their families who will have to pay for $40,000 a year nursing home bills . Not only will seniors be forced to pay more money for fewer services, they also will have to give up their own doctors as they are herded into HMO's. Finally, many hospital officials have predicted that up to 25 percent of all hospitals could close their doors because of these Republican Medicare cutbacks.

Mr. Chairman, I am submitting for the record a chart showing the billions of dollars that hospitals, nursing homes, and home health care agencies in my district will lose so that my constituents can see the negative impact that Republican Medicare and Medicaid cuts will have on the quality of health care services they receive.

PRELIMINARY ANALYSIS OF THE HOUSE AND SENATE MEDICARE REFORM PROPOSAL ON NEW YORK STATE

[7-YEAR IMPACT 1996 TO 2002—LOSSES IN $MILLIONS]

District	Representative	Type of facility	Facility name	Medicaid-Federal funds		Medicare		
				House	Senate	House	Senate	Budget cap/ lookback
11	Major R. Owens	Hospitals	Catholic medical center (St. Mary's of Brooklyn division	$122.9	$136.3	$31.0	$32.7	$6.1 to $16.2
			HHC (Kings County Hospital Center)	376.5	429.1	59.5	50.0	5.3 to 14.0
			Interfaith Medical Center (All Divisions)	114.6	142.6	71.9	56.5	8.5 to 22.5
			Kingsbrook Jewish Medical Center	44.6	38.1	74.4	57.7	10.7 to 28.4
			University Hospital of Brooklyn	79.5	77.0	93.1	71.9	11.4 to 30.4
		Nursing homes [1]	Carlton Nursing Home Inc	8.2	6.4			
			Caton Park Nursing Home	6.8	5.3			
			Center for Nursing & Rehabilitation Inc	24.2	18.7			
			Dover Nursing Home	2.3	1.7			
			Flatbush Manor Care Center	12.7	9.8			
			Madonna Residence	17.3	13.3			
			Marcus Garvey Nursing Home Company Inc	18.4	14.2			
			NY Congregational Home for the Aged	4.1	3.1			
			Oxford Nursing Home	12.8	9.9			
			Prospect Park Nursing Home	11.4	8.8			
			Rutland Nursing Home Co. Inc	47.9	37.1			
		Certified home health [1]	Interfaith Med Ctr/Jewish Hosp Med Ctr of Brooklyn Home Care Dept	1.0	0.8			
			Kingsbrook Jewish Medical Center Home Care Department	2.9	2.3			
			St. Mary's Hospital of Brooklyn Inc. Home Care Department	17.0	13.1			
			The Brooklyn Hospital Center Home Health Services Division	3.2	2.5			
			Visiting Nurse Association of Brooklyn, Inc	15.3	11.8			
		Long term home health [1]	St. Mary's Hospital of Brooklyn	11.0	8.5			
			Visiting Nurse Association of Brooklyn Inc	15.4	11.9			

[1] Insufficient Medicare data to estimate facility-and agency-specific impacts.

Mr. HEINEMAN. Mr. Chairman, I rise today as a 65-year-old citizen on Medicare. I speak not only for myself today, but I speak for the millions of seniors in our country who depend on Medicare. I also speak for my children and grandchildren who will one day need a financially sound Medicare system.

Mr. Chairman, as a senior citizen I have been very disturbed by all the rhetoric, scare tactics and fear which have been injected into the Medicare debate. People who use these negative tactics are wrong. They are not being truthful in addressing the problem we have with Medicare. It is a simple fact. In 7 years, in the year 2002, the system will go broke unless it is reformed.

The Medicare Preservation Act will save the Medicare Program $270 billion—savings which will go directly into the Medicare Program by law.

The President knows the problem. In 1993, Bill Clinton said, and I quote ''I will recommend reducing the growth of spending in Medicare dramatically and in Medicaid. This will not be a cut. Don't let people tell you it is a cut. We simply have to reduce this incredible rate of spending to save the system.'' I agree with Bill Clinton—he is right.

While the House Democratic leadership offered no plan, our Democratic colleagues in the other body finally put out their version of a plan to reform Medicare. It saves $90 billion. It has one problem—it simply delays the date of bankruptcy for 3 years beyond 2002.

The Medicare Preservation Act will increase per beneficiary spending from $4,800 to $6,700 in 2002. Seniors will stay in the current Medicare system—with no increases in deductibles or copayments—unless they choose MedicarePlus. If a senior chooses MedicarePlus he or she will be able to choose from a variety of plans, with different benefit options. The Medicare Preservation Act also attacks waste, fraud, and abuse and rewards seniors who help weed out fraud.

Let's stop playing politics with Medicare. It is too important for our senior citizens; they deserve better.

I urge my colleagues on both sides of the aisle to reject the rhetoric and start dealing with reality. Vote for H.R. 2425, support our senior citizens and save Medicare.

[From the Raleigh News & Observer, Oct. 16, 1995]

DEMOCRATS HOPE THAT SCARING GRANNY WILL BRING VOTES

(By Rob Christensen)

There's a new soap opera on the tube these days: a political commercial paid for by the Teamsters and aimed at Republican Rep. Fred Heineman.

A middle-aged couple stand in their kitchen, fretting. Hubby says he can't believe how the Republicans want to cut Medicare just to give a tax break to the rich. The Mrs. says she might have to quit her job to take care of Granny if the cuts go through.

Meanwhile, Granny is eavesdropping in the dining room, an anguished look on her face.

The commercial nearly brought tears to my eyes. I wanted to reach out, pat her on the arm and say: ''It's all right, Granny. The Democrats will take care of you.''

The TV ad is part of a national campaign by the Democratic Party and its allies to portray the Republicans in Congress as a group of cold-hearted rich folks who want to deny the elderly crutches and walkers so they can buy a nicer Mercedes.

The reason for the Democratic public relations blitz is a GOP plan making its way through Congress to reduce projected spending for Medicare by $270 billion during the next seven years.

At a forum at Durham's Preiss-Steele Place the other day, the Democratic Party rolled out some of its biggest guns to attack the Republican Medicare plan.

''Insane,'' Dick Gephardt, the House Democratic leader, said of the GOP Medicare proposal. ''A tax cut for the wealthy,'' said Rep. Eva Clayton. ''Extreme cuts,'' said Rep. Mel Watt.

To put a nice face on the Democratic attacks, let's call it political hyperbole. It's a good example of why Congress finds it so difficult to balance the federal budget and reduce the huge debt.

What the Democrats fail to mention is that the Republican plan proposes to INCREASE Medicare, not cut it.

The GOP plans calls for a slowing of Medicare's annual growth from 10 percent per year to 6.4 percent.

In 1994, we spent $160 billion on Medicare. If left unchanged, annual Medicare costs are projected to rise to $345 billion by 2002. Under the GOP plan, Medicare spending would increase to $247 billion per year by 2002, an INCREASE of 54 percent.

Of the $270 billion in Medicare growth reductions in the GOP plan, about $200 billion is designed to limit the growth in payments to hospitals and doctors.

That's not to say the Republican plan won't cause pain. It will lead to higher premiums, less choice in doctors and other new restrictions on coverage. It could cause hospitals heavily dependent on Medicare and Medicaid to close—especially the hospitals serving the poor in inner cities or rural areas.

But some pain is necessary if we are to stem the tide of red ink and to prevent the Medicare program from growing broke.

Nearly every serious examination of the federal budget deficit has concluded that we must slow the growth of the huge entitlement programs such as Social Security and Medicare.

People are living longer. Medicine and medical treatment is becoming more expensive. In 1965, 14 percent of the federal budget went for Social Security and Medicare. Today, it's more than one-third.

If you rule out a tax increase, the only realistic way to balance the budget is to slow the tremendous growth in such entitlement programs as Medicare, Medicaid and Social Security, said Dick Stubbing, a public policy professor at Duke University and a federal budget expert.

Scaring Granny has always been a political winner for the Democrats.

Much of the public has never trusted the Republicans to protect social programs. Social Security and Medicare were passed by Democratic liberals—under the leadership of Franklin Roosevelt and Lyndon Johnson—over the opposition of conservative Republicans who decried such programs as socialism. According to a recent Times-Mirror poll, 45 percent of those surveyed trusted the Democrats to reform the Medicare program, while 32 percent trusted the Republicans.

''Some who are pushing for current Medicare plan are of the same view as those who fought the creation of Medicare in 1965 and in 1995 are trying to deny the comforts our senior citizens,'' Clayton told the Preiss-Steele residents in Durham. ''Should they be trusted? I think not.''

The Democrats are trying to tie Medicare growth cutbacks to $245 billion in tax cuts the Republicans are pushing. But the proposed tax cuts, which would be like pouring gasoline on the roaring fire of the federal debt, are a separate issue.

Of course, the Democrats did not invent political demagoguery. Most recently, the Republicans did their part to scare the elderly and everyone else when they distorted the

Clinton administration's health care proposal.

But for the moment, it's the Republicans who are trying to do right—and the Democrats who are trying to scare Granny.

[From the Herald-Sun, Oct. 17, 1995]

GIVE GOP CREDIT FOR IDEAS

However much one might quibble with the way the GOP in Congress is bearing down on the Federal deficit, this must be said: At least somebody in Washington is trying to lasso those dollar-gorging entitlement programs.

Everybody knows that entitlements—Social Security, Medicare, Medicaid and so on—are the arch stones of a balanced budget. Unless these programs are brought under control, they will literally bankrupt the United States. It's that simple, and it's that serious.

Democrats on Capitol Hill do the country and themselves a disservice by running around and screaming that the GOP in effect plans to cast the elderly loose on ice floes, Fling that $270 billion ''cut'' in Medicare spending over the next seven years out to a chapter of the AARP, and the gasps will come on cue.

In fact, even under the GOP plan, federal outlays for Medicare and Medicaid are expected to rise through the year 2002. However, the rate of increase will be slowed, and that's where much of the projected $270 billion in savings will come from.

Somehow, this part of the GOP plan never gets beyond the Democrats' gatekeepers.

This is not to say, though, that the GOP plan is above criticism. Converting Medicaid into a block-grant program for the states is a risky venture, especially for poor states. If the block grant money runs out, the states will have to come up with the balance—not an easy thing to do in North Carolina, Maine, Mississippi, New Mexico and other low-wage states.

Furthermore, the GOP plan scraps an important law that prohibits physicians from ''double dipping'' their patients. Double-dipping occurs when a physician charges patients for blood work and other tests done at a laboratory in which the physician has a financial stake. The law came about a few years ago in response to widespread abuses in such arrangements, but the GOP promised last week to toss it out in return for the American Medical Association's endorsement of the reform plan.

If the Democrats have a straight-flying arrow in their quiver, it's their criticism of the GOP's proposed $245 billion tax cut. The leadership of both houses of Congress has signed off on the cut. Reducing entitlement spending while cutting taxes has all the flavor of guns and butter. It would be far better to get a grip on entitlement programs, then go for tax cuts.

As we said, quibbles. The GOP seized the initiative in this struggle a year ago, and seems likely to keep it. The Democrats—yes, there are some still left in Congress—have only themselves to blame for their impotence.

Mr. HILLEARY. Mr. Chairman I rise in support of H.R. 2425—the Medicare Preservation Act and encourage my colleagues to do the same. This issue is so important to so many people, it should be above partisan politics, misinformation, and lies.

Throughout this autumn's important debate on how to save Medicare from bankruptcy, opponents of the Republican plan have used one—and only one—argument against the plan: The Republicans are cutting Medicare to pay for tax cuts for the rich. This is the same hollow rhetoric, based on class envy, that was soundly rejected at the polls in last year's historic elections. And of course, this year's rhetoric is just as untrue as it has been in previous years.

This issue is so important to so many people, it should be above partisan politics, misinformation, and lies. But because the American people deserve to know what's really going on, it has become necessary for Republicans to respond to these false claims.

Let's analyze the sole argument Democrat critics have used in this debate: The Republicans are cutting Medicare to pay for tax cuts for the rich. There are three distinct parts to this statement, and all three of them are completely false. In this World Series season, they hope to convert these pitches into a home run, but all they do is strike out. Big Time.

Pitch 1: ''The Republicans are cutting Medicare . . .'' This is simply not true. Any way you slice it, more money will be spent on Medicare every single year. If Republican reforms are enacted, overall spending will rise from $161 billion this year to $274 billion in 2002. The average Medicare recipient will receive $4,800 in benefits this year, and the average recipient will receive $6,700 7 years from now.

What Republicans are doing is containing the current growth rate of 10.5 percent, which is unsustainable and will bankrupt the Medicare system in 7 years. The good news is that we can save the program from bankruptcy by limiting growth to approximately 6 percent a year. This comes to roughly a 40 percent increase over the next 7 years. Only in Washington is a 40-percent spending increase considered a cut. Strike One.

Pitch 2: ''. . . to pay for tax cuts . . .'' The fact is that every red cent of Medicare savings will go directly to the Medicare trust fund, and not one penny will go to pay for tax cuts of any kind. To make this perfectly clear, the Ways and Means Committee adopted a lockbox amendment which specifically states that all Medicare savings must be used to make the system solvent, and not to pay for tax cuts. There is absolutely no link between Republican efforts to save Medicare and to lower taxes.

The House passed its tax reform bill last spring, and every one of those cuts were paid for at the time by cutting wasteful spending in other areas. Also, even if the budget were already balanced, and the tax burden were at an acceptable level, Medicare would still have to be saved from bankruptcy. In other words, the Medicare trust fund would be broke in 7 years no matter what kind of income tax policy we have. Strike Two.

Pitch 3: ''. . . for the rich.'' By now, it should be clear that Republicans are not cutting Medicare, and that Medicare reform is unrelated to tax reform. The third piece of misinformation in the Democrats' one-sentence Medicare strategy is that our tax reform package is geared toward the wealthy.

The truth is that if the House-passed tax reform bill becomes law, the rich will pay a larger share of taxes. According to the Joint Economic Committee, the richest 10 percent will pay 48.6 percent of all taxes—up from the current 46.6 percent. Moreover, the top 1 percent will pay 18.2 percent—up from the currently 18 percent.

The idea that the Republican tax reform bill unfairly benefits the rich is simply ridiculous. The centerpiece of our package is the $500-per-child tax credit, of which 74 percent of the credit will go to families which make less than $75,000 a year. This credit also means that families earning less than $25,000 will not pay any Federal taxes, and those earning $30,000 will see a 48 percent Federal tax cut.

Other aspects of our tax package include a capital gains tax cut—77 percent of beneficiaries will be families that earn less than $75,000, a repeal of President Clinton's tax on Social Security benefits, and an adoption tax credit to families making less than $60,000 a year.

Obviously, any claim that Republican middle class tax cuts are aimed at the rich is inaccurate to say the least. Moreover, if the Republican Medicare reform plan is passed, the wealthiest seniors will have to pay a greater percentage of their Medicare premiums, while middle income recipients will pay the same share—31.5 percent—that they are paying now. Strike Three. This last false claim completes the strikeout in the Democrats' attempt to hit a home run with ideas they should have retired years ago.

Perhaps the most destructive result of spreading false information and using class warfare tactics is that they purposely divide Americans at a time when we need to try to bring people back together. Instead of spreading misinformation and envy, we should be having an honest debate about how we can make all Americans healthier and more financially stable in their old age. Anything less is just plain wrong, and I hope that the Clinton Democrats decide to put aside their class warfare and join us in an honest debate very soon. I believe this bill is a step in the right direction and I'm proud to support it.

Mr. BUNNING. Mr. Chairman, I rise in support of the Medicare Preservation Act. It's a good bill.

It preserves Medicare—it strengthens Medicare.

It keeps Medicare from going bankrupt. And best of all it gives senior citizens more options—more choices.

I think you will all agree that Members of the U.S. Congress have a pretty good health care system.

We get a booklet every year that lists the options available to us—insurance plans or PPO's and HMO's. We get a wide range of choices. We can pick a plan that suits our needs and our family's needs. It's a pretty good deal.

I have enrolled in a PPO. I still get to see my family doctor. I show him this card and my office visit only costs me $10. And I have this other card that I can take to the drug store and pick up my prescription medicine and no matter how much it costs, I only pay $10.

It's a pretty good deal.

This Medicare reform bill that we are considering today gives the senior citizens of our country the same kind of options that Members of Congress now have. It will give them the same kind of choices we have.

That's the beauty of this bill. We save Medicare. We strengthen Medicare and on top of it all, we make Medicare better.

We are going to hear a lot of outrageous rhetoric about how we are slashing benefits. That's hogwash. It's political hogwash. And I, for one, think that this program is a little too important to play political games with.

This bill is a good bill. It gives senior citizens the same kind of health care that Members of Congress enjoy now. That's a pretty good deal for everybody.

We don't cut benefits for senior citizens. Our bill doesn't increase copayments. It doesn't increase deductibles.

It increases the average amount of money that Medicare spends on every beneficiary by nearly $2,000 over the next 7 years.

Sure we slow the growth rate. If we don't slow the growth rate of Medicare spending, Medicare will bounce over the cliff to bankruptcy in just a few years.

Ten percent growth rates simply cannot be sustained. Everybody knows that. And our bill slows the growth rate to 6½ percent. But that is still growth. It is not a cut.

It is not a cut because we slow the rate of growth in Medicare spending by providing more choices, not by cutting benefits.

By providing more options—more choices—we introduce competition into Medicare. We put private sector ideas to work. We inject the free enterprise system into the Medicare system. It will make it more efficient and more cost-effective.

At the same time, if someone is happy with Medicare just the way it is; if someone is a little nervous about trying something new; if they are happy with the traditional fee for service and don't want to change, they can keep their existing Medicare plan.

Our bill doesn't force anybody to change. It doesn't force anyone to join an HMO if they don't want to. It doesn't force them to change doctors or hospitals or anything. Anyone who likes Medicare just the way it is can keep going along just like they have been.

People like this—people who don't want to change Medicare—should like this bill too. It preserves Medicare and traditional fee for service for them. It keeps Medicare from going bankrupt.

We are not in a situation where we can stick our heads in the sand and say don't change anything, don't touch Medicare. If we do nothing, Medicare will go bankrupt in 7 years.

President Clinton's appointees who serve as trustees to the Medicare trust fund have told us that we need to make changes to keep the program solvent. We can't do nothing. Medicare is far too important to too many people.

The Democrats in Congress want to stick their heads in the sand. The President wants to stick his head in the sand. They know full well that we are doing the right thing. They know full well that Medicare needs fixing. But they would rather play political games.

They know they can win political points by crying wolf, by saying that Republicans are cutting Medicare to pay for tax cuts for the rich. They know it isn't true but they know they can win points by scaring people who are dependent on Medicare.

Republicans knew there were political risks when we took on this task. We knew it was dangerous politically to tackle Medicare's problems. It would have been much easier for us to pretend—like the President—that Medicare wasn't in that bad of shape.

It would have been much easier and safer politically to slap a band-aid on Medicare like the President wanted to do.

But we didn't take the easy way out. Republicans in Congress stepped up to the responsibility of leadership and did the right thing. We didn't dodge the issue. And we ended up with a bill that I think is about as good as possible.

It might not be perfect. It makes sweeping changes in a huge program and deals with a ton of complex issues. And we might have to go back in next year or the year after and fine tune it. But this bill provides a good basic foundation for the long term financial health of our Medicare Program.

It preserves Medicare. It strengthens Medicare. It gives senior citizens the same kind of choices in health care that Members of Congress have. And it makes Medicare more efficient and more cost-effective.

I urge my colleagues to support and pass this bill. And I urge the President to quit playing politics with the health care of our senior citizens and sign this bill when it reaches his desk.

Ms. SLAUGHTER. Mr. Chairman, I am very concerned that we are being forced to vote on this measure—which if enacted would be devastating to the health and well-being of our seniors—without adequate time for the American public or the Members of this House to study the bill and learn exactly how the 37 million people covered by Medicare will be affected. Such drastic changes to a system as massive and crucial as Medicare cannot be responsibly considered with just 3 hours of floor debate.

We will don't fully understand the consequences of what this bill will do, but what little we do know is looking pretty bad. In addition to doubling senior's Medicare payments, forcing seniors to give up their long-time doctors and shutting millions of infirm Americans out of nursing homes, there are some little known provisions that seriously and negatively affect the health and well-being of our seniors.

Take, for example, the bill's provisions to ease the ban on physician self-referrals—that is, doctors who refer Medicare patients to labs in which they have a financial stake. We have long know that this is a situation that is ripe for abuse. In fact, the HH's Office of Inspector General found that patients of referring physicians who owned or invested in independent clinical labs received 45 percent more services than all other Medicare patients in general. And the Consumer Federation of America found that doctors with a financial interest in labs ordered 34 percent to 95 percent more tests than other physicians. And the New England Journal of Medicine reported that doctors who owned imaging devices—like MRI's, for example—ordered imaging tests four times more often than doctors who did not.

That's why regulations have been implemented to prohibit doctors from sending patients for tests and services from which the doctor would profit. The Congressional Budget Office has estimated that easing this ban on self-referrals will add another $1.1 billion to the cost of Medicare, through excessive and unnecessary testing and services.

Another provision of this bill that deserves a lot more study and discussion is the section which would eliminate most Federal regulation of medical laboratories located in doctors' offices. These regulations came about after Congress heard horror stories of patients suffering and dying as a result of inaccurate lab tests. Most serious were the women who died from cervical cancer—a disease that is almost always curable if caught early—because their Pap smear test were misread.

The fight against waste, fraud and abuse has earned bipartisan support throughout recent debates on health care financing. But, cutting vital regulations without giving serious consideration to the affect on the health and well-being of millions of our citizens is irresponsible.

Mr. Chairman, it is ludicrous to rush this enormous and far-reaching legislation through the House in the hopes that the public won't be quick enough to figure out what's in it. I urge all my colleagues, in the name of the 37 million senior citizens we represent, to reject this course of action, and vote against this bill.

Mr. BALLENGER. Mr. Chairman, I rise today to express my support for H.R. 2425, the Medicare Preservation Act. Furthermore, I rise to thank the Members who understood the urgency of the Medicare Board of Trustees report showing that trust fund reserves will be fully depleted by 2002 and created a plan to save it. Unfortunately, President Clinton has been content to do nothing. I think the message is clear folks—Medicare is going broke and the Republican leadership has undertaken the task of saving it.

The Republican plan, the Medicare Preservation Act, will not take away Medicare but rather will protect, preserve, and strengthen it. We are not cutting Medicare, instead, we are allowing Medicare to grow at about 6 percent. Under the Republican budget, spending per beneficiary will increase from $4,800 to $6,700 over the next 7 years. You will get to keep your current doctors, and the Government won't force you into any plan that you don't want to be in. This is your right—to a choice of doctors, of plans, and to a system that's secure for current and future retirees. Each year Medicare beneficiaries will receive a form from the Government that lists available plans—traditional Medicare, managed care organizations, new groups known as provider sponsored networks that will be set up by doctors and hospitals, and medical savings accounts, where you purchase a high-deductible policy and the Government deposits money to cover that deductible in an interest-bearing account. If you do nothing, you're automatically enrolled in traditional Medicare. If you want another plan, that's up to you.

Furthermore, to accumulate more savings, the GOP plan would eventually end the subsidy that goes to wealthy seniors who choose to remain in the traditional Medicare Program. Wealthy beneficiaries—single people earning more than $75,000 a year and couples earning more than $150,000 a year—would pay the total cost of their premiums for the doctor portion of Medicare part B. Projected savings would be approximately $10 billion.

Our plan also combats fraud and abuse. As Medicare is designed right now, doctors are paid for procedures whether or not the patient needs them. That means the taxpayers get ripped off, and the Medicare patient doesn't get the best care. By allowing providers, hospitals, and insurers to compete for your business, the system will root out fraud and abuse and will squeeze out the waste. Seniors who find fraud in their bills will be rewarded with a percentage of the money recovered. In addition, regulatory relief would allow hospitals serving the same geographical areas to jointly plan to provide services and facilities, which they are currently precluded from doing by antitrust laws. The intent is to prevent a duplication of expensive machines and services and to remove the costly use of an insurance company or managed care organization as an intermediary. This would help beneficiaries in rural areas where there are few managed care groups.

I urge all Members to support the Medicare Preservation Act. With the support of the American Medical Association [AMA], the Seniors Coalition, U.S. Chambers of Commerce, the National Taxpayers Union, and millions of seniors, we are providing Medicare for future generations.

Mr. COLEMAN. Mr. Chairman, I am privileged to represent El Paso, TX, a community of approximately 600,000 people. Of this amount, almost 60,000 people receive Medicare. In other words, 10 percent of El Paso's population is on Medicare. That is a significant number. These are significant cuts.

I regret that the majority has not scheduled more time for hearings nor the ability to review the plan. The Democratic leadership has been forced to schedule additional days of hearings on the only space provided to us, the lawn of the Capitol, so that the American people can have a chance to participate in the process that will affect 37 million of them.

In fact, this back room dealing on the Medicare plan has gone so far as to force senior citizens to stage protests in the Commerce Committee and be arrested by the Capitol Police. Also, in an article titled ''Bribes for Doctors'' the New York Times points out that Speaker GINGRICH ''brought the American Medical Association behind his Medicare reform program last week by handing out three concessions.'' These concessions were not given in the light of day after debate. No, they were given in a last minute desperate secret attempt to reign the AMA in.

I have had over 500 constituents writing or calling to urge me to oppose these cuts. One constituent writes:

My wish is that the Democratic Party would hammer on the fact that President Clinton wanted health care reform 2 years ago. . . . The Republican Party bombarded the air waves stating that if it was not broken, don't fix it. It's ironic that the moment the Republicans came into office, health [care] had deteriorated so quickly, that now, the Republicans are the only solution to Medicare.

I could not agree more. Not only has the Republican Party opposed the original drafting of this legislation, but they have continued to be antagonistic toward its existence for years. Now after providing only an outline, we are supposed to realistically debate the Republican effort to save Medicare in one day? I have the same trouble believing this as my constituent does.

However, I will limit my comments to the minor details I am aware of regarding this plan.

PART B PREMIUMS

First and foremost is my problem with the increase in part B premiums. The plan calls for a continuation of the 31-percent premium instead of dropping the level to 25 percent as current law now dictates. This allows for an increase of almost $700 a year by 2002.

Not one penny of this increase will go toward the part A trust fund. This increase will only go toward the general fund and can be used to balance the budget while giving a $245-billion tax cut to the wealthy.

CHOICE

The outline states that it offers a choice to seniors in the type of health care organization they would like to become a part of without limiting their ability to stay in the traditional Medicare program.

However, the different choices available to seniors have not been subjected to a test to determine if they will save any money. And plans such as medical savings accounts and HMO's are only viable options for wealthy and relatively healthy senior citizens. Therefore, these options are only available to the few seniors who fit that description.

WASTE, FRAUD, AND ABUSE

Waste, fraud, and abuse is the single biggest concern of my constituency regarding Medicare. I have spoken to many El Pasoans and, by far, the largest complaint regarding Medicare I have heard is ''Stop the waste and fraud and you will find the money to support Medicare.''

The Republican plan offers only three minor initiatives, a hotline, making nursing facilities provide cost estimates, and stiffer penalties for those found guilty of fraud.

Again, there is no estimate on how much these programs will actually save and these measures are not comprehensive enough to deal with the entrenched problem of fraud and abuse throughout the system.

EFFECT ON HOSPITALS AND PROVIDERS

The plan also contains significant changes in assistance to health care providers. I had previously sent a letter to El Paso hospitals outlining the possible changes that might occur under this plan and asked them to illustrate how these changes might effect the day to day functioning of their hospitals. I would like to illustrate the destructive change this plan would have by reading one of those letters:

Expected Effects to . . . as a Result of Medicare and Medicaid Reductions:

Staffing:

If funding is not available, . . . would face the very real possibility of staff reduction by as much as 992 positions during the 7 year period. We would lose $31,982,080 over the next 7-year period for the El Paso economy.

Clinics:

Our clinics currently operate five days a week. The reductions would force a 50% cutback in operations to 2.5 days a week.

Reduction in Services.

The hospital district's mandate is to care for indigent patients and we do not believe that we could eliminate basic services. A reduction in both Medicare and Medicaid dollars would lead to a rationing of resources that would be manifested in a number of ways:

1. Eliminate Level One Trauma Services;
2. Reduction of Pharmacy, Physical Therapy and all other outpatient services;
3. Frequent delays in all inpatient services throughout every area of care.
4. Elimination of elective cases in the operating room and reserving the operating room for emergencies only. This would lead to less funding support to the rest of the hospital and create a greater need for tax payor [sic] support.
5. Our current funding for Physician Service totaling $5,000,000 could be reduced by as much as 50% causing us to care for mainly indigent care patients.
6. Residency Programs: Our current funding of 148 residents would be reduced by as much as 60% or to only 59 residents. This sets the pattern for future physician shortages.

The above possibilities could eliminate all funded patients, putting greater risk on the tax base. All planned admissions could be delayed and the hospital could become one giant emergency room and triage hospital.

This is just one example of the type of destructive impact this plan would have on our community. I have received similar letters from all the other hospitals in El Paso.

MEANS TESTING

The plan also proposes to charge seniors with incomes over $75,000 for individuals and $150,000 for couples higher premiums. Again, these premiums will not put one penny in the part A trust fund. However, this revenue will go directly into the general fund. Means testing in this form is unnecessary.

FAIL SAFE PROVISION

The entire Republican budget plan rests on their ability to provide $270 billion in savings from the Medicare Program. However, the plan falls short of these savings by $90 billion. Yesterday, NEWT GINGRICH said he was afraid that his own CBO would substantially underscore the savings he believed could be accomplished by using HMO's and other provider plans.

If the CBO cannot come up with the magic numbers Speaker GINGRICH wants, where do you think they will come from? From the 37 million beneficiaries that Medicare now serves.

Aware that this plan may not total the $270 billion, it includes a fail safe provision that will allow future bureaucrats to make additional costs.

This hidden provision subjects beneficiaries to unknown future liability. If future decisions expose health care providers to additional cuts, they may pass the cost directly to the beneficiary or drop out of the program altogether. This would mean that even after paying more money for less services this year, seniors would be asked to do the sacrifice again, sometime in the next seven years, to achieve the same savings the original plan proposed and have a choice of much fewer providers.

This plan is the wrong way to achieve the savings that Medicare needs. This plan allows the Republicans to attempt to balance the budget while giving a huge tax break to the most wealthy Americans on the backs of senior citizens and the disabled. It is wrong.

Mr. BEREUTER. Mr. Chairman, this Member is pleased that the leadership has agreed to improve the AAPCC formula used to determine county capitation payments for the MedicarePlus program. This change is critically important and will ensure that rural Americans have the same access to the options in the MedicarePlus program as citizens in urban areas.

This change will greatly improve the health care options in rural areas by creating a formula floor of $300 per month the first year for all counties now below that level. It would rise to at least $320 the next year. Almost all counties in Nebraska fall in this category. In fact, in the 1st Congressional District of Nebraska, 21 out of 25 counties, including Lancaster County, will benefit because they are now well under the $300 county capitation rate.

This change also rectified the problem experienced in some metropolitan areas such as Seattle and Minneapolis whose medical communities are more efficient providers of health care than other urban areas.

Mr. Chairman, since this improvement was made in the bill, this Member is pleased to support it.

Ms. BROWN of Florida. Mr. Chairman, the House of Representatives is the People's House. We were sent here to Congress with a mission: to serve the people. As Members of Congress, we should be listening to our constituents and voting against proposals that will devastate our seniors.

Here I have hundreds of questionnaires that my constituents signed opposing drastic Medicare cuts. During the break, I met with over 3,000 of my constituents at 14 town meetings and they told me they are appalled at the Republican plan to cut Medicare. Oh, did I say CUT? I meant GUT.

Mr. Chairman, the Republican Leadership is unhappy about us using the word CUT to describe the Republicans' Medicare plan. Okay, fine. Maybe CUT is not quite the right word. Well how about G-U-T? How do you like the word GUT? The fact is that Republicans want to destroy Medicare's security and leave our seniors stranded to fend for themselves. They say they are ''saving'' Medicare.

Well, I come from Florida where I served for 10 years in the Florida House. In Florida we have a saying for that kind of thing, ''That dog won't hunt.''

Thousands of my constituents have told me that they are outraged at the Republicans' reverse Robin Hood tactics, stealing from the working people and giving tax breaks to the wealthy. As we say in Florida, ''That dog won't hunt.''

Two days ago, I spoke to the National Council of Senior Citizens, who have been leading the fight against drastic cuts in Medicare. NCSC has shown great courage and true leadership in this fight and I want to say to them: Thank you. Thank you for your work. Thank you for your bravery. And thank you for your commitment to seniors.

Recently in Washington, NCSC led a rally against Republican Medicare cuts by rolling out a giant Trojan Horse representing Republicans' empty promises on Medicare.

And last week, seniors from NCSC came to Congress to protest the fact that the Commerce Committee was voting on a Medicare bill without having one hearing on it. For that, they were arrested?

Shame on my Republican colleagues for shutting out seniors from Congress—the People's House. As a Democrat who believes in the Democratic process, I believe those seniors deserve to be heard, and not arrested.

Seniors are the ones who made this country great, and we owe it to them to protect their health care. We should be celebrating and embracing our seniors, not stabbing them in the back by taking away their health care.

Mr. KIM. Mr. Chairman, I rise today in support of the Republican plan to save Medicare.

I think everyone would agree that the Medicare program has been an enormous success over the past 30 years. Because of Medicare, millions of senior citizens have gained access to the health care that they otherwise wouldn't have been unable to afford.

But trouble looms just over the horizon for Medicare. As many people have heard by now, the Medicare trustees recently warned that the Medicare trust fund is going to be broke by 2002. That would be a catastrophe: If the Medicare trust fund is exhausted, the program cannot legally continue to provide benefits to senior citizens- leaving millions of seniors without needed health care.

In response, Republicans have put forth a dramatic plan to save Medicare from bankruptcy. Unfortunately, many of my Democratic colleagues are skeptical of the need for reform. ''We agree the system is in trouble,'' my colleagues argue, ''but the Medicare trust fund has faced bankruptcy before and the program has survived. Why do we have to make sure dramatic changes now?''

The answer is simple: The current Medicare crisis is of such magnitude that it demands a long-term, comprehensive reform of the system.

In the past, Congress has always dealt with Medicare's financial problems with short-term, quick fixes. Several times over the past two decades, Congress has tinkered with Medicare to shore up the financial problems in the program. Usually, these short term solutions involved raising payroll taxes, cutting payments to providers, or raising premiums and copayments for seniors. And these quick fixes worked, at least temporarily. After each one, Medicare was able to limp along for a few more years, until the program had to be ''fixed'' again.

But the day of reckoning has arrived for Medicare. For the first time in the program's history, the costs of Medicare are growing so rapidly that no amount of ''tinkering'' can make up the difference. If Congress does nothing, Medicare spending will nearly double by 2002—growing from $160 billion today to $318 billion in just 7 years. And that's before the first wave of baby boomers starts to draw benefits from Medicare. If left unchecked, such astronomical growth will swamp the Medicare program and add trillions of dollars to the national debt.

Why is Medicare growing so fast? The main problem is that the current Medicare program simply does not deliver health care cost effectively. While innovations in the private health care market have had some success in controlling health care costs, costs in the government-run Medicare program have continued to skyrocket. For example, while large private insurers cut their health care costs by 1.1 percent last year, Medicare costs grew by more than 10 percent. Of course, these results should not be shocking: Should we really be surprised that a government-run program such as Medicare is characterized by rampant inefficiency and skyrocketing costs? I think not.

To put it simply, Medicare is a 1960's government insurance program that simply does not meet the demands of providing health care in the 1990's. The system needs fundamental reform in order to survive.

That is why Republicans are proposing the ''Medicare Preservation Act''. Our proposal is an attempt to save the Medicare system from bankruptcy by making the program more efficient and cost effective. In doing so, it would reduce the growth of Medicare by $270 billion over the next 7 years?

So how does our plan reduce the growth of Medicare?

The plan starts by declaring war on Medicare waste and fraud. Among other things, the plan dramatically increases penalties for fraud, provides funds for new computer technology that can identify fraudulent activities, and sets up procedures for giving cash rewards to seniors who report abuse in the Medicare program. The plan also implements malpractice reform to eliminate frivolous lawsuits which drive up costs for everyone in the system. Finally, our proposal reforms how Medicare pays doctors and hospitals to make sure that health care providers don't order extra tests or unnecessary procedures simply for financial gain.

The plan also asks doctors, hospitals and seniors each to contribute a little toward saving the program. For example, doctors and hospitals will continue to see their Medicare payments grow—but not as fast as they would under current law. Seniors will be asked to pay a little more Part B premiums. Note that even with these premium increases, seniors will continue to only pay about 1/3d of the cost of Part B—and taxpayers will continue to subsidize 2/3ds of the cost. I think this is fair—we cannot force working families, many of whom can't afford health insurance themselves, to increase their subsidy of the Part B program.

But our proposal goes much further than just attacking waste and limiting the growth of payments to doctors and hospitals. The core of the Republican proposal is a truly revolutionary idea: Let seniors have the same health insurance choices that their children and grandchildren have.

Under our plan seniors would have three options: First, join a private health insurance plan and have Medicare pay the premiums; Second, use Medicare dollars to purchase a high-deductible health plan and have savings placed in a medical savings account. or Third, stay in the current system. So, for example, if you like the health plan you have at work, you can keep it when you retire—and Medicare will pay the premiums. If you want to join another private insurance plan, you can—without being excluded for preexisting conditions. And if you want to stay in the current government-run Medicare system, you can do that, too. The idea is that, by allowing seniors to join more efficient private insurance plans, we can save money and give seniors more health care options at the same time.

In short, the Republican proposal is a fundamental departure from past attempts to reform Medicare. Instead of trying to squeeze more money out the current system, we are proposing to change the system so that it can provide the same benefits for less money. And don't forget: Republicans are not proposing to cut Medicare—under our plan, benefits will still grow from $4,700 per person today to $6,700 per person in 2002.

Unfortunately, opponents of our plan reject the kind of fundamental reform Republicans are proposing. They want to tinker with the system some more—maybe push Medicare's bankruptcy back a couple of years. The problem is, under this approach, we will be right back here in a few years, arguing over these same issues. Except, by then, the deficit will have grown substantially, the Medicare trust fund will be in even worse shape, and—most importantly—the baby boom generation will be that much closer to retirement. In fact, a recent study estimated that the Medicare reform plan offered by the Democrats would leave Medicare $300 billion dollars in debt just as we have to start paying for the baby boomers. To me, that's irresponsible.

Finally, I want to respond to my Democratic colleagues who accuse Republicans of cutting Medicare to provide a ''tax cut for the rich''. I am here to tell you that nothing could be far-

ther from the truth. The fact, is Republicans have already passed more than enough spending cuts than are needed to pay for our proposed tax cut. The Republican budget resolution—passed last April—contains $622 billion in non-Medicare spending cuts. That is two-and-a-half times the amount of spending cuts needed to pay for tax cuts. And let's look at the tax cuts themselves: Is a $500 per-child tax credit a tax cut for the rich? Is a $500 tax credit for the care of an elderly relative a tax cut for the rich? Is cutting taxes on IRA withdrawals or the sale of a home a tax cut for the rich? I think not.

So let's end this partisan bickering. We must act now to save Medicare—while there is still time to engage in rational, thoughtful reform of the Medicare system. By making the system work more cost-effectively, we can preserve, strengthen and simplify Medicare—and make sure current and future generations of seniors will have access to this vital program. For these reason, I urge my colleagues to support the Republican plan to save Medicare.

Mr. PORTMAN. Mr. Chairman, Medicare's problems are now well known. The question is whether official Washington has the courage and foresight to fix them. If the partisan bickering continues and nothing is done, the Federal program providing health care insurance for roughly 33 million seniors and 4 million disabled Americans won't be there for anyone.

We know that skyrocketing medical costs, an aging population and a decline in the ratio of workers paying into the system have placed Medicare in dire financial straits. We know about the alarming Medicare Trustees' report—the Part A Trust Fund—which covers hospital, skilled nursing and home health services—starts paying out more than it takes in next year and goes broke 6 years later. We also know that Medicare offers limited choices to beneficiaries, is rife with fraud and abuse and, typical and entitlement programs, lacks a cost control mechanism. Such cost increases are simply unsustainable in a program that now accounts for over 11 percent of the Federal budget. This has led to annual cost increases in excess of 10 percent, at least twice as high as private health care costs.

With all of this knowledge and after more than two dozen public hearings and hundreds of town hall meetings, comprehensive Medicare reform legislation was introduced in the House at the end of September. Democrats have dismissed the plan as a mere means for paying for Republican-sponsored tax cuts. This misses the point. The tax relief has already been paid for with spending cuts and has nothing to do with Medicare reform. Republicans, in turn, are too defensive about the politically sensitive task of curbing entitlement spending. Both sides need to be honest about the facts, get down to work on the serious challenge before them, and stop the political gamesmanship. Here's what the proposal just introduced does and doesn't do.

It does allow beneficiaries to keep their current coverage. If someone is currently enrolled in the traditional fee-for-service plan—which over 90 percent of beneficiaries are—by doing nothing that plan is continued. But many will want to change. The innovative aspect of the proposal is that it offers seniors choices until now only available in the private sector—coordinated care, Medical Savings Accounts and provider-sponsored networks, to name a few—and sufficient information to make good choices.

Some may opt for coordinated care to reduce out-of-pocket costs or obtain prescription drugs, eyeglasses or other coverage currently excluded under Medicare. Others may want to take advantage of a Medicare Savings Account where beneficiaries can purchase a high deductible, low-cost insurance policy and the government deposits money that would have gone toward more traditional Medicare benefits into an interest bearing account that can be withdrawn tax-free to cover medical expenses.

Contrary to the heated rhetoric, Medicare is not being ''cut''; spending per beneficiary will actually increase under the proposal from about $4,800 in 1996 to $6,700 in 2002. Granted, that is not as steep an increase as currently projected, but it remains a generous program. Moreover, despite claims from the plan's critics, the House proposal does not increase copayments or deductibles. Premiums will increase in absolute numbers under the House GOP plan, a bit more than they would under current law. This is because the proposal locks in today's premium of 31.5 percent of the cost of Part B services (doctors visits, lab work, etc. . . .), rather than having the percentage paid by beneficiaries decrease (and the percentage of the public subsidy increase) as it would under current law. As a result, instead of paying $61 a month seven years from now as would be the case under current law, the amount would be approximately $87 a month. This reflects the fact that health care costs will go up in that time period. Most seniors I talk to are willing to see this kind of increase if it is part of getting the system on its feet.

Only those better off (individuals with incomes over $75,000 and couples with incomes over $125,000) will pay a higher percentage of Part B premium costs. Again and again in my town meetings and discussions with seniors, I've been impressed with the willingness of people to pay a little more if it helps put Medicare back on its feet.

The proposal also tackles fraud and abuse. Seniors in my District and around the country have offered innovative ideas to curb the fraud and abuse that adds billions of dollars in health care costs each year. The proposal rewards seniors who report fraud to the government and the government, in turn, increases penalties for those who defraud the system.

Those who have taken a hard look at the benefits of increased choice and competition believe that health care delivery can be improved and costs reduced. In conjunction with affluence testing and reduced fraud and abuse, many believe that savings will be generated adequate to keep the program solvent at least until the baby boom generation begins to retire. But they may be wrong. That's why the current plan also builds in a ''failsafe'' mechanism, under which government payments to providers will be reduced if targets are not met.

Is this plan perfect? No. It surely can be improved and there ought to be a bipartisan effort to do so. But it's the only plan out there that seriously addresses Medicare's financial troubles. For the 37 million Americans in the system and those millions more in years to come, let's hope Congress and the White House can get beyond the rhetoric and work together to produce a responsible plan that saves this vital system. And, in the process, let's hope both sides can be more honest with the American public about how that's achieved.

I urge my colleagues to support this legislation as a responsible approach to a very real problem.

Mr. FOGLIETTA. Mr. Chairman, there has been a lot of talk this year about contracts. First, there was the Contract With America. Or as they call it in my neighborhood in south Philadelphia, the contract on America. There is the contract with the American family.

Now I studied contracts in law school. A contract is not a very complicated thing: you agree to do something for me and I will do something for you.

As we vote on this bill today, let us all think about what our parents did for us and for America. The generations of parents who stand at risk because of this legislation gave decades of their lives at work to raise us, feed us, clothe us, to educate us.

They fought the Second World War for us, they saved the world from an enemy so evil it is unthinkable to consider what would have happened without them, our parents.

After World War II, men and women in this Chamber did a profound thing. They created a way for our parents to live out their lives in security, in peace, and in health.

The created the Social Security and Medicare systems.

These programs represent a covenant among generations. But now we are tearing up that contract.

They are tearing up that contract when they raise premiums on elderly Medicare recipients who just cannot afford it, and next week they propose to cut Medicare to the bone to pay for a tax cut for the wealthiest Americans.

They are tearing up the contract by pushing people too hard into a system that will take their choice away.

They are tearing up that contract with huge cuts to hospitals and doctors and that slam the door on access.

These are senior citizens who have held up their end of the contract. We have to keep our part of the bargain. I urge my colleagues to oppose this bill and support the Gibbons-Dingell substitute.

Mr. CASTLE. Mr. Chairman, I rise in support of the Medicare Preservation Act. This is a realistic proposal which addresses the serious problem of Medicare's pending bankruptcy. For the last 6 months, I've traveled throughout Delaware, held town meetings, and visited with senior centers to talk about this important program, which provides health care for roughly 100,000 aged and disabled Delawareans. Delawareans want to know that this critical program will be there for them in the future. They recognize that the Government cannot afford to continue the Medicare Program as it currently exists.

Medicare, created in 1965, is comprised of two parts, part A and part B, which provide hospital coverage and doctor coverage for 99 percent of all older Americans. President Clinton's Medicare trustees have clearly and succinctly stated that the program is in financial dire straits. Why? The Medicare Program grew at a rate of 10.5 percent last year—three times that of inflation and twice as much as private sector medical costs. Further, the General Accounting Office [GAO] has estimated that as much as $44 billion a year is wasted on Medicare and Medicaid fraud, and about 30 cents of every dollar is wasted or lost due to mismanagement by a Federal agency.

Thirty-seven million people depend on the Medicare Program, and it is frustrating to see the program politicized. No one—not Democrats, not Republicans—invented Medicare's financial crisis. The program has been heading toward bankruptcy for years. During the last Congress, President Clinton created a bipartisan Commission on Entitlement and Tax Reform, on which I was selected to serve, to try to transcend politics and address entitlement programs in a responsible, bipartisan manner.

In forming the Commission, President Clinton said ''This Commission will be asked to grapple with real issues of entitlement reforms. . . . This panel, I expect, will ask and answer the tough questions. . . . Many regard this as a thankless task. It will not be thankless if it gives us a strong and secure and healthy American economy and society moving into the 21st Century.'' While the final report to the President did not endorse specific proposals to reform entitlement programs, it stated ''We must act promptly to address this imbalance between the government's promises and its ability to pay.'' However, no further action was taken by the Democratic leadership in Congress or the President.

In contrast, Republican leadership in Congress has bravely confronted the issue, refusing to be thrown off track by those who are trying to turn Medicare reform into a political hot button. The Republican proposal recognizes that we simply must control the program's spiraling growth rate to guarantee that the program is maintained well into the future. The proposal does not bow to the political pressure of those who want a feel-good proposal that only scratches the surface of reform in order to provide a quick fix until after the next election.

Having said that, I think it would be naive to throw unconditional support behind any proposal that modernizes a 30-year program. Reforming Medicare is complicated business, and we do not have crystal balls allowing us to predict perfectly the outcome of these bold reforms. I do have some reservations about the proposal. For example, I am concerned about the potential impact of the ''look back'' provision that allows additional savings to come from doctor and hospital reimbursement rates if the amount of savings predicted under the bill do not measure up. I want to ensure that nursing homes continue to be a safe place for our seniors. I want to ensure that some of the deregulatory provisions in the bill don't ultimately increase costs, like those relating to physician self-referral.

Given the stakes here, however, the good cannot be set aside while we try to achieve the perfect. In its entirety, the proposal is realistic, sensible, and fair. The proposal saves Medicare from bankruptcy and recognizes that dramatic changes must be made and new options must be provided to this important program.

Next year, the Federal Government starts spending more on Medicare than it takes in and in 6 short years, the Medicare Program is insolvent. Under the Republican plan, Medicare is preserved until 2010, benefits will continue to grow and patient choice is not only maintained—it is expanded. Older Americans receiving Medicare can stay in the current system, with their current doctor, without having to choose another health care plan. Or, they can choose a private sector plan that offers more benefits, like prescription drugs or eyeglasses or put their funds into a medical savings account.

Under the Republican plan, there are no cuts in spending—spending goes up 40 percent over 7 years, with per beneficiary spending increasing from $4,800 today to $6,700 in 2002; there is no increase in Medicare copayments; there is no increase in Medicare deductibles; and there is no change in the current rate of Medicare premiums. Today and tomorrow, premiums are 31.5 percent of Medicare part B costs. They will continue to be calculated that way.

In addition, the bill cracks down on waste, fraud, and abuse that pervades the current system, enacts tough malpractice reforms to end runaway spending and frivolous lawsuits, and allows doctors and hospitals to join hands in providing health care in a provider network arrangement. Lastly, the Medicare Preservation Act clearly states that the savings from slowing Medicare's growth rate must go back into the health care system in a lock box and cannot be used for any other purpose.

Enacting a bold Medicare preservation plan is not only absolutely necessary; it is the responsible action and the least we can do for the 37 million Americans who depend upon Medicare now and for the millions of Americans who will depend upon Medicare in the future.

Mrs. THURMAN. Mr. Chairman, I rise today to express my opposition to the Republican plan to cut Medicare to finance a $245 billion tax cut for the wealthy. Under the Republican plan, Florida will lose $28 billion from Medicare. As a result, my constituents will play higher premiums, face uncertainty about their ability to stay with trusted doctors, and lose their sense of health care security.

Republicans have promised a utopian world of free choice and complete access to services. But, there is no choice when cuts in the fee-for-service program force seniors into health maintenance organizations. And there is no quality service when our health care system for the elderly is cut to free up money for tax cuts. Paying more for the same service is a cut, and the Republicans know it.

We need to stand up for the seniors of America. Seniors were forcibly silenced during the so-called debate on this issue in committee. When we tried to expose the Republicans plan for what it is, we were shut out of hearings and forced to meet on the Capitol lawn. It is our obligation, as representatives of all citizens, including the most vulnerable, to speak out and vote against these drastic cuts.

Mr. LATHAM. Mr. Chairman, I rise to support the Medicare Preservation Act.

Medicare has successfully provided basic health care for our Nation's senior citizens. However, the Medicare Program is sick, very sick. According to President Clinton's own advisors, the Medicare system will face bankruptcy in the next decade if fundamental reforms do not take place. If the program goes broke, seniors will lose their Medicare hospital coverage.

During the Medicare reform debate, I have worked to ensure that four goals are achieved. First, the long-term integrity of the Medicare system must be preserved for present and future retirees. Second, lower-income seniors must be protected from cost increases that they cannot afford. Third, Medicare reforms should provide more competition and consumer choice, not more Government control. And finally, the huge reimbursement discrepancy between rural and urban counties must be fairly adjusted. I am proud to say that the Medicare Preservation Act meets these goals.

The Medicare Preservation Act will ensure that every Medicare recipient will continue to receive affordable, high quality health care now and in the future. Medicare spending will increase from $4,800 to $6,700 per person over the next 7 years. Seniors will have more health care options including traditional fee-for-service Medicare, managed care plans, and medical savings accounts. Finally, the increase in per capita payments for rural counties will ensure that seniors who live in rural communities will have the same health care options as their friends in urban areas.

The Medicare Preservation Act strengthens Medicare for the 21st century. I strongly urge my colleagues to support passage of the H.R. 2425.

Mr. KLECZKA. Mr. Chairman, today the new Republican majority has demonstrated that their position on Medicare has not changed in 30 years. In 1965, Democrats enacted the Medicare Program amidst Republican opposition. and today, despite the overwhelming success of this program, Republicans have voted to undermine it. I am not surprised that the GPO has voted to make unprecedented cuts in this critical health care program, after all, they have never consistently supported Medicare. But to take $270 billion out of a program that protects senior citizens in order to pay for tax cuts and to balance the budget—this is simply extreme.

Republicans claim these cuts are to strengthen the trust fund, which according to the Medicare trustees is expected to become insolvent 7 years from now, in 2002. But in the last 20 years the trustees have projected that the fund would be insolvent in 7 years or less at least nine times. In fact, just last year, the trust fund was projected to become insolvent in the year 2001—7 years out. Yet my Republican colleagues said nothing. In fact, the only provision proposed to date by the Republican majority that has a measurable impact on the trust fund actually takes more than $87 billion out of the fund over the next 10 years! For 30 years it has been up to the Democrats to protect and preserve Medicare. It looks as if it will be up to us for the next 30 as well.

In their new found concern about the Medicare trust fund, the GOP plan cuts the program by $270 billion over 7 years. And their plan does extend the life of the trust fund to the year 2006. However, what they don't tell you is that the Medicare actuaries estimate that only $90 billion is needed to extend the trust fund to that year. What are they doing

with the balance of the money? They are using it to pay for tax cuts and deficit reduction.

In contrast, the Democrats have introduced alternative plans that achieve the same level of solvency that the Republican plan achieves, but at only a third of the cost. These proposals reduce Medicare expenditures by only $90 billion over 7 years and still assure that the trust fund remains solvent for the next 10 years. Because every penny of this $90 billion is targeted to the trust fund, we are able to strengthen the fund without weakening the program for current beneficiaries.

The Democratic substitute contains a series of responsible reforms combined with modest improvements that put beneficiaries first. This alternative does not increase premiums, copayments or deductibles. In fact, the plan even eliminates excessive copayments that beneficiaries currently pay for hospital outpatient services. Moreover, Medicare's current limits on balance billing are retained, essential protections for Medicare beneficiaries in nursing homes are preserved, and tough laws against fraud and abuse remain on the books.

The Democratic bill updates Medicare benefits to prevent cancer and complications from diabetes including colorectal screening, pap smears, pelvic examinations, and increased coverage of breast cancer screening. Also, payment would be authorized for diabetes outpatient self-management services and for blood-testing strips for individuals with diabetes.

Our plan also offers expanded choice of providers and plans, permitting beneficiaries to enroll in preferred provider organizations [PPO], point-of-service [POS] plans and provider service organizations in addition to the current fee-for-service and HMO options. But unlike the Republican bill, our reform proposal also ensures that these new options are real choices. Plans must honor limits on balanced billing and they are paid adequately in order to shield beneficiaries from additional out-of-pocket costs.

Certainly, efforts to control spending require that some limits be places on reimbursements to all providers, including physicians. Since the American Medical Association has been so supportive of the GOP plan, the Democratic alternative largely mirrors the Republican proposal with respect to payment reforms. Special caution is taken with reductions in payments to hospitals. Excessive cuts in hospitals, like those proposed by the majority, could be counter productive, negatively affecting the quality of care, reducing access to care and resulting in higher costs for the private sector. The alternative plans includes reasonable reductions in hospital payments but also safeguards hospitals that serve the uninsured in rural and urban areas.

I urge my Republican colleagues to stop marching blindly for just one moment to consider this worthy, thoughtful alternative. If your goal is to preserve the trust fund, this alternative plan accomplishes that goal. If you want to strengthen the Medicare program and bring it into the twentieth century, this plan gets there. If instead, you wish to pursue this scorched earth policy in order to balance the budget and pay for tax cuts, then you have that option before you today. But at least stop long enough to think about what it is that you want to achieve.

It dismays me that we have come this far in the process and are left with a Republican plan or the Democratic alternative. It did not have to come down to this. Democrats on the Ways and Means Committee and on the Commerce Committee attempted to work with Republicans to add these protections included in the Democratic alternative to the Republican plan and to improve the GOP proposal. Ways and Means Democrats offered more than 35 constructive amendments to the Republican bill. Of these, only four were accepted by the Republican majority.

Today we will not have the opportunity to present constructive amendments because the rule is closed. But they cannot hide from their agenda. Republicans on the Ways and Means Committee voted in lockstep to reject an amendment to extend basic consumer protections to Medicare beneficiaries who choose managed care plans. They opposed an amendment, offered by myself, to safeguard beneficiaries from a practice called balance billing in which the patient is expected to pay the difference between what the doctor charges and what Medicare pays. Republican members voted against an amendment that would have restored funding for inner city and rural hospitals who serve the uninsured, and rejected an amendment to retain the current standards for nursing homes. They also voted against amendments to increase screening for breast and cervical cancer, rejected amendments to provide coverage for colorectal and prostate cancer screening, and turned back an amendment to provide better coverage for diabetics.

These are just some of the proposals on which the Republicans have gone on record. But today is the day to keep score. Today we each have a choice—to support senior citizens or to support tax cuts for wealthy Americans. I urge my colleagues to not take lightly this decision.

Mr. MFUME. Mr. Chairman, I rise today in opposition to H.R. 2425, the Medicare Preservation Act. This bill makes the most sweeping changes in the Medicare Program since its establishment in 1965. Since assuming control of Congress this January, House and Senate Republicans have been pushing for passage of the deepest package of Medicare cuts in the program's 30-year history. These changes will increase the cost of Medicare to the average senior citizen by nearly $1,000 and force many to give up their own doctors. According to the American Association of Retired Persons, the Republican Medicare cuts would be ''the end of Medicare as we know it.''

There is much in the bill that concerns me and my constituents. However, the provisions of this bill to change nursing home standards have raised the ire of many others. H.R. 2425 repeals current federal standards for nursing homes participating in the Medicare Program and replaces them with a requirement that nursing homes be State certified.

Many of my elderly constituents and their families recall the days when some nursing homes were little more than abusive prisons for America's seniors. They are not impressed by this so-called preservation effort.

Why the assault on Medicare? Why propose deep and potentially devastating cuts in a program that is a contract between Government and seniors who have paid into the program all their lives? Some Republicans will say that they are trying to save the program from bankruptcy. Others will say they need to raid Medicare to balance the budget (although at the same time they are proposing huge tax breaks for the wealthiest Americans). What are the real answers?

In understanding this latest attack on Medicare, I believe it is important to look beyond the latest conservative rhetoric about Medicare and examine the record instead. The fact is, since the 1950's, the GOP has consistently opposed even the creation of Medicare. Many of the party's prominent leaders voted against Medicare when it was first established in 1965. And current party leaders have repeatedly attacked Medicare and Social Security.

If the Republican Party had been in the majority in 1965, Medicare simply would not exist. A full 93 percent of House Republicans voted against Medicare when it was introduced. In fact, the Republicans voted overwhelmingly against the creation of Medicare on three other occasions in the early 1960's.

Their arguments were extreme then and they're extreme now. In 1965 they called Medicare ''socialized medicine'' and claimed it would ''impair the quality of health care, retard the advancement of medicine and displace private insurance.'' Nevertheless, Medicare passed, and for many years was widely hailed, even by Republicans, as a triumph of government.

Despite the doomsday predictions 30 years ago, Medicare has dramatically improved the health and welfare of American seniors and ensured that the elderly will never again have to choose between health care and food or rent.

Ironically, one of the reasons we even have a debate about reforming Medicare is because of its profound success. Americans are living longer and more productive lives. That means many more reach an age where greater health problems can emerge. We should not use the success of Medicare as a reason to recklessly cut the program.

The Medicare Preservation Act being voted on today does not preserve Medicare. Rather, it will violate the compact made with American's elderly over 30 years ago. This bill will push patients into managed care; provide obstacles for Medicare beneficiaries to find a physician willing to provide them care because of lower reimbursement rates; double Part B premiums for seniors living on a fixed income by the year 2002; close inner-city and rural hospitals which are already on the brink of bankruptcy and give a few bad doctors an open license to provide shoddy treatment since patients would no longer be able to rely on the court system for redress. Additionally this bill would repeal balance billing requirements for some categories of beneficiaries; encourage doctors to perform unnecessary tests—increasing overall health care costs—and allow them to refer patients to facilities they have a financial stake in; and increase costs by allowing healthier, younger seniors to opt out of Medicare through Medical Savings Accounts while leaving sicker and older patients in traditional Medicare.

The Republican cuts in Medicare are misguided and faulty. They go way beyond what is reasonable or necessary to maintain the solvency of the program. And when you strip away the rhetoric, all that remains is a huge tax break for the wealthy. They need a way to pay for their trickle-down tax break, and they believe they can pull it out of the pockets of

struggling seniors. America's seniors were told that their deepest beliefs in fairness, personal responsibility, social duty and contribution to society would be rewarded if they trusted Congress with their health care. Now Congress is using Medicare cuts to pay for a tax break for the wealthy.

Despite the feel-good rhetoric, the reality is that Medicare has been moved into the bullseye of the GOP target for massive cuts. When you look at the shotgun of this crew and the other targets of the conservatives—student aid, summer jobs, Federal workers—it looks less like responsible budget cutting and more like a drive-by shooting.

Mr. EWING. Mr. Chairman, the Medicare Board of Trustees reported last spring that ''The Medicare Trust Fund continues to be severely out of balance and is projected to be exhausted in 7 years.'' This report was signed by, among others, President Clinton's Secretary of the Treasury, his Secretary of Labor, and his Secretary of Health and Human Services.

Mr. Chairman, I am proud to stand up in support of legislation which will provide a long-term solution to the financial problems in the Medicare Program and guarantee that the program will be available for senor citizens well into the next century. In addition, this legislation will provide senior citizens with more choices in their health care decisions, while guaranteeing that senior citizens in Medicare now may remain in the program and keep their current doctor and hospital if they choose. This bill provides for an increase of Medicare spending from $4,800 per person now to $6,700 per person over the next 7 years, while at the same time guaranteeing the solvency of Medicare. I am proud to support legislation which protects and preserves Medicare without changing Medicare benefits, does not increase deductibles, and does not change co-payments.

I would like to commend the Republican leadership for agreeing to alterations in the legislation which will guarantee a minimum Medicare reimbursement level for rural counties which for years have received substantially less than more populous areas. This agreement will make the Medicare program more fair than it has been for seniors who live in rural America, while at the same time providing an incentive for HMO's and managed care programs to expand their services into rural America. This will provide seniors in rural areas more choice in their health care decisions.

It is extremely unfortunate that some have decided to play politics with Medicare by scaring senior citizens into thinking that their benefits will be cut by this legislation. It is unconscionable. Senior citizens deserve to live with the security that Medicare will continue to be there for them when they need it, and they should not be the subject of partisan politics.

This legislation simply controls the rate of growth of Medicare, which has been growing more than 10 percent every year, much higher than inflation. Spending on the program will continue to increase, only at a more controlled rate. The bill accomplishes this objective by maintaining premiums at the current 31 percent level (rather than decreasing as scheduled), reducing waste and fraud in Medicare, and encouraging managed care without forcing anyone into it.

Senior citizens don't want a band-aid solution to the pending bankruptcy of Medicare. They want a long-term solution which guarantees that Medicare will be there for them. This legislation does just that.

Mr. GALLEGLY. Mr. Chairman, I rise in support of H.R. 2425, the Medicare Preservation Act of 1995.

Mr. Chairman, when the majority in the Congress first took up the challenge of a potentially bankrupt Medicare System as presented by the Board of Trustees, I wanted to ensure that any reforms we initiated achieved two goals: first, the reforms must make the trust fund solvent as far into the future as possible; and second, none of the reforms could result in any degradation of current health services now enjoyed by those covered by the Medicare System.

In the days and weeks leading to today's vote on the Medicare Preservation Act of 1995, literally thousands of constituents contacted me to discuss this legislation and to voice their specific questions/concerns. As I began to research and consider the proposed reforms, their questions became my questions and I realized I could not in good faith cast my vote before I had all the answers.

One of the things they wanted to know was whether the new plan would allow beneficiaries to remain in the traditional Medicare System. The answer, of course, is absolutely. Only Medicare beneficiaries who choose to participate in one of the new MedicarePlus options will change plans.

Some were concerned by reports that the Republican plan was ''cutting'' Medicare benefits. Was this true? Were we cutting Medicare? The answer was absolutely not. The plan we adopted today significantly increases Medicare spending. Under the Medicare Preservation Act of 1995, average spending per beneficiary in California goes from $5,821 to $8,139 over the next seven years—an increase of more than $2,300.

Many of those who contacted me had been exposed to the false and inflammatory reports that the money we were saving by reforming Medicare would be used toward deficit reduction or tax cuts. In fact, nothing could be further from the truth. Any savings realized through our reform of Medicare must stay in Medicare. Period.

A final concern many seniors expressed to me was whether the quality of the care they currently receive would decline under a reformed Medicare. Well, I can report that—at a bare minimum—seniors under this plan will be guaranteed the same benefits they have now, no matter what specific plan they choose. At the same time, many seniors will be able to select a plan that may offer something they do not currently receive, whether it be prescription drugs, eyeglasses, or better hospital care. The bottom line is that the quality of benefits in all cases will measure up to yesterday's Medicare and, in many cases, will improve.

These were the kinds of things I needed to know before casting my vote today in favor of the Medicare Preservation Act of 1995. Like many of my constituents—and colleagues—I was concerned about the rhetoric and misinformation swirling around this issue prior to the vote. However, once I had the facts at my disposal I saw only one appropriate course. That course was supporting a reformed Medicare System which increases benefits, expands the options to beneficiaries, and is structured in such a way that it will survive far into the future.

H.R. 2425, the Medicare Preservation Act of 1995, accomplishes all of these goals while retaining the essential elements of traditional Medicare. I truly believe that we have done the right thing today in adopting these reforms. We have taken a program that was failing, a program on track to consume itself and we have given it new life. We rose above the scare tactics and sound bites aimed at preventing us from having the courage to do the right thing and we did the right thing.

I am proud to have had a hand in bringing about these badly needed reforms, and I look forward to celebrating the positive impact our action today will have on current and future Medicare beneficiaries.

Mr. HALL of Ohio. Mr. Chairman, today we are debating H.R. 2425, the so-called Medicare Preservation Act. Who can be opposed to preserving a program on which more than 37 million Americans are dependent? Unfortunately, the bill does not live up to its title.

Its supporters claim that unless action is taken, the part A trust fund will be bankrupt in the year 2002. However, all that this bill does is to move the date of insolvency back to the third quarter of 2006 according to actuaries at the Health Care Financing Administration. At what cost?

The part B premium will rise by an estimated 89 percent. Payments to hospitals will be cut, especially to hospitals that provide a disproportional share of care to indigent patients and teaching hospitals, and as a result, many hospitals will be forced to close. Payments for home health care will be reduced which will lead to more people being placed in nursing homes, but payments for nursing homes will also be reduced.

This is a bill to cut $270 billion from the growth of the Medicare Program over the next 7 years, far more than is needed to keep the program solvent. As painful as the cuts in the bill are, the program changes in the bill are even worse.

The bill is predicated on beneficiaries moving into managed care plans such as health maintenance organizations. It also provides for establishing medical savings account plans with high deductibles. These accounts could be used for medical services not currently covered by Medicare. These options are all right for people who are basically healthy, but they will have a devastating impact on those who are not. Plans will vigorously compete for those in the first group; but the others will be left behind in traditional fee-for-service plans. As more and more healthy people leave these traditional plans, premiums will skyrocket, which in turn will increase the exodus.

I believe a compromise Medicare bill can be passed, but in crafting this bill, the majority party did not seek input from this side of the aisle. They did not seek input from the public at large by conducting committee hearings. A small group of Members wrote the bill and changes were made at the behest of certain interest groups. This is not the way to legislate.

Mr. OLVER. Mr. Chairman, today the Republican Party takes on the onus for dismantling Medicare, the health care guarantee within Social Security.

And you can bet the Republican Party has its sights on dismantling Social Security as well.

And to what end? To create a comprehensive health care system which 80 percent of Americans want? No.

To serve extremists in the Republican Party.

To serve the insurance companies and the American Medical Association.

The Republican Party is cutting $270 billion from health care for American retirees to give $245 billion in tax cuts.

More than half of the tax cut goes to fat cats already making over $100,000 per year—while 75 percent of the people taking Medicare cuts to pay for that tax cut live on less than $20,000 per year.

The Republican Party is taking health care dollars from low- and middle-income retired Americans to give billions to insurance companies and the already wealthy.

You can bet Americans will remember next November.

Mr. MILLER of Florida. Mr. Chairman, I would like to insert the following letter, polling results, and testimony on the Medicare Preservation Act by the U.S. Chamber of Commerce into the CONGRESSIONAL RECORD.

U.S. CHAMBER OF COMMERCE,
Washington, DC, October 18, 1995.

Members of the U.S. House of Representatives:

The Chamber urges your support for H.R. 2425, the Medicare Preservation Act. Because of the importance of this issue to our members and the budget reconciliation measure, the Chamber will include this vote in its annual How They Voted vote ratings. For your information, I have included the results of a recent poll taken among Chamber members concerning elements of Medicare reform which reflects overwhelming support for this legislation.

Medicare is clearly in a state of crisis. Over the past five years, the program has grown at a staggering annual rate averaging 10½ percent. Immediately ahead of us is a seismic demographic shift: the ratio of taxpayers to Medicare beneficiaries is declining rapidly—from about four to one today, to only two to one in the next fifty years. The program as currently structured simply cannot survive.

Just as clearly, the failed Medicare reform approaches of the past will fail to measure up to this crisis and will threaten both business and the economy. Since 1970, Congress has raised payroll taxes over 20 times and the Medicare Trustee's 1995 Report pointed out that payroll taxes would have to be raised by another 1.3 to 3.5 percentage points to bring the system into balance. When you consider that many small and medium size businesses already pay more in payroll taxes than income taxes and that payroll taxes must be paid regardless of economic conditions, it becomes clear why Medicare requires solutions other than tax increases.

We believe the long-term solution to Medicare's problem is comprehensive reform that increases competition while restraining the growth in spending. Competition will help bring prices down and will provide secure and expanded benefits for seniors. The Medicare Preservation Act is a bold means of securing the solvency of the Medicare Trust Fund and setting Medicare on a secure path for the future.

We urge your support for the Medicare Preservation Act during its consideration on the House floor and throughout debate on the budget reconciliation measure.

Sincerely,

R. BRUCE JOSTEN.

U.S. CHAMBER OF COMMERCE—MEDICARE FAX POLL RESULTS

On October 11, 1995, the U.S. Chamber surveyed 9,700 business, chamber and association members on their attitudes concerning Medicare reform and specific reform elements. Responses to the Chamber survey (nearly 10 percent responded, 68.9% of which employ fewer than 50 workers) indicated strong support for market-oriented Medicare reform comparable to the House and Senate Majority plans for Medicare reform. The complete survey and results are provided below.

Medicare is ''severely out of financial balance and the Trustees believe that . . . prompt, effective and decisive action is necessary.''

Medicare reform has become a focal point of the budget debate. Medicare—the national health insurance program for seniors—will run out of money in seven years, according to the system's trustees. Spending on Medicare and other entitlements threatens to crowd out all other budget priorities and increase the budget deficit.

Previous approaches to Medicare reform have failed to slow Medicare's growth. Worse, these approaches have increased the burden on businesses and their employees through higher payroll taxes and higher insurance premiums.

Since 1970, Congress has raised payroll taxes over 20 times and the Trustee's Report pointed out that payroll taxes would have to be raised by another 1.3 to 3.5 percentage points to bring the system into balance. When you consider that many small and medium size businesses already pay more in payroll taxes than income taxes and that payroll taxes must be paid regardless of economic conditions, it becomes clear why Medicare requires solutions other than tax increases.

We need your help. Please review the following questions on Medicare reform and FAX back your answers by close of business October 16.

1. Medicare should be modernized by adopting the market-based strategies private employers and health plans are using successfully to improve health care quality and control costs. These strategies include improving the quality of care provided to enrollees, increasing enrollee choice by expanding health plan options, and reducing the rate of growth of Medicare spending.

Agree, 98.9 percent; Disagree, 0.6 percent.

2. Two competing approaches to Medicare reform have emerged in Congress. One more limited approach addresses the Medicare Part A trust fund, delaying insolvency for an additional two years through $89 billion in Medicare Part A trust fund, delaying insolvency for an additional two years through $89 billion in Medicare savings, primarily from reducing the rate of growth in Medicare payments to providers A second approach is more comprehensive in nature, addressing both Medicare part A (hospital bills) and Part B (doctors bills). Medicare Part A would be protected at least an additional 10 years through $270 billion in Medicare savings achieved through increased competition and reducing the rate of growth in Medicare payments to providers. Which approach would you favor?

Limited, 4.3 percent; Comprehensive, 94.6 percent.

3. Do you favor or oppose the following elements of Medicare reform?

a. Provide seniors choices between competing health plans including existing fee-for-service benefits.

Favor, 97.4 percent; Oppose, 1.6 percent.

b. Contain Medicare spending by increasing competition and reducing the rate of growth in Medicare payments.

Favor, 97.4 percent; Oppose 2.9 percent.

c. Increase managed care options for seniors.

favor, 93.8 percent; Oppose, 43.3 percent.

d. Provide seniors a medical savings account option.

Favor, 88.2 percent; Oppose, 7.3 percent.

e. Allow provider groups (i.e., doctors and hospitals) to offer health coverage (similar to managed care networks) directly to seniors—a new proposal known as provider sponsored networks or PSNs.

Favor, 91.9 percent; Oppose, 5.7 percent.

f. Require managed care plans to provide out-of-network benefits at a higher cost to the beneficiary.

Favor, 72.4 percent; Oppose, 18.2 percent.

4. For purposes of tabulation: type of organization: Business, 93.2 percent; Chamber, 4.3 percent; Other, 2.0 percent. Approximate number of employees: under 10, 29.4 percent; 10–49, 39.5 percent; 50–99, 12.5 percent; 100–249, 8.6 percent; 250–499, 3.7 percent; 500–4,999, 3.7 percent; 5,000 +, 1.4 percent.

[From the U.S. Chamber of Commerce, Economic Policy Division]

THE MEDICARE CRISIS: THE TAX SOLUTION IS NO SOLUTION

The only solution detailed by the Medicare Board of Trustees for achieving financial balance in Medicare Part A is to raise taxes. Unfortunately, this is no solution at all. Higher taxes will rob working individuals of their hard-won dollars, significantly increase costs on small and large businesses alike and bring the economy to the brink of recession.

The Trustees calculate that balancing the Medicare trust fund for the next 75 years requires us to immediately hike the Medicare payroll tax from 2.90% to 6.42%. While the tax increase may seem to amount to only a few percentage points, it amounts to hundreds of dollars to the typical worker, thousands of dollars to the small business, and billions of dollars for the economy. Analysis by the Economic Policy Division of the U.S. Chamber of Commerce suggests the following impacts on individuals, businesses and the economy:

For a worker making $30,000 a year, total Medicare payroll taxes paid would jump to $1,926 from the current $870.

A small business employing 25 such workers would be liable for an additional $13,200 tax payment per year.

When aggregated across the entire economy, the effect would be to lower real GDP by $179.4 billion within two years and hold GDP about $95 billion lower 10 years later. This amount to a 3.1% decline in GDP in the short run. With economic growth projected to average less than 3% over the next five years, this decline could easily result in a recession.

These results are even more startling when you consider that they represent an optimistic evaluation, not a worst-case scenario.

OVERVIEW OF MEDICARE: WHY REFORM IS NECESSARY

Medicare is a nationwide health insurance program for older Americans and certain disabled persons. It is composed of two parts: Part A, the hospital insurance (HI) program, and Part B, the supplementary medical insurance (SMI) program.

Part A covers expenses for the first sixty days of inpatient care less a deductible ($716 in 1995) for those age 65 and older and for the long-term disabled. It also covers skilled nursing care, home health care and hospice care. The HI program is financed primarily by payroll taxes. Employees and employers each pay 1.45% of taxable earnings, while self-employed persons pay 2.90%. In 1994, the HI earnings caps were eliminated, meaning that the HI tax applies to all payroll earnings.

Part B is a voluntary program which pays for physicians' services, outpatient hospital services, and other medical expenses for persons aged 65 and over and for the long-term

disabled. It generally pays 80% of the approved amount for covered services in excess of an annual deductible ($100). About a quarter of the funding comes from monthly premiums ($46.10 in 1995); the remainder comes from general tax revenues and interest.

Medicare is not a means-tested program. That is, income is not a factor in determining an individual's eligibility or, for Part B, premium levels. Age is the primary eligibility criteria, with the program also extending to qualified disabled individuals younger than 65.

Over the years, tax revenues for Medicare Part A have exceeded disbursements, and so the remaining revenues have been credited to the Medicare HI Trust Fund. At the end of 1994, the trust fund held $132.8 billion.

CONCLUSION OF THE TRUSTEES

Each year, trustees of Medicare's Hospital Insurance Trust Fund analyze the current status and the long-term outlook for the trust fund, and their findings are published in an annual report. The 1995 edition, issued in April, demonstrated that the Medicare system is in serious financial trouble. The program's six trustees—four of whom are Clinton appointees (cabinet secretaries Robert Rubin, Robert Reich and Donna Shalala, and commissioner of Social Security, Shirley Chater)—reported the following conclusions:

Based on the financial projections developed for this report, the Trustees apply an explicit test of short-range financial adequacy. The HI trust fund fails this test by a wide margin. In particular, the trust fund is projected to become insolvent within the next 6 to 11 years . . . (HI Annual Report, pg. 2)

Under the Trustees' intermediate assumptions, the present financing schedule for the HI program is sufficient to ensure the payment of benefits only over the next 7 years (pg. 3)

The program is severely out of financial balance and substantial measures will be required to increase revenues and/or reduce expenditures. (pg. 18)

. . . the HI program is severely out of financial balance and the Trustees believe that the Congress must take timely action to establish long-term financial stability for the program. (pg. 28)

The Trustees believe that prompt, effective and decisive action is necessary (pg. 28)

The same set of Trustees also oversees the Medicare Part B program. In their 1995 Annual Report, they wrote: ''Although the SMI program (Medicare Part B) is currently actuarially sound, the Trustees note with great concern the past and projected rapid growth in the cost of the program. . . Growth rates have been so rapid that outlays of the program have increased 53% in the aggregate and 40% per enrollee in the last 5 years.'' (SMI Annual Report, pg. 3). ''The Trustees believe that prompt, effective and decisive action is necessary.'' (pg. 3)

Obviously, the Trustees believe that the Medicare program deserves our careful, immediate attention. The following pages present the figures that led the Trustees to their conclusions.

WHERE MEDICARE STANDS TODAY

Medicare is a huge federal program. In 1994: Medicare expenditures reached $160 billion, just over half the size of Social Security; Expenditures grew 11.4% from 1993; Eleven cents of every dollar spent by the federal government went to Medicare; Medicare represented one-fifth of total entitlement spending.

Between 1990 and 1994, Medicare grew at a 10.4% average annual rate, almost three times the 3.6% average inflation rate over the same period and twice the 5.1% average annual growth of the economy as a whole.

MEDICARE AND THE FEDERAL BUDGET

Medicare spending must be addressed as part of the solution to balancing the federal budget. That's because spending on federal entitlements—such as Medicare, Medicaid and Social Security—soared 8.4% annually on average between 1990 and 1994. Spending on discretionary, annually appropriated programs—such as defense, education and infrastructure—increased 2.2%, which is less than the rate of inflation. Coming decades will see even more pressure for entitlement growth, as the leading edge of the Baby Boom generation reaches 65 in 2011.

Entitlements are not only the fastest growing portion of the federal budget, they're already its largest component, as shown in the accompanying chart. Just over half of all federal expenditures is spent on entitlements; only a third go to discretionary programs. If we are going to balance the federal budget—and keep it in balance over the long term—entitlement reform must be part of the solution

WHERE MEDICARE IS HEADED IF WE DO NOTHING

Under current law, Medicare is projected by the Congressional Budget Office to grow at a 10.4% average annual rate over the next seven years. In 2002, the CBO projects Medicare spending will reach $344 billion, claiming almost 16 cents of every dollar spent by the federal government.

Moreover, beginning next year, Medicare HI expenditures will exceed the program's revenues. The HI Trust fund, which at year-end 1994 held $132.8 billion, will have to be tapped to cover the projected $867 million difference.

However, according to the Trustees' Annual Report, this shortfall isn't temporary. Instead, it will balloon to be about seven times larger in 1997, which is just the following year, and more than twenty times larger by 1999. Under assumptions reflecting the most likely demographic and economic trends. 1996 will be the first year of hemorrhage that will deplete the entire trust fund by 2002—just seven years away. The optimistic set of assumptions buys us only a little time, with trust fund depletion projected in 2006. Under the pessimistic scenario, the fund is exhausted as early as 2001. In other words, within the next 6 to 11 years, it's virtually certain that Medicare will be insolvent—unless we take action.

The danger of inaction was made clear last winter when the President's Bipartisan Commission on Entitlement and Tax Reform, chaired by Sen. Bob Kerrey and then-Sen. John Danforth, issued its final report. The focus of the report was to look not years ahead, but decades ahead to assess the impact of federal budget trends. The report is sobering: Under current trends, virtually all federal government revenues are absorbed by entitlement spending and net interest by 2010, as shown in Chart 2. Deficit-financing will be required to cover almost all of the discretionary programs, including defense, health research, the FBI, support for education, and the federal judicial system.

Ten years later, the situation is worse. Growth in entitlements is so explosive that not only would the government have to borrow to pay for discretionary expenses, it would have to borrow funds to pay the lion's share of interest payments on the national debt.

MEDICARE'S IMPACT ON THE PAY STUB

In addition to detailing the projected dissipation of Trust Fund under current law, the Trustees' Report also describes the measures that would be necessary to shore up the trust fund over the next 25, 50 and 75 years. If the expenditure formulas are not altered, then preserving the trust fund can only be done through increases in the payroll tax or additional subsidies from general revenues. Table 1 illustrates the payroll tax increases that would be necessary to balance the trust fund.

CURRENT LAW

Currently, the combined (employee and employer) Medicare tax rate is 2.90%, applied to all payroll earnings. A worker earning $30,000 a year in salary or wages, for instance, is directly taxed 1.45%, or $435 annually, for Medicare Part A, the hospital insurance program. Employers then match that payment with another $435, resulting in $870 of tax revenue earmarked for the Medicare HI trust fund generated by having that worker on the payroll.

The Medicare contributions from both the worker and firm don't stop there, however. Because two-thirds of Medicare Part B (SMI) is financed through general revenues (the other third coming from Medicare premiums and interest), a portion of the worker's and the firm's general income taxes are also financing Medicare. The Trustees reported that $36.2 billion of general funds were used to pay Medicare Part B claims in 1994.

TABLE 1.—MEDICARE HOSPITAL INSURANCE PAYROLL TAXES

	Current law employee plus employer	To balance the HI trust fund over the next—					
		25 yrs.		50 yrs.		75 yrs.	
		Additional tax	Total HI tax	Additional tax	Total HI tax	Additional tax	Total HI tax
Tax rates (pct.)	2.90	1.33	4.23	2.68	5.58	3.52	6.42
Pct. increase over current law	.....	.....	45.9	.....	92.4	.....	121.4
Payroll earnings:							
$10,000	$290	$133	$423	$268	$558	$352	$642
20,000	580	266	846	536	1,116	704	1,284
30,000	870	399	1,269	804	1,674	1,056	1,926
40,000	1,160	532	1,692	1,072	2,232	1,408	2,568
50,000	1,450	665	2,115	1,340	2,790	1,760	3,210
60,000	1,740	798	2,538	1,608	3,348	2,112	3,852
70,000	2,030	931	2,961	1,876	3,906	2,464	4,494
80,000	2,320	1,064	3,384	2,144	4,464	2,816	5,136
90,000	2,610	1,197	3,807	2,412	5,022	3,168	5,778
100,000	2,900	1,330	4,230	2,680	5,580	3,520	6,420

Source (for all tables): 1995 Annual Report of the Board of Trustees. Medicare Hospital Insurance Trust Fund. Table 1.D3, page 22, Calculations and macroeconomics simulations by the U.S. Chamber of Commerce.

To Balance the Medicare HI Trust Fund for the Next 25 Years (through 2019): According to the Trustees' analysis, the hospital insurance payroll tax would have to rise from 2.90% to 4.23% (a 46% increase) to keep the HI trust fund in balance for the next 25 years. Further, the increase would have to be made immediately and maintained through the entire 25-year period.

For our $30,000/year worker for whom $870 is currently provided to Medicare HI, this increase means an additional tax of $399, bringing total annual hospital insurance payroll taxes to $1,269. And that's before any other federal and state payroll taxes (such as unemployment insurance and Social Security) or federal and state income taxes.

However, even this increase in payroll taxes still leaves the trust fund exhausted in 2019, with the oldest of the baby boomers just shy of reaching their life expectancy. Because of this demographic bulge, balancing the HI trust fund over a longer period would require even higher payroll taxes.

To Balance the Medicare Trust Fund for the Next 50 Years (through 2044): Balancing the trust fund over the next fifty years—a span long enough to see most of the Baby Boomers through their lifetimes—would require virtually doubling the hospital insurance payroll tax from 2.90% to 5.58%. The increase would have to be made immediately and remain permanent through the entire 50-year period. Again, for the worker earning $30,000 a year, the total HI payroll tax rises from $870 to $1,674, an increase of 92.4%.

To Balance the Medicare Trust Fund for the Next 75 Years (through 2069): Balancing the trust fund over the next seventy-five years—roughly through the life expectancy of an individual born this year, and the usual period for long-term fiscal solvency—would require an immediate boost in the Medicare tax rate of 121.4%, from 2.90% to 6.42%. Total HI payroll taxes for a worker earning $30,000 a year would rise from $870 to $1,926.

MEDICARE'S IMPACT ON BUSINESS

Because it's levied on employment levels, not income, the payroll tax due remains the same through both good and bad economic times. This feature accentuates the pain of a downturn on employers, who need to pay the tax regardless of profitability. Consequently, relative to the income tax, a payroll tax can be particularly punishing to start-up firms or companies trying to weather a drop in business.

Table 2 shows the liability for Medicare HI payroll taxes that would be faced by firms of various sizes. Total liability is shown under current law and under the three tax rates computed by the Trustees to bring the HI trust fund in balance over periods of 25, 50 and 75 years.

For instance, a 25-person firm where the average worker earns $20,000 per year is currently liable for a $7,250 tax payment for the Medicare HI program (for their contribution, the workers themselves would be taxed an identical amount). To balance the trust fund over the next 25 years, the combined employee and employer tax rate would have to rise from the current 2.90% to 4.23%. Assuming that the liability continues to be evenly split between the employee and employer, the firm will face an HI payroll tax of about 2.11% per worker. For our 25-person firm, the total HI payroll tax would rise from $7,250 to $10,575 per year.

TABLE 2.—MEDICARE HOSPITAL INSURANCE PAYROLL TAX ANNUAL EMPLOYER TAX LIABILITY

[In dollars]

	Number of employees—						
	5	10	25	50	100	500	1,000
Average salary: $20,000:							
Current law	1,450	2,900	7,250	14,500	29,000	145,000	290,000
To balance Medicare HI over the next:							
25 yrs	2,115	4,230	10,575	21,150	42,300	211,500	423,000
50 yrs	2,790	5,580	13,950	27,900	55,800	279,000	558,000
75 yrs	3,210	6,420	16,050	32,100	64,200	321,000	642,000
Average salary: $30,000:							
Current law	2,175	4,350	10,875	21,750	43,500	217,500	435,000
To balance Medicare HI over the next:							
25 yrs	3,173	6,345	15,862	31,725	63,450	317,250	634,500
50 yrs	4,185	8,370	20,925	41,850	83,700	418,500	837,000
75 yrs	4,815	9,630	24,075	48,150	96,300	481,500	963,000

MEDICARE'S IMPACT ON THE ECONOMY

Raising payroll taxes to keep the Medicare Hospital Insurance trust fund afloat imposes substantial burdens on both workers and firms. To measure what that means for the economy as a whole, we conducted several policy simulations using the highly respected Washington University Macro Model from Laurence H. Meyer & Associates of St. Louis, MO.

The results are striking: The economy would suffer through sharply slower economic growth and higher unemployment in the near term. Over a longer period, the economy is saddled with a permanent loss of production and employment. As shown in Tables 3 and 4, the degree of severity for GDP and employment depends upon the increase in Medicare taxes enacted.

The tables compare each of three alternative tax simulations specified in the Trustees' Annual Report to LHM&A's June 1995 baseline forecast. To demonstrate the policy change working its way through the economy, we display the results for three of the ten years of our simulation: 1997, 2000 and 2004. This gives us snapshots of he short-term, intermediate-term and long-term impacts on economic output and employment. In each case, the imposition of the Medicare payroll tax increase takes place in the fourth quarter of 1995.

TABLE 3.—IMPACT ON GROSS DOMESTIC PRODUCT

[Balancing the HI Trust Fund Through Raising Payroll Tax Rates]

Yrs to balance HI trust fund	Required Medicare tax rate (pct.)	Difference from baseline in given year, billions of 1987 dollars			Pct difference from baseline in given year (pct.)		
		1997	2000	2004	1997	2000	2004
25 Yrs	4.23	−68.4	−30.1	−36.1	−1.2	−0.5	−0.5
50 Yrs	5.58	−137.1	−60.5	−72.1	−2.4	−1.0	−1.1
75 Yrs	6.42	−179.4	−79.4	−95.6	−3.16	−1.3	−1.4

As shown in Table 3, if the government imposed the most modest payroll tax increase—enough to keep the Medicare trust fund in balance for the next 25 years—production in the economy would be 1.2%, or almost $70 billion, lower in 1997 than it would have been otherwise. By 2000, the percentage-point gap between the alternative closes to within 0.5% of the baseline level of production, but that distance is maintained even ten years after the tax increase took effect.

The short-term loss in output translates into 1.2 million fewer jobs relative to what we would have had otherwise, as shown in Table 4. While this decline to about 1% of the economy's jobs, moderates over time, the economy appears to have lost over 0.5% of its jobs permanently.

Of course, all of this economic turbulence puts the Medicare HI trust fund in actuarial balance for only the next 25 years. To generate long-term actuarial balance for the full 75-year period, the Medicare payroll tax rate would have to jump form 2.90% to 6.42%, triggering even stronger economic impacts than those described above. Production in the economy would be about 3% lower in 1997 than it would have been otherwise, with the long-term loss in output projected at 1.5%. Over 3 million jobs would be eliminated in 1997 relative to the baseline, with a projected permanent loss of about 1.5% of total employment over the long term.

TABLE 4.—IMPACT ON EMPLOYMENT

[Balancing the HI Trust Fund Through Raising Payroll Tax Rates]

Yrs to balance HI trust fund	Required Medicare tax rate (pct.)	Difference from baseline in given year, millions of jobs			Percent difference from baseline in given year (pct.)		
		1997	2000	2004	1997	2000	2004
25 Yrs	4.23	−1.2	−0.6	−0.8	−0.9	−0.4	−0.6
50 Yrs	5.58	−2.4	−1.2	−1.6	−1.9	−0.9	−1.2
75 Yrs	6.42	−3.2	−1.5	−2.2	−2.5	−1.2	−1.5

As dramatic as these figures are, there's good reason to believe that they are optimistic estimates. Because the macro model used in these simulations treats the Medicare payroll tax like the Social Security payroll tax, the increases in the tax rates apply only to the first $61,200 earned (in 1995, and rising afterwards). That is, the model is not picking up the economic impact of applying the higher tax rates to incomes over the taxable base. Thus, these results should be considered a minimum measure of the economic impact of raising Medicare payroll taxes. Attempts to account for this problem yield significantly greater job loss and lower GDP. These results are available from the Economic Policy Division of the U.S. Chamber of Commerce.

It is important to note that, even with the set of numbers presented here with its inherent bias toward underestimating the economic impact, we can see that using payroll taxes to balance the Medicare trust fund imposes severe costs on the U.S. economy. These results clearly indicate that the Medicare problem must be solved by fundamental program reform, not tax increases.

Mr. BLILEY. Mr. Chairman, I yield back the balance of my time.

The CHAIRMAN (Mr. LINDER). All time for general debate has expired.

Pursuant to the rule, an amendment in the nature of a substitute consisting of the text of H.R. 2485, modified by the amendment printed in House Report 104–282, is adopted and the bill, as amended, is considered as an original bill for the purpose of further amendment and is considered read.

The text of the amendment in the nature of a substitute, as modified, is as follows:

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

SECTION 1. PURPOSE.

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

TITLE XV—MEDICARE

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

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

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

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

of 1990 (Public Law 101–508), and the Omnibus Budget Reconciliation Act of 1993 (Public Law 103–66), respectively.

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

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

Subtitle A—MedicarePlus Program

PART 1—INCREASING CHOICE UNDER THE MEDICARE PROGRAM

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

''PART C—PROVISIONS RELATING TO MEDICAREPLUS

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

PART 2—SPECIAL RULES FOR MEDICAREPLUS MEDICAL SAVINGS ACCOUNTS

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

PART 3—SPECIAL ANTITRUST RULE FOR PROVIDER SERVICE NETWORKS

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

PART 4—COMMISSIONS

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

PART 5—TREATMENT OF HOSPITALS WHICH PARTICIPATE IN PROVIDER-SPONSORED ORGANIZATIONS

Sec. 15041. Treatment of hospitals which participate in provider-sponsored organizations.

Subtitle B—Preventing Fraud and Abuse

PART 1—GENERAL PROVISIONS

Sec. 15101. Increasing awareness of fraud and abuse.
Sec. 15102. Beneficiary incentive programs.
Sec. 15103. Intermediate sanctions for medicare health maintenance organizations.
Sec. 15104. Voluntary disclosure program.
Sec. 15105. Revisions to current sanctions.
Sec. 15106. Direct spending for anti-fraud activities under medicare.
Sec. 15107. Permitting carriers to carry out prior authorization for certain items of durable medical equipment.
Sec. 15108. National Health Care Anti-Fraud Task Force.
Sec. 15109. Study of adequacy of private quality assurance programs.
Sec. 15110. Penalty for false certification for home health services.
Sec. 15111. Pilot projects.

PART 2—REVISIONS TO CRIMINAL LAW

Sec. 15121. Definition of Federal health care offense.
Sec. 15122. Health care fraud.
Sec. 15123. Theft or embezzlement.
Sec. 15124. False statements.
Sec. 15125. Bribery and graft.
Sec. 15126. Illegal remuneration with respect to health care benefit programs.
Sec. 15127. Obstruction of criminal investigations of health care offenses.
Sec. 15128. Civil penalties for violations of Federal health care offenses.
Sec. 15129. Injunctive relief relating to health care offenses.
Sec. 15130. Authorized investigative demand procedures.
Sec. 15131. Grand jury disclosure.
Sec. 15132. Miscellaneous amendments to title 18, United States Code.

Subtitle C—Regulatory Relief

PART 1—PHYSICIAN OWNERSHIP REFERRAL REFORM

Sec. 15201. Repeal of prohibitions based on compensation arrangements.
Sec. 15202. Revision of designated health services subject to prohibition.
Sec. 15203. Delay in implementation until promulgation of regulations.
Sec. 15204. Exceptions to prohibition.
Sec. 15205. Repeal of reporting requirements.
Sec. 15206. Preemption of State law.
Sec. 15207. Effective date.

PART 2—OTHER MEDICARE REGULATORY RELIEF

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

PART 3—PROMOTING PHYSICIAN SELF-POLICING

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

Subtitle D—Medical Liability Reform

PART 1—GENERAL PROVISIONS

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

PART 2—UNIFORM STANDARDS FOR HEALTH CARE LIABILITY ACTIONS

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

Subtitle E—Teaching Hospitals and Graduate Medical Education

PART 1—TEACHING HOSPITAL AND GRADUATE MEDICAL EDUCATION TRUST FUND

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

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

''PART A—ESTABLISHMENT OF FUND

''Sec. 2201. Establishment of Fund.

''PART B—PAYMENTS TO TEACHING HOSPITALS

''Subpart 1—Requirement of Payments

''Sec. 2211. Formula payments to teaching hospitals.

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

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

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

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

''Subpart 4—General Provisions

''Sec. 2241. Adjustments in payment amounts.''

PART 2—AMENDMENTS TO MEDICARE PROGRAM

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

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

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

''PART C—OTHER MATTERS

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

Subtitle F—Provisions Relating to Medicare Part A

PART 1—HOSPITALS

SUBPART A—GENERAL PROVISIONS RELATING TO HOSPITALS

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

SUBPART B—PROVISIONS RELATING TO RURAL HOSPITALS

Sec. 15511. Sole community hospitals.
Sec. 15512. Clarification of treatment of EAC and RPC hospitals.
Sec. 15513. Establishment of rural emergency access care hospitals.
Sec. 15514. Classification of rural referral centers.
Sec. 15515. Floor on area wage index.

PART 2—PAYMENTS TO SKILLED NURSING FACILITIES

Sec. 15521. Payments for routine service costs.

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

PART 3—CLARIFICATION OF CREDITS TO PART A TRUST FUND

Sec. 15531. Clarification of amount of taxes credited to Federal Hospital Insurance Trust Fund.

Subtitle G—Provisions Relating to Medicare Part B

PART 1—PAYMENT REFORMS

Sec. 15601. Payments for physicians' services.
Sec. 15602. Elimination of formula-driven overpayments for certain outpatient hospital services.
Sec. 15603. Payments for durable medical equipment.
Sec. 15604. Reduction in updates to payment amounts for clinical diagnostic laboratory tests.
Sec. 15605. Extension of reductions in payments for costs of hospital outpatient services.
Sec. 15606. Freeze in payments for ambulatory surgical center services.
Sec. 15607. Rural emergency access care hospitals.
Sec. 15608. Ensuring payment for physician and nurse for jointly furnished anesthesia services.
Sec. 15609. Statewide fee schedule area for physicians' services.
Sec. 15609A. Establishment of fee schedule for ambulance services.
Sec. 15609B. Standards for physical therapy services furnished by physicians.

PART 2—PART B PREMIUM

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

PART 3—ADMINISTRATION AND BILLING OF LABORATORY SERVICES

Sec. 15621. Administrative simplification for laboratory services.
Sec. 15622. Restrictions on direct billing for laboratory services.

PART 4—QUALITY STANDARDS FOR DURABLE MEDICAL EQUIPMENT

Sec. 15631. Recommendations for quality standards for durable medicare equipment.

Subtitle H—Provisions Relating to Medicare Parts A and B

PART 1—PAYMENT FOR HOME HEALTH SERVICES

Sec. 15701. Payment for home health services.
Sec. 15702. Maintaining savings resulting from temporary freeze on payment increases for home health services.
Sec. 15703. Extension of waiver of presumption of lack of knowledge of exclusion from coverage for home health agencies.
Sec. 15704. Report on recommendations for payments and certification for home health services of Christian Science providers.
Sec. 15705. Extension of period of home health agency certification.

PART 2—MEDICARE SECONDARY PAYER IMPROVEMENTS

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

PART 3—FAILSAFE

Sec. 15721. Failsafe budget mechanism.

PART 4—ADMINISTRATIVE SIMPLIFICATION

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

PART 5—OTHER PROVISIONS RELATING TO PARTS A AND B

Sec. 15741. Clarification of medicare coverage of items and services associated with certain medical devices approved for investigational use.
Sec. 15742. Additional exclusion from coverage.
Sec. 15743. Competitive bidding for certain items and services.
Sec. 15744. Disclosure of criminal convictions relating to provision of home health services.
Sec. 15745. Requiring renal dialysis facilities to make services available on a 24-hour basis.

Subtitle I—Clinical Laboratories

Sec. 15801. Exemption of physician office laboratories.

Subtitle J—Lock-Box Provisions for Medicare Part B Savings from Growth Reductions

Sec. 15901. Establishment of Medicare Growth Reduction Trust Fund for Part B savings.

Subtitle A—MedicarePlus Program

PART 1—INCREASING CHOICE UNDER THE MEDICARE PROGRAM

Subtitle A, Part 1

SEC. 15001. INCREASING CHOICE UNDER MEDICARE.

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

''PROVIDING FOR CHOICE OF COVERAGE

''SEC. 1805. (a) CHOICE OF COVERAGE.—

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

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

''(B) THROUGH A MEDICAREPLUS PRODUCT.—Through a MedicarePlus product (as defined in paragraph (2)), which may be—

''(i) a high deductible/medisave product (and a contribution into a MedicarePlus medical savings account (MSA)),

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

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

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

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

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

''(A) NON-MEDICAREPLUS OPTION.—An individual who has made the election described in paragraph (1)(A) is considered to have elected the 'Non-MedicarePlus option'.

''(B) MEDICAREPLUS OPTION.—An individual who has made the election described in paragraph (1)(B) to obtain coverage through a MedicarePlus product is considered to have elected the 'MedicarePlus option' for that product.

''(b) SPECIAL RULES.—

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

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

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

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

''(ii) in the case of a MedicarePlus organization that is a union sponsor or a Taft-Hartley sponsor (as defined in section 1852(c)(4)), the individual elected under this section a MedicarePlus product offered by the sponsor during the first enrollment period in which the individual was eligible to make such election with respect to such sponsor.

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

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

''(c) PROCESS FOR EXERCISING CHOICE.—

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

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

''(3) COORDINATION THROUGH MEDICAREPLUS ORGANIZATIONS.—

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

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

''(4) DEFAULT.—

''(A) INITIAL ELECTION.—

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

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

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

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

''(ii) a MedicarePlus product is discontinued, if the individual had elected such product at the time of the discontinuation.

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

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

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

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

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

''(A) INFORMATION BOOKLET.—

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

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

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

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

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

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

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

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

''(e) COVERAGE ELECTION PERIODS.—

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

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

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

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

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

''(B) OPEN DISENROLLMENT BEFORE END OF TRANSITION PERIOD.—

''(i) IN GENERAL.—During the transition period, an individual who has elected a MedicarePlus option for a MedicarePlus product may change such election to another MedicarePlus product or to the non-MedicarePlus option.

''(ii) SPECIAL RULE.—During the transition period, an individual who has elected a high deductible/medisave product may not change such election to a MedicarePlus product that is not a high deductible/medisave product unless the individual has had such election in effect for 12 months.

''(3) ANNUAL, COORDINATED ELECTION PERIOD.—

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

''(B) ANNUAL, COORDINATED ELECTION PERIOD.—For purposes of this section, the term 'annual, coordinated election period' means, with respect to a calendar year (beginning with 1998), the month of October before such year.

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

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

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

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

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

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

''(B) in the case of an individual who has elected a MedicarePlus product offered by a MedicarePlus organization, the individual is no longer eligible to elect the product because of a change in the individual's place of residence or other change in circumstances (specified by the Secretary, but not including termination of membership in a qualified association in the case of a product offered by a qualified association or termination of the individual's enrollment on the basis described in clause (i) or (ii) section 1852(c)(3)(B));

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

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

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

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

''(6) SPECIAL RULE FOR HIGH DEDUCTIBLE/MEDISAVE PRODUCTS.—Notwithstanding the previous provisions of this subsection, an individual may elect a high deductible/medisave product only during an annual, coordinated election period described in paragraph (3)(B) or during the month of October, 1996.

''(f) EFFECTIVENESS OF ELECTIONS.—

''(1) DURING INITIAL COVERAGE ELECTION PERIOD.—An election of coverage made during the initial coverage election period under subsection (e)(1)(A) shall take effect upon the date the individual becomes entitled to benefits under part A and enrolled under part B, except as the Secretary may provide (consistent with section 1838) in order to prevent retroactive coverage.

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

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

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

with protecting continuity of health benefit coverage.

''(g) EFFECT OF ELECTION OF MEDICAREPLUS OPTION.—Subject to the provisions of section 1855(f), payments under a contract with a MedicarePlus organization under section 1858(a) with respect to an individual electing a MedicarePlus product offered by the organization shall be instead of the amounts which (in the absence of the contract) would otherwise be payable under parts A and B for items and services furnished to the individual.

''(h) ADMINISTRATION.—

''(1) IN GENERAL.—This part and sections 1805 and 1876 shall be administered through an operating division (A) that is established or identified by the Secretary in the Department of Health and Human Services, (B) that is separate from the Health Care Financing Administration, and (C) the primary function of which is the administration of this part and such sections. The director of such division shall be of equal pay and rank to that of the individual responsible for overall administration of parts A and B.

''(2) TRANSFER AUTHORITY.—The Secretary shall transfer such personnel, administrative support systems, assets, records, funds, and other resources in the Health Care Financing Administration to the operating division referred to in paragraph (1) as are used in the administration of section 1876 and as may be required to implement the provisions referred to in such paragraph promptly and efficiently.''.

SEC. 15002. MEDICAREPLUS PROGRAM.

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

''PART C—PROVISIONS RELATING TO MEDICAREPLUS

''REQUIREMENTS FOR MEDICAREPLUS ORGANIZATIONS WITH HIGH-DEDUCTIBLE/MEDISAVE PRODUCTS

II is amended by redesignating part C as part D and by inserting after part B the following new part:

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

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

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

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

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

''(4) EXCEPTION FOR QUALIFIED ASSOCIATIONS.—Paragraph (1) shall not apply to a MedicarePlus organization that is a qualified association (as defined in section 1852(c)(4)(C)).

''(c) PREPAID PAYMENT.—A MedicarePlus organization shall be compensated (except for deductibles, coinsurance, and copayments) for the provision of health care services to enrolled members by a payment which is paid on a periodic basis without regard to the date the health care services are provided and which is fixed without regard to the frequency, extent, or kind of health care service actually provided to a member.

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

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

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

''(3) may obtain insurance or make other arrangements for not more than 90 percent of the amount by which its costs for any of its fiscal years exceed 115 percent of its income for such fiscal year, and

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

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

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

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

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

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

''(f) HIGH DEDUCTIBLE/MEDISAVE PRODUCT DEFINED.—

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

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

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

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

''(i) 100 percent of such expenses, or

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

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

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

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

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

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

''(g) ORGANIZATIONS TREATED AS MEDICAREPLUS ORGANIZATIONS DURING TRANSITION.—Any of the following organizations shall be considered to qualify as a MedicarePlus organization for contract years beginning before January 1, 1998:

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

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

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

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

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

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

''(h) MEDIGRANT DEMONSTRATION PROJECTS.—The Secretary shall provide, in at least 10 States, for demonstration projects which would permit MediGrant programs under title XXI to be treated as MedicarePlus organizations under this part for individuals who are qualified to elect the MedicarePlus option and who eligible to receive medical assistance under the MediGrant program, for the purpose of demonstrating the delivery of primary, acute, and long-term care through an integrated delivery network which emphasizes noninstitutional care.

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

''SEC. 1852. (a) BENEFITS COVERED.—

''(1) IN GENERAL.—Except as provided in section 1851(f)(1) with respect to high deductible/medisave products, each MedicarePlus product offered under this part shall provide benefits for at least the items and services for which benefits are available under parts A and B consistent with the standards for coverage of such items and services applicable under this title.

''(2) ORGANIZATION AS SECONDARY PAYER.—Notwithstanding any other provision of law, a MedicarePlus organization may (in the case of the provision of items and services to an individual under this part under circumstances in which payment under this

title is made secondary pursuant to section 1862(b)(2)) charge or authorize the provider of such services to charge, in accordance with the charges allowed under such law or policy—

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

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

''(3) SATISFACTION OF REQUIREMENT.—A MedicarePlus product (other than a high deductible/medisave product) offered by a MedicarePlus organization satisfies paragraph (1) with respect to benefits for items and services if the following requirements are met:

''(A) FEE FOR SERVICE PROVIDERS.—In the case of benefits furnished through a provider that does not have a contract with the organization, the product provides for at least the dollar amount of payment for such items and services as would otherwise be provided under parts A and B.

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

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

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

''(b) ANTIDISCRIMINATION.—A MedicarePlus organization may not deny, limit, or condition the coverage or provision of benefits under this part based on the health status, claims experience, receipt of health care, medical history, or lack of evidence of insurability, of an individual.

''(c) GUARANTEED ISSUE AND RENEWAL.—

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

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

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

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

''(3) LIMITATION ON TERMINATION OF ELECTION.—

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

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

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

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

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

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

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

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

''(A) UNIONS.—

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

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

''(B) TAFT-HARTLEY SPONSORS.—

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

''(ii) TAFT-HARTLEY SPONSOR.—In this part and section 1805, the term 'Taft-Hartley sponsor' means, in relation to a group health plan that is established or maintained by two or more employers or jointly by one or more employers and one or more employee organizations, the association, committee, joint board of trustees, or other similar group of representatives of parties who establish or maintain the plan.

''(C) QUALIFIED ASSOCIATIONS.—

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

''(ii) LIMITATION ON TERMINATION OF COVERAGE.—Such a qualifying association offering a MedicarePlus product to an individual may not terminate coverage of the individual on the basis that the individual is no longer a member of the association except pursuant to a change of election during an open election period occurring on or after the date of the termination of membership.

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

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

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

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

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

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

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

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

''(d) SUBMISSION AND CHARGING OF PREMIUMS.—

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

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

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

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

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

''(B)(i) 1/12 of the annual MedicarePlus capitation rate specified in section 1855(b)(2) for the area and period involved, or (ii) in the case of a high deductible/medisave product, the monthly adjusted MedicarePlus capitation rate specified in section 1855(b)(1) for the individual and period involved.

''(3) UNIFORM PREMIUM.—

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

''(B) EXCEPTION FOR HIGH DEDUCTIBLE/MEDISAVE PRODUCTS.—A MedicarePlus organization shall establish premiums for any high deductible/medisave product it offers in a payment area based on each of the risk adjustment categories established for purposes of determining the amount of the payment to MedicarePlus organizations under section 1855(b)(1) and using the identical demographic and other adjustments among such categories as are used for such purposes.

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

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

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

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

''(1) REQUIREMENT.—

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

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

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

''(ii) the actuarial value of the minimum benefits described in subsection (a)(1) under the product for individuals under this part, as determined based upon an adjusted community rate described in paragraph (5) (as reduced for the actuarial value of the coinsurance and deductibles under parts A and B).

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

''(D) NO APPLICATION TO HIGH DEDUCTIBLE/MEDISAVE PRODUCT.—Subparagraph (A) shall not apply to a high deductible/medisave product.

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

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

''(2) LIMITATION ON AMOUNT OF PART B PREMIUM DISCOUNT REBATE.—In no case shall the amount of a part B premium discount rebate under paragraph (1)(A) exceed, with respect to a month, the amount of premiums imposed under part B (not taking into account section 1839(b) (relating to penalty for late enrollment) or 1839(h) (relating to affluence testing)), for the individual for the month. Except as provided in the previous sentence, a MedicarePlus organization is not authorized to provide for cash or other monetary rebates as an inducement for enrollment or otherwise.

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

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

''(5) ADJUSTED COMMUNITY RATE.—

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

''(i) the rate of payment for that service or services which the Secretary annually determines would apply to an individual electing a MedicarePlus product under this part if the rate of payment were determined under a 'community rating system' (as defined in section 1302(8) of the Public Health Service Act, other than subparagraph (C)), or

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

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

''(B) SPECIAL RULE FOR PROVIDER-SPONSORED ORGANIZATIONS.—In the case of a MedicarePlus organization that is a provider-sponsored organization, the adjusted community rate under subparagraph (A) for a MedicarePlus product may be computed (in a manner specified by the Secretary) using data in the general commercial marketplace or (during a transition period) based on the costs incurred by the organization in providing such a product.

''(f) RULES REGARDING PHYSICIAN PARTICIPATION.—

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

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

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

''(C) providing a process within the organization for appealing adverse decisions, including the presentation of information and views of the physician regarding such decision.

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

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

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

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

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

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

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

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

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

''(4) LIMITATION ON PROVIDER INDEMNIFICATION.—A MedicarePlus organization may not provide (directly or indirectly) for a provider (or group of providers) to indemnify the organization against any liability resulting from a civil action brought by or on behalf of an enrollee under this part for any damage caused to the enrollee by the organization's denial of medically necessary care.

''(5) EXCEPTION FOR CERTAIN FEE-FOR-SERVICE PLANS.—The previous provisions of this subsection shall not apply in the case of a MedicarePlus organization in relation to a MedicarePlus product if the organization

does not have agreements between physicians and the organization for the provision of benefits under the product.

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

''(h) COORDINATED ACUTE AND LONG-TERM CARE BENEFITS UNDER A MEDICAREPLUS PRODUCT.—Nothing in this part shall be construed as preventing a State from coordinating benefits under its MediGrant program under title XXI with those provided under a MedicarePlus product in a manner that assures continuity of a full-range of acute care and long-term care services to poor elderly or disabled individuals eligible for benefits under this title and under such program.

''(i) TRANSITIONAL FILE AND USE FOR CERTAIN REQUIREMENTS.—

''(1) IN GENERAL.—In the case of a MedicarePlus product proposed to be offered before the end of the transition period (as defined in section 1805(e)(1)(B)), by a MedicarePlus organization described in section 1851(g)(3) or by a MedicarePlus organization with a contract in effect under section 1858, if the organization submits complete information to the Secretary regarding the product demonstrating that the product meets the requirements and standards under subsections (a), (d), and (e) (relating to benefits and premiums), the product shall be deemed as meeting such requirements and standards under such subsections unless the Secretary disapproves the product within 60 days after the date of submission of the complete information.

''(2) CONSTRUCTION.—Nothing in paragraph (1) shall be construed as waiving the requirement of a contract under section 1858 or waiving requirements and standards not referred to in paragraph (1).

''PATIENT PROTECTION STANDARDS

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

''(1) Benefits under the MedicarePlus product offered, including exclusions from coverage and, if it is a high deductible/medisave product, a comparison of benefits under such a product with benefits under other MedicarePlus products.

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

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

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

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

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

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

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

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

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

''(b) ACCESS TO SERVICES.—

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

''(A) the organization makes such benefits available and accessible to each individual electing the product within the product service area with reasonable promptness and in a manner which assures continuity in the provision of benefits;

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

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

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

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

''(D) coverage is provided for emergency services (as defined in paragraph (4)) without regard to prior authorization or the emergency care provider's contractual relationship with the organization.

''(2) MINIMUM PAYMENT LEVELS WHERE PROVIDING POINT-OF-SERVICE COVERAGE.—If a MedicarePlus product provides benefits for items and services (not described in paragraph (1)(C)) through a network of providers and also permits payment to be made under the product for such items and services not provided through such a network, the payment level under the product with respect to such items and services furnished outside the network shall be at least 70 percent (or, if the effective cost-sharing rate is 50 percent, at least 40 percent) of the lesser of—

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

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

''(3) PROTECTION OF ENROLLEES FOR CERTAIN EMERGENCY SERVICES.—

''(A) PARTICIPATING PROVIDERS.—In the case of emergency services described in subparagraph (C) which are furnished by a participating physician or provider of services to an individual enrolled with a MedicarePlus organization under this section, the applicable participation agreement is deemed to provide that the physician or provider of services will accept as payment in full from the organization for such emergency services described in subparagraph (C) the amount that would be payable to the physician or provider of services under part B and from the individual under such part, if the individual were not enrolled with such an organization under this part.

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

''(C) EMERGENCY SERVICES DESCRIBED.—The emergency services described in this subparagraph are emergency services which are furnished to an enrollee of a MedicarePlus organization under this part by a physician or provider of services that is not under a contract with the organization.

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

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

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

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

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

''(c) CONFIDENTIALITY AND ACCURACY OF ENROLLEE RECORDS.—Each MedicarePlus organization shall establish procedures—

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

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

''(d) QUALITY ASSURANCE PROGRAM.—

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

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

''(A) stress health outcomes;

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

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

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

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

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

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

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

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

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

''(K) provide for external accreditation or review, by a utilization and quality control peer review organization under part B of title XI or other qualified independent review organization, of the quality of services furnished by the organization meets professionally recognized standards of health care (including providing adequate access of enrollees to services).

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

''(4) TREATMENT OF ACCREDITATION.—The Secretary shall provide that a MedicarePlus

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

''(e) COVERAGE DETERMINATIONS.—

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

''(2) APPEALS.—

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

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

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

''(f) GRIEVANCES AND APPEALS.—

''(1) GRIEVANCE MECHANISM.—Each MedicarePlus organization must provide meaningful procedures for hearing and resolving grievances between the organization (including any entity or individual through which the organization provides health care services) and enrollees under this part.

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

''(3) INDEPENDENT REVIEW OF CERTAIN COVERAGE DENIALS.—The Secretary shall contract with an independent, outside entity to review and resolve appeals of denials of coverage related to urgent or emergency services with respect to MedicarePlus products.

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

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

''(h) APPROVAL OF MARKETING MATERIALS.—

''(1) SUBMISSION.—Each MedicarePlus organization may not distribute marketing materials unless—

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

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

''(2) REVIEW.—The standards established under section 1856 shall include guidelines for the review of all such material submitted and under such guidelines the Secretary shall disapprove such material if the material is materially inaccurate or misleading or otherwise makes a material misrepresentation.

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

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

''PROVIDER-SPONSORED ORGANIZATIONS

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

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

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

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

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

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

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

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

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

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

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

''(b) PROCESS FOR ESTABLISHING STANDARDS FOR PROVIDER-SPONSORED ORGANIZATIONS.—For process of establishing of standards for provider-sponsored organizations, see section 1856(c).

''(c) PROCESS FOR STATE CERTIFICATION OF PROVIDER-SPONSORED ORGANIZATIONS.—For process of State certification of provider-sponsored organizations, see section 1857(c).

''(d) PREEMPTION OF STATE INSURANCE LICENSING REQUIREMENTS.—

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

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

''(B) imposes requirements that would have the effect of prohibiting the organization from complying with the applicable requirements of this part,

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

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

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

''PAYMENTS TO MEDICAREPLUS ORGANIZATIONS

''SEC. 1855. (a) PAYMENTS.—

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

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

''(A) the annual MedicarePlus capitation rate for each payment area for the year, and

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

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

''(4) EXPLANATION OF ASSUMPTIONS.—In each announcement made under paragraph (2) for a year, the Secretary shall include an explanation of the assumptions (including any benefit coverage assumptions) and changes in methodology used in the announcement in sufficient detail so that MedicarePlus organizations can compute monthly adjusted MedicarePlus capitation rates for classes of individuals located in each payment area which is in whole or in

part within the service area of such an organization.

''(b) MONTHLY ADJUSTED MEDICAREPLUS CAPITATION RATE.—

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

''(2) ANNUAL MEDICAREPLUS CAPITATION RATES.—For purposes of this section, the annual MedicarePlus capitation rate for a payment area for a year is equal to the annual MedicarePlus capitation rate for the area for the previous year (or, in the case of 1996, the average annual per capita rate of payment described in section 1876(a)(1)(C) for the area for 1995) increased by the per capita growth rate for that area and year (as determined under subsection (c)).

''(3) PAYMENT AREA DEFINED.—In this section, the term 'payment area' means a county (or equivalent area specified by the Secretary), except that in the case of the population group described in paragraph (5)(C), the payment area shall be each State.

''(4) CLASSES.—

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

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

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

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

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

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

''(c) PER CAPITA GROWTH RATES.—

''(1) FOR 1996.—

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

''(i) LOWEST SERVICE UTILIZATION COHORT.—For areas assigned to the lowest service utilization cohort, 9.0 percent plus the additional percent provided under subparagraph (B)(ii).

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

''(iii) MEDIAN SERVICE UTILIZATION COHORT.—For areas assigned to the median service utilization cohort, 5.1 percent.

''(iv) HIGHER SERVICE UTILIZATION COHORT.—For areas assigned to the higher service utilization cohort, 4.7 percent.

''(v) HIGHEST SERVICE UTILIZATION COHORT.—For areas assigned to the highest service utilization cohort, 4.0 percent.

''(B) BUDGET NEUTRAL ADJUSTMENT.—In order to assure that the total capitation payments under this section during 1996 are the same as the amount such payments would have been if the per capita growth rate for all such areas for 1996 were equal to the national average per capita growth rate, specified in paragraph (3) for 1996, the Secretary shall adjust the per capita growth rates for payment areas as follows:

''(i) INCREASE UP TO FLOOR.—First, such additional percent increase as may be necessary to assure that the annual MedicarePlus capitation rate for each payment area is at least 12 times $300 for 1996.

''(ii) RESIDUAL INCREASE TO LOWEST SERVICE UTILIZATION COHORT.—Next, for payment areas assigned to the lowest service utilization cohort, such additional percent increase as will assure that the total capitation payments under this section during 1996 are the same as the amount such payments would have been if the per capita growth rate for all such areas for 1996 were equal to the national average per capita growth rate. The increase under this clause may apply to a payment area described in clause (i) and shall be applied after the increase provided under such clause.

''(2) FOR SUBSEQUENT YEARS.—

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

''(i) MEDIAN SERVICE UTILIZATION COHORT SET AT NATIONAL AVERAGE PER CAPITA GROWTH RATE.—The per capita growth rate for areas assigned to the median service utilization cohort for the year shall be the national average per capita growth rate for the year (as specified under paragraph (3)), subject to subparagraph (C).

''(ii) HIGHEST SERVICE UTILIZATION COHORT SET AT 75 PERCENT OF NATIONAL AVERAGE PER CAPITA GROWTH RATE.—The per capita growth rate for areas assigned to the highest service utilization cohort for the year shall be 75 percent of the national average per capita growth rate for the year.

''(iii) LOWEST SERVICE UTILIZATION COHORT SET AT 187.5 PERCENT OF NATIONAL AVERAGE PER CAPITA GROWTH RATE.—The per capita growth rate for areas assigned to the lowest service utilization cohort for the year shall be 187.5 percent of the national average per capita growth rate for the year, subject to subparagraph (C).

''(iv) LOWER SERVICE UTILIZATION COHORT SET AT 150 PERCENT OF NATIONAL AVERAGE PER CAPITA GROWTH RATE.—

''(I) IN GENERAL.—Subject to subclause (II), the per capita growth rate for areas assigned to the lower service utilization cohort for the year shall be 150 percent of the national average per capita growth rate for the year.

''(II) ADJUSTMENT.—If the Secretary has established under clause (v) the per capita growth rate for areas assigned to the higher service utilization cohort for the year at 75 percent of the national average per capita growth rate, the Secretary may provide for a reduced per capita growth rate under subclause (I) to the extent necessary to comply with subparagraph (B).

''(v) HIGHER SERVICE UTILIZATION COHORT.—The per capita growth rate for areas assigned to the higher service utilization cohort for the year shall be such percent (not less than 75 percent) of the national average per capita growth rate, as the Secretary may determine consistent with subparagraph (B).

''(B) AVERAGE PER CAPITA GROWTH RATE AT NATIONAL AVERAGE TO ASSURE BUDGET NEUTRALITY.—The Secretary shall compute per capita growth rates for a year under subparagraph (A) (before the application of subparagraph (C)) in a manner so that the weighted average per capita growth rate for all areas for the year (weighted to reflect the number of medicare beneficiaries in each area) is equal to the national average per capita growth rate under paragraph (3) for the year.

''(C) FINAL ADJUSTMENT OF GROWTH RATES.—After computing per capita growth rates under the previous provisions of this paragraph for a year, the Secretary shall—

''(i) reduce the per capita growth rate for areas assigned to the median service utilization cohort by the ratio of .1 to 5.3;

''(ii) if the year is 1997, increase per capita growth rates for payment areas to the extent necessary to assure that the annual MedicarePlus capitation rate for each payment area for such year is at least 12 times $320; and

''(iii) adjust (consistent with clause (ii)) the per capita growth rate for areas assigned to the lowest service utilization cohort by such proportion as the Secretary determines will result in no net increase in outlays resulting from the application of this subparagraph for the year involved.''; and

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

''(A) 1996 is 5.3 percent,

''(B) 1997 is 3.8 percent,

''(C) 1998 is 4.6 percent,

''(D) 1999 is 4.3 percent,

''(E) 2000 is 3.8 percent,

''(F) 2001 is 5.5 percent,

''(G) 2002 is 5.6 percent, and

''(H) each subsequent year is 5.0 percent.

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

''(1) IN GENERAL.—For purposes of determining per capita growth rates under subsection (c) for areas for a year, the Secretary shall assign each payment area to a service utilization cohort (based on the service utilization index value for that area determined under paragraph (2)) as follows:

''(A) LOWEST SERVICE UTILIZATION COHORT.—Areas with a service utilization index value of less than .80 shall be assigned to the lowest service utilization cohort.

''(B) LOWER SERVICE UTILIZATION COHORT.—Areas with a service utilization index value of at least .80 but less than .90 shall be assigned to the lower service utilization cohort.

''(C) MEDIAN SERVICE UTILIZATION COHORT.—Areas with a service utilization index value of at least .90 but less than 1.10 shall be assigned to the median service utilization cohort.

''(D) HIGHER SERVICE UTILIZATION COHORT.—Areas with a service utilization index value of at least 1.10 but less than 1.20 shall be assigned to the higher service utilization cohort.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

''(iv) for part B services—

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

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

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

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

''(e) PAYMENT PROCESS.—

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

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

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

''(B) SPECIAL RULE FOR CERTAIN ENROLLEES.—

''(i) IN GENERAL.—Subject to clause (ii), the Secretary may make retroactive adjustments under subparagraph (A) to take into account individuals enrolled during the period beginning on the date on which the individual enrolls with a MedicarePlus organization under a product operated, sponsored, or contributed to by the individual's employer or former employer (or the employer or former employer of the individual's spouse) and ending on the date on which the individual is enrolled in the organization under this part, except that for purposes of making such retroactive adjustments under this subparagraph, such period may not exceed 90 days.

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

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

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

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

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

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

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

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

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

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

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

''(h) SPECIAL RULE FOR CERTAIN INPATIENT HOSPITAL STAYS.—In the case of an individual who is receiving inpatient hospital services from a subsection (d) hospital (as defined in section 1886(d)(1)(B)) as of the effective date of the individual's—

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

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

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

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

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

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

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

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

''ESTABLISHMENT OF STANDARDS FOR MEDICARE-PLUS ORGANIZATIONS AND PRODUCTS

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

''(1) RECOMMENDATIONS OF NAIC.—The Secretary shall request the National Association of Insurance Commissioners to develop and submit to the Secretary, not later than 12 months after the date of the enactment of the Medicare Preservation Act of 1995, proposed standards consistent with the requirements of this part for MedicarePlus organizations (other than union sponsors, Taft-Hartley sponsors, and provider-sponsored organizations) and MedicarePlus products offered by such organizations, except that such proposed standards may relate to MedicarePlus organizations that are qualified associations only with respect to MedicarePlus products offered by them and only if such products are issued by organizations to which section 1851(b)(1) applies.

''(2) REVIEW.—If the Association submits such standards on a timely basis, the Secretary shall review such standards to determine if the standards meet the requirements of the part. The Secretary shall complete the review of the standards not later than 90 days after the date of their submission. The Secretary shall promulgate such proposed

standards to apply to organizations and products described in paragraph (1) except to the extent that the Secretary modifies such proposed standards because they do not meet such requirements.

''(3) FAILURE TO SUBMIT.—If the Association does not submit such standards on a timely basis, the Secretary shall promulgate such standards by not later than the date the Secretary would otherwise have been required to promulgate standards under paragraph (2).

''(4) USE OF INTERIM RULES.—For the period in which this part is in effect and standards are being developed and established under the preceding provisions of this subsection, the Secretary shall provide by not later than June 1, 1996, for the application of such interim standards (without regard to any requirements for notice and public comment) as may be appropriate to provide for the expedited implementation of this part. Such interim standards shall not apply after the date standards are established under the preceding provisions of this subsection.

''(b) UNION AND TAFT-HARTLEY SPONSORS, QUALIFIED ASSOCIATIONS, AND PRODUCTS.—

''(1) IN GENERAL.—The Secretary shall develop and promulgate by regulation standards consistent with the requirements of this part for union and Taft-Hartley sponsors, for qualified associations, and for MedicarePlus products offered by such organizations (other than MedicarePlus products offered by qualified associations that are issued by organizations to which section 1851(b)(1) applies).

''(2) CONSULTATION WITH LABOR.—The Secretary shall consult with the Secretary of Labor with respect to such standards for such sponsors and products.

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

''(c) ESTABLISHMENT OF STANDARDS FOR PROVIDER-SPONSORED ORGANIZATIONS.—

''(1) IN GENERAL.—The Secretary shall establish, on an expedited basis and using a negotiated rulemaking process under subchapter 3 of chapter 5 of title 5, United States Code, standards that entities must meet to qualify as provider-sponsored organizations under this part.

''(2) PUBLICATION OF NOTICE.—In carrying out the rulemaking process under this subsection, the Secretary, after consultation with the National Association of Insurance Commissioners, the American Academy of Actuaries, organizations representative of medicare beneficiaries, and other interested parties, shall publish the notice provided for under section 564(a) of title 5, United States Code, by not later than 45 days after the date of the enactment of Medicare Preservation Act of 1995.

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

''(4) ABBREVIATED PERIOD FOR SUBMISSION OF COMMENTS.—In applying section 564(c) of such title under this subsection, '15 days' shall be substituted for '30 days'.

''(5) APPOINTMENT OF NEGOTIATED RULEMAKING COMMITTEE AND FACILITATOR.—The Secretary shall provide for—

''(A) the appointment of a negotiated rulemaking committee under section 565(a) of such title by not later than 30 days after the end of the comment period provided for under section 564(c) of such title (as shortened under paragraph (4)), and

''(B) the nomination of a facilitator under section 566(c) of such title by not later than 10 days after the date of appointment of the committee.

''(6) PRELIMINARY COMMITTEE REPORT.—The negotiated rulemaking committee appointed under paragraph (5) shall report to the Secretary, by not later than June 1, 1996, regarding the committee's progress on achieving a concensus with regard to the rulemaking proceeding and whether such consensus is likely to occur before one month before the target date for publication of the rule. If the committee reports that the committee has failed to make significant progress towards such consensus or is unlikely to reach such consensus by the target date, the Secretary may terminate such process and provide for the publication of a rule under this subsection through such other methods as the Secretary may provide.

''(7) FINAL COMMITTEE REPORT.—If the committee is not terminated under paragraph (6), the rulemaking committee shall submit a report containing a proposed rule by not later than one month before the target publication date.

''(8) INTERIM, FINAL EFFECT.—The Secretary shall publish a rule under this subsection in the Federal Register by not later than the target publication date. Such rule shall be effective and final immediately on an interim basis, but is subject to change and revision after public notice and opportunity for a period (of not less than 60 days) for public comment. In connection with such rule, the Secretary shall specify the process for the timely review and approval of applications of entities to be certified as provider-sponsored organizations pursuant to such rules and consistent with this subsection.

''(9) PUBLICATION OF RULE AFTER PUBLIC COMMENT.—The Secretary shall provide for consideration of such comments and republication of such rule by not later than 1 year after the target publication date.

''(10) PROCESS FOR APPROVAL OF APPLICATIONS FOR CERTIFICATION.—

''(A) IN GENERAL.—The Secretary shall establish a process for the receipt and approval of applications of entities for certification as provider-sponsored organizations under this part. Under such process, the Secretary shall act upon a complete application submitted within 60 days after the date it is received.

''(B) CIRCULATION OF PROPOSED APPLICATION FORM.—By March 1, 1996, the Secretary, after consultation with the negotiated rulemaking committee, shall circulate a proposed application form that could be used by entities considering becoming certified as a provider-sponsored organization under this part.

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

''(e) USE OF CURRENT STANDARDS FOR INTERIM STANDARDS.—To the extent practicable and consistent with the requirements of this part, standards established on an interim basis to carry out requirements of this part may be based on currently applicable standards, such as the rules established under section 1876 (as in effect as of the date of the enactment of this section) to carry out analogous provisions of such section or standards established or developed for application in the private health insurance market.

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

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

''MEDICARE-PLUS CERTIFICATION

''SEC. 1857. (a) STATE CERTIFICATION PROCESS FOR STATE-REGULATED ORGANIZATIONS.—

''(1) APPROVAL OF STATE PROCESS.—The Secretary shall approve a MedicarePlus certification and enforcement program established by a State for applying the standards established under section 1856 to MedicarePlus organizations (other than union sponsors, Taft-Hartley sponsors, and provider-sponsored organizations) and MedicarePlus products offered by such organizations if the Secretary determines that the program effectively provides for the application and enforcement of such standards in the State with respect to such organizations and products. Such program shall provide for certification of compliance of MedicarePlus organizations and products with the applicable requirements of this part not less often than once every 3 years.

''(2) EFFECT OF CERTIFICATION UNDER STATE PROCESS.—A MedicarePlus organization and MedicarePlus product offered by such an organization that is certified under such program is considered to have been certified under this subsection with respect to the offering of the product to individuals residing in the State.

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

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

''(5) EFFECT OF NO STATE PROGRAM.—Beginning on the date standards are established under section 1856, in the case of organizations and products in States in which a certification program has not been approved and in operation under paragraph (1), the Secretary shall establish a process for the certification of MedicarePlus organizations (other than union sponsors, Taft-Hartley sponsors, and provider-sponsored organizations) and products of such organizations as meeting such standards.

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

''(b) FEDERAL CERTIFICATION PROCESS FOR UNION SPONSORS, TAFT-HARTLEY SPONSORS, AND PROVIDER-SPONSORED ORGANIZATIONS.—

''(1) ESTABLISHMENT.—The Secretary shall establish a process for the certification of union sponsors, Taft-Hartley sponsors, and provider-sponsored organizations and MedicarePlus products offered by such sponsors and organizations as meeting the applicable standards established under section 1856.

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

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

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

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

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

''(c) CERTIFICATION OF PROVIDER-SPONSORED ORGANIZATIONS BY STATES.—

''(1) IN GENERAL.—The Secretary shall establish a process under which a State may propose to provide for certification of entities as meeting the requirements of this part to be provider-sponsored organizations.

''(2) CONDITIONS FOR APPROVAL.—The Secretary may not approve a State program for certification under paragraph (1) unless the Secretary determines that the certification program applies standards and requirements that are identical to the standards and requirements of this part and the applicable provisions for enforcement of such standards and requirements do not result in a lower level or quality of enforcement than that which is otherwise applicable under this title.

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

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

''CONTRACTS WITH MEDICAREPLUS ORGANIZATIONS

''SEC. 1858. (a) IN GENERAL.—The Secretary shall not permit the election under section 1805 of a MedicarePlus product offered by a MedicarePlus organization under this part, and no payment shall be made under section 1856 to an organization, unless the Secretary has entered into a contract under this section with an organization with respect to the offering of such product. Such a contract with an organization may cover more than one MedicarePlus product. Such contract shall provide that the organization agrees to comply with the applicable requirements and standards of this part and the terms and conditions of payment as provided for in this part.

''(b) MINIMUM ENROLLMENT REQUIREMENTS.—

''(1) IN GENERAL.—Subject to paragraphs (1) and (2), the Secretary may not enter into a contract under this section with a MedicarePlus organization (other than a union sponsor or Taft-Hartley sponsor) unless the organization has at least 5,000 individuals (or 1,500 individuals in the case of an organization that is a provider-sponsored organization) who are receiving health benefits through the organization, except that the standards under section 1856 may permit the organization to have a lesser number of beneficiaries (but not less than 500 in the case of an organization that is a provider-sponsored organization) if the organization primarily serves individuals residing outside of urbanized areas.

''(2) EXCEPTION FOR HIGH DEDUCTIBLE/MEDISAVE PRODUCT.—Paragraph (1) shall not apply with respect to a contract that relates only to a high deductible/medisave product.

''(3) ALLOWING TRANSITION.—The Secretary may waive the requirement of paragraph (1) during the first 3 contract years with respect to an organization.

''(c) CONTRACT PERIOD AND EFFECTIVENESS.—

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

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

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

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

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

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

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

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

''(5) NO CONTRACTING AUTHORITY.—The authority vested in the Secretary by this part may be performed without regard to such provisions of law or regulations relating to the making, performance, amendment, or modification of contracts of the United States as the Secretary may determine to be inconsistent with the furtherance of the purpose of this title.

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

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

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

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

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

''(3) DISCLOSURE.—

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

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

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

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

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

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

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

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

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

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

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

''(I) is an officer or director;

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

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

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

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

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

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

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

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

''(f) INTERMEDIATE SANCTIONS.—

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

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

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

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

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

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

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

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

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

''(G) employs or contracts with any individual or entity that is excluded from participation under this title under section 1128 or 1128A for the provision of health care, utilization review, medical social work, or administrative services or employs or contracts with any entity for the provision (directly or indirectly) through such an excluded individual or entity of such services; the Secretary may provide, in addition to any other remedies authorized by law, for any of the remedies described in paragraph (2).

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

''(A) civil money penalties of not more than $25,000 for each determination under paragraph (1) or, with respect to a determination under subparagraph (D) or (E)(i) of such paragraph, of not more than $100,000 for each such determination, plus, with respect to a determination under paragraph (1)(B), double the excess amount charged in violation of such paragraph (and the excess amount charged shall be deducted from the penalty and returned to the individual concerned), and plus, with respect to a determination under paragraph (1)(D), $15,000 for each individual not enrolled as a result of the practice involved,

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

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

''(3) OTHER INTERMEDIATE SANCTIONS.—In the case of a MedicarePlus organization for which the Secretary makes a determination under subsection (c)(2) the basis of which is not described in paragraph (1), the Secretary may apply the following intermediate sanctions:

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

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

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

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

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

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

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

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

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

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

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

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

(1) in paragraph (1)—

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

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

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

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

(e) CONFORMING AMENDMENT.—Section 1866(a)(1)(O) (42 U.S.C. 1395cc(a)(1)(O)) is amended by inserting before the semicolon at the end the following: ''and in the case of hospitals to accept as payment in full for inpatient hospital services that are emergency services (as defined in section 1853(b)(4)) that are covered under this title and are furnished to any individual enrolled under part C with a MedicarePlus organization which does not have a contract establishing payment amounts for services furnished to members of the organization the amounts that would be made as a payment in full under this title if the individuals were not so enrolled''.

SEC. 15003. DUPLICATION AND COORDINATION OF MEDICARE-RELATED PRODUCTS.

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

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

(A) by amending clause (i) to read as follows:

''(i) It is unlawful for a person to sell or issue to an individual entitled to benefits under part A or enrolled under part B of this title or electing a MedicarePlus product under section 1805—

''(I) a health insurance policy (other than a medicare supplemental policy) with knowledge that the policy duplicates health benefits to which the individual is otherwise entitled under this title or title XIX,

''(II) in the case of an individual not electing a MedicarePlus product, a medicare supplemental policy with knowledge that the individual is entitled to benefits under another medicare supplemental policy, or

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

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

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

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

''(v) For purposes of this subparagraph, a health insurance policy (or a rider to an insurance contract which is not a health insurance policy), including a policy (such as a long-term care insurance contract described in section 7702B(b) of the Internal Revenue Code of 1986, as added by the Contract with America Tax Relief Act of 1995 (H.R. 1215))

providing benefits for long-term care, nursing home care, home health care, or community-based care, that coordinates against or excludes items and services available or paid for under this title and (for policies sold or issued after January 1, 1996) that discloses such coordination or exclusion in the policy's outline of coverage, is not considered to 'duplicate' health benefits under this title. For purposes of this clause, the terms 'coordinates' and 'coordination' mean, with respect to a policy in relation to health benefits under this title, that the policy under its terms is secondary to, or excludes from payment, items and services to the extent available or paid for under this title.

''(vi) Notwithstanding any other provision of law, no criminal or civil penalty may be imposed at any time under this subparagraph and no legal action may be brought or continued at any time in any Federal or State court if the penalty or action is based on an act or omission that occurred after November 5, 1991, and before the date of the enactment of this clause, and relates to the sale, issuance, or renewal of any health insurance policy during such period, if such policy meets the requirements of clause (iv) or (v).

''(vii) A State may not impose, with respect to the sale or issuance of a policy (or rider) that meets the requirements of this title pursuant to clause (iv) or (v) to an individual entitled to benefits under part A or enrolled under part B or enrolled under a MedicarePlus product under part C, any requirement based on the premise that such a policy or rider duplicates health benefits to which the individual is otherwise entitled under this title.''.

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

(A) in subparagraph (B), by inserting ''(including any MedicarePlus product)'' after ''health insurance policies'';

(B) in subparagraph (C)—

(i) by striking ''with respect to (i)'' and inserting ''with respect to'', and

(ii) by striking '', (ii) the sale'' and all that follows up to the period at the end; and

(C) by striking subparagraph (D).

(3) MEDICAREPLUS PRODUCTS NOT TREATED AS MEDICARE SUPPLEMENTARY POLICIES.—Section 1882(g) (42 U.S.C. 1395ss(g)) is amended by inserting ''a MedicarePlus product or'' after ''and does not include''

(4) REPORT ON DUPLICATION AND COORDINATION OF HEALTH INSURANCE POLICIES THAT ARE NOT MEDICARE SUPPLEMENTAL POLICIES.—Not later than 3 years after the date of the enactment of this Act, the Secretary of Health and Human Services shall prepare and submit to Congress a report on the advisability and feasibility of restricting the sale to medicare beneficiaries of health insurance policies that duplicate (within the meaning of section 1882(d)(3)(A) of the Social Security Act) other health insurance policies that such a beneficiary may have. In preparing such report, the Secretary shall seek the advice of the National Association of Insurance Commissioners and shall take into account the standards established under section 1807 of the Social Security Act for the electronic coordination of benefits.

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

''(u)(1) Notwithstanding the previous provisions of this section, the following provisions shall not apply to a health insurance policy (other than a medicare supplemental policy) provided to an individual who has elected the MedicarePlus option under section 1805:

''(A) Subsections (o)(1), (o)(2), (p)(1)(A)(i), (p)(2), (p)(3), (p)(8), and (p)(9) (insofar as they relate to limitations on benefits or groups of benefits that may be offered).

''(B) Subsection (r) (relating to loss-ratios).

''(2)(A) It is unlawful for a person to sell or issue a policy described in subparagraph (B) to an individual with knowledge that the individual has in effect under section 1805 an election of a high deductible/medisave product.

''(B) A policy described in this subparagraph is a health insurance policy that provides for coverage of expenses that are otherwise required to be counted toward meeting the annual deductible amount provided under the high deductible/medisave product.''.

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

(a) TRANSITION FROM CURRENT CONTRACTS.—

(1) LIMITATION ON NEW CONTRACTS.—

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

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

(2) TERMINATION OF CURRENT CONTRACTS.—

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

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

(b) CONFORMING PAYMENT RATES.—

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

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

(B) with respect to individuals only entitled to benefits under part B of such title, by substituting an appropriate proportion of such rates (reflecting the relative proportion of payments under such title attributable to such part) for the payment rates otherwise established under section 1876(a) of such Act. For purposes of carrying out this paragraph for payment for months in 1996, the Secretary shall compute, announce, and apply the payment rates under section 1855(a) of such Act (notwithstanding any deadlines specified in such section) in as timely a manner as possible and may (to the extent necessary) provide for retroactive adjustment in payments made not in accordance with such rates.

(2) COST CONTRACTS.—Notwithstanding any other provision of law, the Secretary shall provide that payment amounts under cost reimbursement contracts under section 1876(a) of the Social Security Act shall take into account adjustments in payment amounts made in parts A and B of title XVIII of such Act pursuant to the amendments made by this title.

(c) ELIMINATION OF 50:50 RULE.—

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

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

(A) in subsection (c)(3)(A)(i), by striking ''would result in failure to meet the requirements of subsection (f) or'', and

(B) in subsection (i)(1)(C), by striking ''(e), and (f)'' and inserting ''and (e)''.

(3) EFFECTIVE DATE.—The amendments made by this section shall apply to contract years beginning on or after January 1, 1996.

PART 2—SPECIAL RULES FOR MEDICAREPLUS MEDICAL SAVINGS ACCOUNTS

SEC. 15011. MEDICAREPLUS MSA'S.

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

''SEC. 137. MEDICAREPLUS MSA'S.

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

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

''(1) MEDICAREPLUS MSA.—The term 'MedicarePlus MSA' means a trust created or organized in the United States exclusively for the purpose of paying the qualified medical expenses of the account holder, but only if the written governing instrument creating the trust meets the following requirements:

''(A) Except in the case of a trustee-to-trustee transfer described in subsection (d)(4), no contribution will be accepted unless it is made by the Secretary of Health and Human Services under section 1855(f)(1)(B) of the Social Security Act.

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

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

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

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

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

''(2) QUALIFIED MEDICAL EXPENSES.—

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

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

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

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

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

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

''(c) TAX TREATMENT OF ACCOUNTS.—

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

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

''(d) TAX TREATMENT OF DISTRIBUTIONS.—

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

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

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

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

''(ii) the excess (if any) of—

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

''(II) an amount equal to 60 percent of the deductible under the high deductible/medisave product covering the account holder as of January 1 of the calendar year in which the taxable year begins.

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

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

''(ii) dies.

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

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

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

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

''(3) WITHDRAWAL OF ERRONEOUS CONTRIBUTIONS.—Paragraphs (1) and (2) shall not apply to any payment or distribution from a MedicarePlus MSA to the Secretary of Health and Human Services of an erroneous contribution to such MSA and of the net income attributable to such contribution.

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

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

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

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

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

''(B) SPECIAL RULES IF SPOUSE NOT MEDICARE ELIGIBLE.—If, as of the date of such death, such spouse is not entitled to benefits under title XVIII of the Social Security Act, then after the date of such death—

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

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

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

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

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

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

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

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

''(f) REPORTS.—

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

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

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

as the Secretary may require by regulations.

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

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

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

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

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

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

''SEC. 2057. MEDICAREPLUS MSA'S.

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

(c) TAX ON PROHIBITED TRANSACTIONS.—

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

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

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

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

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

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

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

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

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

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

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

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

''(a) REPORTS.—

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

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

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

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

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

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

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

(e) CLERICAL AMENDMENTS.—

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

''Sec. 137. MedicarePlus MSA's.

''Sec. 138. Cross references to other Acts.''

(2) The table of sections for part 1 of subchapter B of chapter 68 of such Code is amended by striking the item relating to

section 6693 and inserting the following new item:

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

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

''Sec. 2057. MedicarePlus MSA's.''

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

SEC. 15012. CERTAIN REBATES EXCLUDED FROM GROSS INCOME.

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

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

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

PART 3—SPECIAL ANTITRUST RULE FOR PROVIDER SERVICE NETWORKS

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

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

(1) the conduct of a provider service network in negotiating, making, or performing a contract (including the establishment and modification of a fee schedule and the development of a panel of physicians), to the extent such contract is for the purpose of providing health care services to individuals under the terms of a MedicarePlus PSO product, and

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

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

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

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

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

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

(4) MEDICAREPLUS PROGRAM.—The term ''MedicarePlus program'' means the program under part C of title XVIII of the Social Security Act.

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

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

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

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

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

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

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

(iii) provides for the distribution of such compensation,

(D) has established, consistent with the requirements of the MedicarePlus program for provider-sponsored organizations, a program to review, pursuant to written guidelines, the quality, efficiency, and appropriateness of treatment methods and setting of services for all health care providers and all patients participating in such product, along with internal procedures to correct identified deficiencies relating to such methods and such services,

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

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

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

Such term may include a provider-sponsored organization.

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

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

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

PART 4—COMMISSIONS

SEC. 15031. MEDICARE PAYMENT REVIEW COMMISSION.

(a) IN GENERAL.—Title XVIII, as amended by section 15001(a), is amended by inserting after section 1805 the following new section:

''MEDICARE PAYMENT REVIEW COMMISSION

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

''(b) DUTIES.—

''(1) GENERAL DUTIES AND REPORTS.—

''(A) IN GENERAL.—The Commission shall review, and make recommendations to Congress concerning, payment policies under this title.

''(B) ANNUAL REPORTS.—By not later than June 1 of each year, the Commission shall submit a report to Congress containing an examination of issues affecting the medicare program, including the implications of changes in health care delivery in the United States and in the market for health care services on the medicare program.

''(C) ADDITIONAL REPORTS.—The Commission may submit to Congress from time to time such other reports as the Commission deems appropriate. By not later than May 1, 1997, the Commission shall submit to Congress a report on the matter described in paragraph (2)(G).

''(D) SECRETARIAL RESPONSE IN RULEMAKING.—The Secretary shall respond to recommendations of the Commission in notices of rulemaking proceedings under this title.

''(2) SPECIFIC DUTIES RELATING TO MEDICAREPLUS PROGRAM.—Specifically, the Commission shall review, with respect to the MedicarePlus program under part C—

''(A) the appropriateness of the methodology for making payment to plans under such program, including the making of differential payments and the distribution of differential updates among different payment areas);

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

''(C) the implications of risk selection both among MedicarePlus organizations and between the MedicarePlus option and the non-MedicarePlus option;

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

''(E) the impact of the MedicarePlus program on access to care for medicare beneficiaries;

''(F) the feasibility and desirability of extending the rules for open enrollment that apply during the transition period to apply in each county during the first 2 years in which MedicarePlus products are made available to individuals residing in the county; and

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

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

''(A) the appropriateness of the expenditure projections by the Secretary under section 1895(c) for each medicare sector;

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

''(C) the appropriateness of the mechanisms for implementing reductions in payment amounts for different sectors, including any adjustments to reflect changes in

volume or intensity resulting for any payment reductions;

''(D) the impact of the mechanism on provider participation in parts A and B and in the MedicarePlus program; and

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

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

''(A) the factors affecting expenditures for services in different sectors, including the process for updating hospital, physician, and other fees,

''(B) payment methodologies; and

''(C) the impact of payment policies on access and quality of care for medicare beneficiaries.

''(5) SPECIFIC DUTIES RELATING TO INTERACTION OF PAYMENT POLICIES WITH HEALTH CARE DELIVERY GENERALLY.—Specifically the Commission shall review the effect of payment policies under this title on the delivery of health care services under this title and assess the implications of changes in the health services market on the medicare program.

''(c) MEMBERSHIP.—

''(1) NUMBER AND APPOINTMENT.—The Commission shall be composed of 15 members appointed by the Comptroller General.

''(2) QUALIFICATIONS.—The membership of the Commission shall include individuals with national recognition for their expertise in health finance and economics, actuarial science, health facility management, health plans and integrated delivery systems, reimbursement of health facilities, allopathic and osteopathic physicians, and other providers of services, and other related fields, who provide a mix of different professionals, broad geographic representation, and a balance between urban and rural representatives, including physicians and other health professionals, employers, third party payors, individuals skilled in the conduct and interpretation of biomedical, health services, and health economics research and expertise in outcomes and effectiveness research and technology assessment. Such membership shall also include representatives of consumers and the elderly.

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

''(4) TERMS.—

''(A) IN GENERAL.—The terms of members of the Commission shall be for 3 years except that the Comptroller General shall designate staggered terms for the members first appointed.

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

''(5) COMPENSATION.—While serving on the business of the Commission (including traveltime), a member of the Commission shall be entitled to compensation at the per diem equivalent of the rate provided for level IV of the Executive Schedule under section 5315 of title 5, United States Code; and while so serving away from home and member's regular place of business, a member may be allowed travel expenses, as authorized by the Chairman of the Commission. Physicians serving as personnel of the Commission may be provided a physician comparability allowance by the Commission in the same manner as Government physicians may be provided such an allowance by an agency under section 5948 of title 5, United States Code, and for such purpose subsection (i) of such section shall apply to the Commission in the same manner as it applies to the Tennessee Valley Authority. For purposes of pay (other than pay of members of the Commission) and employment benefits, rights, and privileges, all personnel of the Commission shall be treated as if they were employees of the United States Senate.

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

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

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

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

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

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

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

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

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

''(e) POWERS.—

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

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

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

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

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

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

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

''(f) AUTHORIZATION OF APPROPRIATIONS.—

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

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

(b) ABOLITION OF PROPAC AND PPRC.—

(1) PROPAC.—

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

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

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

(B) CONFORMING AMENDMENT.—Section 1862 (42 U.S.C. 1395y) is amended by striking ''Prospective Payment Assessment Commission'' each place it appears in subsection (a)(1)(D) and subsection (i) and inserting ''Medicare Payment Review Commission''.

(2) PPRC.—

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

(B) CONFORMING AMENDMENTS.—

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

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

(iii) Section 1848 (42 U.S.C. 1395w–4) is amended by striking ''Physician Payment Review Commission'' and inserting ''Medicare Payment Review Commission'' each place it appears in paragraph (2)(A)(ii), (2)(B)(iii), and (5) of subsection (c), subsection (d)(2)(F), paragraphs (1)(B), (3), and (4)(A) of subsection (f), and paragraphs (6)(C) and (7)(C) of subsection (g).

(c) EFFECTIVE DATE; TRANSITION.—

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

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

(3) CONTINUING RESPONSIBILITY FOR REPORTS.—The MPRC shall be responsible for the preparation and submission of reports required by law to be submitted (and which have not been submitted by the date of establishment of the MPRC) by the ProPAC and PPRC, and, for this purpose, any reference in law to either such Commission is

deemed, after the appointment of the MPRC, to refer to the MPRC.

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

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

(b) DUTIES.—

(1) IN GENERAL.—The Commission shall—

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

(B) make specific recommendations to the Congress respecting a comprehensive approach to preserve the medicare program for the period during which such individuals are eligible for medicare.

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

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

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

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

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

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

(c) MEMBERSHIP.—

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

(A) The President shall appoint 3 members.

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

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

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

(3) VACANCIES.—Any vacancy in the membership of the Commission shall be filled in the manner in which the original appointment was made and shall not affect the power of the remaining members to execute the duties of the Commission.

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

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

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

(d) STAFF AND CONSULTANTS.—

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

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

(e) POWERS.—

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

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

(3) COST ESTIMATES BY CONGRESSIONAL BUDGET OFFICE.—

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

(B) The Commission shall reimburse the Director of the Congressional Budget Office for expenses relating to the employment in the office of the Director of such additional staff as may be necessary for the Director to comply with requests by the Commission under subparagraph (A).

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

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

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

(7) OBTAINING INFORMATION.—The Commission may secure directly from any Federal agency information necessary to enable it to carry out its duties, if the information may be disclosed under section 552 of title 5, United States Code. Upon request of the Chairman of the Commission, the head of such agency shall furnish such information to the Commission.

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

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

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

(f) REPORT.—Not later than May 1, 1997, the Commission shall submit to Congress a report containing its findings and recommendations regarding how to protect and preserve the medicare program in a financially solvent manner until 2030 (or, if later, throughout the period of projected solvency of the Federal Old-Age and Survivors Insurance Trust Fund). The report shall include detailed recommendations for appropriate legislative initiatives respecting how to accomplish this objective.

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

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

SEC. 15033. CHANGE IN APPOINTMENT OF ADMINISTRATOR OF HCFA.

(a) IN GENERAL.—Section 1117 (42 U.S.C. 1317) is amended by striking ''President by and with the advice and consent of the Senate'' and inserting ''Secretary of Health and Human Services''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on the date of the enactment of this Act and shall apply to Administrators appointed on or after the date of the enactment of this Act.

PART 5—TREATMENT OF HOSPITALS WHICH PARTICIPATE IN PROVIDER-SPONSORED ORGANIZATIONS

SEC. 15041. TREATMENT OF HOSPITALS WHICH PARTICIPATE IN PROVIDER-SPONSORED ORGANIZATIONS.

(a) IN GENERAL.—Section 501 of the Internal Revenue Code of 1986 (relating to exemption from tax on corporations, certain trusts, etc.) is amended by redesignating subsection (n) as subsection (o) and by inserting after subsection (m) the following new subsection:

''(n) TREATMENT OF HOSPITALS PARTICIPATING IN PROVIDER-SPONSORED ORGANIZATIONS.—An organization shall not fail to be treated as organized and operated exclusively for a charitable purpose for purposes of subsection (c)(3) solely because a hospital which is owned and operated by such organization participates in a provider-sponsored organization (as defined in section 1854(a)(1) of the Social Security Act), whether or not the provider-sponsored organization is exempt from tax. For purposes of subsection (c)(3), any person with a material financial interest in such a provider-sponsored organization shall be treated as a private shareholder or individual with respect to the hospital.''

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

Subtitle B—Preventing Fraud and Abuse

PART 1—GENERAL PROVISIONS

SEC. 15101. INCREASING AWARENESS OF FRAUD AND ABUSE.

(a) BENEFICIARY OUTREACH EFFORTS.—The Secretary of Health and Human Services (acting through the Administrator of the Health Care Financing Administration and the Inspector General of the Department of Health and Human Services) shall make ongoing efforts (through public service announcements, publications, and other appropriate methods) to alert individuals entitled to benefits under the medicare program of the existence of fraud and abuse committed

against the program and the costs to the program of such fraud and abuse, and of the existence of the toll-free telephone line operated by the Secretary to receive information on fraud and abuse committed against the program.

(b) CLARIFICATION OF REQUIREMENT TO PROVIDE EXPLANATION OF MEDICARE BENEFITS.—The Secretary shall provide an explanation of benefits under the medicare program with respect to each item or service for which payment may be made under the program which is furnished to an individual, without regard to whether or not a deductible or coinsurance may be imposed against the individual with respect to the item or service.

(c) PROVIDER OUTREACH EFFORTS; PUBLICATION OF FRAUD ALERTS.—

(1) SPECIAL FRAUD ALERTS.—

(A) IN GENERAL.—

(i) REQUEST FOR SPECIAL FRAUD ALERTS.—Any person may present, at any time, a request to the Secretary to issue and publish a special fraud alert.

(ii) SPECIAL FRAUD ALERT DEFINED.—In this section, a ''special fraud alert'' is a notice which informs the public of practices which the Secretary considers to be suspect or of particular concern under the medicare program or a State health care program (as defined in section 1128(h) of the Social Security Act).

(B) ISSUANCE AND PUBLICATION OF SPECIAL FRAUD ALERTS.—

(i) INVESTIGATION.—Upon receipt of a request for a special fraud alert under subparagraph (A), the Secretary shall investigate the subject matter of the request to determine whether a special fraud alert should be issued. If appropriate, the Secretary (in consultation with the Attorney General) shall issue a special fraud alert in response to the request. All special fraud alerts issued pursuant to this subparagraph shall be published in the Federal Register.

(ii) CRITERIA FOR ISSUANCE.—In determining whether to issue a special fraud alert upon a request under subparagraph (A), the Secretary may consider—

(I) whether and to what extent the practices that would be identified in the special fraud alert may result in any of the consequences described in 15214(b); and

(II) the extent and frequency of the conduct that would be identified in the special fraud alert.

(2) PUBLICATION OF ALL HCFA FRAUD ALERTS IN FEDERAL REGISTER.—Each notice issued by the Health Care Financing Administration which informs the public of practices which the Secretary considers to be suspect or of particular concern under the medicare program or a State health care program (as defined in section 1128(h) of the Social Security Act) shall be published in the Federal Register, without regard to whether or not the notice is issued by a regional office of the Health Care Financing Administration.

SEC. 15102. BENEFICIARY INCENTIVE PROGRAMS.

(a) PROGRAM TO COLLECT INFORMATION ON FRAUD AND ABUSE.—

(1) ESTABLISHMENT OF PROGRAM.—Not later than 3 months after the date of the enactment of this Act, the Secretary of Health and Human Services (hereinafter in this subtitle referred to as the ''Secretary'') shall establish a program under which the Secretary shall encourage individuals to report to the Secretary information on individuals and entities who are engaging or who have engaged in acts or omissions which constitute grounds for the imposition of a sanction under section 1128, section 1128A, or section 1128B of the Social Security Act, or who have otherwise engaged in fraud and abuse against the medicare program for which there is a sanction provided under law. The program shall discourage provision of, and not consider, information which is frivolous or otherwise not relevant or material to the imposition of such a sanction.

(2) PAYMENT OF PORTION OF AMOUNTS COLLECTED.—If an individual reports information to the Secretary under the program established under paragraph (1) which serves as the basis for the collection by the Secretary or the Attorney General of any amount of at least $100 (other than any amount paid as a penalty under section 1128B of the Social Security Act), the Secretary may pay a portion of the amount collected to the individual (under procedures similar to those applicable under section 7623 of the Internal Revenue Code of 1986 to payments to individuals providing information on violations of such Code).

(b) PROGRAM TO COLLECT INFORMATION ON PROGRAM EFFICIENCY.—

(1) ESTABLISHMENT OF PROGRAM.—Not later than 3 months after the date of the enactment of this Act, the Secretary shall establish a program under which the Secretary shall encourage individuals to submit to the Secretary suggestions on methods to improve the efficiency of the medicare program.

(2) PAYMENT OF PORTION OF PROGRAM SAVINGS.—If an individual submits a suggestion to the Secretary under the program established under paragraph (1) which is adopted by the Secretary and which results in savings to the program, the Secretary may make a payment to the individual of such amount as the Secretary considers appropriate.

SEC. 15103. INTERMEDIATE SANCTIONS FOR MEDICARE HEALTH MAINTENANCE ORGANIZATIONS.

(a) APPLICATION OF INTERMEDIATE SANCTIONS FOR ANY PROGRAM VIOLATIONS.—

(1) IN GENERAL.—Section 1876(i)(1) (42 U.S.C. 1395mm(i)(1)) is amended by striking ''the Secretary may terminate'' and all that follows and inserting the following: ''in accordance with procedures established under paragraph (9), the Secretary may at any time terminate any such contract or may impose the intermediate sanctions described in paragraph (6)(B) or (6)(C) (whichever is applicable) on the eligible organization if the Secretary determines that the organization—

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

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

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

''(D) no longer substantially meets the applicable conditions of subsections (b), (c), and (e).''.

(2) OTHER INTERMEDIATE SANCTIONS FOR MISCELLANEOUS PROGRAM VIOLATIONS.—Section 1876(i)(6) (42 U.S.C. 1395mm(i)(6)) is amended by adding at the end the following new subparagraph:

''(C) In the case of an eligible organization for which the Secretary makes a determination under paragraph (1) the basis of which is not described in subparagraph (A), the Secretary may apply the following intermediate sanctions:

''(i) civil money penalties of not more than $25,000 for each determination under paragraph (1) if the deficiency that is the basis of the determination has directly adversely affected (or has the substantial likelihood of adversely affecting) an individual covered under the organization's contract;

''(ii) civil money penalties of not more than $10,000 for each week beginning after the initiation of procedures by the Secretary under paragraph (9) during which the deficiency that is the basis of a determination under paragraph (1) exists; and

''(iii) suspension of enrollment of individuals under this section after the date the Secretary notifies the organization of a determination under paragraph (1) and until the Secretary is satisfied that the deficiency that is the basis for the determination has been corrected and is not likely to recur.''.

(3) PROCEDURES FOR IMPOSING SANCTIONS.—Section 1876(i) (42 U.S.C. 1395mm(i)) is amended by adding at the end the following new paragraph:

''(9) The Secretary may terminate a contract with an eligible organization under this section or may impose the intermediate sanctions described in paragraph (6) on the organization in accordance with formal investigation and compliance procedures established by the Secretary under which—

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

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

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

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

(4) CONFORMING AMENDMENTS.—(A) Section 1876(i)(6)(B) (42 U.S.C. 1395mm(i)(6)(B)) is amended by striking the second sentence.

(B) Section 1876(i)(6) (42 U.S.C. 1395mm(i)(6)) is further amended by adding at the end the following new subparagraph:

''(D) The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under subparagraph (A) or (B) in the same manner as they apply to a civil money penalty or proceeding under section 1128A(a).''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to contract years beginning on or after January 1, 1996.

SEC. 15104. VOLUNTARY DISCLOSURE PROGRAM.

Title XI (42 U.S.C. 1301 et seq.) is amended by inserting after section 1128B the following new section:

''VOLUNTARY DISCLOSURE OF ACTS OR OMISSIONS

''SEC. 1129. (a) ESTABLISHMENT OF VOLUNTARY DISCLOSURE PROGRAM.—Not later than 3 months after the date of the enactment of this section, the Secretary shall establish a program to encourage individuals and entities to voluntarily disclose to the Secretary information on acts or omissions of the individual or entity which constitute grounds for the imposition of a sanction described in section 1128, 1128A, or 1128B.

''(b) EFFECT OF VOLUNTARY DISCLOSURE.—If an individual or entity voluntarily discloses information with respect to an act or omission to the Secretary under subsection (a), the following rules shall apply:

''(1) The Secretary may waive, reduce, or otherwise mitigate any sanction which would otherwise be applicable to the individual or entity under section 1128, 1128A, or 1128B as a result of the act or omission involved.

''(2) No qui tam action may be brought pursuant to chapter 37 of title 31, United States Code, against the individual or entity with respect to the act or omission involved.''.

SEC. 15105. REVISIONS TO CURRENT SANCTIONS.

(a) DOUBLING THE AMOUNT OF CIVIL MONETARY PENALTIES.—The maximum amount of civil monetary penalties specified in section 1128A of the Social Security Act or under title XVIII of such Act (as in effect on the day before the date of the enactment of this Act) shall, effective for violations occurring after the date of the enactment of this Act, be double the amount otherwise provided as of such date.

(b) ESTABLISHMENT OF MINIMUM PERIOD OF EXCLUSION FOR CERTAIN INDIVIDUALS AND ENTITIES SUBJECT TO PERMISSIVE EXCLUSION.—Section 1128(c)(3) (42 U.S.C. 1320a–7(c)(3)) is amended by adding at the end the following new subparagraphs:

''(D) In the case of an exclusion of an individual or entity under paragraph (1), (2), or (3) of subsection (b), the period of the exclusion shall be 3 years, unless the Secretary determines in accordance with regulations that a shorter period is appropriate because of mitigating circumstances or that a longer period is appropriate because of aggravating circumstances.

''(E) In the case of an exclusion of an individual or entity under subsection (b)(4) or (b)(5), the period of the exclusion shall not be less than the period during which the individual's or entity's license to provide health care is revoked, suspended, or surrendered, or the individual or the entity is excluded or suspended from a Federal or State health care program.

''(F) In the case of an exclusion of an individual or entity under subsection (b)(6)(B), the period of the exclusion shall be not less than 1 year.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to acts or omissions occurring on or after January 1, 1996.

SEC. 15106. DIRECT SPENDING FOR ANTI-FRAUD ACTIVITIES UNDER MEDICARE.

(a) ESTABLISHMENT OF MEDICARE INTEGRITY PROGRAM.—Title XVIII is amended by adding at the end the following new section:

''MEDICARE INTEGRITY PROGRAM

''SEC. 1893. (a) ESTABLISHMENT OF PROGRAM.—There is hereby established the Medicare Integrity Program (hereafter in this section referred to as the 'Program') under which the Secretary shall promote the integrity of the medicare program by entering into contracts in accordance with this section with eligible private entities to carry out the activities described in subsection (b).

''(b) ACTIVITIES DESCRIBED.—The activities described in this subsection are as follows:

''(1) Review of activities of providers of services or other individuals and entities furnishing items and services for which payment may be made under this title (including skilled nursing facilities and home health agencies), including medical and utilization review and fraud review (employing similar standards, processes, and technologies used by private health plans, including equipment and software technologies which surpass the capability of the equipment and technologies used in the review of claims under this title as of the date of the enactment of this section).

''(2) Audit of cost reports.

''(3) Determinations as to whether payment should not be, or should not have been, made under this title by reason of section 1862(b), and recovery of payments that should not have been made.

''(4) Education of providers of services, beneficiaries, and other persons with respect to payment integrity and benefit quality assurance issues.

''(c) ELIGIBILITY OF ENTITIES.—An entity is eligible to enter into a contract under the Program to carry out any of the activities described in subsection (b) if—

''(1) the entity has demonstrated capability to carry out such activities;

''(2) in carrying out such activities, the entity agrees to cooperate with the Inspector General of the Department of Health and Human Services, the Attorney General of the United States, and other law enforcement agencies, as appropriate, in the investigation and deterrence of fraud and abuse in relation to this title and in other cases arising out of such activities;

''(3) the entity's financial holdings, interests, or relationships will not interfere with its ability to perform the functions to be required by the contract in an effective and impartial manner; and

''(4) the entity meets such other requirements as the Secretary may impose.

''(d) PROCESS FOR ENTERING INTO CONTRACTS.—The Secretary shall enter into contracts under the Program in accordance with such procedures as the Secretary may by regulation establish, except that such procedures shall include the following:

''(1) The Secretary shall determine the appropriate number of separate contracts which are necessary to carry out the Program and the appropriate times at which the Secretary shall enter into such contracts.

''(2) The provisions of section 1153(e)(1) shall apply to contracts and contracting authority under this section, except that competitive procedures must be used when entering into new contracts under this section, or at any other time considered appropriate by the Secretary.

''(3) A contract under this section may be renewed without regard to any provision of law requiring competition if the contractor has met or exceeded the performance requirements established in the current contract.

''(e) LIMITATION ON CONTRACTOR LIABILITY.—The Secretary shall by regulation provide for the limitation of a contractor's liability for actions taken to carry out a contract under the Program, and such regulation shall, to the extent the Secretary finds appropriate, employ the same or comparable standards and other substantive and procedural provisions as are contained in section 1157.

''(f) TRANSFER OF AMOUNTS TO MEDICARE ANTI-FRAUD AND ABUSE TRUST FUND.—For each fiscal year, the Secretary shall transfer from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund to the Medicare Anti-Fraud and Abuse Trust Fund under subsection (g) such amounts as are necessary to carry out the activities described in subsection (b). Such transfer shall be in an allocation as reasonably reflects the proportion of such expenditures associated with part A and part B.

''(g) MEDICARE ANTI-FRAUD AND ABUSE TRUST FUND.—

''(1) ESTABLISHMENT.—

''(A) IN GENERAL.—There is hereby established in the Treasury of the United States the Anti-Fraud and Abuse Trust Fund (hereafter in this subsection referred to as the 'Trust Fund'). The Trust Fund shall consist of such gifts and bequests as may be made as provided in subparagraph (B) and such amounts as may be deposited in the Trust Fund as provided in subsection (f), paragraph (3), and title XI.

''(B) AUTHORIZATION TO ACCEPT GIFTS AND BEQUESTS.—The Trust Fund is authorized to accept on behalf of the United States money gifts and bequests made unconditionally to the Trust Fund, for the benefit of the Trust Fund or any activity financed through the Trust Fund.

''(2) INVESTMENT.—

''(A) IN GENERAL.—The Secretary of the Treasury shall invest such amounts of the Fund as such Secretary determines are not required to meet current withdrawals from the Fund in government account serial securities.

''(B) USE OF INCOME.—Any interest derived from investments under subparagraph (A) shall be credited to the Fund.

''(3) AMOUNTS DEPOSITED INTO TRUST FUND.—In addition to amounts transferred under subsection (f), there shall be deposited in the Trust Fund—

''(A) that portion of amounts recovered in relation to section 1128A arising out of a claim under title XVIII as remains after application of subsection (f)(2) (relating to repayment of the Federal Hospital Insurance Trust Fund or the Federal Supplementary Medical Insurance Trust Fund) of that section, as may be applicable,

''(B) fines imposed under section 1128B arising out of a claim under this title, and

''(C) penalties and damages imposed (other than funds awarded to a relator or for restitution) under sections 3729 through 3732 of title 31, United States Code (pertaining to false claims) in cases involving claims relating to programs under title XVIII, XIX, or XXI.

''(4) DIRECT APPROPRIATION OF FUNDS TO CARRY OUT PROGRAM.—

''(A) IN GENERAL.—There are appropriated from the Trust Fund for each fiscal year such amounts as are necessary to carry out the Medicare Integrity Program under this section, subject to subparagraph (B).

''(B) AMOUNTS SPECIFIED.—The amount appropriated under subparagraph (A) for a fiscal year is as follows:

''(i) For fiscal year 1996, such amount shall be not less than $430,000,000 and not more than $440,000,000.

''(ii) For fiscal year 1997, such amount shall be not less than $490,000,000 and not more than $500,000,000.

''(iii) For fiscal year 1998, such amount shall be not less than $550,000,000 and not more than $560,000,000.

''(iv) For fiscal year 1999, such amount shall be not less than $620,000,000 and not more than $630,000,000.

''(v) For fiscal year 2000, such amount shall be not less than $670,000,000 and not more than $680,000,000.

''(vi) For fiscal year 2001, such amount shall be not less than $690,000,000 and not more than $700,000,000.

''(vii) For fiscal year 2002, such amount shall be not less than $710,000,000 and not more than $720,000,000.

''(5) ANNUAL REPORT.—The Secretary shall submit an annual report to Congress on the amount of revenue which is generated and disbursed by the Trust Fund in each fiscal year.''.

(b) ELIMINATION OF FI AND CARRIER RESPONSIBILITY FOR CARRYING OUT ACTIVITIES SUBJECT TO PROGRAM.—

(1) RESPONSIBILITIES OF FISCAL INTERMEDIARIES UNDER PART A.—Section 1816 (42 U.S.C. 1395h) is amended by adding at the end the following new subsection:

''(l) No agency or organization may carry out (or receive payment for carrying out) any activity pursuant to an agreement under this section to the extent that the activity is carried out pursuant to a contract under the Medicare Integrity Program under section 1893.''.

(2) RESPONSIBILITIES OF CARRIERS UNDER PART B.—Section 1842(c) (42 U.S.C. 1395u(c)) is amended by adding at the end the following new paragraph:

''(6) No carrier may carry out (or receive payment for carrying out) any activity pursuant to a contract under this subsection to the extent that the activity is carried out pursuant to a contract under the Medicare Integrity Program under section 1893.''.

(c) CONFORMING AMENDMENT.—Section 1128A(f)(3) (42 U.S.C. 1320a–7a(f)(3)) is amended by striking ''as miscellaneous receipts of the Treasury of the United States'' and inserting ''in the Anti-Fraud and Abuse Trust Fund established under section 1893(g)''.

(d) DIRECT SPENDING FOR MEDICARE-RELATED ACTIVITIES OF INSPECTOR GENERAL.—Section 1893, as added by subsection (a), is amended by adding at the end the following new subsection:

''(h) DIRECT SPENDING FOR MEDICARE-RELATED ACTIVITIES OF INSPECTOR GENERAL.—

''(1) IN GENERAL.—There are appropriated from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund to the Inspector General of the Department of Health and Human Services for each fiscal year such amounts as are necessary to enable the Inspector General to carry out activities relating to the medicare program (as described in paragraph (2)), subject to paragraph (3).

''(2) ACTIVITIES DESCRIBED.—The activities described in this paragraph are as follows:

''(A) Prosecuting medicare-related matters through criminal, civil, and administrative proceedings.

''(B) Conducting investigations relating to the medicare program.

''(C) Performing financial and performance audits of programs and operations relating to the medicare program.

''(D) Performing inspections and other evaluations relating to the medicare program.

''(E) Conducting provider and conumer education activities regarding the requirements of this title.

''(3) AMOUNTS SPECIFIED.—The amount appropriated under paragraph (1) for a fiscal year is as follows:

''(A) For fiscal year 1996, such amount shall be $130,000,000.

''(B) For fiscal year 1997, such amount shall be $181,000,000.

''(C) For fiscal year 1998, such amount shall be $204,000,000.

''(D) For each subsequent fiscal year, the amount appropriated for the previous fiscal year, increased by the percentage increase in aggregate expenditures under this title for the fiscal year involved over the previous fiscal year.

''(4) ALLOCATION OF PAYMENTS AMONG TRUST FUNDS.—The appropriations made under paragraph (1) shall be in an allocation as reasonably reflects the proportion of such expenditures associated with part A and part B.''.

SEC. 15107. PERMITTING CARRIERS TO CARRY OUT PRIOR AUTHORIZATION FOR CERTAIN ITEMS OF DURABLE MEDICAL EQUIPMENT.

(a) IN GENERAL.—Section 1834(a)(15) (42 U.S.C. 1395m(a)(15)), as amended by section 135(b) of the Social Security Act Amendments of 1994, is amended by adding at the end the following new subparagraphs:

''(D) APPLICATION BY CARRIERS.—A carrier may develop (and periodically update) a list of items under subparagraph (A) and a list of suppliers under subparagraph (B) in the same manner as the Secretary may develop (and periodically update) such lists.

''(E) WAIVER OF PUBLICATION REQUIREMENT.—A carrier may make an advance determination under subparagraph (C) with respect to an item or supplier on a list developed by the Secretary or the carrier without regard to whether or not the Secretary has promulgated a regulation with respect to the list, except that the carrier may not make such an advance determination with respect to an item or supplier on a list until the expiration of the 30-day period beginning on the date the Secretary or the carrier places the item or supplier on the list.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect as if included in the enactment of the Social Security Act Amendments of 1994.

SEC. 15108. NATIONAL HEALTH CARE ANTI-FRAUD TASK FORCE.

(a) ESTABLISHMENT.—The Attorney General, in consultation with the Secretary of Health and Human Services, shall establish a national health care anti-fraud task force (in this section referred to as the ''task force''). The Attorney General shall establish the task force within 120 days after the date of the enactment of this Act.

(b) COMPOSITION.—The task force shall include representatives of Federal agencies involved in the investigation and prosecution of persons violating laws relating to health care fraud and abuse, including at least one representative from each of the following agencies:

(1) The Department of Justice and the Federal Bureau of Investigation.

(2) The Department of Health and Human Services and the Office of the Inspector General within the Department.

(3) The office in the Department of Defense responsible for administration of the CHAMPUS program.

(4) The Department of Veterans' Affairs.

(5) The United States Postal Inspection Service.

(6) The Internal Revenue Service.

The Attorney General (or the designee of the Attorney General) shall serve as chair of the task force.

(c) DUTIES.—The task force shall coordinate Federal law enforcement activities relating to health care fraud and abuse in order to better control fraud and abuse in the delivery of health care in the United States. Specifically, the task force shall coordinate activities—

(1) in order to assure the effective targeting and investigation of persons who organize, direct, finance, or otherwise knowingly engage in health care fraud, and

(2) in order to assure full and effective cooperation between Federal and State agencies involved in health care fraud investigations.

(d) STAFF.—Each member of the task force who represents an agency shall be responsible for providing for the detail (from the agency) of at least one full-time staff person to staff the task force. Such detail shall be without change in salary, compensation, benefits, and other employment-related matters.

SEC. 15109. STUDY OF ADEQUACY OF PRIVATE QUALITY ASSURANCE PROGRAMS.

(a) IN GENERAL.—The Administrator of the Health Care Financing Administration (acting through the Director of the Office of Research and Demonstrations) shall enter into an agreement with a private entity to conduct a study during the 5-year period beginning on the date of the enactment of this Act of the adequacy of the quality assurance programs and consumer protections used by the MedicarePlus program under part C of title XVIII of the Social Security Act (as inserted by section 15002(a)), and shall include in the study an analysis of the effectiveness of such programs in protecting plan enrollees against the risk of insufficient provision of benefits which may result from utilization controls.

(b) REPORT.—Not later than 6 months after the conclusion of the 5-year period described in subsection (a), the Administrator shall submit a report to Congress on the study conducted under subsection (a).

SEC. 15110. PENALTY FOR FALSE CERTIFICATION FOR HOME HEALTH SERVICES.

(a) IN GENERAL.—Section 1128A(b) (42 U.S.C. 1320a–7a(b)) is amended by adding at the end the following new paragraph:

''(3)(A) Any physician who executes a document described in subparagraph (B) with respect to an individual knowing that all of the requirements referred to in such subparagraph are not met with respect to the individual shall be subject to a civil monetary penalty of not more than the greater of—

''(i) $5,000, or

''(ii) three times the amount of the payments under title XVIII for home health services which are made pursuant to such certification.

''(B) A document described in this subparagraph is any document that certifies, for purposes of title XVIII, that an individual meets the requirements of section 1814(a)(2)(C) or 1835(a)(2)(A) in the case of home health services furnished to the individual.''.

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

SEC. 15111. PILOT PROJECTS.

The Secretary of Health and Human Services shall establish and operate 5 pilot projects (in various geographic regions of the United States) under which the Secretary shall implement innovative approaches to monitor payment claims under the medicare program to detect those claims that are wasteful or fraudulent.

PART 2—REVISIONS TO CRIMINAL LAW

SEC. 15121. DEFINITION OF FEDERAL HEALTH CARE OFFENSE.

(a) IN GENERAL.—Chapter 2 of title 18, United States Code, is amended by adding at the end the following:

''§ 24. Definition of Federal health care offense

''(a) As used in this title, the term 'Federal health care offense' means—

''(1) a violation of, or criminal conspiracy to violate section 226, 227, 669, 1035, 1347, or 1518 of this title;

''(2) a violation of, or criminal conspiracy to violate section 1128B of the Social Security Act (42 U.S.C. 1320a–7b);

''(3) a violation of, or criminal conspiracy to violate section 201, 287, 371, 664, 666, 1001, 1027, 1341, 1343, or 1954 of this title, if the violation or conspiracy relates to a health care benefit program;

''(4) a violation of, or criminal conspiracy to violate section 501 or 511 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1131 or 29 U.S.C. 1141), if the violation or conspiracy relates to a health care benefit program;

''(5) the commission of, or attempt to commit, an act which constitutes grounds for the imposition of a penalty under section 303 of the Federal Food, Drug, and Cosmetic Act, if the act or attempt relates to a health care benefit program; or

''(6) a violation of, or criminal conspiracy to violate, section 3 of the Anti-Kickback Act of 1986 (41 U.S.C. 53), if the violation or conspiracy relates to a health care benefit program.

''(b) As used in this title, the term 'health care benefit program' has the meaning given such term in section 1347(b) of this title.''.

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 2 of title 18, United States Code, is amended by inserting after the item relating to section 23 the following new item:

''24. Definition relating to Federal health care offense defined.''.

SEC. 15122. HEALTH CARE FRAUD.

(a) IN GENERAL.—Chapter 63 of title 18, United States Code, is amended by adding at the end the following:

''§ 1347. Health care fraud

''(a) Whoever, having devised or intending to devise a scheme or artifice, commits or

attempts to commit an act in furtherance of or for the purpose of executing such scheme or artifice—

''(1) to defraud any health care benefit program; or

''(2) to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health care benefit program,

shall be fined under this title or imprisoned not more than 10 years, or both. If the violation results in serious bodily injury (as defined in section 1365 of this title), such person shall be fined under this title or imprisoned not more than 20 years, or both; and if the violation results in death, such person shall be fined under this title, or imprisoned for any term of years or for life, or both.

''(b) As used in this section, the term 'health care benefit program' means any public or private plan or contract under which any medical benefit, item, or service is provided to any individual, and includes any individual or entity who is providing a medical benefit, item, or service for which payment may be made under the plan or contract.''.

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 63 of title 18, United States Code, is amended by adding at the end the following:

''1347. Health care fraud.''

SEC. 15123. THEFT OR EMBEZZLEMENT.

(a) IN GENERAL.—Chapter 31 of title 18, United States Code, is amended by adding at the end the following:

''§ 669. Theft or embezzlement in connection with health care

''(a) Whoever embezzles, steals, or otherwise without authority willfully and unlawfully converts to the use of any person other than the rightful owner, or intentionally misapplies any of the moneys, funds, securities, premiums, credits, property, or other assets of a health care benefit program, shall be fined under this title or imprisoned not more than 10 years, or both.

''(b) As used in this section, the term 'health care benefit program' has the meaning given such term in section 1347(b) of this title.''.

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 31 of title 18, United States Code, is amended by adding at the end the following:

''669. Theft or embezzlement in connection with health care.''.

SEC. 15124. FALSE STATEMENTS.

(a) IN GENERAL.—Chapter 47 of title 18, United States Code, is amended by adding at the end the following:

''§ 1035. False statements relating to health care matters

''(a) Whoever, in any matter involving a health care benefit program, knowingly and willfully falsifies, conceals, or covers up by any trick, scheme, or device a material fact, or makes any false, fictitious, or fraudulent statements or representations, or makes or uses any false writing or document knowing the same to contain any false, fictitious, or fraudulent statement or entry, shall be fined under this title or imprisoned not more than 5 years, or both.

''(b) As used in this section, the term 'health care benefit program' has the meaning given such term in section 1347(b) of this title.''.

''(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 47 of title 18, United States Code, is amended by adding at the end the following new item:

''1035. False statements relating to health care matters.''.

SEC. 15125. BRIBERY AND GRAFT.

(a) IN GENERAL.—Chapter 11 of title 18, United States Code, is amended by adding at the end the following:

''§ 226. Bribery and graft in connection with health care

''(a) Whoever—

''(1) directly or indirectly, corruptly gives, offers, or promises anything of value to a health care official, or offers or promises to give anything of value to any other person, or attempts to violate this subsection, with intent—

''(A) to influence any of the health care official's actions, decisions, or duties relating to a health care benefit program;

''(B) to influence such an official to commit or aid in the committing, or collude in or allow, any fraud, or make opportunity for the commission of any fraud, on a health care benefit program; or

''(C) to induce such an official to engage in any conduct in violation of the lawful duty of such official; or

''(2) being a health care official, directly or indirectly, corruptly demands, seeks, receives, accepts, or agrees to accept anything of value personally or for any other person or entity, the giving of which violates paragraph (1) of this subsection, or attempts to violate this subsection,

shall be fined under this title or imprisoned not more than 15 years, or both.

''(b) Whoever—

''(1) otherwise than as provided by law for the proper discharge of any duty, directly or indirectly gives, offers, or promises anything of value to a health care official, for or because of any of the health care official's actions, decisions, or duties relating to a health care benefit program, or attempts to violate this subsection; or

''(2) being a health care official, otherwise than as provided by law for the proper discharge of any duty, directly or indirectly, demands, seeks, receives, accepts or agrees to accept anything of value personally or for any other person or entity, the giving of which violates paragraph (1) of this subsection, or attempts to violate this subsection.

shall be fined under this title, or imprisoned not more than 2 years, or both.

''(c) As used in this section—

''(1) the term 'health care official'' means—

''(A) an administrator, officer, trustee, fiduciary, custodian, counsel, agent, or employee of any health care benefit program;

''(B) an officer, counsel, agent, or employee, of an organization that provides services under contract to any health care benefit program; or

''(C) an official, employee, or agent of an entity having regulatory authority over any health care benefit program; and

''(2) the term 'health care benefit program' has the meaning given such term in section 1347(b) of this title.''.

(b) CLERICAL AMENDMENT.—The table of chapters at the beginning of chapter 11 of title 18, United States Code, is amended by adding at the end the following new item:

''226. Bribery and graft in connection with health care.''.

SEC. 15126. ILLEGAL REMUNERATION WITH RESPECT TO HEALTH CARE BENEFIT PROGRAMS.

(a) IN GENERAL.—Chapter 11 of title 18, United States Code, is amended by adding at the end the following:

''§ 227. Illegal remuneration with respect to health care benefit programs

''(a) Whoever knowingly and willfully solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind—

''(1) in return for referring any individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part by any health care benefit program; or

''(2) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part by any health care benefit program, or attempting to do so,

shall be fined under this title or imprisoned for not more than 5 years, or both.

''(b) Whoever knowingly and willfully offers or pays any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly, or covertly, in cash or in kind to any person to induce such person—

''(1) to refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part by any health benefit program; or

''(2) to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part by any health benefit program or attempts to do so,

shall be fined under this title or imprisoned for not more than 5 years, or both.

''(c) Subsections (a) and (b) shall not apply to—

''(1) a discount or other reduction in price obtained by a provider of services or other entity under a health care benefit program if the reduction in price is properly disclosed and appropriately reflected in the costs claimed or charges made by the provider or entity under a health care benefit program;

''(2) any amount paid by an employer to an employee (who has a bona fide employment relationship with such employer) for employment in the provision of covered items or services if the amount of the remuneration under the arrangement is consistent with the fair market value of the services and is not determined in a manner that takes into account (directly or indirectly) the volume or value of any referrals;

''(3) any amount paid by a vendor of goods or services to a person authorized to act as a purchasing agent for a group of individuals or entities who are furnishing services reimbursed under a health care benefit program if—

''(A) the person has a written contract, with each such individual or entity, which specifies the amount to be paid the person, which amount may be a fixed amount or a percentage of the value of the purchases made by each such individual or entity under the contract, and

''(B) in the case of an entity that is a provider of services (as defined in section 1861(u) of the Social Security Act, the person discloses (in such form and manner as the Secretary of Health and Human Services requires) to the entity and, upon request, to the Secretary the amount received from each such vendor with respect to purchases made by or on behalf of the entity;

''(4) a waiver of any coinsurance under part B of title XVIII of the Social Security Act by a federally qualified health care center with respect to an individual who qualifies for subsidized services under a provision of the Public Health Service Act; and

''(5) any payment practice specified by the Secretary of Health and Human Services in regulations promulgated pursuant to section 14(a) of the Medicare and Medicaid Patient and Program Protection Act of 1987.

''(d) Any person injured in his business or property by reason of a violation of this section or section 226 of this title may sue there

for in any appropriate United States district court and shall recover threefold the damages such person sustains and the cost of the suit, including a reasonable attorney's fee.

''(e) As used in this section, 'health care benefit program' has the meaning given such term in section 1347(b) of this title.''.

''(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 11 of title 18, United States Code, is amended by adding at the end the following:

''227. Illegal remuneration with respect to health care benefit programs.''.

(c) CONFORMING AMENDMENT.—Section 1128B of the Social Security Act (42 U.S.C. 1320a—7b) is amended by striking subsection (b).

SEC. 15127. OBSTRUCTION OF CRIMINAL INVESTIGATIONS OF HEALTH CARE OFFENSES.

''(a) IN GENERAL.—Chapter 73 of title 18, United States Code, is amended by adding at the end the following:

''§ 1518. Obstruction of criminal investigations of health care offenses

''(a) Whoever willfully prevents, obstructs, misleads, delays or attempts to prevent, obstruct, mislead, or delay the communication of information or records relating to a violation of a health care offense to a criminal investigator shall be fined under this title or imprisoned not more than 5 years, or both.

''(b) As used in this section the term 'health care offense' has the meaning given such term in section 24 of this title.

''(c) As used in this section the term 'criminal investigator' means any individual duly authorized by a department, agency, or armed force of the United States to conduct or engage in investigations for prosecutions for violations of health care offenses.''.

''(b) ''CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 73 of title 18, United States Code, is amended by adding at the end the following new item:

''1518. Obstruction of criminal investigations of health care offenses.''.

SEC. 15128. CIVIL PENALTIES FOR VIOLATIONS OF FEDERAL HEALTH CARE OFFENSES.

(a) IN GENERAL.—Chapter 63 of title 18, United States Code, is amended by adding at the end the following:

''§ 1348. Civil penalties for violations of Federal health care offenses

''The Attorney General may bring a civil action in the appropriate United States district court against any person who engages in conduct constituting a violation of Federal health care offense, as that term is defined in section 24 of this title and, upon proof of such conduct by a preponderance of the evidence, such person shall be subject to a civil penalty of not more than $50,000 for each violation or the amount of compensation or proceeds which the person received or offered for the prohibited conduct, whichever amount is greater. The imposition of a civil penalty under this section does not preclude any other criminal or civil statutory, common law, or administrative remedy, which is available by law to the United States or any other person.''.

(b) CLERICAL AMENDMENT.—The table of sections for chapter 63 of title 18, United States Code, is amended by adding at the end the following item:

''1348. Civil penalties for violations of Federal health care offenses.''.

SEC. 15129. INJUNCTIVE RELIEF RELATING TO HEALTH CARE OFFENSES.

Section 1345(a)(1) of title 18, United States Code, is amended—

(1) by striking ''or'' at the end of subparagraph (A);

(2) by inserting ''or'' at the end of subparagraph (B); and

(3) by adding at the end the following:

''(C) committing or about to commit a Federal health care offense (as defined in section 24 of this title).''.

SEC. 15130. AUTHORIZED INVESTIGATIVE DEMAND PROCEDURES.

(a) IN GENERAL.—Chapter 233 of title 18, United States Code, is amended by adding after section 3485 the following:

''§ 3486. Authorized investigative demand procedures

''(a) AUTHORIZATION.—(1) In any investigation relating to functions set forth in paragraph (2), the Attorney General or the Director of the Federal Bureau of Investigation or their designees may issue in writing and cause to be served a summons compelling the attendance and testimony of witnesses and requiring the production of any records (including any books, papers, documents, electronic media, or other objects or tangible things), which may be relevant to an authorized law enforcement inquiry, that a person or legal entity may possess or have care, custody, or control. The attendance of witnesses and the production of records may be required from any place in any State or in any territory or other place subject to the jurisdiction of the United States at any designated place of hearing; except that a witness shall not be required to appear at any hearing more than 500 miles distant from the place where he was served with a subpoena. Witnesses summoned under this section shall be paid the same fees and mileage that are paid witnesses in the courts of the United States. A summons requiring the production of records shall describe the objects required to be produced and prescribe a return date within a reasonable period of time within which the objects can be assembled and made available.

''(2) Investigative demands utilizing an administrative summons are authorized for:

''(A) Any investigation with respect to any act or activity constituting an offense involving a Federal health care offense as that term is defined in section 24 of title 18, United States Code.

''(B) Any investigation, with respect to violations of sections 1073 and 1074 of title 18, United States Code, or in which an individual has been lawfully charged with a Federal offense and such individual is avoiding prosecution or custody or confinement after conviction of such offense or attempt.

''(b) SERVICE.—A subpoena issued under this section may be served by any person designated in the subpoena to serve it. Service upon a natural person may be made by personal delivery of the subpoena to him. Service may be made upon a domestic or foreign corporation or upon a partnership or other unincorporated association which is subject to suit under a common name, by delivering the subpoena to an officer, to a managing or general agent, or to any other agent authorized by appointment or by law to receive service to process. The affidavit of the person serving the subpoena entered on a true copy thereof by the person serving it shall be proof of service.

''(c) ENFORCEMENT.—In the case of contumacy by or refusal to obey a subpoena issued to any person, the Attorney General may invoke the aid of any court of the United States within the jurisdiction of which the investigation is carried on or of which the subpoenaed person is an inhabitant, or in which he carries on business or may be found, to compel compliance with the subpoena. The court may issue an order requiring the subpoenaed person to appear before the Attorney General to produce records, if so ordered, or to give testimony touching the matter under investigation. Any failure to obey the order of the court may be punished by the court as a contempt thereof. All process in any such case may be served in any judicial district in which such person may be found.

''(d) IMMUNITY FROM CIVIL LIABILITY.—Notwithstanding any Federal, State, or local law, any person, including officers, agents, and employees, receiving a summons under this section, who complies in good faith with the summons and thus produces the materials sought, shall not be liable in any court of any State or the United States to any customer or other person for such production or for nondisclosure of that production to the customer.''.

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 223 of title 18, United States Code, is amended by inserting after the item relating to section 3485 the following new item:

''3486. Authorized investigative demand procedures.''.

(c) CONFORMING AMENDMENT.—Section 1510(b)(3)(B) of title 18, United States Code, is amended by inserting ''or a Federal Bureau of Investigation summons (issued under section 3486 of title 18),'' after ''subpoena''.

SEC. 15131. GRAND JURY DISCLOSURE.

Section 3322 of title 18, United States Code, is amended—

(1) by redesignating subsections (c) and (d) as subsection (d) and (e), respectively; and

(2) by inseritng after subsection (b) the following:

''(c) A person who is privy to grand jury information concerning a health care offense—

''(1) received in the course of duty as an attorney for the Government; or

''(2) disclosed under rule 6(e)(3)(A)(ii) of the Federal Rules of Criminal Procedure;

may disclose that information to an attorney for the Government to use in any civil investigation or proceeding related to a Federal health care offense (as defined in section 24 of this title).''.

SEC. 15132. MISCELLANEOUS AMENDMENTS TO TITLE 18, UNITED STATES CODE.

(a) LAUNDERING OF MONETARY INSTRUMENTS.—Section 1956(c)(7) of title 18, United States Code, is amended by adding at the end thereof the following:

''(F) Any act or activity constituting an offense involving a Federal health care offense as that term is defined in section 24 of title 18, United States Code.''.

(b) ENHANCED PENALTIES.—Section 2326(2) of title 18, United States Code, is amended by striking ''sections that—'' and inserting ''or in the case of a Federal health care offense as that term is defined in section 24 of this title, that—''.

(c) AUTHORIZATION FOR INTERCEPTION OF WIRE, ORAL, OR ELECTRONIC COMMUNICATIONS.—Section 2516(1)(c) of title 18, United States Code is amended—

(1) by inserting ''section 226 (bribery and graft in connection with health care), section 227 (illegal remunerations)'' after ''section 224 (bribery in sporting contests),''; and

(2) by inserting ''section 1347 (health care fraud)'' after ''section 1344 (relating to bank fraud),''.

(d) DEFINITIONS.—Section 1961(1) of title 18, United States Code, is amended—

(1) by inserting ''sections 226 and 227 (relating to bribery and graft, and illegal remuneration in connection with health care)'' after ''section 224 (relating to sports bribery),'';

(2) by inserting ''section 669 (relating to theft or embezzlement in connection with health care)'' after ''section 664 (relating to embezzlement from pension and welfare funds),''; and

(3) by inserting ''section 1347 (relating to health care fraud)'' after ''section 1344 (relating to financial institution fraud),''.

(e) CRIMINAL FORFEITURE.—Section 982(a) of title 18, United States Code, is amended by adding at the end the following new paragraph:

''(6) The court in imposing sentence on a person convicted of a Federal health care offense as defined in section 24 of this title, shall order that the offender forfeit to the United States any real or personal property constituting or derived from proceeds that the offender obtained directly or indirectly as the result of the offense.''.

(f) REWARDS FOR INFORMATION LEADING TO PROSECUTION AND CONVICTION.—Section 3059(c)(1) of title 18, United States Code, is amended by inserting ''or furnishes information unknown to the Government relating to a possible prosecution of a Federal health care offense as defined in section 24 of this title, which results in a conviction'' before the period at the end.

Subtitle C—Regulatory Relief

PART 1—PHYSICIAN OWNERSHIP REFERRAL REFORM

SEC. 15201. REPEAL OF PROHIBITIONS BASED ON COMPENSATION ARRANGEMENTS.

(a) IN GENERAL.—Section 1877(a)(2) (42 U.S.C. 1395nn(a)(2)) is amended by striking ''is—'' and all that follows through ''equity,'' and inserting the following: ''is (except as provided in subsection (c)) an ownership or investment interest in the entity through equity,''.

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

(1) In subsection (b)—

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

(B) by redesignating paragraph (4) as paragraph (7).

(2) In subsection (c)—

(A) by amending the heading to read as follows: ''EXCEPTION FOR OWNERSHIP OR INVESTMENT INTEREST IN PUBLICLY TRADED SECURITIES AND MUTUAL FUNDS''; and

(B) in the matter preceding paragraph (1), by striking ''subsection (a)(2)(A)'' and inserting ''subsection (a)(2)''.

(3) In subsection (d)—

(A) by striking the matter preceding paragraph (1);

(B) in paragraph (3), by striking ''paragraph (1)'' and inserting ''paragraph (4)''; and

(C) by redesignating paragraphs (1), (2), and (3) as paragraphs (4), (5), and (6), and by transferring and inserting such paragraphs after paragraph (3) of subsection (b).

(4) By striking subsection (e).

(5) In subsection (f)(2)—

(A) in the matter preceding paragraph (1), by striking ''ownership, investment, and compensation'' and inserting ''ownership and investment'';

(B) in paragraph (2), by striking ''subsection (a)(2)(A)'' and all that follows through ''subsection (a)(2)(B)),'' and inserting ''subsection (a)(2),''; and

(C) in paragraph (2), by striking ''or who have such a compensation relationship with the entity''.

(6) In subsection (h)—

(A) by striking paragraphs (1), (2), and (3);

(B) in paragraph (4)(A), by striking clauses (iv) and (vi);

(C) in paragraph (4)(B), by striking ''RULES.—'' and all that follows through ''(ii) FACULTY'' and inserting ''RULES FOR FACULTY''; and

(D) by adding at the end of paragraph (4) the following new subparagraph:

''(C) MEMBER OF A GROUP.—A physician is a 'member' of a group if the physician is an owner or a bona fide employee, or both, of the group.''.

SEC. 15202. REVISION OF DESIGNATED HEALTH SERVICES SUBJECT TO PROHIBITION.

(a) IN GENERAL.—Section 1877(h)(6) (42 U.S.C. 1395nn(h)(6)) is amended by striking subparagraphs (B) through (K) and inserting the following:

''(B) Parenteral and enteral nutrients, equipment, and supplies.

''(C) Magnetic resonance imaging and computerized tomography services.

''(D) Outpatient physical or occupational therapy services.''.

(b) CONFORMING AMENDMENTS.—

(1) Section 1877(b)(2) (42 U.S.C. 1395nn(b)(2)) is amended in the matter preceding subparagraph (A) by striking ''services'' and all that follows through ''supplies)—'' and inserting ''services—''.

(2) Section 1877(h)(5)(C) (42 U.S.C. 1395nn(h)(5)(C)) is amended—

(A) by striking '', a request by a radiologist for diagnostic radiology services, and a request by a radiation oncologist for radiation therapy,'' and inserting ''and a request by a radiologist for magnetic resonance imaging or for computerized tomography'', and

(B) by striking ''radiologist, or radiation oncologist'' and inserting ''or radiologist''.

SEC. 15203. DELAY IN IMPLEMENTATION UNTIL PROMULGATION OF REGULATIONS.

(a) IN GENERAL.—Section 13562(b) of OBRA–1993 (42 U.S.C. 1395nn note) is amended—

(1) in paragraph (1), by striking ''paragraph (2)'' and inserting ''paragraphs (2) and (3)''; and

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

''(3) PROMULGATION OF REGULATIONS.—Notwithstanding paragraphs (1) and (2), the amendments made by this section shall not apply to any referrals made before the effective date of final regulations promulgated by the Secretary of Health and Human Services to carry out such amendments.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall take effect as if included in the enactment of OBRA–1993.

SEC. 15204. EXCEPTIONS TO PROHIBITION.

(a) REVISIONS TO EXCEPTION FOR IN-OFFICE ANCILLARY SERVICES.—

(1) REPEAL OF SITE-OF-SERVICE REQUIREMENT.—Section 1877 (42 U.S.C. 1395nn) is amended—

(A) by amending subparagraph (A) of subsection (b)(2) to read as follows:

''(A) that are furnished personally by the referring physician, personally by a physician who is a member of the same group practice as the referring physician, or personally by individuals who are under the general supervision of the physician or of another physician in the group practice, and'', and

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

''(7) GENERAL SUPERVISION.—An individual is considered to be under the 'general supervision' of a physician if the physician (or group practice of which the physician is a member) is legally responsible for the services performed by the individual and for ensuring that the individual meets licensure and certification requirements, if any, applicable under other provisions of law, regardless of whether or not the physician is physically present when the individual furnishes an item or service.''.

(2) CLARIFICATION OF TREATMENT OF PHYSICIAN OWNERS OF GROUP PRACTICE.—Section 1877(b)(2)(B) (42 U.S.C. 1395nn(b)(2)(B)) is amended by striking ''physician or such group practice'' and inserting ''physician, such group practice, or the physician owners of such group practice''.

(3) CONFORMING AMENDMENT.—Section 1877(b)(2) (42 U.S.C. 1395nn(b)(2)) is amended by amending the heading to read as follows: ''ANCILLARY SERVICES FURNISHED PERSONALLY OR THROUGH GROUP PRACTICE.—''.

(b) CLARIFICATION OF EXCEPTION FOR SERVICES FURNISHED IN A RURAL AREA.—Paragraph (5) of section 1877(b) (42 U.S.C. 1395nn(b)), as transferred by section 15201(b)(3)(C), is amended by striking ''substantially all'' and inserting ''not less than 75 percent''.

(c) REVISION OF EXCEPTION FOR CERTAIN MANAGED CARE ARRANGEMENTS.—Section 1877(b)(3) (42 U.S.C. 1395nn(b)(3)) is amended—

(1) in the heading by inserting ''MANAGED CARE ARRANGEMENTS'' after ''PREPAID PLANS'';

(2) in the matter preceding subparagraph (A), by striking ''organization—'' and inserting ''organization, directly or through contractual arrangements with other entities, to individuals enrolled with the organization—'';

(3) in subparagraph (A), by inserting ''or part C'' after ''section 1876'';

(4) by striking ''or'' at the end of subparagraph (C);

(5) by striking the period at the end of subparagraph (D) and inserting a comma; and

(6) by adding at the end the following new subparagraphs:

''(E) with a contract with a State to provide services under the State plan under title XIX (in accordance with section 1903(m)) or a State MediGrant plan under title XXI; or

''(F) which is a MedicarePlus organization under part C or which provides or arranges for the provision of health care items or services pursuant to a written agreement between the organization and an individual or entity if the written agreement places the individual or entity at substantial financial risk for the cost or utilization of the items or services which the individual or entity is obligated to provide, whether through a withhold, capitation, incentive pool, per diem payment, or any other similar risk arrangement which places the individual or entity at substantial financial risk.''.

(d) NEW EXCEPTION FOR SHARED FACILITY SERVICES.—

(1) IN GENERAL.—Section 1877(b) (42 U.S.C. 1395nn(b)), as amended by section 15201(b)(3)(C), is amended—

(A) by redesignating paragraphs (4) through (7) as paragraphs (5) through (8); and

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

''(4) SHARED FACILITY SERVICES.—In the case of a designated health service consisting of a shared facility service of a shared facility—

''(A) that is furnished—

''(i) personally by the referring physician who is a shared facility physician or personally by an individual directly employed or under the general supervision of such a physician,

''(ii) by a shared facility in a building in which the referring physician furnishes substantially all of the services of the physician that are unrelated to the furnishing of shared facility services, and

''(iii) to a patient of a shared facility physician; and

''(B) that is billed by the referring physician or a group practice of which the physician is a member.''.

(2) DEFINITIONS.—Section 1877(h) (42 U.S.C. 1395nn(h)), as amended by section 15201(b)(6), is amended by inserting before paragraph (4) the following new paragraph:

''(1) SHARED FACILITY RELATED DEFINITIONS.—

''(A) SHARED FACILITY SERVICE.—The term 'shared facility service' means, with respect to a shared facility, a designated health service furnished by the facility to patients of shared facility physicians.

''(B) SHARED FACILITY.—The term 'shared facility' means an entity that furnishes shared facility services under a shared facility arrangement.

''(C) SHARED FACILITY PHYSICIAN.—The term 'shared facility physician' means, with respect to a shared facility, a physician (or a group practice of which the physician is a member) who has a financial relationship under a shared facility arrangement with the facility.

''(D) SHARED FACILITY ARRANGEMENT.—The term 'shared facility arrangement' means, with respect to the provision of shared facility services in a building, a financial arrangement—

''(i) which is only between physicians who are providing services (unrelated to shared facility services) in the same building,

''(ii) in which the overhead expenses of the facility are shared, in accordance with methods previously determined by the physicians in the arrangement, among the physicians in the arrangement, and

''(iii) which, in the case of a corporation, is wholly owned and controlled by shared facility physicians.''.

(e) NEW EXCEPTION FOR SERVICES FURNISHED IN COMMUNITIES WITH NO ALTERNATIVE PROVIDERS.—Section 1877(b) (42 U.S.C. 1395nn(b)), as amended by section 15201(b)(3)(C) and subsection (d)(1), is amended—

(1) by redesignating paragraphs (5) through (8) as paragraphs (6) through (9); and

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

''(5) NO ALTERNATIVE PROVIDERS IN AREA.—In the case of a designated health service furnished in any area with respect to which the Secretary determines that individuals residing in the area do not have reasonable access to such a designated health service for which subsection (a)(1) does not apply.''.

(f) NEW EXCEPTION FOR SERVICES FURNISHED IN AMBULATORY SURGICAL CENTERS.—Section 1877(b) (42 U.S.C. 1395nn(b)), as amended by section 15201(b)(3)(C), subsection (d)(1), and subsection (e)(1), is amended—

(1) by redesignating paragraphs (6) through (9) as paragraphs (7) through (10); and

(2) by inserting after paragraph (5) the following new paragraph:

''(6) SERVICES FURNISHED IN AMBULATORY SURGICAL CENTERS.—In the case of a designated health service furnished in an ambulatory surgical center described in section 1832(a)(2)(F)(i).''.

(g) NEW EXCEPTION FOR SERVICES FURNISHED IN RENAL DIALYSIS FACILITIES.—Section 1877(b) (42 U.S.C. 1395nn(b)), as amended by section 15201(b)(3)(C), subsection (d)(1), subsection (e)(1), and subsection (f), is amended—

(1) by redesignating paragraphs (7) through (10) as paragraphs (8) through (11); and

(2) by inserting after paragraph (6) the following new paragraph:

''(7) SERVICES FURNISHED IN RENAL DIALYSIS FACILITIES.—In the case of a designated health service furnished in a renal dialysis facility under section 1881.''.

(h) NEW EXCEPTION FOR SERVICES FURNISHED IN A HOSPICE.—Section 1877(b) (42 U.S.C. 1395nn(b)), as amended by section 15201(b)(3)(C), subsection (d)(1), subsection (e)(1), subsection (f), and subsection (g), is amended—

(1) by redesignating paragraphs (8) through (11) as paragraphs (9) through (12); and

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

''(8) SERVICES FURNISHED BY A HOSPICE PROGRAM.—In the case of a designated health service furnished by a hospice program under section 1861(dd)(2).''.

(i) NEW EXCEPTION FOR SERVICES FURNISHED IN A COMPREHENSIVE OUTPATIENT REHABILITATION FACILITY.—Section 1877(b) (42 U.S.C. 1395nn(b)), as amended by section 15201(b)(3)(C), subsection (d)(1), subsection (e)(1), subsection (f), subsection (g), and subsection (h), is amended—

(1) by redesignating paragraphs (9) through (12) as paragraphs (10) through (13); and

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

''(9) SERVICES FURNISHED IN A COMPREHENSIVE OUTPATIENT REHABILITATION FACILITY.—In the case of a designated health service furnished in a comprehensive outpatient rehabilitation facility (as defined in section 1861(cc)(2)).''.

(i) DEFINITION OF REFERRAL.—Section 1877(h)(5)(A) (42 U.S.C. 1395nn(h)(5)(A)) is amended—

(1) by striking ''an item or service'' and inserting ''a designated health service'', and

(2) by striking ''the item or service'' and inserting ''the designated health service''.

SEC. 15205. REPEAL OF REPORTING REQUIREMENTS.

Section 1877 (42 U.S.C. 1395nn) is amended—

(1) by striking subsection (f); and

(2) by striking subsection (g)(5).

SEC. 15206. PREEMPTION OF STATE LAW.

Section 1877 (42 U.S.C. 1395nn) is amended by adding at the end the following new subsection:

''(i) PREEMPTION OF STATE LAW.—This section preempts State law to the extent State law is inconsistent with this section.''.

SEC. 15207. EFFECTIVE DATE.

Except as provided in section 15203(b), the amendments made by this part shall apply to referrals made on or after August 14, 1995, regardless of whether or not regulations are promulgated to carry out such amendments.

PART 2—OTHER MEDICARE REGULATORY RELIEF

SEC. 15211. REPEAL OF MEDICARE AND MEDICAID COVERAGE DATA BANK.

(a) IN GENERAL.—Section 1144 (42 U.S.C. 1320b–14) is repealed.

(b) CONFORMING AMENDMENTS.—

(1) MEDICARE.—Section 1862(b)(5) (42 U.S.C. 1395y(b)(5)) is amended—

(A) in subparagraph (B), by striking ''under—'' and all that follows through the end and inserting ''subparagraph (A) for purposes of carrying out this subsection.'', and

(B) in subparagraph (C)(i), by striking ''subparagraph (B)(i)'' and inserting ''subparagraph (B)''.

(2) MEDICAID.—Section 1902(a)(25)(A)(i) (42 U.S.C. 1396a(a)(25)(A)(i)) is amended by striking ''including the use of'' and all that follows through ''any additional measures''.

(3) ERISA.—Section 101(f) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1021(f)) is repealed.

(4) DATA MATCHES.—Section 552a(a)(8)(B) of title 5, United States Code, is amended—

(A) by adding ''; or'' at the end of clause (v),

(B) by striking ''or'' at the end of clause (vi), and

(C) by striking clause (vii).

SEC. 15212. CLARIFICATION OF LEVEL OF INTENT REQUIRED FOR IMPOSITION OF SANCTIONS.

(a) CLARIFICATION OF LEVEL OF KNOWLEDGE REQUIRED FOR IMPOSITION OF CIVIL MONETARY PENALTIES.—

(1) IN GENERAL.—Section 1128A(a) (42 U.S.C. 1320a–7a(a)) is amended—

(A) in paragraphs (1) and (2), by inserting ''knowingly'' before ''presents'' each place it appears; and

(B) in paragraph (3), by striking ''gives'' and inserting ''knowingly gives or causes to be given''.

(2) DEFINITION OF STANDARD.—Section 1128A(i) (42 U.S.C. 1320a–7a(i)) is amended by adding at the end the following new paragraph:

''(6) The term 'should know' means that a person, with respect to information—

''(A) acts in deliberate ignorance of the truth or falsity of the information; or

''(B) acts in reckless disregard of the truth or falsity of the information,

and no proof of specific intent to defraud is required.''.

(b) CLARIFICATION OF EFFECT AND APPLICATION OF SAFE HARBOR EXCEPTIONS.—For purposes of section 1128B(b)(3) of the Social Security Act, the specification of any payment practice in regulations promulgated pursuant to section 14(a) of the Medicare and Medicaid Program and Patient Protection Act of 1987 is—

(1) solely for the purpose of adding additional exceptions to the types of conduct which are not subject to an anti-kickback penalty under such section and not for the purpose of limiting the scope of such exceptions; and

(2) for the purpose of prescribing criteria for qualifying for such an exception notwithstanding the intent of the party involved.

(c) LIMITING IMPOSITION OF ANTI-KICKBACK PENALTIES TO ACTIONS WITH SIGNIFICANT PURPOSE TO INDUCE REFERRALS.—Section 1128B(b)(2) (42 U.S.C. 1320a–7b(b)(2)) is amended in the matter preceding subparagraph (A) by striking ''to induce'' and inserting ''for the significant purpose of inducing''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to acts or omissions occurring on or after January 1, 1996.

SEC. 15213. ADDITIONAL EXCEPTION TO ANTI-KICKBACK PENALTIES FOR MANAGED CARE ARRANGEMENTS.

(a) IN GENERAL.—Section 1128B(b)(3) (42 U.S.C. 1320a–7b(b)(3)) is amended—

(1) by striking ''and'' at the end of subparagraph (D);

(2) by striking the period at the end of subparagraph (E) and inserting ''; and''; and

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

''(F) any remuneration between an organization and an individual or entity providing services pursuant to a written agreement between the organization and the individual or entity if the organization is a MedicarePlus organization under part C of title XVIII or if the written agreement places the individual or entity at substantial financial risk for the cost or utilization of the items or services which the individual or entity is obligated to provide, whether through a withhold, capitation, incentive pool, per diem payment, or any other similar risk arrangement which places the individual or entity at substantial financial risk.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to acts or omissions occurring on or after January 1, 1996.

SEC. 15214. SOLICITATION AND PUBLICATION OF MODIFICATIONS TO EXISTING SAFE HARBORS AND NEW SAFE HARBORS.

(a) IN GENERAL.—

(1) SOLICITATIONS.—Not later than January 1, 1996, and not less than annually thereafter, the Secretary of Health and Human Services shall publish a notice in the Federal Register soliciting proposals, which will be accepted during a 60-day period, for—

(A) modifications to existing safe harbors issued pursuant to section 14(a) of the Medicare and Medicaid Patient and Program Protection Act of 1987;

(B) additional safe harbors specifying payment practices that shall not be treated as a criminal offense under section 1128B(b) of the Social Security Act and shall not serve as the basis for an exclusion under section 1128(b)(7) of such Act; and

(C) special fraud alerts to be issued pursuant to section 15101(c).

(2) PUBLICATION OF PROPOSED MODIFICATIONS AND PROPOSED ADDITIONAL SAFE HARBORS.—Not later than 120 days after receiving the proposals described in subparagraphs (A) and (B) of paragraph (1), the Secretary, after considering such proposals in consultation with the Attorney General, shall publish in the Federal Register proposed modifications to existing safe harbors and proposed additional safe harbors, if appropriate, with a 60-day comment period. After considering any public comments received during this period, the Secretary shall issue final rules modifying the existing safe harbors and establishing new safe harbors, as appropriate.

(3) REPORT.—The Inspector General shall, in an annual report to Congress or as part of the year-end semiannual report required by section 5 of the Inspector General Act of 1978, describe the proposals received under subparagraphs (A) and (B) of paragraph (1) and explain which proposals were included in the publication described in paragraph (2), which proposals were not included in that publication, and the reasons for the rejection of the proposals that were not included.

(b) CRITERIA FOR MODIFYING AND ESTABLISHING SAFE HARBORS.—In modifying and establishing safe harbors under subsection (a)(2), the Secretary may consider the extent to which providing a safe harbor for the specified payment practice may result in any of the following:

(1) An increase or decrease in access to health care services.

(2) An increase or decrease in the quality of health care services.

(3) An increase or decrease in patient freedom of choice among health care providers.

(4) An increase or decrease in competition among health care providers.

(5) An increase or decrease in the cost to health care programs of the Federal Government.

(6) An increase or decrease in the potential overutilization of health care services.

(7) Any other factors the Secretary deems appropriate in the interest of preventing fraud and abuse in health care programs of the Federal Government.

SEC. 15215. ISSUANCE OF ADVISORY OPINIONS UNDER TITLE XI.

(a) IN GENERAL.—Title XI (42 U.S.C. 1301 et seq.), as amended by section 15104(a), is amended by inserting after section 1129 the following new section:

''ADVISORY OPINIONS

''SEC. 1130. (a) ISSUANCE OF ADVISORY OPINIONS.—The Secretary shall issue written advisory opinions as provided in this section.

''(b) MATTERS SUBJECT TO ADVISORY OPINIONS.—The Secretary shall issue advisory opinions as to the following matters:

''(1) What constitutes prohibited remuneration within the meaning of section 1128B(b).

''(2) Whether an arrangement or proposed arrangement satisfies the criteria set forth in section 1128B(b)(3) for activities which do not result in prohibited remuneration.

''(3) Whether an arrangement or proposed arrangement satisfies the criteria which the Secretary has established, or shall establish by regulation for activities which do not result in prohibited remuneration.

''(4) What constitutes an inducement to reduce or limit services to individuals entitled to benefits under title XVIII or title XIX or title XXI within the meaning of section 1128B(b).

''(5) Whether any activity or proposed activity constitutes grounds for the imposition of a sanction under section 1128, 1128A, or 1128B.

''(c) MATTERS NOT SUBJECT TO ADVISORY OPINIONS.—Such advisory opinions shall not address the following matters:

''(1) Whether the fair market value shall be, or was paid or received for any goods, services or property.

''(2) Whether an individual is a bona fide employee within the requirements of section 3121(d)(2) of the Internal Revenue Code of 1986.

''(d) EFFECT OF ADVISORY OPINIONS.—

''(1) BINDING AS TO SECRETARY AND PARTIES INVOLVED.—Each advisory opinion issued by the Secretary shall be binding as to the Secretary and the party or parties requesting the opinion.

''(2) FAILURE TO SEEK OPINION.—The failure of a party to seek an advisory opinion may not be introduced into evidence to prove that the party intended to violate the provisions of sections 1128, 1128A, or 1128B.

''(e) REGULATIONS.—

''(1) IN GENERAL.—Not later than 180 days after the date of the enactment of this section, the Secretary shall issue regulations to carry out this section. Such regulations shall provide for—

''(A) the procedure to be followed by a party applying for an advisory opinion;

''(B) the procedure to be followed by the Secretary in responding to a request for an advisory opinion;

''(C) the interval in which the Secretary shall respond;

''(D) the reasonable fee to be charged to the party requesting an advisory opinion; and

''(E) the manner in which advisory opinions will be made available to the public.

''(2) SPECIFIC CONTENTS.—Under the regulations promulgated pursuant to paragraph (1)—

''(A) the Secretary shall be required to respond to a party requesting an advisory opinion by not later than 30 days after the request is received; and

''(B) the fee charged to the party requesting an advisory opinion shall be equal to the costs incurred by the Secretary in responding to the request.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to requests for advisory opinions made on or after January 1, 1996.

SEC. 15216. PRIOR NOTICE OF CHANGES IN BILLING AND CLAIMS PROCESSING REQUIREMENTS FOR PHYSICIANS' SERVICES.

Except as may be specifically provided by Congress, the Secretary of Health and Human Services may not implement any change in the requirements imposed on the billing and processing of claims for payment for physicians' services under part B of the medicare program unless the Secretary notifies the individuals furnishing such services of the change not later than 120 days before the effective date of the change.

PART 3—PROMOTING PHYSICIAN SELF-POLICING

SEC. 15221. EXEMPTION FROM ANTITRUST LAWS FOR CERTAIN ACTIVITIES OF MEDICAL SELF-REGULATORY ENTITIES.

(a) EXEMPTION DESCRIBED.—An activity relating to the provision of health care services shall be exempt from the antitrust laws, and any State law similar to the antitrust laws, if the activity is within the safe harbor described in subsection (b).

(b) SAFE HARBOR FOR ACTIVITIES OF MEDICAL SELF-REGULATORY ENTITIES.—

(1) IN GENERAL.—The safe harbor referred to in subsection (a) is, subject to paragraph (2), any activity of a medical self-regulatory entity relating to standard setting or standard enforcement activities that are designed to promote the quality of health care services provided to patients.

(2) EXCEPTION.—No activity of a medical self-regulatory entity may be deemed to fall under the safe harbor established under paragraph (1) if the activity—

(A) is conducted for purposes of financial gain, or

(B) interferes with the provision of health care services by any health care provider who is not a member of the specific profession which is subject to the authority of the medical self-regulatory entity.

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

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

(2) HEALTH BENEFIT PLAN.—The term ''health benefit plan'' means—

(A) a hospital or medical expense incurred policy or certificate,

(B) a hospital or medical service plan contract,

(C) a health maintenance subscriber contract,

(D) a multiple employer welfare arrangement or employee benefit plan (as defined under the Employee Retirement Income Security Act of 1974), or

(E) a MedicarePlus product (offered under part C of title XVIII of the Social Security Act),

that provides benefits with respect to health care services.

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

(4) MEDICAL SELF-REGULATORY ENTITY.—The term ''medical self-regulatory entity'' means a medical society or association, a specialty board, a recognized accrediting agency, or a hospital medical staff, and includes the members, officers, employees, consultants, and volunteers or committees of such an entity.

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

(6) STANDARD SETTING OR STANDARD ENFORCEMENT ACTIVITIES.—The term ''standard setting or standard enforcement activities'' means—

(A) accreditation of health care practitioners, health care providers, medical education institutions, or medical education programs,

(B) technology assessment and risk management activities,

(C) the development and implementation of practice guidelines or practice parameters, or

(D) official peer review proceedings undertaken by a hospital medical staff (or committee thereof) or a medical society or association for purposes of evaluating the professional conduct or quality of health care provided by a medical professional.

Subtitle D—Medical Liability Reform

PART 1—GENERAL PROVISIONS

SEC. 15301. FEDERAL REFORM OF HEALTH CARE LIABILITY ACTIONS.

(a) APPLICABILITY.—This subtitle shall apply with respect to any health care liability action brought in any State or Federal court, except that this subtitle shall not apply to—

(1) an action for damages arising from a vaccine-related injury or death to the extent that title XXI of the Public Health Service Act applies to the action, or

(2) an action under the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 et seq.).

(b) PREEMPTION.—This subtitle shall preempt any State law to the extent such law is inconsistent with the limitations contained in this subtitle. This subtitle shall not preempt any State law that provides for defenses or places limitations on a person's liability in addition to those contained in this subtitle or otherwise imposes greater restrictions than those provided in this subtitle.

(c) EFFECT ON SOVEREIGN IMMUNITY AND CHOICE OF LAW OR VENUE.—Nothing in subsection (b) shall be construed to—

(1) waive or affect any defense of sovereign immunity asserted by any State under any provision of law;

(2) waive or affect any defense of sovereign immunity asserted by the United States;

(3) affect the applicability of any provision of the Foreign Sovereign Immunities Act of 1976;

(4) preempt State choice-of-law rules with respect to claims brought by a foreign nation or a citizen of a foreign nation; or

(5) affect the right of any court to transfer venue or to apply the law of a foreign nation or to dismiss a claim of a foreign nation or of a citizen of a foreign nation on the ground of inconvenient forum.

(d) AMOUNT IN CONTROVERSY.—In an action to which this subtitle applies and which is brought under section 1332 of title 28, United States Code, the amount of noneconomic damages or punitive damages, and attorneys' fees or costs, shall not be included in determining whether the matter in controversy exceeds the sum or value of $50,000.

(e) FEDERAL COURT JURISDICTION NOT ESTABLISHED ON FEDERAL QUESTION GROUNDS.—Nothing in this subtitle shall be construed to establish any jurisdiction in the district courts of the United States over health care liability actions on the basis of section 1331 or 1337 of title 28, United States Code.

SEC. 15302. DEFINITIONS.

As used in this subtitle:

(1) ACTUAL DAMAGES.—The term ''actual damages'' means damages awarded to pay for economic loss.

(2) ALTERNATIVE DISPUTE RESOLUTION SYSTEM; ADR.—The term ''alternative dispute resolution system'' or ''ADR'' means a system established under Federal or State law that provides for the resolution of health care liability claims in a manner other than through health care liability actions.

(3) CLAIMANT.—The term ''claimant'' means any person who brings a health care liability action and any person on whose behalf such an action is brought. If such action is brought through or on behalf of an estate, the term includes the claimant's decedent. If such action is brought through or on behalf of a minor or incompetent, the term includes the claimant's legal guardian.

(4) CLEAR AND CONVINCING EVIDENCE.—The term ''clear and convincing evidence'' is that measure or degree of proof that will produce in the mind of the trier of fact a firm belief or conviction as to the truth of the allegations sought to be established. Such measure or degree of proof is more than that required under preponderance of the evidence but less than that required for proof beyond a reasonable doubt.

(5) COLLATERAL SOURCE PAYMENTS.—The term ''collateral source payments'' means any amount paid or reasonably likely to be paid in the future to or on behalf of a claimant, or any service, product, or other benefit provided or reasonably likely to be provided in the future to or on behalf of a claimant, as a result of an injury or wrongful death, pursuant to—

(A) any State or Federal health, sickness, income-disability, accident or workers' compensation Act;

(B) any health, sickness, income-disability, or accident insurance that provides health benefits or income-disability coverage;

(C) any contract or agreement of any group, organization, partnership, or corporation to provide, pay for, or reimburse the cost of medical, hospital, dental, or income disability benefits; and

(D) any other publicly or privately funded program.

(6) DRUG.—The term ''drug'' has the meaning given such term in section 201(g)(1) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321(g)(1)).

(7) ECONOMIC LOSS.—The term ''economic loss'' means any pecuniary loss resulting from injury (including the loss of earnings or other benefits related to employment, medical expense loss, replacement services loss, loss due to death, burial costs, and loss of business or employment opportunities), to the extent recovery for such loss is allowed under applicable State law.

(8) HARM.—The term ''harm'' means any legally cognizable wrong or injury for which punitive damages may be imposed.

(9) HEALTH BENEFIT PLAN.—The term ''health benefit plan'' means—

(A) a hospital or medical expense incurred policy or certificate,

(B) a hospital or medical service plan contract,

(C) a health maintenance subscriber contract, or

(D) a MedicarePlus product (offered under part C of title XVIII of the Social Security Act),

that provides benefits with respect to health care services.

(10) HEALTH CARE LIABILITY ACTION.—The term ''health care liability action'' means a civil action brought in a State or Federal court against a health care provider, an entity which is obligated to provide or pay for health benefits under any health benefit plan (including any person or entity acting under a contract or arrangement to provide or administer any health benefit), or the manufacturer, distributor, supplier, marketer, promoter, or seller of a medical product, in which the claimant alleges a claim (including third party claims, cross claims, counter claims, or distribution claims) based upon the provision of (or the failure to provide or pay for) health care services or the use of a medical product, regardless of the theory of liability on which the claim is based or the number of plaintiffs, defendants, or causes of action.

(11) HEALTH CARE LIABILITY CLAIM.—The term ''health care liability claim'' means a claim in which the claimant alleges that injury was caused by the provision of (or the failure to provide) health care services.

(12) HEALTH CARE PROVIDER.—The term ''health care provider'' means any person that is engaged in the delivery of health care services in a State and that is required by the laws or regulations of the State to be licensed or certified by the State to engage in the delivery of such services in the State.

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

(14) MEDICAL DEVICE.—The term ''medical device'' has the meaning given such term in section 201(h) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321(h)).

(15) NONECONOMIC DAMAGES.—The term ''noneconomic damages'' means damages paid to an individual for pain and suffering, inconvenience, emotional distress, mental anguish, loss of consortium, injury to reputation, humiliation, and other nonpecuniary losses.

(16) PERSON.—The term ''person'' means any individual, corporation, company, association, firm, partnership, society, joint stock company, or any other entity, including any governmental entity.

(17) PRODUCT SELLER.—

(A) IN GENERAL.—Subject to subparagraph (B), the term ''product seller'' means a person who, in the course of a business conducted for that purpose—

(i) sells, distributes, rents, leases, prepares, blends, packages, labels, or is otherwise involved in placing, a product in the stream of commerce, or

(ii) installs, repairs, or maintains the harm-causing aspect of a product.

(B) EXCLUSION.—Such term does not include—

(i) a seller or lessor of real property;

(ii) a provider of professional services in any case in which the sale or use of a product is incidental to the transaction and the essence of the transaction is the furnishing of judgment, skill, or services; or

(iii) any person who—

(I) acts in only a financial capacity with respect to the sale of a product; or

(II) leases a product under a lease arrangement in which the selection, possession, maintenance, and operation of the product are controlled by a person other than the lessor.

(18) PUNITIVE DAMAGES.—The term ''punitive damages'' means damages awarded against any person not to compensate for actual injury suffered, but to punish or deter such person or others from engaging in similar behavior in the future.

(19) STATE.—The term ''State'' means each of the several States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, the Northern Mariana Islands, and any other territory or possession of the United States.

SEC. 15303. EFFECTIVE DATE.

This subtitle will apply to any health care liability action brought in a Federal or State court and to any health care liability claim subject to an alternative dispute resolution system, that is initiated on or after the date of enactment of this subtitle, except that any health care liability claim or action arising from an injury occurring prior to the date of enactment of this subtitle shall be governed by the applicable statute of limitations provisions in effect at the time the injury occurred.

PART 2—UNIFORM STANDARDS FOR HEALTH CARE LIABILITY ACTIONS

SEC. 15311. STATUTE OF LIMITATIONS.

A health care liability action may not be brought after the expiration of the 2-year period that begins on the date on which the alleged injury that is the subject of the action was discovered or should reasonably have been discovered, but in no case after the expiration of the 5-year period that begins on the date the alleged injury occurred.

SEC. 15312. CALCULATION AND PAYMENT OF DAMAGES.

(a) TREATMENT OF NONECONOMIC DAMAGES.—

(1) LIMITATION ON NONECONOMIC DAMAGES.—The total amount of noneconomic damages that may be awarded to a claimant for losses resulting from the injury which is the subject of a health care liability action may not exceed $250,000, regardless of the number of parties against whom the action is brought or the number of actions brought with respect to the injury.

(2) JOINT AND SEVERAL LIABILITY.—In any health care liability action brought in State or Federal court, a defendant shall be liable

only for the amount of noneconomic damages attributable to such defendant in direct proportion to such defendant's share of fault or responsibility for the claimant's actual damages, as determined by the trier of fact. In all such cases, the liability of a defendant for noneconomic damages shall be several and not joint.

(b) TREATMENT OF PUNITIVE DAMAGES.—

(1) GENERAL RULE.—Punitive damages may, to the extent permitted by applicable State law, be awarded in any health care liability action for harm in any Federal or State court against a defendant if the claimant establishes by clear and convincing evidence that the harm suffered was the result of conduct—

(A) specifically intended to cause harm, or

(B) conduct manifesting a conscious, flagrant indifference to the rights or safety of others.

(2) PROPORTIONAL AWARDS.—The amount of punitive damages that may be awarded in any health care liability action subject to this subtitle shall not exceed 3 times the amount of damages awarded to the claimant for economic loss, or $250,000, whichever is greater. This paragraph shall be applied by the court and shall not be disclosed to the jury.

(3) APPLICABILITY.—This subsection shall apply to any health care liability action brought in any Federal or State court on any theory where punitive damages are sought. This subsection does not create a cause of action for punitive damages. This subsection does not preempt or supersede any State or Federal law to the extent that such law would further limit the award of punitive damages.

(4) BIFURCATION.—At the request of any party, the trier of fact shall consider in a separate proceeding whether punitive damages are to be awarded and the amount of such award. If a separate proceeding is requested, evidence relevant only to the claim of punitive damages, as determined by applicable State law, shall be inadmissible in any proceeding to determine whether actual damages are to be awarded.

(5) DRUGS AND DEVICES.—

(A) IN GENERAL.—(i) Punitive damages shall not be awarded against a manufacturer or product seller of a drug or medical device which caused the claimant's harm where—

(I) such drug or device was subject to premarket approval by the Food and Drug Administration with respect to the safety of the formulation or performance of the aspect of such drug or device which caused the claimant's harm, or the adequacy of the packaging or labeling of such drug or device which caused the harm, and such drug, device, packaging, or labeling was approved by the Food and Drug Administration; or

(II) the drug is generally recognized as safe and effective pursuant to conditions established by the Food and Drug Administration and applicable regulations, including packaging and labeling regulations.

(ii) Clause (i) shall not apply in any case in which the defendant, before or after premarket approval of a drug or device—

(I) intentionally and wrongfully withheld from or misrepresented to the Food and Drug Administration information concerning such drug or device required to be submitted under the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 301 et seq.) or section 351 of the Public Health Service Act (42 U.S.C. 262) that is material and relevant to the harm suffered by the claimant, or

(II) made an illegal payment to an official or employee of the Food and Drug Administration for the purpose of securing or maintaining approval of such drug or device.

(B) PACKAGING.—In a health care liability action for harm which is alleged to relate to the adequacy of the packaging or labeling of a drug which is required to have tamper-resistant packaging under regulations of the Secretary of Health and Human Services (including labeling regulations related to such packaging), the manufacturer or product seller of the drug shall not be held liable for punitive damages unless such packaging or labeling is found by the court by clear and convincing evidence to be substantially out of compliance with such regulations.

(c) PERIODIC PAYMENTS FOR FUTURE LOSSES.—

(1) GENERAL RULE.—In any health care liability action in which the damages awarded for future economic and noneconomic loss exceeds $50,000, a person shall not be required to pay such damages in a single, lump-sum payment, but shall be permitted to make such payments periodically based on when the damages are found likely to occur, as such payments are determined by the court.

(2) FINALITY OF JUDGMENT.—The judgment of the court awarding periodic payments under this subsection may not, in the absence of fraud, be reopened at any time to contest, amend, or modify the schedule or amount of the payments.

(3) LUMP-SUM SETTLEMENTS.—This subsection shall not be construed to preclude a settlement providing for a single, lump-sum payment.

(d) TREATMENT OF COLLATERAL SOURCE PAYMENTS.—

(1) INTRODUCTION INTO EVIDENCE.—In any health care liability action, any defendant may introduce evidence of collateral source payments. If any defendant elects to introduce such evidence, the claimant may introduce evidence of any amount paid or contributed or reasonably likely to be paid or contributed in the future by or on behalf of the claimant to secure the right to such collateral source payments.

(2) NO SUBROGATION.—No provider of collateral source payments shall recover any amount against the claimant or receive any lien or credit against the claimant's recovery or be equitably or legally subrogated the right of the claimant in a health care liability action.

(3) APPLICATION TO SETTLEMENTS.—This subsection shall apply to an action that is settled as well as an action that is resolved by a fact finder.

SEC. 15313. ALTERNATIVE DISPUTE RESOLUTION.

Any ADR used to resolve a health care liability action or claim shall contain provisions relating to statute of limitations, noneconomic damages, joint and several liability, punitive damages, collateral source rule, and periodic payments which are identical to the provisions relating to such matters in this subtitle.

Subtitle E—Teaching Hospitals and Graduate Medical Education

PART 1—TEACHING HOSPITAL AND GRADUATE MEDICAL EDUCATION TRUST FUND

SEC. 15401. ESTABLISHMENT OF FUND; PAYMENTS TO TEACHING HOSPITALS.

The Social Security Act (42 U.S.C. 300 et seq.) is amended by adding after title XXI the following title:

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

''PART A—ESTABLISHMENT OF FUND

"SEC. 2201. ESTABLISHMENT OF FUND.

''(a) IN GENERAL.—There is established in the Treasury of the United States a fund to be known as the Teaching Hospital and Graduate Medical Education Trust Fund (in this title referred to as the 'Fund'), consisting of amounts appropriated to the Fund in subsection (d) and subsection (e)(3), amounts transferred to the Fund under section 1886(j), and such gifts and bequests as may be deposited in the Fund pursuant to subsection (f). Amounts in the Fund are available until expended.

''(b) EXPENDITURES FROM FUND.—Amounts in the Fund are available to the Secretary for making payments under section 2211.

''(c) ACCOUNTS IN FUND.—There are established within the Fund the following accounts:

''(1) The Indirect-Costs Medical Education Account.

''(2) The Medicare Direct-Costs Medical Education Account.

''(3) The General Direct-Costs Medical Education Account.

''(d) GENERAL TRANSFERS TO FUND.—

''(1) IN GENERAL.—For fiscal year 1997 and each subsequent fiscal year, there are appropriated to the Fund (effective on the applicable date under paragraph (2)), out of any money in the Treasury not otherwise appropriated, the following amounts (as applicable to the fiscal year involved):

''(A) For fiscal year 1997, $1,300,000,000.

''(B) For fiscal year 1998, $1,500,000,000.

''(C) For fiscal year 1999, $2,300,000,000.

''(D) For fiscal year 2000, $3,100,000,000.

''(E) For fiscal year 2001, $3,600,000,000.

''(F) For fiscal year 2002, $4,000,000,000.

''(G) For fiscal year 2003 and each subsequent fiscal year, the greater of the amount appropriated for the preceding fiscal year or an amount equal to the product of—

''(i) the amount appropriated for the preceding fiscal year; and

''(ii) 1 plus the percentage increase in the nominal gross domestic product for the one-year period ending upon July 1 of such preceding fiscal year.

''(2) EFFECTIVE DATE FOR ANNUAL APPROPRIATION.—For purposes of paragraph (1) (and for purposes of section 2221(a)(1), and subsections (b)(1)(A) and (c)(1)(A) of section 2231)), the applicable date for a fiscal year is the first day of the fiscal year, exclusive of Saturdays, Sundays, and Federal holidays.

''(3) ALLOCATION AMONG CERTAIN ACCOUNTS.—Of the amount appropriated in paragraph (1) for a fiscal year—

''(A) there shall be allocated to the Indirect-Costs Medical Education Account the percentage determined under paragraph (4)(B); and

''(B) there shall be allocated to the General Direct-Costs Medical Education Account the percentage determined under paragraph (4)(C).

''(4) DETERMINATION OF PERCENTAGES.—The Secretary of Health and Human Services, acting through the Administrator of the Health Care Financing Administration, shall determine the following:

''(A) The total amount of payments that were made under subsections (d)(5)(B) and (h) of section 1886 for fiscal year 1994.

''(B) The percentage of such total that was constituted by payments under subsection (d)(5)(B) of such section.

''(C) The percentage of such total that was constituted by payments under subsection (h) of such section.

''(e) INVESTMENT.—

''(1) IN GENERAL.—The Secretary of the Treasury shall invest such amounts of the Fund as such Secretary determines are not required to meet current withdrawals from the Fund. Such investments may be made only in interest-bearing obligations of the United States. For such purpose, such obligations may be acquired on original issue at the issue price, or by purchase of outstanding obligations at the market price.

''(2) SALE OF OBLIGATIONS.—Any obligation acquired by the Fund may be sold by the Secretary of the Treasury at the market price.

''(3) AVAILABILITY OF INCOME.—Any interest derived from obligations acquired by the Fund, and proceeds from any sale or redemption of such obligations, are hereby appropriated to the Fund.

''(f) ACCEPTANCE OF GIFTS AND BEQUESTS.—The Fund may accept on behalf of the United States money gifts and bequests made unconditionally to the Fund for the benefit of the Fund or any activity financed through the Fund.

''PART B—PAYMENTS TO TEACHING HOSPITALS

''Subpart 1—Requirement of Payments

''SEC. 2211. FORMULA PAYMENTS TO TEACHING HOSPITALS.

''(a) IN GENERAL.—Subject to subsection (d), in the case of each teaching hospital that in accordance with subsection (b) submits to the Secretary a payment document for fiscal year 1997 or any subsequent fiscal year, the Secretary shall make payments for the year to the teaching hospital for the costs of operating approved medical residency training programs. Such payments shall be made from the Fund, and the total of the payments to the hospital for the fiscal year shall equal the sum of the following:

''(1) An amount determined under section 2221 (relating to the indirect costs of graduate medical education).

''(2) An amount determined under section 2231 (relating to the direct costs of graduate medical education).

''(b) PAYMENT DOCUMENT.—For purposes of subsection (a), a payment document is a document containing such information as may be necessary for the Secretary to make payments under such subsection to a teaching hospital for a fiscal year. The document is submitted in accordance with this subsection if the document is submitted not later than the date specified by the Secretary, and the document is in such form and is made in such manner as the Secretary may require. The Secretary may require that information under this subsection be submitted to the Secretary in periodic reports.

''(c) ADMINISTRATOR OF PROGRAMS.—This part, and the subsequent parts of this title, shall be carried out by the Secretary acting through the Administrator of the Health Care Financing Administration.

''(d) SPECIAL RULES.—

''(1) AUTHORITY REGARDING PAYMENTS TO CONSORTIA OF PROVIDERS.—In the case of payments under subsection (a) that are determined under section 2231:

''(A) The requirement under such subsection to make the payments to teaching hospitals is subject to the authority of the Secretary under section 2233(a) to make payments to qualifying consortia.

''(B) If the Secretary authorizes such a consortium for purposes of section 2233(a), subsections (a) and (b) of this section apply to the consortium to the same extent and in the same manner as the subsections apply to teaching hospitals.

''(2) CERTAIN HOSPITALS.—Paragraph (1) of subsection (a) is subject to sections 2222 and 2223 of subpart 2. Paragraph (2) of subsection (a) is subject to sections 2232 through 2234 of subpart 3.

''(e) APPROVED MEDICAL RESIDENCY TRAINING PROGRAM.—For purposes of this title, the term 'approved medical residency training program' has the meaning given such term in section 1886(h)(5)(A).

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

''SEC. 2221. DETERMINATION OF AMOUNT RELATING TO INDIRECT COSTS.

''(a) IN GENERAL.—For purposes of section 2211(a)(1), the amount determined under this section for a teaching hospital for a fiscal year is the product of—

''(1) the amount in the Indirect-Costs Medical Education Account on the applicable date under section 2201(d) (once the appropriation under such section is made); and

''(2) the percentage determined for the hospital under subsection (b).

''(b) HOSPITAL-SPECIFIC PERCENTAGE.—

''(1) IN GENERAL.—For purposes of subsection (a)(2), the percentage determined under this subsection for a teaching hospital is the mean average of the respective percentages determined under paragraph (3) for each fiscal year of the applicable period (as defined in paragraph (2)), adjusted by the Secretary (upward or downward, as the case may be) on a pro rata basis to the extent necessary to ensure that the sum of the percentages determined under this paragraph for all teaching hospitals is equal to 100 percent. The preceding sentence is subject to sections 2222 and 2223.

''(2) APPLICABLE PERIOD REGARDING RELEVANT DATA; FISCAL YEARS 1992 THROUGH 1994.—For purposes of this part, the term 'applicable period' means the period beginning on the first day of fiscal year 1992 and continuing through the end of fiscal year 1994.

''(3) RESPECTIVE DETERMINATIONS FOR FISCAL YEARS OF APPLICABLE PERIOD.—For purposes of paragraph (1), the percentage determined under this paragraph for a teaching hospital for a fiscal year of the applicable period is the percentage constituted by the ratio of—

''(A) the total amount of payments received by the hospital under section 1886(d)(5)(B) for discharges occurring during the fiscal year involved; to

''(B) the sum of the respective amounts determined under subparagraph (A) for the fiscal year for all teaching hospitals.

''(c) AVAILABILITY OF DATA.—If a teaching hospital received the payments specified in subsection (b)(3)(A) during the applicable period but a complete set of the relevant data is not available to the Secretary for purposes of determining an amount under such subsection for the fiscal year involved, the Secretary shall for purposes of such subsection make an estimate on the basis of such data as are available to the Secretary for the applicable period.

''SEC. 2222. INDIRECT COSTS; SPECIAL RULES REGARDING DETERMINATION OF HOSPITAL-SPECIFIC PERCENTAGE.

''(a) SPECIAL RULE REGARDING FISCAL YEARS 1995 AND 1996.—

''(1) IN GENERAL.—In the case of a teaching hospital whose first payments under section 1886(d)(5)(B) were for discharges occurring in fiscal year 1995 or in fiscal year 1996 (referred to in this subsection individually as a 'first payment year'), the percentage determined under paragraph (2) for the hospital is deemed to be the percentage applicable under section 2221(b) to the hospital, except that the percentage under paragraph (2) shall be adjusted in accordance with section 2221(b)(1) to the extent determined by the Secretary to be necessary with respect to a sum that equals 100 percent.

''(2) DETERMINATION OF PERCENTAGE.—For purposes of paragraph (1), the percentage determined under this paragraph for a teaching hospital is the percentage constituted by the ratio of the amount determined under subparagraph (A) to the amount determined under subparagraph (B), as follows:

''(A)(i) If the first payment year for the hospital is fiscal year 1995, the amount determined under this subparagraph is the total amount of payments received by the hospital under section 1886(d)(5)(B) for discharges occurring during fiscal year 1995.

''(ii) If the first payment year for the hospital is fiscal year 1996, the amount determined under this subparagraph is an amount equal to an estimate by the Secretary of the total amount of payments that would have been paid to the hospital under section 1886(d)(5)(B) for discharges occurring during fiscal year 1995 if such section, as in effect for fiscal year 1996, had applied to the hospital for discharges occurring during fiscal year 1995.

''(B)(i) If the first payment year for the hospital is fiscal year 1995, the amount determined under this subparagraph is the aggregate total of the payments received by teaching hospitals under section 1886(d)(5)(B) for discharges occurring during fiscal year 1995.

''(ii) If the first payment year for the hospital is fiscal year 1996—

''(I) the Secretary shall make an estimate in accordance with subparagraph (A)(ii) for all teaching hospitals; and

''(II) the amount determined under this subparagraph is the sum of the estimates made by the Secretary under subclause (I).

''(b) NEW TEACHING HOSPITALS.—

''(1) IN GENERAL.—Subject to paragraph (4), in the case of a teaching hospital that did not receive payments under section 1886(d)(5)(B) for any of the fiscal years 1992 through 1996, the percentage determined under paragraph (3) for the hospital is deemed to be the percentage applicable under section 2221(b) to the hospital, except that the percentage under paragraph (3) shall be adjusted in accordance with section 2221(b)(1) to the extent determined by the Secretary to be necessary with respect to a sum that equals 100 percent.

''(2) DESIGNATED FISCAL YEAR REGARDING DATA.—The determination under paragraph (3) of a percentage for a teaching hospital described in paragraph (1) shall be made for the most recent fiscal year for which the Secretary has sufficient data to make the determination (referred to in this subsection as the 'designated fiscal year').

''(3) DETERMINATION OF PERCENTAGE.—For purposes of paragraph (1), the percentage determined under this paragraph for the teaching hospital involved is the percentage constituted by the ratio of the amount determined under subparagraph (A) to the amount determined under subparagraph (B), as follows:

''(A) The amount determined under this subparagraph is an amount equal to an estimate by the Secretary of the total amount of payments that would have been paid to the hospital under section 1886(d)(5)(B) for the designated fiscal year if such section, as in effect for the first fiscal year for which payments pursuant to this subsection are to be made to the hospital, had applied to the hospital for the designated fiscal year.

''(B) The Secretary shall make an estimate in accordance with subparagraph (A) for all teaching hospitals. The amount determined under this subparagraph is the sum of the estimates made by the Secretary under the preceding sentence.

''(4) LIMITATION.—This subsection does not apply to a teaching hospital described in paragraph (1) if the hospital is in a State for which a demonstration project under section 1814(b)(3) is in effect.

''(c) CONSOLIDATIONS AND MERGERS.—In the case of two or more teaching hospitals that have each received payments pursuant to section 2221 for one or more fiscal years and that undergo a consolidation or merger, the percentage applicable to the resulting teaching hospital for purposes of section 2221(b) is the sum of the respective percentages that would have applied pursuant to such section if the hospitals had not undergone the consolidation or merger.

"SEC. 2223. INDIRECT COSTS; ALTERNATIVE PAYMENTS REGARDING TEACHING HOSPITALS IN CERTAIN STATES.

''(a) IN GENERAL.—In the case of a teaching hospital in a State for which a demonstration project under section 1814(b)(3) is in effect, this section applies in lieu of section 2221. For purposes of section 2211(a)(1), the amount determined for such a teaching hospital for a fiscal year is the product of—

''(1) the amount in the Indirect-Costs Medical Education Account for the fiscal year pursuant to the allocation under section 2201(d)(3)(A) for the year; and

''(2) the percentage determined under subsection (b) for the hospital.

''(b) DETERMINATION OF PERCENTAGE.—For purposes of subsection (a)(2):

''(1) The Secretary shall make an estimate of the total amount of payments that would have been received under section 1886(d)(5)(B) by the hospital involved with respect to each of the fiscal years of the applicable period if such section (as in effect for such fiscal years) had applied to the hospital for such years.

''(2) The percentage determined under this subsection for the hospital for a fiscal year is a mean average percentage determined for the hospital in accordance with the methodology of section 2221(b)(1), except that the estimate made by the Secretary under paragraph (1) of this subsection for a fiscal year of the applicable period is deemed to be the amount that applies for purposes of section 2221(b)(3)(A) for such year.

''(c) RULE REGARDING PAYMENTS FROM CERTAIN AMOUNTS.—In the case of a teaching hospital described in subsection (a), this section does not authorize any payment to the hospital from amounts transferred to the Fund under section 1886(j).

''(d) ADJUSTMENT REGARDING PAYMENTS TO OTHER HOSPITALS.—In the case of a fiscal year for which payments pursuant to subsection (a) are made to one or more teaching hospitals, the following applies:

''(1) The Secretary shall determine a percentage equal to the sum of the respective percentages determined for the hospitals under subsection (b).

''(2) The Secretary shall determine an amount equal to the product of—

''(A) the percentage determined under paragraph (1); and

''(B) the amount in the Indirect-Costs Medical Education Account for the fiscal year pursuant to the transfer under section 1886(j)(1).

''(3) The Secretary shall, for each hospital (other than hospitals described in subsection (a)), make payments to the hospital in amounts whose sum for the fiscal year is equal to the product of—

''(A) the amount determined under paragraph (2); and

''(B) the percentage that applies to the hospital for purposes of section 2221(b), except that such percentage shall be adjusted in accordance with the methodology of section 2221(b)(1) to the extent determined by the Secretary to be necessary with respect to a sum that equals 100 percent.

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

"SEC. 2231. DETERMINATION OF AMOUNT RELATING TO DIRECT COSTS.

''(a) IN GENERAL.—For purposes of section 2211(a)(2), the amount determined under this section for a teaching hospital for a fiscal year is the sum of—

''(1) the amount determined under subsection (b) (relating to the General Direct-Costs Medical Education Account); and

''(2) the amount determined under subsection (c) (relating to the Medicare Direct-Costs Medical Education Account).

''(b) PAYMENT FROM GENERAL ACCOUNT.—

''(1) IN GENERAL.—For purposes of subsection (a)(1), the amount determined under this subsection for a teaching hospital for a fiscal year is the product of—

''(A) the amount in the General Direct-Costs Medical Education Account on the applicable date under section 2201(d) (once the appropriation under such section is made); and

''(B) the percentage determined for the hospital under paragraph (2).

''(2) HOSPITAL-SPECIFIC PERCENTAGE.—

''(A) IN GENERAL.—For purposes of paragraph (1)(B), the percentage determined under this paragraph for a teaching hospital is the mean average of the respective percentages determined under subparagraph (B) for each fiscal year of the applicable period (as defined in section 2221(b)(2)), adjusted by the Secretary (upward or downward, as the case may be) on a pro rata basis to the extent necessary to ensure that the sum of the percentages determined under this subparagraph for all teaching hospitals is equal to 100 percent. The preceding sentence is subject to sections 2232 through 2234.

''(B) RESPECTIVE DETERMINATIONS FOR FISCAL YEARS OF APPLICABLE PERIOD.—For purposes of subparagraph (A), the percentage determined under this subparagraph for a teaching hospital for a fiscal year of the applicable period is the percentage constituted by the ratio of—

''(i) the total amount of payments received by the hospital under section 1886(h) for cost reporting periods beginning during the fiscal year involved; to

''(ii) the sum of the respective amounts determined under clause (i) for the fiscal year for all teaching hospitals.

''(3) AVAILABILITY OF DATA.—If a teaching hospital received the payments specified in paragraph (2)(B)(i) during the applicable period but a complete set of the relevant data is not available to the Secretary for purposes of determining an amount under such paragraph for the fiscal year involved, the Secretary shall for purposes of such paragraph make an estimate on the basis of such data as are available to the Secretary for the applicable period.

''(c) PAYMENT FROM MEDICARE ACCOUNT.—

''(1) IN GENERAL.—For purposes of subsection (a)(2), the amount determined under this subsection for a teaching hospital for a fiscal year is the product of—

''(A) the amount in the Medicare Direct-Costs Medical Education Account on the applicable date under section 2201(d) (once the appropriation under such section is made); and

''(B) the percentage determined for the hospital under paragraph (2) for the fiscal year.

''(2) HOSPITAL-SPECIFIC PERCENTAGE.—For purposes of paragraph (1)(B), the percentage determined under this subsection for a teaching hospital for a fiscal year is the percentage constituted by the ratio of—

''(A) the estimate made by the Secretary for the hospital for the fiscal year under section 1886(j)(2)(B); to

''(B) the sum of the respective estimates referred to in subparagraph (A) for all teaching hospitals.

"SEC. 2232. DIRECT COSTS; SPECIAL RULES REGARDING DETERMINATION OF HOSPITAL-SPECIFIC PERCENTAGE.

''(a) SPECIAL RULE REGARDING FISCAL YEARS 1995 AND 1996.—

''(1) IN GENERAL.—In the case of a teaching hospital whose first payments under section 1886(h) were for the cost reporting period beginning in fiscal year 1995 or in fiscal year 1996 (referred to in this subsection individually as a 'first payment year'), the percentage determined under paragraph (2) for the hospital is deemed to be the percentage applicable under section 2231(b)(2) to the hospital, except that the percentage under paragraph (2) shall be adjusted in accordance with section 2231(b)(2)(A) to the extent determined by the Secretary to be necessary with respect to a sum that equals 100 percent.

''(2) DETERMINATION OF PERCENTAGE.—For purposes of paragraph (1), the percentage determined under this paragraph for a teaching hospital is the percentage constituted by the ratio of the amount determined under subparagraph (A) to the amount determined under subparagraph (B), as follows:

''(A)(i) If the first payment year for the hospital is fiscal year 1995, the amount determined under this subparagraph is the total amount of payments received by the hospital under section 1886(h) for cost reporting periods beginning in fiscal year 1995.

''(ii) If the first payment year for the hospital is fiscal year 1996, the amount determined under this subparagraph is an amount equal to an estimate by the Secretary of the total amount of payments that would have been paid to the hospital under section 1886(h) for cost reporting periods beginning in fiscal year 1995 if such section, as in effect for fiscal year 1996, had applied to the hospital for fiscal year 1995.

''(B)(i) If the first payment year for the hospital is fiscal year 1995, the amount determined under this subparagraph is the aggregate total of the payments received by teaching hospitals under section 1886(h) for cost reporting periods beginning in fiscal year 1995.

''(ii) If the first payment year for the hospital is fiscal year 1996—

''(I) the Secretary shall make an estimate in accordance with subparagraph (A)(ii) for all teaching hospitals; and

''(II) the amount determined under this subparagraph is the sum of the estimates made by the Secretary under subclause (I).

''(b) NEW TEACHING HOSPITALS.—

''(1) IN GENERAL.—Subject to paragraph (4), in the case of a teaching hospital that did not receive payments under section 1886(h) for any of the fiscal years 1992 through 1996, the percentage determined under paragraph (3) for the hospital is deemed to be the percentage applicable under section 2231(b)(2) to the hospital, except that the percentage under paragraph (3) shall be adjusted in accordance with section 2231(b)(2)(A) to the extent determined by the Secretary to be necessary with respect to a sum that equals 100 percent.

''(2) DESIGNATED FISCAL YEAR REGARDING DATA.—The determination under paragraph (3) of a percentage for a teaching hospital described in paragraph (1) shall be made for the most recent fiscal year for which the Secretary has sufficient data to make the determination (referred to in this subsection as the 'designated fiscal year').

''(3) DETERMINATION OF PERCENTAGE.—For purposes of paragraph (1), the percentage determined under this paragraph for the teaching hospital involved is the percentage constituted by the ratio of the amount determined under subparagraph (A) to the amount determined under subparagraph (B), as follows:

''(A) The amount determined under this subparagraph is an amount equal to an estimate by the Secretary of the total amount of payments that would have been paid to the hospital under section 1886(h) for the designated fiscal year if such section, as in effect for the first fiscal year for which payments pursuant to this subsection are to be made to the hospital, had applied to the hospital for cost reporting periods beginning in the designated fiscal year.

''(B) The Secretary shall make an estimate in accordance with subparagraph (A) for all

teaching hospitals. The amount determined under this subparagraph is the sum of the estimates made by the Secretary under the preceding sentence.

''(4) LIMITATION.—This subsection does not apply to a teaching hospital described in paragraph (1) if the hospital is in a State for which a demonstration project under section 1814(b)(3) is in effect.

''(c) CONSOLIDATIONS AND MERGERS.—In the case of two or more teaching hospitals that have each received payments pursuant to section 2231 for one or more fiscal years and that undergo a consolidation or merger, the percentage applicable to the resulting teaching hospital for purposes of section 2231(b) is the sum of the respective percentages that would have applied pursuant to such section if the hospitals had not undergone the consolidation or merger.

''SEC. 2233. DIRECT COSTS; AUTHORITY FOR PAYMENTS TO CONSORTIA OF PROVIDERS.

''(a) IN GENERAL.—In lieu of making payments to teaching hospitals pursuant to section 2231, the Secretary may make payments under this section to consortia that meet the requirements of subsection (b).

''(b) QUALIFYING CONSORTIUM.—For purposes of subsection (a), a consortium meets the requirements of this subsection if the consortium is in compliance with the following:

''(1) The consortium consists of an approved medical residency training program and one or more of the following entities:

''(A) Schools of allopathic medicine or osteopathic medicine.

''(B) Teaching hospitals.

''(C) Other approved medical residency training programs.

''(D) Federally qualified health centers.

''(E) Medical group practices.

''(F) Managed care entities.

''(G) Entities furnishing outpatient services.

''(H) Such other entities as the Secretary determines to be appropriate.

''(2) The members of the consortium have agreed to participate in the programs of graduate medical education that are operated by the entities in the consortium.

''(3) With respect to the receipt by the consortium of payments made pursuant to this section, the members of the consortium have agreed on a method for allocating the payments among the members.

''(4) The consortium meets such additional requirements as the Secretary may establish.

''(c) PAYMENTS FROM ACCOUNTS.—

''(1) IN GENERAL.—Subject to subsection (d), the total of payments to a qualifying consortium for a fiscal year pursuant to subsection (a) shall be the sum of—

''(1) the aggregate amount determined for the teaching hospitals of the consortium pursuant to paragraph (1) of section 2231(a); and

''(2) an amount determined in accordance with the methodology that applies pursuant to paragraph (2) of such section, except that the estimate used for purposes of subsection (c)(2)(A) of such section shall be the estimate made for the consortium under section 1886(j)(2)(C)(ii).

''(d) LIMITATION ON AGGREGATE TOTAL OF PAYMENTS TO CONSORTIA.—The aggregate total of the amounts paid under subsection (c)(2) to qualifying consortia for a fiscal year may not exceed the sum of—

''(1) the aggregate total of the amounts that would have been paid under section 2231(c) for the fiscal year to the teaching hospitals of the consortia if the hospitals had not been participants in the consortia; and

''(2) an amount equal to 1 percent of the amount that applies under section 2231(c)(1)(A) for the fiscal year (relating to the Medicare Direct-Costs Medical Education Account).

''(e) DEFINITION.—For purposes of this title, the term 'qualifying consortium' means a consortium that meets the requirements of subsection (b).

''SEC. 2234. DIRECT COSTS; ALTERNATIVE PAYMENTS REGARDING TEACHING HOSPITALS IN CERTAIN STATES.

''(a) IN GENERAL.—In the case of a teaching hospital in a State for which a demonstration project under section 1814(b)(3) is in effect, this section applies in lieu of section 2231. For purposes of section 2211(a)(2), the amount determined for a teaching hospital for a fiscal year is the product of—

''(1) the amount in the General Direct-Costs Medical Education Account on the applicable date under section 2201(d) (once the appropriation under such section is made); and

''(2) the percentage determined under subsection (b) for the hospital.

''(b) DETERMINATION OF PERCENTAGE.—For purposes of subsection (a)(2):

''(1) The Secretary shall make an estimate of the total amount of payments that would have been received under section 1886(h) by the hospital involved with respect to each of the fiscal years of the applicable period if such section (as in effect for such fiscal years) had applied to the hospital for such years.

''(2) The percentage determined under this subsection for the hospital for a fiscal year is a mean average percentage determined for the hospital in accordance with the methodology of section 2231(b)(2)(A), except that the estimate made by the Secretary under paragraph (1) of this subsection for a fiscal year of the applicable period is deemed to be the amount that applies for purposes of section 2231(b)(2)(B)(i) for such year.

''(c) RULE REGARDING PAYMENTS FROM CERTAIN AMOUNTS.—In the case of a teaching hospital described in subsection (a), this section does not authorize any payment to the hospital from amounts transferred to the Fund under section 1886(j).

''Subpart 4—General Provisions

''SEC. 2241. ADJUSTMENTS IN PAYMENT AMOUNTS.

''(a) COLLECTION OF DATA ON ACCURACY OF ESTIMATES.—The Secretary shall collect data on whether the estimates made by the Secretary under section 1886(j) for a fiscal year were substantially accurate.

''(b) ADJUSTMENTS.—If the Secretary determines under subsection (a) that an estimate for a fiscal year was not substantially accurate, the Secretary shall, for the first fiscal year beginning after the Secretary makes the determination—

''(1) make adjustments accordingly in transfers to the Fund under section 1886(j); and

''(2) make adjustments accordingly in the amount of payments to teaching hospitals pursuant to 2231(c) (or, as applicable, to qualifying consortia pursuant to section 2233(c)(2)).''.

PART 2—AMENDMENTS TO MEDICARE PROGRAM

SEC. 15411. TRANSFERS TO TEACHING HOSPITAL AND GRADUATE MEDICAL EDUCATION TRUST FUND.

Section 1886 (42 U.S.C. 1395ww) is amended—

(1) in subsection (d)(5)(B), in the matter preceding clause (i), by striking ''The Secretary shall provide'' and inserting the following: ''For discharges occurring on or before September 30, 1996, the Secretary shall provide'';

(2) in subsection (h)—

(A) in paragraph (1), in the first sentence, by striking ''the Secretary shall provide'' and inserting ''the Secretary shall, subject to paragraph (6), provide''; and

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

''(6) LIMITATION.—

''(A) IN GENERAL.—The authority to make payments under this subsection applies only with respect to cost reporting periods ending on or before September 30, 1996, except as provided in subparagraph (B).

''(B) RULE REGARDING PORTION OF LAST COST REPORTING PERIOD.—In the case of a cost reporting period that extends beyond September 30, 1996, payments under this subsection shall be made with respect to such portion of the period as has lapsed as of such date.

''(C) RULE OF CONSTRUCTION.—This paragraph may not be construed as authorizing any payment under section 1861(v) with respect to graduate medical education.''; and

(3) by adding at the end the following subsection:

''(j) TRANSFERS TO TEACHING HOSPITAL AND GRADUATE MEDICAL EDUCATION TRUST FUND.—

''(1) INDIRECT COSTS OF MEDICAL EDUCATION.—

''(A) IN GENERAL.—From the Federal Hospital Insurance Trust Fund, the Secretary shall, for fiscal year 1997 and each subsequent fiscal year, transfer to the Indirect-Costs Medical Education Account (under section 2201) an amount determined by the Secretary in accordance with subparagraph (B).

''(B) DETERMINATION OF AMOUNTS.—The Secretary shall make an estimate for the fiscal year involved of the nationwide total of the amounts that would have been paid under subsection (d)(5)(B) to hospitals during the fiscal year if such payments had not been terminated for discharges occurring after September 30, 1996. For purposes of subparagraph (A), the amount determined under this subparagraph for the fiscal year is the estimate made by the Secretary under the preceding sentence.

''(2) DIRECT COSTS OF MEDICAL EDUCATION.—

''(A) IN GENERAL.—From the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, the Secretary shall, for fiscal year 1997 and each subsequent fiscal year, transfer to the Medicare Direct-Costs Medical Education Account (under section 2201) the sum of—

''(i) an amount determined by the Secretary in accordance with subparagraph (B); and

''(ii) as applicable, an amount determined by the Secretary in accordance with subparagraph (C)(ii).

''(B) DETERMINATION OF AMOUNTS.—For each hospital (other than a hospital that is a member of a qualifying consortium referred to in subparagraph (C)), the Secretary shall make an estimate for the fiscal year involved of the amount that would have been paid under subsection (h) to the hospital during the fiscal year if such payments had not been terminated for cost reporting periods ending on or before September 30, 1996. For purposes of subparagraph (A)(i), the amount determined under this subparagraph for the fiscal year is the sum of all estimates made by the Secretary under the preceding sentence.

''(C) ESTIMATES REGARDING QUALIFYING CONSORTIA.—If the Secretary elects to authorize one or more qualifying consortia for purposes of section 2233(a), the Secretary shall carry out the following:

''(i) The Secretary shall establish a methodology for making payments to qualifying consortia with respect to the reasonable direct costs of such consortia in carrying out

programs of graduate medical education. The methodology shall be the methodology established in subsection (h), modified to the extent necessary to take into account the participation in such programs of entities other than hospitals.

''(ii) For each qualifying consortium, the Secretary shall make an estimate for the fiscal year involved of the amount that would have been paid to the consortium during the fiscal year if, using the methodology under clause (i), payments had been made to the consortium for the fiscal year as reimbursements with respect to cost reporting periods. For purposes of subparagraph (A)(ii), the amount determined under this clause for the fiscal year is the sum of all estimates made by the Secretary under the preceding sentence.

''(D) ALLOCATION BETWEEN FUNDS.—In providing for a transfer under subparagraph (A) for a fiscal year, the Secretary shall provide for an allocation of the amounts involved between part A and part B (and the trust funds established under the respective parts) as reasonably reflects the proportion of direct graduate medical education costs of hospitals associated with the provision of services under each respective part.

''(3) APPLICABILITY OF CERTAIN AMENDMENTS.—Amendments made to subsection (d)(5)(B) and subsection (h) that are effective on or after October 1, 1996, apply only for purposes of estimates under paragraphs (1) and (2) and for purposes of determining the amount of payments under 2211. Such amendments do not require any adjustment to amounts paid under subsection (d)(5)(B) or (h) with respect to fiscal year 1996 or any prior fiscal year.

''(4) RELATIONSHIP TO CERTAIN DEMONSTRATION PROJECTS.—In the case of a State for which a demonstration project under section 1814(b)(3) is in effect, the Secretary, in making determinations of the rates of increase under such section, shall include all amounts transferred under this subsection. Such amounts shall be so included to the same extent and in the same manner as amounts determined under subsections (d)(5)(B) and (h) were included in such determination under the provisions of this title in effect on September 30, 1996.''.

SEC. 15412. MODIFICATION IN PAYMENT POLICIES REGARDING GRADUATE MEDICAL EDUCATION.

(a) INDIRECT COSTS OF MEDICAL EDUCATION; APPLICABLE PERCENTAGE.—

(1) MODIFICATION REGARDING 5.6 PERCENT.—Section 1886(d)(5)(B)(ii) (42 U.S.C. 1395ww(d)(5)(B)(ii)) is amended—

(A) by striking ''on or after October 1, 1988,'' and inserting ''on or after October 1, 1999,''; and

(B) by striking ''1.89'' and inserting ''1.38''.

(2) SPECIAL RULE REGARDING FISCAL YEARS 1996 THROUGH 1998; MODIFICATION REGARDING 6 PERCENT.—Section 1886(d)(5)(B)(ii), as amended by paragraph (1), is amended by adding at the end the following: ''In the case of discharges occurring on or after October 1, 1995, and before October 1, 1999, the preceding sentence applies to the same extent and in the same manner as the sentence applies to discharges occurring on or after October 1, 1999, except that the term '1.38' is deemed to be '1.48'.''.

(3) CONFORMING AMENDMENT RELATING TO DETERMINATION OF STANDARDIZED AMOUNTS.—Section 1886(d)(2)(C)(i) (42 U.S.C. 1395ww(d)(2)(C)(i)) is amended by striking ''1985'' and inserting the following: ''1985, but (for discharges occurring after September 30, 1995) not taking into account any reductions in such costs resulting from the amendments made by section 15412(a) of the Medicare Preservation Act of 1995''.

(b) DIRECT COSTS OF MEDICAL EDUCATION.—

(1) LIMITATION ON NUMBER OF FULL-TIME-EQUIVALENT RESIDENTS.—Section 1886(h)(4) (42 U.S.C. 1395ww(h)(4)) is amended by adding at the end the following new subparagraph:

''(F) LIMITATION ON NUMBER OF RESIDENTS FOR CERTAIN FISCAL YEARS.—

''(i) IN GENERAL.—Such rules shall provide that for purposes of a cost reporting period beginning on or after October 1, 1995, and on or before September 30, 2002, the number of full-time-equivalent residents determined under this paragraph with respect to an approved medical residency training program may not exceed the number of full-time-equivalent residents with respect to the program as of August 1, 1995 (except that this subparagraph applies only to approved medical residency training programs in the fields of allopathic medicine and osteopathic medicine).

''(ii) DISPOSITION OF UNUSED RESIDENCY POSITIONS.—In the case of a cost reporting period to which the limitation under clause (i) applies, if for such a period the number of full-time-equivalent residents determined under this paragraph with respect to an approved medical residency training program is less than the maximum number applicable to the program under such clause, the Secretary may authorize for one or more other approved medical residency training programs offsetting increases in the respective maximum numbers that otherwise would be applicable under such clause to the programs. In authorizing such increases with respect to a cost reporting period, the Secretary shall ensure that the national total of the respective maximum numbers determined under such clause with respect to approved medical residency training programs is not exceeded.''.

(2) EXCLUSION OF RESIDENTS AFTER INITIAL RESIDENCY PERIOD.—Section 1886(h)(4)(C) (42 U.S.C. 1395ww(h)(4)(C)) is amended to read as follows:

''(C) WEIGHTING FACTORS FOR RESIDENTS.—Effective for cost reporting periods beginning on or after October 1, 1997, such rules shall provide that, in the calculation of the number of full-time-equivalent residents in an approved residency program, the weighting factor for a resident who is in the initial residency period (as defined in paragraph (5)(F)) is 1.0 and the weighting factor for a resident who has completed such period is 0.0. (In the case of cost reporting periods beginning before October 1, 1997, the weighting factors that apply in such calculation are the weighting factors that were applicable under this subparagraph on the day before the date of the enactment of the Medicare Preservation Act of 1995.)''.

(3) REDUCTIONS IN PAYMENTS FOR ALIEN RESIDENTS.—Section 1886(h)(4) (42 U.S.C. 1395ww(h)(4)), as amended by paragraph (1), is amended by adding at the end the following new subparagraph:

''(G) SPECIAL RULES FOR ALIEN RESIDENTS.—In the case of individuals who are not citizens or nationals of the United States, aliens lawfully admitted to the United States for permanent residence, aliens admitted to the United States as refugees, or citizens of Canada, in the calculation of the number of full-time-equivalent residents in an approved medical residency program, the following rules shall apply with respect to such individuals who are residents in the program:

''(i) For a cost reporting period beginning during fiscal year 1996, for each such individual the Secretary shall apply a weighting factor of .75.

''(ii) For a cost reporting period beginning during fiscal year 1997, for each such individual the Secretary shall apply a weighting factor of .50.

''(iii) For a cost reporting period beginning during fiscal year 1998 or any subsequent fiscal year, for each such individual the Secretary shall apply a weighting factor of .25.''.

(4) EFFECTIVE DATE.—Except as provided otherwise in this subsection (or in the amendments made by this subsection), the amendments made by this subsection apply to hospital cost reporting periods beginning on or after October 1, 1995.

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

SEC. 15421. ESTABLISHMENT OF ADVISORY PANEL FOR RECOMMENDING POLICIES.

Title XXII of the Social Security Act, as added by section 15401, is amended by adding at the end the following part:

''PART C—OTHER MATTERS

''SEC. 2251. ADVISORY PANEL ON REFORM IN FINANCING OF TEACHING HOSPITALS AND GRADUATE MEDICAL EDUCATION.

''(a) ESTABLISHMENT.—The Chair of the Medicare Payment Review Commission under section 1806 shall establish a temporary advisory panel to be known as the Advisory Panel on Financing for Teaching Hospitals and Graduate Medical Education (in this section referred to as the 'Panel').

''(b) DUTIES.—The Panel shall develop recommendations on whether and to what extent Federal policies regarding teaching hospitals and graduate medical education should be reformed, including recommendations regarding the following:

''(1) The financing of graduate medical education, including consideration of alternative broad-based sources of funding for such education.

''(2) The financing of teaching hospitals, including consideration of the difficulties encountered by such hospitals as competition among health care entities increases. Matters considered under this paragraph shall include consideration of the effects on teaching hospitals of the method of financing used for the MedicarePlus program under part C of title XVIII.

''(3) The methodology for making payments for graduate medical education, and the selection of entities to receive the payments. Matters considered under this paragraph shall include the following:

''(A) The methodology under part B for making payments from the Fund, including the use of data from the fiscal years 1992 through 1994, and including the methodology that applies with respect to consolidations and mergers of participants in the program under such part and with respect to the inclusion of additional participants in the program.

''(B) Issues regarding children's hospitals, and approved medical residency training programs in pediatrics.

''(C) Whether and to what extent payments are being made (or should be made) for graduate training in the various nonphysician health professions.

''(4) Federal policies regarding international medical graduates.

''(5) The dependence of schools of medicine on service-generated income.

''(6) The effects of the amendments made by section 15412 of the Medicare Preservation Act of 1995, including adverse effects on teaching hospitals that result from modifications in policies regarding international medical graduates.

''(7) Whether and to what extent the needs of the United States regarding the supply of physicians will change during the 10-year period beginning on October 1, 1995, and whether and to what extent any such changes will have significant financial effects on teaching hospitals.

''(8) The appropriate number and mix of residents.

''(c) COMPOSITION.—Not later than three months after being designated as the initial chair of the Medicare Payment Review Commission, the Chair of the Commission shall appoint to the Panel 19 individuals who are not members of the Commission, who are not officers or employees of the United States, and who possess expertise on matters on which the Panel is to make recommendations under subsection (b). Such individuals shall include the following:

''(1) Deans from allopathic and osteopathic schools of medicine.

''(2) Chief executive officers (or equivalent administrative heads) from academic health centers, integrated health care systems, approved medical residency training programs, and teaching hospitals that sponsor approved medical residency training programs.

''(3) Chairs of departments or divisions from allopathic and osteopathic schools of medicine, schools of dentistry, and approved medical residency training programs in oral surgery.

''(4) Individuals with leadership experience from each of the fields of advanced practice nursing, physician assistants, and podiatric medicine.

''(5) Individuals with substantial experience in the study of issues regarding the composition of the health care workforce of the United States.

''(6) Individuals with expertise on the financing of health care.

''(7) Representatives from health insurance organizations and health plan organizations.

''(d) RELATIONSHIP OF PANEL TO MEDICARE PAYMENT REVIEW COMMISSION.—From amounts appropriated under subsection (n), the Medicare Payment Review Commission shall provide for the Panel such staff and administrative support (including quarters for the Panel) as may be necessary for the Panel to carry out the duties under subsection (b).

''(e) CHAIR.—The Panel shall designate a member of the Panel to serve as the Chair of the Panel.

''(f) MEETINGS.—The Panel shall meet at the call of the Chair or a majority of the members, except that the first meeting of the Panel shall be held not later than three months after the date on which appointments under subsection (c) are completed.

''(g) TERMS.—The term of a member of the Panel is the duration of the Panel.

''(h) VACANCIES.—

''(1) IN GENERAL.—A vacancy in the membership of the Panel does not affect the power of the remaining members to carry out the duties under subsection (b). A vacancy in the membership of the Panel shall be filled in the manner in which the original appointment was made.

''(2) INCOMPLETE TERM.—If a member of the Panel does not serve the full term applicable to the member, the individual appointed to fill the resulting vacancy shall be appointed for the remainder of the term of the predecessor of the individual.

''(i) COMPENSATION; REIMBURSEMENT OF EXPENSES.—

''(1) COMPENSATION.—Members of the Panel shall receive compensation for each day (including traveltime) engaged in carrying out the duties of the Committee. Such compensation may not be in an amount in excess of the daily equivalent of the annual maximum rate of basic pay payable under the General Schedule (under title 5, United States Code) for positions above GS–15.

''(2) REIMBURSEMENT.—Members of the Panel may, in accordance with chapter 57 of title 5, United States Code, be reimbursed for travel, subsistence, and other necessary expenses incurred in carrying out the duties of the Panel.

''(j) CONSULTANTS.—The Panel may procure such temporary and intermittent services of consultants under section 3109(b) of title 5, United States Code, as the Panel may determine to be useful in carrying out the duties under subsection (b). The Panel may not procure services under this subsection at any rate in excess of the daily equivalent of the maximum annual rate of basic pay payable under the General Schedule for positions above GS–15. Consultants under this subsection may, in accordance with chapter 57 of title 5, United States Code, be reimbursed for travel, subsistence, and other necessary expenses incurred for activities carried out on behalf of the Panel pursuant to subsection (b).

''(k) POWERS.—

''(1) IN GENERAL.—For the purpose of carrying out the duties of the Panel under subsection (b), the Panel may hold such hearings, sit and act at such times and places, take such testimony, and receive such evidence as the Panel considers appropriate.

''(2) OBTAINING OFFICIAL INFORMATION.—Upon the request of the Panel, the heads of Federal agencies shall furnish directly to the Panel information necessary for the Panel to carry out the duties under subsection (b).±

''(3) USE OF MAILS.—The Panel may use the United States mails in the same manner and under the same conditions as Federal agencies.

''(l) REPORTS.—

''(1) FIRST INTERIM REPORT.—Not later than one year after the date of the enactment of the Medicare Preservation Act of 1995, the Panel shall submit to the Congress a report providing the recommendations of the Panel regarding the matters specified in paragraphs (1) through (4) of subsection (b).

''(2) SECOND INTERIM REPORT.—Not later than 2 years after the date of enactment specified in paragraph (1), the Panel shall submit to the Congress a report providing the recommendations of the Panel regarding the matters specified in paragraphs (5) and (6) of subsection (b).

''(3) FINAL REPORT.—Not later than 3 years after the date of enactment specified in paragraph (1), the Panel shall submit to the Congress a final report providing the recommendations of the Panel under subsection (b).

''(m) DURATION.—The Panel terminates upon the expiration of the 180-day period beginning on the date on which the final report under subsection (l)(3) is submitted to the Congress.

''(n) AUTHORIZATION OF APPROPRIATIONS.—

''(1) IN GENERAL.—Subject to paragraph (2), for the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 1996 through 1999.

''(2) LIMITATION.—The authorization of appropriations established in paragraph (1) is effective only with respect to appropriations made from allocations under section 302(b) of the Congressional Budget Act of 1974—

''(A) for the Subcommittee on Labor, Health and Human Services, and Education, Committee on Appropriations of the House of Representatives, in the case of any bill, resolution, or amendment considered in the House; and

''(B) for the Subcommittee on Labor, Health and Human Services, and Education, Committee on Appropriations of the Senate, in the case of any bill, resolution, or amendment considered in the Senate.''.

Subtitle F—Provisions Relating to Medicare Part A

PART 1—HOSPITALS

Subpart A—General Provisions Relating to Hospitals

SEC. 15501. REDUCTIONS IN INFLATION UPDATES FOR PPS HOSPITALS.

Section 1886(b)(3)(B)(i) (42 U.S.C. 1395ww(b)(3)(B)(i)) is amended by striking subclauses (XI), (XII), and (XIII) and inserting the following:

''(XI) for fiscal year 1996, the market basket percentage increase minus 2.5 percentage points for hospitals in all areas,

''(XII) for each of the fiscal years 1997 through 2002, the market basket percentage increase minus 2.0 percentage points for hospitals in all areas, and

''(XIII) for fiscal year 2003 and each subsequent fiscal year, the market basket percentage increase for hospitals in all areas.''.

SEC. 15502. REDUCTIONS IN DISPROPORTIONATE SHARE PAYMENT ADJUSTMENTS.

(a) IN GENERAL.—Section 1886(d)(5)(F) (42 U.S.C. 1395ww(d)(5)(F)) is amended—

(1) in clause (ii), by striking ''The amount'' and inserting ''Subject to clause (ix), the amount''; and

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

''(ix) In the case of discharges occurring on or after October 1, 1995, the additional payment amount otherwise determined under clause (ii) shall be reduced as follows:

''(I) For discharges occurring on or after October 1, 1995, and on or before September 30, 1996, by 20 percent.

''(II) For discharges occurring on or after October 1, 1996, and on or before September 30, 1997, by 25 percent.

''(III) For discharges occurring on or after October 1, 1997, by 30 percent.''.

(b) CONFORMING AMENDMENT RELATING TO DETERMINATION OF STANDARDIZED AMOUNTS.—Section 1886(d)(2)(C)(iv) (42 U.S.C. 1395ww(d)(2)(C)(iv)) is amended by striking the period at the end and inserting the following: '', and the Secretary shall not take into account any reductions in the amount of such additional payments resulting from the amendments made by section 15502(a) of the Medicare Preservation Act of 1995.''.

SEC. 15503. PAYMENTS FOR CAPITAL-RELATED COSTS FOR INPATIENT HOSPITAL SERVICES.

(a) REDUCTION IN PAYMENTS FOR PPS HOSPITALS.—

(1) CONTINUATION OF CURRENT REDUCTIONS.—Section 1886(g)(1)(A) (42 U.S.C. 1395ww(g)(1)(A)) is amended in the second sentence—

(A) by striking ''through 1995'' and inserting ''through 2002''; and

(B) by inserting after ''10 percent reduction'' the following: ''(or a 15 percent reduction in the case of payments during fiscal years 1996 through 2002)''.

(2) REDUCTION IN BASE PAYMENT RATES.—Section 1886(g)(1)(A) (42 U.S.C. 1395ww(g)(1)(A)) is amended by adding at the end the following new sentence: ''In addition to the reduction described in the preceding sentence, for discharges occurring after September 30, 1995, the Secretary shall reduce by 7.47 percent the unadjusted standard Federal capital payment rate (as described in 42 CFR 412.308(c), as in effect on the date of the enactment of the Medicare Preservation Act of 1995) and shall reduce by 8.27 percent the unadjusted hospital-specific rate (as described in 42 CFR 412.328(e)(1), as in effect on such date of enactment).''.

(b) REDUCTION IN PAYMENTS FOR PPS-EXEMPT HOSPITALS.—Section 1886(g) (42 U.S.C. 1395ww(g)) is amended by adding at the end the following new paragraph:

''(4)(A) Except as provided in subparagraph (B), in determining the amount of the payments that may be made under this title with respect to all the capital-related costs of inpatient hospital services furnished during fiscal years 1996 through 2002 of a hospital which is not a subsection (d) hospital or a subsection (d) Puerto Rico hospital, the Secretary shall reduce the amounts of such payments otherwise determined under this title by 15 percent.

''(B) Subparagraph (A) shall not apply to payments with respect to the capital-related costs of any hospital that is a sole community hospital (as defined in subsection (d)(5)(D)(iii) or a rural primary care hospital (as defined in section 1861(mm)(1)).''.

(c) HOSPITAL-SPECIFIC ADJUSTMENT FOR CAPITAL-RELATED TAX COSTS.—Section 1886(g)(1) (42 U.S.C. 1395ww(g)(1)) is amended—

(1) by redesignating subparagraph (C) as subparagraph (D), and

(2) by inserting after subparagraph (B) the following:

''(C)(i) For discharges occurring after September 30, 1995, such system shall provide for an adjustment in an amount equal to the amount determined under clause (iv) for capital-related tax costs for each hospital that is eligible for such adjustment.

''(ii) Subject to clause (iii), a hospital is eligible for an adjustment under this subparagraph, with respect to discharges occurring in a fiscal year, if the hospital—

''(I) is a hospital that may otherwise receive payments under this subsection,

''(II) is not a public hospital, and

''(III) incurs capital-related tax costs for the fiscal year.

''(iii)(I) In the case of a hospital that first incurs capital-related tax costs in a fiscal year after fiscal year 1992 because of a change from nonproprietary to proprietary status or because the hospital commenced operation after such fiscal year, the first fiscal year for which the hospital shall be eligible for such adjustment is the second full fiscal year following the fiscal year in which the hospital first incurs such costs.

''(II) In the case of a hospital that first incurs capital-related tax costs in a fiscal year after fiscal year 1992 because of a change in State or local tax laws, the first fiscal year for which the hospital shall be eligible for such adjustment is the fourth full fiscal year following the fiscal year in which the hospital first incurs such costs.

''(iv) The per discharge adjustment under this clause shall be equal to the hospital-specific capital-related tax costs per discharge of a hospital for fiscal year 1992 (or, in the case of a hospital that first incurs capital-related tax costs for a fiscal year after fiscal year 1992, for the first full fiscal year for which such costs are incurred), updated to the fiscal year to which the adjustment applies. Such per discharge adjustment shall be added to the Federal capital rate, after such rate has been adjusted as described in 42 CFR 412.312 (as in effect on the date of the enactment of the Medicare Preservation Act of 1995), and before such rate is multiplied by the applicable Federal rate percentage.

''(v) For purposes of this subparagraph, capital-related tax costs include—

''(I) the costs of taxes on land and depreciable assets owned by a hospital (or related organization) and used for patient care,

''(II) payments in lieu of such taxes (made by hospitals that are exempt from taxation), and

''(III) the costs of taxes paid by a hospital (or related organization) as lessee of land, buildings, or fixed equipment from a lessor that is unrelated to the hospital (or related organization) under the terms of a lease that requires the lessee to pay all expenses (including mortgage, interest, and amortization) and leaves the lessor with an amount free of all claims (sometimes referred to as a 'net net net' or 'triple net' lease).

In determining the adjustment required under clause (i), the Secretary shall not take into account any capital-related tax costs of a hospital to the extent that such costs are based on tax rates and assessments that exceed those for similar commercial properties.

''(vi) The system shall provide that the Federal capital rate for any fiscal year after September 30, 1995, shall be reduced by a percentage sufficient to ensure that the adjustments required to be paid under clause (i) for a fiscal year neither increase nor decrease the total amount that would have been paid under this system but for the payment of such adjustments for such fiscal year.''.

(d) REVISION OF EXCEPTIONS PROCESS UNDER PROSPECTIVE PAYMENT SYSTEM FOR CERTAIN PROJECTS.—

(1) IN GENERAL.—Section 1886(g)(1) (42 U.S.C. 1395ww(g)(1)), as amended by subsection (c), is amended—

(A) by redesignating subparagraph (D) as subparagraph (E), and

(B) by inserting after subparagraph (C) the following:

''(D) The exceptions under the system provided by the Secretary under subparagraph (B)(iii) shall include the provision of exception payments under the special exceptions process provided under 42 CFR 412.348(g) (as in effect on September 1, 1995), except that the Secretary shall revise such process as follows:

''(i) A hospital with at least 100 beds which is located in an urban area shall be eligible under such process without regard to its disproportionate patient percentage under subsection (d)(5)(F) or whether it qualifies for additional payment amounts under such subsection.

''(ii) The minimum payment level for qualifying hospitals shall be 85 percent.

''(iii) A hospital shall be considered to meet the requirement that it completes the project involved no later than the end of the hospital's last cost reporting period beginning after October 1, 2001, if—

''(I) the hospital has obtained a certificate of need for the project approved by the State or a local planning authority, and

''(II) by September 1, 1995, the hospital has expended on the project at least $750,000 or 10 percent of the estimated cost of the project.

''(iv) The amount of the exception payment made shall not be reduced by any offsetting amounts.''.

(2) CONFORMING AMENDMENT.—Section 1886(g)(1)(B)(iii) (42 U.S.C. 1395ww(g)(1)(B)(iii)) is amended by striking ''may provide'' and inserting ''shall provide (in accordance with subparagraph (D))''.

SEC. 15504. REDUCTION IN ADJUSTMENT FOR INDIRECT MEDICAL EDUCATION.

For provisions modifying medicare payment policies regarding graduate medical education, see part 2 of subtitle E.

SEC. 15505. TREATMENT OF PPS-EXEMPT HOSPITALS.

(a) UPDATES.—Section 1886(b)(3)(B)(ii)(V) (42 U.S.C. 1395ww(b)(3)(B)(ii)(V)) is amended by striking ''thorugh 1997'' and inserting ''through 2002''.

(b) REBASING FOR CERTAIN LONG-TERM CARE HOSPITALS.—

(1) IN GENERAL.—Section 1886(b)(3) (42 U.S.C. 1395ww(b)(3)) is amended—

(A) in subparagraph (A), by striking ''and (E)'' and inserting ''(E), and (F)'';

(B) in subparagraph (B)(ii), by striking ''(A) and (E)'' and inserting ''(A), (E), and (F)''; and

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

''(F)(i) In the case of a qualified long-term care hospital (as defined in clause (ii)), the term 'target amount' means—

''(I) with respect to the first 12-month cost reporting period in which this subparagraph is applied to the hospital, the allowable operating costs of inpatient hospital services (as defined in subsection (a)(4)) recognized under this title for the hospital for the 12-month cost reporting period beginning during fiscal year 1991; or

''(II) with respect to a later cost reporting period, the target amount for the preceding cost reporting period, increase by the applicable percentage increase under subparagraph (B)(ii) for that later cost reporting period.

''(ii) In clause (i), a 'qualified long-term care hospital' means, with respect to a cost reporting period, a hospital described in clause (iv) of subsection (d)(1)(B) during fiscal year 1995 for which the hospital's allowable operating costs of inpatient hospital services recognized under this title for each of the two most recent previous 12-month cost reporting periods exceeded the hospital's target amount determined under this paragraph for such cost reporting periods, if the hospital—

''(I) has a disproportionate patient percentage during such cost reporting period (as determined by the Secretary under subsection (d)(5)(F)(vi) as if the hospital were a subsection (d) hospital) of at least 25 percent, or

''(II) is located in a State for which no payment is made under the State plan under title XIX for days of inpatient hospital services furnished to any individual in excess of the limit on the number of days of such services furnished to the individual for which payment may be made under this title.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to discharges occurring during cost reporting periods beginning on or after October 1, 1995.

(c) TREATMENT OF CERTAIN LONG-TERM CARE HOSPITALS LOCATED WITHIN OTHER HOSPITALS.—

(1) IN GENERAL.—Section 1886(d)(1)(B) (42 U.S.C. 1395ww(d)(1)(B)) is amended in the matter following clause (v) by striking the period and inserting the following: '', or a hospital classified by the Secretary as a long-term care hospital on or before September 30, 1995, and located in the same building as, or on the same campus as, another hospital.''.

(2) STUDY BY REVIEW COMMISSION.—Not later than 12 months after the date a majority of the members of the Medicare Payment Review Commission are first appointed, the Commission shall submit a report to Congress containing recommendations for appropriate revisions in the treatment of long-term care hospitals located in the same building as or on the same campus as another hospital for purposes of section 1886 of the Social Security Act.

(3) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to discharges occurring on or after October 1, 1995.

(d) STUDY OF PROSPECTIVE PAYMENT SYSTEM FOR REHABILITATION HOSPITALS AND UNITS.—

(1) IN GENERAL.—After consultation with the Prospective Payment Assessment Commission, providers of rehabilitation services, and other appropriate parties, the Secretary of Health and Human Services shall submit to Congress, by not later than June 1, 1996, a report on the advisability and feasibility of providing for payment based on a prospective payment system for inpatient services of rehabilitation hospitals and units under the medicare program.

(2) ITEMS INCLUDED.—The report shall include the following:

(A) The available and preferred systems of classifying rehabilitation patients relative to duration and intensity of inpatient services, including the use of functional-related groups (FRGs).

(B) The means of calculating medicare program payments to reflect such patient requirements.

(C) Other appropriate adjustments which should be made, such as for geographic variations in wages and other costs and outliers.

(D) A timetable under which such a system might be introduced.

(E) Whether such a system should be applied to other types of providers of inpatient rehabilitation services.

SEC. 15506. REDUCTION IN PAYMENTS TO HOSPITALS FOR ENROLLEES' BAD DEBTS.

(a) IN GENERAL.—Section 1861(v)(1) (42 U.S.C. 1395x(v)(1)) is amended by adding at the end the following new subparagraph:

''(T)(i) In determining such reasonable costs for hospitals, the amount of bad debts otherwise treated as allowable costs which are attributable to the deductibles and coinsurance amounts under this title shall be reduced by—

''(I) 75 percent for cost reporting periods beginning during fiscal year 1996,

''(II) 60 percent for cost reporting periods beginning during fiscal year 1997, and

''(III) 50 percent for subsequent cost reporting periods.

''(ii) Clause (i) shall not apply with respect to bad debt of a hospital described in section 1886(d)(1)(B)(iv) if the debt is attributable to uncollectable deductible and coinsurance payments owed by individuals enrolled in a State plan under title XIX or under the MediGrant program under title XXI.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to hospital cost reporting periods beginning on or after October 1, 1995.

SEC. 15507. PERMANENT EXTENSION OF HEMOPHILIA PASS-THROUGH.

Effective as if included in the enactment of OBRA–1989, section 6011(d) of such Act (as amended by section 13505 of OBRA–1993) is amended by striking ''and shall expire September 30, 1994''.

SEC. 15508. CONFORMING AMENDMENT TO CERTIFICATION OF CHRISTIAN SCIENCE PROVIDERS.

(a) HOSPITALS.—Section 1861(e) (42 U.S.C. 1395x(e)) is amended in the sixth sentence by inserting after ''Massachusetts,'' the following: ''or by the Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.,''.

(b) SKILLED NURSING FACILITIES.—Section 1861(y)(1) is amended by inserting after ''Massachusetts,'' the following: ''or by the Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.,''.

Subpart B—Provisions Relating to Rural Hospitals

SEC. 15511. SOLE COMMUNITY HOSPITALS.

(a) UPDATE.—Section 1886(b)(3)(B)(iv) (42 U.S.C. 1395ww(b)(3)(B)(iv)) is amended—

(A) in subclause (III), by striking ''and'' at the end; and

(B) by striking subclause (IV) and inserting the following:

''(IV) for each of the fiscal years 1996 through 2000, the market basket percentage increase minus 1 percentage points, and

''(V) for fiscal year 2001 and each subsequent fiscal year, the applicable percentage increase under clause (i).''.

(b) STUDY OF IMPACT OF SOLE COMMUNITY HOSPITAL DESIGNATIONS.—

(1) STUDY.—The Medicare Payment Review Commission shall conduct a study of the impact of the designation of hospitals as sole community hospitals under the medicare program on the delivery of health care services to individuals in rural areas, and shall include in the study an analysis of the characteristics of the hospitals designated as such sole community hospitals under the program.

(2) REPORT.—Not later than 12 months after the date a majority of the members of the Commission are first appointed, the Commission shall submit to Congress a report on the study conducted under paragraph (1).

SEC. 15512. CLARIFICATION OF TREATMENT OF EAC AND RPC HOSPITALS.

Paragraphs (1)(A)(i) and (2)(A)(i) of section 1820(i) (42 U.S.C. 1395i–4(i)) are each amended by striking the semicolon at the end and inserting the following: '', or in a State which the Secretary finds would receive a grant under such subsection during a fiscal year if funds were appropriated for grants under such subsection for the fiscal year;''.

SEC. 15513. ESTABLISHMENT OF RURAL EMERGENCY ACCESS CARE HOSPITALS.

(a) IN GENERAL.—Section 1861 (42 U.S.C. 1395x) is amended by adding at the end the following new subsection:

''Rural Emergency Access Care Hospital; Rural Emergency Access Care Hospital Services

''(oo)(1) The term 'rural emergency access care hospital' means, for a fiscal year, a facility with respect to which the Secretary finds the following:

''(A) The facility is located in a rural area (as defined in section 1886(d)(2)(D)).

''(B) The facility was a hospital under this title at any time during the 5-year period that ends on the date of the enactment of this subsection.

''(C) The facility is in danger of closing due to low inpatient utilization rates and operating losses, and the closure of the facility would limit the access to emergency services of individuals residing in the facility's service area.

''(D) The facility has entered into (or plans to enter into) an agreement with a hospital with a participation agreement in effect under section 1866(a), and under such agreement the hospital shall accept patients transferred to the hospital from the facility and receive data from and transmit data to the facility.

''(E) There is a practitioner who is qualified to provide advanced cardiac life support services (as determined by the State in which the facility is located) on-site at the facility on a 24-hour basis.

''(F) A physician is available on-call to provide emergency medical services on a 24-hour basis.

''(G) The facility meets such staffing requirements as would apply under section 1861(e) to a hospital located in a rural area, except that—

''(i) the facility need not meet hospital standards relating to the number of hours during a day, or days during a week, in which the facility must be open, except insofar as the facility is required to provide emergency care on a 24-hour basis under subparagraphs (E) and (F); and

''(ii) the facility may provide any services otherwise required to be provided by a full-time, on-site dietitian, pharmacist, laboratory technician, medical technologist, or radiological technologist on a part-time, off-site basis.

''(H) The facility meets the requirements applicable to clinics and facilities under subparagraphs (C) through (J) of paragraph (2) of section 1861(aa) and of clauses (ii) and (iv) of the second sentence of such paragraph (or, in the case of the requirements of subparagraph (E), (F), or (J) of such paragraph, would meet the requirements if any reference in such subparagraph to a 'nurse practitioner' or to 'nurse practitioners' were deemed to be a reference to a 'nurse practitioner or nurse' or to 'nurse practitioners or nurses'); except that in determining whether a facility meets the requirements of this subparagraph, subparagraphs (E) and (F) of that paragraph shall be applied as if any reference to a 'physician' is a reference to a physician as defined in section 1861(r)(1).

''(2) The term 'rural emergency access care hospital services' means the following services provided by a rural emergency access care hospital and furnished to an individual over a continuous period not to exceed 24 hours (except that such services may be furnished over a longer period in the case of an individual who is unable to leave the hospital because of inclement weather):

''(A) An appropriate medical screening examination (as described in section 1867(a)).

''(B) Necessary stabilizing examination and treatment services for an emergency medical condition and labor (as described in section 1867(b)).''.

(b) REQUIRING RURAL EMERGENCY ACCESS CARE HOSPITALS TO MEET HOSPITAL ANTI-DUMPING REQUIREMENTS.—Section 1867(e)(5) (42 U.S.C. 1395dd(e)(5)) is amended by striking ''1861(mm)(1))'' and inserting ''1861(mm)(1)) and a rural emergency access care hospital (as defined in section 1861(oo)(1))''.

(c) REFERENCE TO PAYMENT PROVISIONS UNDER PART B.—For provisions relating to payment for rural emergency access care hospital services under part B, see section 15607.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to fiscal years beginning on or after October 1, 1995.

SEC. 15514. CLASSIFICATION OF RURAL REFERRAL CENTERS.

(a) PROHIBITING DENIAL OF REQUEST FOR RECLASSIFICATION ON BASIS OF COMPARABILITY OF WAGES.—

(1) IN GENERAL.—Section 1886(d)(10)(D) (42 U.S.C. 1395ww(d)(10)(D)) is amended—

(A) by redesignating clause (iii) as clause (iv); and

(B) by inserting after clause (ii) the following new clause:

''(iii) Under the guidelines published by the Secretary under clause (i), in the case of a hospital which is classified by the Secretary as a rural referral center under paragraph (5)(C), the Board may not reject the application of the hospital under this paragraph on the basis of any comparison between the average hourly wage of the hospital and the average hourly wage of hospitals in the area in which it is located.''.

(2) EFFECTIVE DATE.—Notwithstanding section 1886(d)(10)(C)(ii) of the Social Security Act, a hospital may submit an application to the Medicare Geographic Classification Review Board during the 30-day period beginning on the date of the enactment of this Act requesting a change in its classification for purposes of determining the area wage index applicable to the hospital under section 1886(d)(3)(D) of such Act for fiscal year 1997, if the hospital would be eligible for such a change in its classification under the standards described in section 1886(d)(10)(D) (as amended by paragraph (1)) but for its failure to meet the deadline for applications under section 1886(d)(10)(C)(ii).

(b) CONTINUING TREATMENT OF PREVIOUSLY DESIGNATED CENTERS.—Any hospital classified as a rural referral center by the Secretary of Health and Human Services under section 1886(d)(5)(C) of the Social Security Act for fiscal year 1994 shall be classified as such a rural referral center for fiscal year 1996 and each subsequent fiscal year.

SEC. 15515. FLOOR ON AREA WAGE INDEX.

(a) IN GENERAL.—For purposes of section 1886(d)(3)(E) of the Social Security Act for discharges occurring on or after October 1, 1995, the area wage index applicable under such section to any hospital which is not located in a rural area (as defined in section 1886(d)(2)(D) of such Act) may not be less than the average of the area wage indices applicable under such section to hospitals located in rural areas in the State in which the hospital is located.

(b) BUDGET-NEUTRALITY IN IMPLEMENTATION.—The Secretary of Health and Human Services shall adjust the area wage indices referred to in subsection (a) for hospitals not described in such subsection in a manner which assures that the aggregate payments made under section 1886(d) of the Social Security Act in a fiscal year for the operating costs of inpatient hospital services are not greater or less than those which would have been made in the year if this section did not apply.

PART 2—PAYMENTS TO SKILLED NURSING FACILITIES

SEC. 15521. PAYMENTS FOR ROUTINE SERVICE COSTS.

(a) CLARIFICATION OF DEFINITION OF ROUTINE SERVICE COSTS.—Section 1888 (42 U.S.C. 1395yy) is amended by adding at the end the following new subsection:

''(e) For purposes of this section, the 'routine service costs' of a skilled nursing facility are all costs which are attributable to nursing services, room and board, administrative costs, other overhead costs, and all other ancillary services (including supplies and equipment), excluding costs attributable to covered non-routine services subject to payment limits under section 1888A.''.

(b) CONFORMING AMENDMENT.—Section 1888 (42 U.S.C. 1395yy) is amended in the heading by inserting ''AND CERTAIN ANCILLARY'' after ''SERVICE''.

SEC. 15522. INCENTIVES FOR COST EFFECTIVE MANAGEMENT OF COVERED NON-ROUTINE SERVICES.

(a) IN GENERAL.—Title XVIII is amended by inserting after section 1888 the following new section:

''INCENTIVES FOR COST-EFFECTIVE MANAGEMENT OF COVERED NON-ROUTINE SERVICES OF SKILLED NURSING FACILITIES

''SEC. 1888A. (a) DEFINITIONS.—For purposes of this section:

''(1) COVERED NON-ROUTINE SERVICES.—The term 'covered non-routine services' means post-hospital extended care services consisting of any of the following:

''(A) Physical or occupational therapy or speech-language pathology services, or respiratory therapy, including supplies and support services incident to such services and therapy.

''(B) Prescription drugs.

''(C) Complex medical equipment.

''(D) Intravenous therapy and solutions (including enteral and parenteral nutrients, supplies, and equipment).

''(E) Radiation therapy.

''(F) Diagnostic services, including laboratory, radiology (including computerized tomography services and imaging services), and pulmonary services.

''(2) SNF MARKET BASKET PERCENTAGE INCREASE.—The term 'SNF market basket percentage increase' for a fiscal year means a percentage equal to the percentage increase in routine service cost limits for the year under section 1888(a).

''(3) STAY.—The term 'stay' means, with respect to an individual who is a resident of a skilled nursing facility, a period of continuous days during which the facility provides extended care services for which payment may be made under this title with respect to the individual during the individual's spell of illness.

''(b) NEW PAYMENT METHOD FOR COVERED NON-ROUTINE SERVICES.—

''(1) IN GENERAL.—Subject to subsection (c), a skilled nursing facility shall receive interim payments under this title for covered non-routine services furnished to an individual during a cost reporting period beginning during a fiscal year (after fiscal year 1996) in an amount equal to the reasonable cost of providing such services in accordance with section 1861(v). The Secretary may adjust such payments if the Secretary determines (on the basis of such estimated information as the Secretary considers appropriate) that payments to the facility under this paragraph for a cost reporting period would substantially exceed the cost reporting period limit determined under subsection (c)(1)(B).

''(2) RESPONSIBILITY OF SKILLED NURSING FACILITY TO MANAGE BILLINGS.—

''(A) CLARIFICATION RELATING TO PART A BILLING.—In the case of a covered non-routine service furnished to an individual who (at the time the service is furnished) is a resident of a skilled nursing facility who is entitled to coverage under section 1812(a)(2) for such service, the skilled nursing facility shall submit a claim for payment under this title for such service under part A (without regard to whether or not the item or service was furnished by the facility, by others under arrangement with them made by the facility, under any other contracting or consulting arrangement, or otherwise).

''(B) PART B BILLING.—In the case of a covered non-routine service (other than a portable X-ray or portable electrocardiogram treated as a physician's service for purposes of section 1848(j)(3)) furnished to an individual who (at the time the service is furnished) is a resident of a skilled nursing facility who is not entitled to coverage under section 1812(a)(2) for such service but is entitled to coverage under part B for such service, the skilled nursing facility shall submit a claim for payment under this title for such service under part B (without regard to whether or not the item or service was furnished by the facility, by others under arrangement with them made by the facility, under any other contracting or consulting arrangement, or otherwise).

''(C) MAINTAINING RECORDS ON SERVICES FURNISHED TO RESIDENTS.—Each skilled nursing facility receiving payments for extended care services under this title shall document on the facility's cost report all covered non-routine services furnished to all residents of the facility to whom the facility provided extended care services for which payment was made under part A during a fiscal year (beginning with fiscal year 1996) (without regard to whether or not the services were furnished by the facility, by others under arrangement with them made by the facility, under any other contracting or consulting arrangement, or otherwise).

''(c) RECONCILIATION OF AMOUNTS.—

''(1) LIMIT BASED ON PER STAY LIMIT AND NUMBER OF STAYS.—

''(A) IN GENERAL.—If a skilled nursing facility has received aggregate payments under subsection (b) for covered non-routine services during a cost reporting period beginning during a fiscal year in excess of an amount equal to the cost reporting period limit determined under subparagraph (B), the Secretary shall reduce the payments made to the facility with respect to such services for cost reporting periods beginning during the following fiscal year in an amount equal to such excess. The Secretary shall reduce payments under this subparagraph at such times and in such manner during a fiscal year as the Secretary finds necessary to meet the requirement of this subparagraph.

''(B) COST REPORTING PERIOD LIMIT.—The cost reporting period limit determined under this subparagraph is an amount equal to the product of—

''(i) the per stay limit applicable to the facility under subsection (d) for the period; and

''(ii) the number of stays beginning during the period for which payment was made to the facility for such services.

''(C) PROSPECTIVE REDUCTION IN PAYMENTS.—In addition to the process for reducing payments described in subparagraph (A), the Secretary may reduce payments made to a facility under this section during a cost reporting period if the Secretary determines (on the basis of such estimated information as the Secretary considers appropriate) that payments to the facility under this section for the period will substantially exceed the cost reporting period limit for the period determined under this paragraph.

''(2) INCENTIVE PAYMENTS.—

''(A) IN GENERAL.—If a skilled nursing facility has received aggregate payments under subsection (b) for covered non-routine services during a cost reporting period beginning during a fiscal year in an amount that is less than the amount determined under paragraph (1)(B), the Secretary shall pay the skilled nursing facility in the following fiscal year an incentive payment equal to 50 percent of the difference between such amounts, except that the incentive payment may not exceed 5 percent of the aggregate payments made to the facility under subsection (b) for the previous fiscal year (without regard to subparagraph (B)).

''(B) INSTALLMENT INCENTIVE PAYMENTS.—The Secretary may make installment payments during a fiscal year to a skilled nursing facility based on the estimated incentive payment that the facility would be eligible to receive with respect to such fiscal year.

''(d) DETERMINATION OF FACILITY PER STAY LIMIT.—

''(1) LIMIT FOR FISCAL YEAR 1997.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), the Secretary shall establish separate per stay limits for hospital-based and freestanding skilled nursing facilities for the 12-month cost reporting period beginning during fiscal year 1997 that are equal to the sum of—

''(i) 50 percent of the facility-specific stay amount for the facility (as determined under subsection (e)) for the last 12-month cost reporting period ending on or before September 30, 1994, increased (in a compounded manner) by the SNF market basket percentage increase for fiscal years 1995 through 1997; and

''(ii) 50 percent of the average of all facility-specific stay amounts for all hospital-based facilities or all freestanding facilities (whichever is applicable) during the cost reporting period described in clause (i), increased (in a compounded manner) by the SNF market basket percentage increase for fiscal years 1995 through 1997.

''(B) FACILITIES NOT HAVING 1994 COST REPORTING PERIOD.—In the case of a skilled nursing facility for which payments were not made under this title for covered non-routine services for the last 12-month cost reporting period ending on or before September 30, 1994, the per stay limit for the 12-month cost reporting period beginning during fiscal year 1997 shall be twice the amount determined under subparagraph (A)(ii).

''(2) LIMIT FOR SUBSEQUENT FISCAL YEARS.—The per stay limit for a skilled nursing facility for a 12-month cost reporting period beginning during a fiscal year after fiscal year 1997 is equal to the per stay limit established under this subsection for the 12-month cost reporting period beginning during the previous fiscal year, increased by the SNF market basket percentage increase for such subsequent fiscal year minus 2 percentage points.

''(3) REBASING OF AMOUNTS.—

''(A) IN GENERAL.—The Secretary shall provide for an update to the facility-specific amounts used to determine the per stay limits under this subsection for cost reporting periods beginning on or after October 1, 1999, and every 2 years thereafter.

''(B) TREATMENT OF FACILITIES NOT HAVING REBASED COST REPORTING PERIODS.—Paragraph (1)(B) shall apply with respect to a skilled nursing facility for which payments were not made under this title for covered non-routine services for the 12-month cost reporting period used by the Secretary to update facility-specific amounts under subparagraph (A) in the same manner as such paragraph applies with respect to a facility for which payments were not made under this title for covered non-routine services for the last 12-month cost reporting period ending on or before September 30, 1994.

''(e) DETERMINATION OF FACILITY-SPECIFIC STAY AMOUNTS.—The 'facility-specific stay amount' for a skilled nursing facility for a cost reporting period is the sum of—

''(1) the average amount of payments made to the facility under part A during the period which are attributable to covered non-routine services furnished during a stay; and

''(2) the Secretary's best estimate of the average amount of payments made under part B during the period for covered non-routine services furnished to all residents of the facility to whom the facility provided extended care services for which payment was made under part A during the period (without regard to whether or not the services were furnished by the facility, by others under arrangement with them made by the facility, under any other contracting or consulting arrangement, or otherwise), as estimated by the Secretary.

''(f) INTENSIVE NURSING OR THERAPY NEEDS.—

''(1) IN GENERAL.—In applying subsection (b) to covered non-routine services furnished during a stay beginning during a cost reporting period beginning during a fiscal year to a resident of a skilled nursing facility who requires intensive nursing or therapy services, the per stay limit determined for the fiscal year under the methodology for such resident shall be the per stay limit developed under paragraph (2) instead of the per stay limit determined under subsection (d)(1)(A).

''(2) PER STAY LIMIT FOR INTENSIVE NEED RESIDENTS.—Not later than June 30, 1996, the Secretary, after consultation with the Medicare Payment Review Commission and skilled nursing facility experts, shall develop and publish a methodology for determining on an annual basis a per stay limit for residents of a skilled nursing facility who require intensive nursing or therapy services.

''(3) BUDGET NEUTRALITY.—The Secretary shall adjust payments under subsection (b) in a manner that ensures that total payments for covered non-routine services under this section are not greater or less than total payments for such services would have been but for the application of paragraph (1).

''(g) SPECIAL TREATMENT FOR MEDICARE LOW VOLUME SKILLED NURSING FACILITIES.—This section shall not apply with respect to a skilled nursing facility for which payment is made for routine service costs during a cost reporting period on the basis of prospective payments under section 1888(d).

''(h) EXCEPTIONS AND ADJUSTMENTS TO LIMITS.—

''(1) IN GENERAL.—The Secretary may make exceptions and adjustments to the cost reporting limits applicable to a skilled nursing facility under subsection (c)(1)(B) for a cost reporting period, except that the total amount of any additional payments made under this section for covered non-routine services during the cost reporting period as a result of such exceptions and adjustments may not exceed 5 percent of the aggregate payments made to all skilled nursing facilities for covered non-routine services during the cost reporting period (determined without regard to this paragraph).

''(2) BUDGET NEUTRALITY.—The Secretary shall adjust payments under subsection (b) in a manner that ensures that total payments for covered non-routine services under this section are not greater or less than total payments for such services would have been but for the application of paragraph (1).

''(i) SPECIAL RULE FOR X-RAY SERVICES.—Before furnishing a covered non-routine service consisting of an X-ray service for which payment may be made under part A or part B to a resident, a skilled nursing facility shall consider whether furnishing the service through a provider of portable X-ray service services would be appropriate, taking into account the cost effectiveness of the service and the convenience to the resident.''.

(b) CONFORMING AMENDMENT.—Section 1814(b) (42 U.S.C. 1395f(b)) is amended in the matter preceding paragraph (1) by striking ''1813 and 1886'' and inserting ''1813, 1886, 1888, and 1888A''.

SEC. 15523. PAYMENTS FOR ROUTINE SERVICE COSTS.

(a) MAINTAINING SAVINGS RESULTING FROM TEMPORARY FREEZE ON PAYMENT INCREASES.—

(1) BASING UPDATES TO PER DIEM COST LIMITS ON LIMITS FOR FISCAL YEAR 1993.—

(A) IN GENERAL.—The last sentence of section 1888(a) (42 U.S.C. 1395yy(a)) is amended by inserting before the period at the end the following: ''(except that such updates may not take into account any changes in the routine service costs of skilled nursing facilities occurring during cost reporting periods which began during fiscal year 1994 or fiscal year 1995)''.

(B) NO EXCEPTIONS PERMITTED BASED ON AMENDMENT.—The Secretary of Health and Human Services shall not consider the amendment made by subparagraph (A) in making any adjustments pursuant to section 1888(c) of the Social Security Act.

(2) PAYMENTS DETERMINED ON PROSPECTIVE BASIS.—Any change made by the Secretary of Health and Human Services in the amount of any prospective payment paid to a skilled nursing facility under section 1888(d) of the Social Security Act for cost reporting periods beginning on or after October 1, 1995, may not take into account any changes in the costs of services occurring during cost reporting periods which began during fiscal year 1994 or fiscal year 1995.

(b) ESTABLISHMENT OF SCHEDULE FOR MAKING ADJUSTMENTS TO LIMITS.—Section 1888(c) (42 U.S.C. 1395yy(c)) is amended by striking the period at the end of the second sentence and inserting '', and may only make adjustments under this subsection with respect to a facility which applies for an adjustment during an annual application period established by the Secretary.''.

(c) LIMITATION ON AGGREGATE INCREASE IN PAYMENTS RESULTING FROM ADJUSTMENTS TO LIMITS.—Section 1888(c) (42 U.S.C. 1395yy(c)) is amended—

(1) by striking ''(c) The Secretary'' and inserting ''(c)(1) Subject to paragraph (2), the Secretary''; and

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

''(2) The Secretary may not make any adjustments under this subsection in the limits set forth in subsection (a) for a cost reporting period beginning during a fiscal year to the extent that the total amount of the additional payments made under this title as a result of such adjustments is greater than an amount equal to—

''(A) for cost reporting periods beginning during fiscal year 1997, the total amount of the additional payments made under this title as a result of adjustments under this subsection for cost reporting periods beginning during fiscal year 1996 increased by the SNF market basket percentage increase (as defined in section 1888A(e)(3)) for fiscal year 1997; and

''(B) for cost reporting periods beginning during a subsequent fiscal year, the amount determined under this paragraph for the previous fiscal year increased by the SNF market basket percentage increase for such subsequent fiscal year.''.

(d) IMPOSITION OF LIMITS FOR ALL COST REPORTING PERIODS.—Section 1888(a) (42 U.S.C. 1395yy(a)) is amended in the matter preceding paragraph (1) by inserting after ''extended care services'' the following: ''(for any cost reporting period for which payment is made under this title to the skilled nursing facility for such services)''.

SEC. 15524. REDUCTIONS IN PAYMENT FOR CAPITAL-RELATED COSTS.

Section 1861(v)(1) (42 U.S.C. 1395x(v)(1)), as amended by section 15506, is amended by adding at the end the following new subparagraph:

''(U) Such regulations shall provide that, in determining the amount of the payments that may be made under this title with respect to all the capital-related costs of skilled nursing facilities, the Secretary shall reduce the amounts of such payments otherwise established under this title by 15 percent for payments attributable to portions of cost reporting periods occurring during fiscal years 1996 through 2002.''.

SEC. 15525. TREATMENT OF ITEMS AND SERVICES PAID FOR UNDER PART B.

(a) REQUIRING PAYMENT FOR ALL ITEMS AND SERVICES TO BE MADE TO FACILITY.—

(1) IN GENERAL.—The first sentence of section 1842(b)(6) (42 U.S.C. 1395u(b)(6)) is amended—

(A) by striking ''and (D)'' and inserting ''(D)''; and

(B) by striking the period at the end and inserting the following: '', and (E) in the case of an item or service (other than physicians' services and other than a portable X-ray or portable electrocardiogram treated as a physician's service for purposes of section 1848(j)(3)) furnished to an individual who (at the time the item or service is furnished) is a resident of a skilled nursing facility, payment shall be made to the facility (without regard to whether or not the item or service was furnished by the facility, by others under arrangement with them made by the facility, or otherwise).''.

(2) EXCLUSION FOR ITEMS AND SERVICES NOT BILLED BY FACILITY.—Section 1862(a) (42 U.S.C. 1395y(a)) is amended—

(A) by striking ''or'' at the end of paragraph (14);

(B) by striking the period at the end of paragraph (15) and inserting ''; or''; and

(C) by inserting after paragraph (15) the following new paragraph:

''(16) where such expenses are for covered non-routine services (as defined in section 1888A(a)(1)) (other than a portable X-ray or portable electrocardiogram treated as a physician's service for purposes of section 1848(j)(3)) furnished to an individual who is a resident of a skilled nursing facility and for which the claim for payment under this title is not submitted by the facility.''.

(3) CONFORMING AMENDMENT.—Section 1832(a)(1) (42 U.S.C. 1395k(a)(1)) is amended by striking ''(2);'' and inserting ''(2) and section 1842(b)(6)(E);''.

(b) REDUCTION IN PAYMENTS FOR ITEMS AND SERVICES FURNISHED BY OR UNDER ARRANGEMENTS WITH FACILITIES.—Section 1861(v)(1) (42 U.S.C. 1395x(v)(1)), as amended by sections 15506 and 15524, is amended by adding at the end the following new subparagraph:

''(V) In the case of an item or service furnished by a skilled nursing facility (or by others under arrangement with them made

by a skilled nursing facility) for which payment is made under part B in an amount determined in accordance with section 1833(a)(2)(B), the Secretary shall reduce the reasonable cost for such item or service otherwise determined under clause (i)(I) of such section by 5.8 percent for payments attributable to portions of cost reporting periods occurring during fiscal years 1996 through 2002.''.

SEC. 15526. CERTIFICATION OF FACILITIES MEETING REVISED NURSING HOME REFORM STANDARDS.

(a) IN GENERAL.—Section 1819(a)(3) (42 U.S.C. 1395i–3(a)(3)) is amended to read as follows:

''(3)(A) is certified by the Secretary as meeting the standards established under subsection (b), or (B) is a State-certified facility (as defined in subsection (d)).''.

(b) REQUIREMENTS DESCRIBED.—Section 1819 (42 U.S.C. 1395i–3) is amended by striking subsections (b) through (i) and inserting the following:

''(b) STANDARDS FOR AND CERTIFICATION OF FACILITIES.—

''(1) STANDARDS FOR FACILITIES.—

''(A) IN GENERAL.—The Secretary shall provide for the establishment and maintenance of standards consistent with the contents described in subparagraph (B) for skilled nursing facilities which furnish services for which payment may be made under this title.

''(B) CONTENTS OF STANDARDS.—The standards established for facilities under this paragraph shall contain provisions relating to the following items:

''(i) The treatment of resident medical records.

''(ii) Policies, procedures, and bylaws for operation.

''(iii) Quality assurance systems.

''(iv) Resident assessment procedures, including care planning and outcome evaluation.

''(v) The assurance of a safe and adequate physical plant for the facility.

''(vi) Qualifications for staff sufficient to provide adequate care.

''(vii) Utilization review.

''(viii) The protection and enforcement of resident rights described in subparagraph (C).

''(C) RESIDENT RIGHTS DESCRIBED.—The resident rights described in this subparagraph are the rights of residents to the following:

''(i) To exercise the individual's rights as a resident of the facility and as a citizen or resident of the United States.

''(ii) To receive notice of rights and services.

''(iii) To be protected against the misuse of resident funds.

''(iv) To be provided privacy and confidentiality.

''(v) To voice grievances.

''(vi) To examine the results of inspections under the certification program.

''(vii) To refuse to perform services for the facility.

''(viii) To be provided privacy in communications and to receive mail.

''(ix) To have the facility provide immediate access to any resident by any representative of the certification program, the resident's individual physician, the State long term care ombudsman, and any person the resident has designated as a visitor.

''(x) To retain and use personal property.

''(xi) To be free from abuse, including verbal, sexual, physical and mental abuse, corporal punishment, and involuntary seclusion.

''(xii) To be provided with prior written notice of a pending transfer or discharge.

''(D) REQUIRING NOTICE AND COMMENT.—The standards established for facilities under this paragraph may only take effect after the Secretary has provided the public with notice and an opportunity for comment.

''(2) CERTIFICATION PROGRAM.—

''(A) IN GENERAL.—The Secretary shall provide for the establishment and operation of a program consistent with the requirements of subparagraph (B) for the certification of skilled nursing facilities which meet the standards established under paragraph (1) and the decertification of facilities which fail to meet such standards.

''(B) REQUIREMENTS FOR PROGRAM.—In addition to any other requirements the Secretary may impose, in establishing and operating the certification program under subparagraph (A), the Secretary shall ensure the following:

''(i) The Secretary shall ensure public access (as defined by the Secretary) to the certification program's evaluations of participating facilities, including compliance records and enforcement actions and other reports by the Secretary regarding the ownership, compliance histories, and services provided by certified facilities.

''(ii) Not less often than every 4 years, the Secretary shall audit its expenditures under the program, through an entity designated by the Secretary which is not affiliated with the program, as designated by the Secretary.

''(c) INTERMEDIATE SANCTION AUTHORITY.—

''(1) AUTHORITY.—In addition to any other authority, where the Secretary determines that a nursing facility which is certified for participation under this title (whether certified by the Secretary as meeting the standards established under subsection (b) or a State-ceritified facility) no longer or does not substantially meet the requirements for such a facility under this title as specified under subsection (b) and further determines that the facility's deficiencies—

''(A) immediately jeopardize the health and safety of its residents, the Secretary shall at least provide for the termination of the facility's certification for participation under this title, or

''(B) do not immediately jeopardize the health and safety of its residents, the Secretary may, in lieu of providing for terminating the facility's certification for participation under the plan, provide lesser sanctions including one that provides that no payment will be made under this title with respect to any individual admitted to such facility after a date specified by the Secretary.

''(2) NOTICE.—The Secretary shall not make such a decision with respect to a facility until the facility has had a reasonable opportunity, following the initial determination that it no longer or does not substantially meet the requirements for such a facility under this title, to correct its deficiencies, and, following this period, has been given reasonable notice and opportunity for a hearing.

''(3) EFFECTIVENESS.—The Secretary's decision to deny payment may be made effective only after such notice to the public and to the facility as may be provided for by the Secretary, and its effectiveness shall terminate (A) when the Secretary finds that the facility is in substantial compliance (or is making good faith efforts to achieve substantial compliance) with the requirements for such a facility under this title, or (B) in the case described in paragraph (1)(B), with the end of the eleventh month following the month such decision is made effective, whichever occurs first. If a facility to which clause (B) of the previous sentence applies still fails to substantially meet the provisions of the respective section on the date specified in such clause, the Secretary shall terminate such facility's certification for participation under this title effective with the first day of the first month following the month specified in such clause.

''(d) STATE-CERTIFIED FACILITY DEFINED.—In subsection (a), a 'State-certified facility' means a facility licensed or certified as a skilled nursing facility by the State in which it is located, or a facility which otherwise meets the requirements applicable to providers of nursing facility services under the State plan under title XIX or the MediGrant program under title XXI.''.

(c) CONFORMING AMENDMENTS.—(1) Section 1861(v)(1)(E) (42 U.S.C. 1395x(v)(1)(E)) is amended by striking the second sentence.

(2) Section 1864 (42 U.S.C. 1395aa) is amended by striking subsection (d).

(3) Section 1866(f)(1) (42 U.S.C. 1395cc(f)(1)) is amended by striking ''1819(c)(2)(E),''.

(4) Section 1883(f) (42 U.S.C. 1395tt(f)) is amended—

(A) in the second sentence, by striking ''such a hospital'' and inserting ''a hospital which enters into an agreement with the Secretary under this section''; and

(B) by striking the first sentence.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to cost reporting periods beginning on or after October 1, 1995.

SEC. 15527. MEDICAL REVIEW PROCESS.

In order to ensure that medicare beneficiaries are furnished appropriate extended care services, the Secretary of Health and Human Services shall establish and implement a thorough medical review process to examine the effects of the amendments made by this part on the quality of extended care services furnished to medicare beneficiaries. In developing such a medical review process, the Secretary shall place a particular emphasis on the quality of non-routine covered services for which payment is made under section 1888A of the Social Security Act.

SEC. 15528. REPORT BY MEDICARE PAYMENT REVIEW COMMISSION.

Not later than October 1, 1997, the Medicare Payment Review Commission shall submit to Congress a report on the system under which payment is made under the medicare program for extended care services furnished by skilled nursing facilities, and shall include in the report the following:

(1) An analysis of the effect of the methodology established under section 1888A of the Social Security Act (as added by section 15522) on the payments for, and the quality of, extended care services under the medicare program.

(2) An analysis of the advisability of determining the amount of payment for covered non-routine services of facilities (as described in such section) on the basis of the amounts paid for such services when furnished by suppliers under part B of the medicare program.

(3) An analysis of the desirability of maintaining separate limits for hospital-based and freestanding facilities in the costs of extended care services recognized as reasonable under the medicare program.

(4) An analysis of the quality of services furnished by skilled nursing facilities.

(5) An analysis of the adequacy of the process and standards used to provide exceptions to the limits described in paragraph (3).

SEC. 15529. EFFECTIVE DATE.

Except as otherwise provided in this part, the amendments made by this part shall apply to services furnished during cost reporting periods (or portions of cost reporting periods) beginning on or after October 1, 1996.

PART 3—CLARIFICATION OF CREDITS TO PART A TRUST FUND

SEC. 15531. CLARIFICATION OF AMOUNT OF TAXES CREDITED TO FEDERAL HOSPITAL INSURANCE TRUST FUND.

Section 121(e)(1)(B) of the Social Security Amendments of 1983 (Public Law 98–21) is amended by adding at the end the following: ''The Secretary of the Treasury shall carry out this subparagraph without regard to any amendments to this subsection or to section 86 of the Internal Revenue Code of 1986 which take effect on or after January 1, 1994.''.

Subtitle G—Provisions Relating to Medicare Part B

PART 1—PAYMENT REFORMS

SEC. 15601. PAYMENTS FOR PHYSICIANS' SERVICES.

(a) REPLACEMENT OF VOLUME PERFORMANCE STANDARD WITH SUSTAINABLE GROWTH RATE.—Section 1848(f) (42 U.S.C. 1395w–4(f)) is amended to read as follows:

''(f) SUSTAINABLE GROWTH RATE.—

''(1) SPECIFICATION OF GROWTH RATE.—

''(A) FISCAL YEAR 1996.—The sustainable growth rate for all physicians' services for fiscal year 1996 shall be equal to the product of—

''(i) 1 plus the Secretary's estimate of the percentage change in the medicare economic index for 1996 (described in the fourth sentence of section 1842(b)(3)) (divided by 100),

''(ii) 1 plus the Secretary's estimate of the percentage change (divided by 100) in the average number of individuals enrolled under this part (other than private plan enrollees) from fiscal year 1995 to fiscal year 1996,

''(iii) 1 plus the Secretary's estimate of the projected percentage growth in real gross domestic product per capita (divided by 100) from fiscal year 1995 to fiscal year 1996, plus 2 percentage points, and

''(iv) 1 plus the Secretary's estimate of the percentage change (divided by 100) in expenditures for all physicians' services in fiscal year 1996 (compared with fiscal year 1995) which will result from changes in law, determined without taking into account estimated changes in expenditures due to changes in the volume and intensity of physicians' services or changes in expenditures resulting from changes in the update to the conversion factor under subsection (d),

minus 1 and multiplied by 100.

''(B) SUBSEQUENT FISCAL YEARS.—The sustainable growth rate for all physicians' services for fiscal year 1997 and each subsequent fiscal year shall be equal to the product of—

''(i) 1 plus the Secretary's estimate of the percentage change in the medicare economic index for the fiscal year involved (described in the fourth sentence of section 1842(b)(3)) (divided by 100),

''(ii) 1 plus the Secretary's estimate of the percentage change (divided by 100) in the average number of individuals enrolled under this part (other than private plan enrollees) from the previous fiscal year to the fiscal year involved,

''(iii) 1 plus the Secretary's estimate of the projected percentage growth in real gross domestic product per capita (divided by 100) from the previous fiscal year to the fiscal year involved, plus 2 percentage points, and

''(iv) 1 plus the Secretary's estimate of the percentage change (divided by 100) in expenditures for all physicians' services in the fiscal year (compared with the previous fiscal year) which will result from changes in law (including changes made by the Secretary in response to section 1895), determined without taking into account estimated changes in expenditures due to changes in the volume and intensity of physicians' services or changes in expenditures resulting from changes in the update to the conversion factor under subsection (d)(3),

minus 1 and multiplied by 100.

''(2) EXCLUSION OF SERVICES FURNISHED TO PRIVATE PLAN ENROLLEES.—In this subsection, the term 'physicians' services' with respect to a fiscal year does not include services furnished to an individual enrolled under this part who has elected to receive benefits under this title for the fiscal year through a MedicarePlus product offered under part C or through enrollment with an eligible organization with a risk-sharing contract under section 1876.''.

(b) ESTABLISHING UPDATE TO CONVERSION FACTOR TO MATCH SPENDING UNDER SUSTAINABLE GROWTH RATE.—

(1) IN GENERAL.—Section 1848(d) (42 U.S.C. 1395w–4(d)) is amended—

(A) by striking paragraph (2);

(B) by amending paragraph (3) to read as follows:

''(3) UPDATE.—

''(A) IN GENERAL.—Subject to subparagraph (E), for purposes of this section the update for a year (beginning with 1997) is equal to the product of—

''(i) 1 plus the Secretary's estimate of the percentage increase in the medicare economic index (described in the fourth sentence of section 1842(b)(3)) for the year (divided by 100), and

''(ii) 1 plus the Secretary's estimate of the update adjustment factor for the year (divided by 100),

minus 1 and multiplied by 100.

''(B) UPDATE ADJUSTMENT FACTOR.—The 'update adjustment factor' for a year is equal to the quotient of—

''(i) the difference between (I) the sum of the allowed expenditures for physicians' services furnished during each of the years 1995 through the year involved and (II) the sum of the amount of actual expenditures for physicians' services furnished during each of the years 1995 through the previous year; divided by

''(ii) the Secretary's estimate of allowed expenditures for physicians' services furnished during the year.

''(C) DETERMINATION OF ALLOWED EXPENDITURES.—For purposes of subparagraph (B), allowed expenditures for physicians' services shall be determined as follows (as estimated by the Secretary):

''(i) In the case of allowed expenditures for 1995, such expenditures shall be equal to actual expenditures for services furnished during the 12-month period ending with June of 1995.

''(ii) In the case of allowed expenditures for 1996 and each subsequent year, such expenditures shall be equal to allowed expenditures for the previous year, increased by the sustainable growth rate under subsection (f) for the fiscal year which begins during the year.

''(D) DETERMINATION OF ACTUAL EXPENDITURES.—For purposes of subparagraph (B), the amount of actual expenditures for physicians' services furnished during a year shall be equal to the amount of expenditures for such services during the 12-month period ending with June of the previous year.

''(E) RESTRICTION ON VARIATION FROM MEDICARE ECONOMIC INDEX.—

''(i) IN GENERAL.—Notwithstanding the amount of the update adjustment factor determined under subparagraph (B) for a year, the update in the conversion factor under this paragraph for the year may not be—

''(I) greater than 103 percent of 1 plus the Secretary's estimate of the percentage increase in the medicare economic index (described in the fourth sentence of section 1842(b)(3)) for the year (divided by 100); or

''(II) less than the applicable percentage limit of 1 plus the Secretary's estimate of the percentage increase in the medicare economic index (described in the fourth sentence of section 1842(b)(3)) for the year (divided by 100).

''(ii) APPLICABLE PERCENTAGE LIMIT.—In clause (i)(II), the 'applicable percentage limit' for a year is—

''(I) for 1997, 93 percent;

''(II) for 1998, 92.25 percent; and

''(III) for 1999 and each succeeding year, 92 percent.''; and

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

''(4) REPORTING REQUIREMENTS.—

''(A) IN GENERAL.—Not later than November 1 of each year (beginning with 1996), the Secretary shall transmit to the Congress a report that describes the update in the conversion factor for physicians' services (as defined in subsection (f)(3)(A)) in the following year.

''(B) COMMISSION REVIEW.—The Medicare Payment Review Commission shall review the report submitted under subparagraph (A) for a year and shall submit to the Congress, by not later than December 1 of the year, a report containing its analysis of the conversion factor for the following year.''.

(2) EFFECTIVE DATE.—The amendments made by this subsection shall apply to physicians' services furnished on or after January 1, 1996.

(c) ESTABLISHMENT OF SINGLE CONVERSION FACTOR FOR 1996.—

(1) IN GENERAL.—Section 1848(d)(1) (42 U.S.C. 1395w–4(d)(1)) is amended—

(A) by redesignating subparagraph (C) as subparagraph (D); and

(B) by inserting after subparagraph (B) the following new subparagraph:

''(C) SPECIAL RULE FOR 1996.—For 1996, the conversion factor under this subsection shall be $35.42 for all physicians' services.''.

(2) CONFORMING AMENDMENTS.—Section 1848 (42 U.S.C. 1395w–4), as amended by paragraph (1), is amended—

(A) by striking ''(or factors)'' each place it appears in subsection (d)(1)(A) and (d)(1)(D)(ii);

(B) in subsection (d)(1)(A), by striking ''or updates'';

(C) in subsection (d)(1)(D)(ii), by striking ''(or updates)''; and

(D) in subsection (i)(1)(C), by striking ''conversion factors'' and inserting ''the conversion factor''.

SEC. 15602. ELIMINATION OF FORMULA-DRIVEN OVERPAYMENTS FOR CERTAIN OUTPATIENT HOSPITAL SERVICES.

(a) AMBULATORY SURGICAL CENTER PROCEDURES.—Section 1833(i)(3)(B)(i)(II) (42 U.S.C. 1395l(i)(3)(B)(i)(II)) is amended—

(1) by striking ''of 80 percent''; and

(2) by striking the period at the end and inserting the following: '', less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A).''.

(b) RADIOLOGY SERVICES AND DIAGNOSTIC PROCEDURES.—Section 1833(n)(1)(B)(i)(II) (42 U.S.C. 1395l(n)(1)(B)(i)(II)) is amended—

(1) by striking ''of 80 percent''; and

(2) by striking the period at the end and inserting the following: '', less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A).''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished during portions of cost reporting periods occurring on or after October 1, 1995.

SEC. 15603. PAYMENTS FOR DURABLE MEDICAL EQUIPMENT.

(a) REDUCTION IN PAYMENT AMOUNTS FOR ITEMS OF DURABLE MEDICAL EQUIPMENT.—

(1) FREEZE IN UPDATE FOR COVERED ITEMS.—Section 1834(a)(14) (42 U.S.C. 1395m(a)(14)) is amended—

(A) by striking ''and'' at the end of subparagraph (A);

(B) in subparagraph (B)—

(i) by striking ''a subsequent year'' and inserting ''1993, 1994, and 1995'', and

(ii) by striking the period at the end and inserting a semicolon; and

(C) by adding at the end the following:

''(C) for each of the years 1996 through 2002, 0 percentage points; and

''(D) for a subsequent year, the percentage increase in the consumer price index for all urban consumers (U.S. urban average) for the 12-month period ending with June of the previous year.''.

(2) UPDATE FOR ORTHOTICS AND PROSTHETICS.—Section 1834(h)(4)(A) (42 U.S.C. 1395m(h)(4)(A)) is amended—

(A) by striking ''and'' at the end of clause (iii);

(B) by redesignating clause (iv) as clause (v); and

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

''(iv) for each of the years 1996 through 2002, 1 percent, and''.

(b) OXYGEN AND OXYGEN EQUIPMENT.—Section 1834(a)(9)(C) (42 U.S.C. 1395m(a)(9)(C)) is amended—

(1) by striking ''and'' at the end of clause (iii);

(2) in clause (iv)—

(A) by striking ''a subsequent year'' and inserting ''1993, 1994, and 1995'', and

(B) by striking the period at the end and inserting a semicolon; and

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

''(v) in 1996, is 80 percent of the national limited monthly payment rate computed under subparagraph (B) for the item for the year; and

''(vi) in a subsequent year, is the national limited monthly payment rate computed under subparagraph (B) for the item for the year.''.

(c) PAYMENT FOR UPGRADED DURABLE MEDICAL EQUIPMENT.—Section 1834(a) (42 U.S.C. 1395m(a)) is amended by inserting after paragraph (15) the following new paragraph:

''(16) PAYMENT FOR CERTAIN UPGRADED ITEMS.—

''(A) INDIVIDUAL'S RIGHT TO CHOOSE UPGRADED ITEM.—Notwithstanding any other provision of this title, effective on the date on which the Secretary issues regulations under subparagraph (C), payment may be made under this part for an upgraded item of durable medical equipment in the same manner as payment may be made for a standard item of durable medical equipment.

''(B) PAYMENTS TO SUPPLIER.—In the case of the purchase or rental of an upgraded item under subparagraph (A)—

''(i) the supplier shall receive payment under this subsection with respect to such item as if such item were a standard item; and

''(ii) the individual purchasing or renting the item shall pay the supplier an amount equal to the difference between the supplier's charge and the amount under clause (i). In no event may the supplier's charge for an upgraded item exceed the applicable fee schedule amount (if any) for such item.

''(C) CONSUMER PROTECTION SAFEGUARDS.—The Secretary shall issue regulations providing for consumer protection standards with respect to the furnishing of upgraded equipment under subparagraph (A). Such regulations shall provide for—

''(i) full disclosure by the supplier of the availability and price of standard items and proof of receipt of such disclosure information by the beneficiary before the furnishing of the upgraded item;

''(ii) conditions of participation for suppliers of upgraded items, including conditions relating to billing procedures;

''(iii) sanctions (including exclusion) of suppliers who are determined to have engaged in coercive or abusive practices; and

''(iv) such other safeguards as the Secretary determines are necessary.''.

(d) PAYMENT FREEZE FOR PARENTERAL AND ENTERAL NUTRIENTS, SUPPLIES, AND EQUIPMENT.—In determining the amount of payment under part B of title XVIII of the Social Security Act with respect to parenteral and enteral nutrients, supplies, and equipment during each of the years 1996 through 2002, the charges determined to be reasonable with respect to such nutrients, supplies, and equipment may not exceed the charges determined to be reasonable with respect to such nutrients, supplies, and equipment during 1993.

SEC. 15604. REDUCTION IN UPDATES TO PAYMENT AMOUNTS FOR CLINICAL DIAGNOSTIC LABORATORY TESTS.

(a) CHANGE IN UPDATE.—Section 1833(h)(2)(A)(ii)(IV) (42 U.S.C. 1395l(h)(2)(A)(ii)(IV)) is amended by striking ''1994 and 1995'' and inserting ''1994 through 2002''.

(b) LOWERING CAP ON PAYMENT AMOUNTS.—Section 1833(h)(4)(B) (42 U.S.C. 1395l(h)(4)(B)) is amended—

(1) in clause (vi), by striking ''and'' at the end;

(2) in clause (vii)—

(A) by inserting ''and before January 1, 1997,'' after ''1995,'', and

(B) by striking the period at the end and inserting '', and''; and

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

''(viii) after December 31, 1996, is equal to 65 percent of such median.''.

SEC. 15605. EXTENSION OF REDUCTIONS IN PAYMENTS FOR COSTS OF HOSPITAL OUTPATIENT SERVICES.

(a) REDUCTION IN PAYMENTS FOR CAPITAL-RELATED COSTS.—Section 1861(v)(1)(S)(ii)(I) (42 U.S.C. 1395x(v)(1)(S)(ii)(I)) is amended by striking ''through 1998'' and inserting ''through 2002''.

(b) REDUCTION IN PAYMENTS FOR OTHER COSTS.—Section 1861(v)(1)(S)(ii)(II) (42 U.S.C. 1395x(v)(1)(S)(ii)(II)) is amended by striking ''through 1998'' and inserting ''through 2002''.

SEC. 15606. FREEZE IN PAYMENTS FOR AMBULATORY SURGICAL CENTER SERVICES.

The Secretary of Health and Human Services shall not provide for any inflation update in the payment amounts under subparagraphs (A) and (B) of section 1833(i)(2) of the Social Security Act for any of the fiscal years 1996 through 2002.

SEC. 15607. RURAL EMERGENCY ACCESS CARE HOSPITALS.

(a) COVERAGE UNDER PART B.—Section 1832(a)(2) (42 U.S.C. 1395k(a)(2)) is amended—

(1) by striking ''and'' at the end of subparagraph (I);

(2) by striking the period at the end of subparagraph (J) and inserting ''; and''; and

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

''(K) rural emergency access care hospital services (as defined in section 1861(oo)(2)).''.

(b) PAYMENT BASED ON PAYMENT FOR OUTPATIENT RURAL PRIMARY CARE HOSPITAL SERVICES.—

(1) IN GENERAL.—Section 1833(a)(6) (42 U.S.C. 1395l(a)(6)) is amended by striking ''services,'' and inserting ''services and rural emergency access care hospital services,''.

(2) PAYMENT METHODOLOGY DESCRIBED.—Section 1834(g) (42 U.S.C. 1395m(g)) is amended—

(A) in the heading, by striking ''SERVICES'' and inserting ''SERVICES AND RURAL EMERGENCY ACCESS CARE HOSPITAL SERVICES''; and

(B) by adding at the end the following new sentence: ''The amount of payment for rural emergency access care hospital services provided during a year shall be determined using the applicable method provided under this subsection for determining payment for outpatient rural primary care hospital services during the year.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after October 1, 1995.

SEC. 15608. ENSURING PAYMENT FOR PHYSICIAN AND NURSE FOR JOINTLY FURNISHED ANESTHESIA SERVICES.

(a) PAYMENT FOR JOINTLY FURNISHED SINGLE CASE.—

(1) PAYMENT TO PHYSICIAN.—Section 1848(a)(4) (42 U.S.C. 1395w–4(a)(4)) is amended by adding at the end the following new subparagraph:

''(C) PAYMENT FOR SINGLE CASE.—Notwithstanding section 1862(a)(1)(A), with respect to physicians' services consisting of the furnishing of anesthesia services for a single case that are furnished jointly with a certified registered nurse anesthetist, if the carrier determines that the use of both the physician and the nurse anesthetist to furnish the anesthesia service was not medically necessary, the fee schedule amount for the physicians' services shall be equal to 50 percent (or 55 percent, in the case of services furnished during 1996 or 1997) of the fee schedule amount applicable under this section for anesthesia services personally performed by the physician alone (without regard to this subparagraph). Nothing in this subparagraph may be construed to affect the application of any provision of law regarding balance billing.''.

(2) PAYMENT TO CRNA.—Section 1833(l)(4)(B) (42 U.S.C. 1395l(l)(4)(B)) is amended by adding at the end the following new clause:

''(iv) Notwithstanding section 1862(a)(1)(A), in the case of services of a certified registered nurse anesthetist consisting of the furnishing of anesthesia services for a single case that are furnished jointly with a physician, if the carrier determines that the use of both the physician and the nurse anesthetist to furnish the anesthesia service was not medically necessary, the fee schedule amount for the services furnished by the certified registered nurse anesthetist shall be equal to 50 percent (or 40 percent, in the case of services furnished during 1996 or 1997) of the fee schedule amount applicable under section 1848 for anesthesia services personally performed by the physician alone (without regard to this clause).''.

(b) EFFECTIVE DATE.—The amendments made by subsections (a) shall apply to services furnished on or after July 1, 1996.

SEC. 15609. STATEWIDE FEE SCHEDULE AREA FOR PHYSICIANS' SERVICES.

(a) IN GENERAL.—Notwithstanding section 1848(j)(2) of the Social Security Act, in the case of the State of Wisconsin, the Secretary of Health and Human Services shall treat the State as a single fee schedule area for purposes of determining the fee schedule amount (as referred to in section 1848(a) of such Act) for physicians' services (as defined in section 1848(j)(3) of such Act) under part B of the medicare program.

(b) BUDGET-NEUTRALITY.—Notwithstanding any provision of part B of title XVIII of the Social Security Act, the Secretary shall carry out subsection (a) in a manner that ensures that total payments for physicians' services (as so defined) furnished by physicians in Wisconsin during a year are not greater or less than total payments for such services would have been but for this section.

(c) CONSTRUCTION.—Nothing in this section shall be construed as limiting the availability (to the Secretary, the appropriate agency or organization with a contract under section 1842 of such Act, or physicians in the State of Wisconsin) of otherwise applicable

administrative procedures for modifying the fee schedule area or areas in the State after implementation of subsection (a).

(d) EFFECTIVE DATE.—This section shall apply with respect to physicians' services furnished on or after January 1, 1997.

SEC. 15609A. ESTABLISHMENT OF FEE SCHEDULE FOR AMBULANCE SERVICES.

(a) PAYMENT IN ACCORDANCE WITH FEE SCHEDULE.—Section 1833(a)(1) (42 U.S.C. 1395l(a)(1)) is amended—

(1) by striking ''and (P)'' and inserting ''(P)''; and

(2) by striking the semicolon at the end and inserting the following: '', and (Q) with respect to ambulance service, the amounts paid shall be 80 percent of the lesser of the actual charge for the services or the amount determined by a fee schedule established by the Secretary for the purposes of this subparagraph (in accordance with section 15608(b) of the Medicare Preservation Act);''.

(b) REQUIREMENTS FOR ESTABLISHMENT OF FEE SCHEDULE.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall establish the fee schedule for ambulance services under section 1833(a)(1)(Q) of the Social Security Act (as added by subsection (a)) through a negotiated rulemaking process described in title 5, United States Code, and in accordance with the requirements of this subsection.

(2) CONSIDERATIONS.—In establishing the fee schedule for ambulance services, the Secretary shall—

(A) establish mechanisms to control increases in expenditures for ambulance services under part B of the medicare program which fairly reflect the changing nature of the ambulance service industry;

(B) establish definitions for ambulance services which promote efficiency and link payments (including fees for assessment and treatment services) to the type of service provided;

(C) take into account regional differences which affect cost and productivity, including differences in the costs of resources and the costs of uncompensated care;

(D) apply dynamic adjustments to payment rates to account for inflation, demographic changes in the population of medicare beneficiaries, and changes in the number of providers of ambulance services participating in the medicare program; and

(E) phase in the application of the payment rates under the fee schedule in an efficient and fair manner.

(3) SAVINGS.—In establishing the fee schedule for ambulance services, the Secretary shall—

(A) ensure that the aggregate amount of payments made for ambulance services under part B of the medicare program during 1998 does not exceed the aggregate amount of payments which would have been made for such services under part B of the program during 1998 if the amendments made by this section were not in effect; and

(B) set the payment amounts provided under the fee schedule for services furnished in 1999 and each subsequent year at amounts equal to the payment amounts under the fee schedule for service furnished during the previous year, increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 12-month period ending with June of the previous year.

(4) CONSULTATION.—In establishing the fee schedule for ambulance services, the Secretary shall consult regularly with the American Ambulance Association, the National Association of State Medical Directors, and other national organizations representing individuals and entities who furnish or regulate ambulance services, and shall share with such associations and organizations the data and data analysis used in establishing the fee schedule, including data on variations in payments for ambulance services under part B of the medicare program for years prior to 1998 among geographic areas and types of ambulance service providers.

(c) EFFECTIVE DATE.—The amendment made by subsection (a) and the fee schedule described in subsection (b) shall apply to ambulance services furnished on or after January 1, 1998.

SEC. 15609B. STANDARDS FOR PHYSICAL THERAPY SERVICES FURNISHED BY PHYSICIANS.

(a) APPLICATION OF STANDARDS FOR OTHER PROVIDERS OF PHYSICAL THERAPY SERVICES TO SERVICES FURNISHED BY PHYSICIANS.—Section 1862(a) (42 U.S.C. 1395y(a)), as amended by section 15525(a)(2), is amended—

(1) by striking ''or'' at the end of paragraph (15);

(2) by striking the period at the end of paragraph (16) and inserting ''; or''; and

(3) by inserting after paragraph (16) the following new paragraph:

''(17) in the case of physicians' services under section 1848(j)(3) consisting of outpatient physical therapy services or outpatient occupational therapy services, which are furnished by a physician who does not meet the requirements applicable under section 1861(p) to a clinic or rehabilitation agency furnishing such services.''.

(b) CONFORMING AMENDMENT.—Section 1848(j)(3) (42 U.S.C. 1395w–4(j)(3)) is amended by inserting ''(subject to section 1862(a)(17))'' after ''(2)(D)''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 1996.

PART 2—PART B PREMIUM

SEC. 15611. EXTENSION OF PART B PREMIUM.

(a) IN GENERAL.—Section 1839(e)(1) (42 U.S.C. 1395r(e)(1)) is amended—

(1) in subparagraph (A)—

(A) by striking ''and prior to January 1999'', and

(B) by inserting ''(or, if higher, the percent described in subparagraph (C))'' after ''50 percent''; and

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

''(C) For purposes of subparagraph (A), the percent described in this subparagraph is the ratio (expressed as a percentage) of the monthly premium established under this section for months in 1995 to the monthly actuarial rate for enrollees age 65 and over applicable to such months (as specified in the most recent report of the Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund published prior to the date of the enactment of the Medicare Preservation Act of 1995).''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) apply to premiums for months beginning with January 1996.

SEC. 15612. INCOME-RELATED REDUCTION IN MEDICARE SUBSIDY.

(a) IN GENERAL.—Section 1839 (42 U.S.C. 1395r) is amended by adding at the end the following:

''(h)(1) Notwithstanding the previous subsections of this section, in the case of an individual whose modified adjusted gross income for a taxable year ending with or within a calendar year (as initially determined by the Secretary in accordance with paragraph (3)) exceeds the threshold amount described in paragraph (5)(B), the Secretary shall increase the amount of the monthly premium for months in the calendar year by an amount equal to the difference between—

''(A) 200 percent of the monthly actuarial rate for enrollees age 65 and over as determined under subsection (a)(1) for that calendar year; and

''(B) the total of the monthly premiums paid by the individual under this section (determined without regard to subsection (b)) during such calendar year.

''(2) In the case of an individual described in paragraph (1) whose modified adjusted gross income exceeds the threshold amount by less than $25,000, the amount of the increase in the monthly premium applicable under paragraph (1) shall be an amount which bears the same ratio to the amount of the increase described in paragraph (1) (determined without regard to this paragraph) as such excess bears to $25,000. In the case of a joint return filed under section 6013 of the Internal Revenue Code of 1986 by spouses both of whom are enrolled under this part, the previous sentence shall be applied by substituting '$50,000' for '$25,000'. The preceding provisions of this paragraph shall not apply to any individual whose threshold amount is zero.

''(3) The Secretary shall make an initial determination of the amount of an individual's modified adjusted gross income for a taxable year ending with or within a calendar year for purposes of this subsection as follows:

''(A) Not later than October 1 of the year preceding the year, the Secretary shall provide notice to each individual whom the Secretary finds (on the basis of the individual's actual modified adjusted gross income for the most recent taxable year for which such information is available or other information provided to the Secretary by the Secretary of the Treasury) will be subject to an increase under this subsection that the individual will be subject to such an increase, and shall include in such notice the Secretary's estimate of the individual's modified adjusted gross income for the year.

''(B) If, during the 30-day period beginning on the date notice is provided to an individual under subparagraph (A), the individual provides the Secretary with information on the individual's anticipated modified adjusted gross income for the year, the amount initially determined by the Secretary under this paragraph with respect to the individual shall be based on the information provided by the individual.

''(C) If an individual does not provide the Secretary with information under subparagraph (B), the amount initially determined by the Secretary under this paragraph with respect to the individual shall be the amount included in the notice provided to the individual under subparagraph (A).

''(4)(A) If the Secretary determines (on the basis of final information provided by the Secretary of the Treasury) that the amount of an individual's actual modified adjusted gross income for a taxable year ending with or within a calendar year is less than or greater than the amount initially determined by the Secretary under paragraph (3), the Secretary shall increase or decrease the amount of the individual's monthly premium under this section (as the case may be) for months during the following calendar year by an amount equal to 1/12 of the difference between—

''(i) the total amount of all monthly premiums paid by the individual under this section during the previous calendar year; and

''(ii) the total amount of all such premiums which would have been paid by the individual during the previous calendar year if the amount of the individual's modified adjusted gross income initially determined under paragraph (3) were equal to the actual amount of the individual's modified adjusted gross income determined under this paragraph.

''(B) In the case of an individual who is not enrolled under this part for any calendar

year for which the individual's monthly premium under this section for months during the year would be increased pursuant to subparagraph (A) if the individual were enrolled under this part for the year, the Secretary may take such steps as the Secretary considers appropriate to recover from the individual the total amount by which the individual's monthly premium for months during the year would have been increased under subparagraph (A) if the individual were enrolled under this part for the year.

''(C) In the case of a deceased individual for whom the amount of the monthly premium under this section for months in a year would have been decreased pursuant to subparagraph (A) if the individual were not deceased, the Secretary shall make a payment to the individual's surviving spouse (or, in the case of an individual who does not have a surviving spouse, to the individual's estate) in an amount equal to the difference between—

''(i) the total amount by which the individual's premium would have been decreased for all months during the year pursuant to subparagraph (A); and

''(ii) the amount (if any) by which the individual's premium was decreased for months during the year pursuant to subparagraph (A).

''(5) In this subsection, the following definitions apply:

''(A) The term 'modified adjusted gross income' means adjusted gross income (as defined in section 62 of the Internal Revenue Code of 1986)—

''(i) determined without regard to sections 135, 911, 931, and 933 of such Code, and

''(ii) increased by the amount of interest received or accrued by the taxpayer during the taxable year which is exempt from tax under such Code.

''(B) The term 'threshold amount' means—

''(i) except as otherwise provided in this paragraph, $75,000,

''(ii) $125,000, in the case of a joint return (as defined in section 7701(a)(38) of such Code), and

''(iii) zero in the case of a taxpayer who—

''(I) is married at the close of the taxable year but does not file a joint return (as so defined) for such year, and

''(II) does not live apart from his spouse at all times during the taxable year.''.

(b) CONFORMING AMENDMENT.—Section 1839(f) (42 U.S.C. 1395r(f)) is amended by striking ''if an individual'' and inserting the following: ''if an individual (other than an individual subject to an increase in the monthly premium under this section pursuant to subsection (h))''.

(c) REPORTING REQUIREMENTS FOR SECRETARY OF THE TREASURY.—

(1) IN GENERAL.—Subsection (l) of section 6103 of the Internal Revenue Code of 1986 (relating to confidentiality and disclosure of returns and return information) is amended by adding at the end the following new paragraph:

''(15) DISCLOSURE OF RETURN INFORMATION TO CARRY OUT INCOME-RELATED REDUCTION IN MEDICARE PART B PREMIUM.—

''(A) IN GENERAL.—The Secretary may, upon written request from the Secretary of Health and Human Services, disclose to officers and employees of the Health Care Financing Administration return information with respect to a taxpayer who is required to pay a monthly premium under section 1839 of the Social Security Act. Such return information shall be limited to—

''(i) taxpayer identity information with respect to such taxpayer,

''(ii) the filing status of such taxpayer,

''(iii) the adjusted gross income of such taxpayer,

''(iv) the amounts excluded from such taxpayer's gross income under sections 135 and 911,

''(v) the interest received or accrued during the taxable year which is exempt from the tax imposed by chapter 1 to the extent such information is available, and

''(vi) the amounts excluded from such taxpayer's gross income by sections 931 and 933 to the extent such information is available.

''(B) RESTRICTION ON USE OF DISCLOSED INFORMATION.—Return information disclosed under subparagraph (A) may be used by officers and employees of the Health Care Financing Administration only for the purposes of, and to the extent necessary in, establishing the appropriate monthly premium under section 1839 of the Social Security Act.''

(2) CONFORMING AMENDMENT.—Paragraphs (3)(A) and (4) of section 6103(p) of such Code are each amended by striking ''or (14)'' each place it appears and inserting ''(14), or (15)''.

(d) EFFECTIVE DATE.—The amendments made by subsections (a) and (b) shall apply to the monthly premium under section 1839 of the Social Security Act for months beginning with January 1997.

PART 3—ADMINISTRATION AND BILLING OF LABORATORY SERVICES

SEC. 15621. ADMINISTRATIVE SIMPLIFICATION FOR LABORATORY SERVICES.

(a) IN GENERAL.—Not later than 1 year after the date of the enactment of this Act, the Secretary of Health and Human Services (in accordance with the process described in subsection (b)) shall adopt uniform coverage, administration, and payment policies for clinical diagnostic laboratory tests under part B of the medicare program.

(b) PROCESS FOR ADOPTION OF POLICIES.—The Secretary shall adopt uniform policies under subsection (a) in accordance with the following process:

(1) The Secretary shall select from carriers with whom the Secretary has a contract under part B during 1995 15 medical directors, who will meet and develop recommendations for such uniform policies. The medical directors selected shall represent various geographic areas and have a varied range of experience in relevant medical fields, including pathology and clinical laboratory practice.

(2) The medical directors selected under paragraph (1) shall consult with independent experts in each major discipline of clinical laboratory medicine, including clinical laboratory personnel, bioanalysts, pathologists, and practicing physicians. The medical directors shall also solicit comments from other individuals and groups who wish to participate, including consumers and other affected parties. This process shall be conducted as a negotiated rulemaking under title 5, United States Code.

(3) Under the negotiated rulemaking, the recommendations for uniform policies shall be designed to simplify and reduce unnecessary administrative burdens in connection with the following:

(A) Beneficiary information required to be submitted with each claim.

(B) Physicians' obligations regarding documentation requirements and recordkeeping.

(C) Procedures for filing claims and for providing remittances by electronic media.

(D) The performance of post-payment review of test claims.

(E) The prohibition of the documentation of medical necessity except when determined to be appropriate after identification of aberrant utilization pattern through focused medical review.

(F) Beneficiary responsibility for payment.

(4) During the pendency of the adoption by the Secretary of the uniform policies, fiscal intermediaries and carriers under the medicare program may not implement any new requirement relating to the submission of a claim for clinical diagnostic laboratory tests retroactive to January 1, 1995, and carriers may not initiate any new coverage, administrative, or payment policy unless the policy promotes the goal of administrative simplification of requirements imposed on clinical laboratories in accordance with the Secretary's promulgation of the negotiated rulemaking.

(5) Not later than 6 months after the date of the enactment of this Act, the medical directors shall submit their recommendations to the Secretary, and the Secretary shall publish the recommendations and solicit public comment using negotiated rulemaking in accordance with title 5, United States Code. The Secretary shall publish final uniform policies for coverage, administration, and payment of claims for clinical diagnostic laboratory tests, effective after the expiration of the 180-day period which begins on the date of publication.

(6) After the publication of the final uniform policies, the Secretary shall implement identical uniform documentation and processing policies for all clinical diagnostic laboratory tests paid under the medicare program through fiscal intermediaries or carriers.

(c) OPTIONAL SELECTION OF SINGLE CARRIER.—Effective for claims submitted after the expiration of the 90-day period which begins on the date of the enactment of this Act, an independent laboratory may select a single carrier for the processing of all of its claims for payment under part B of the medicare program, without regard to the location where the laboratory or the patient or provider involved resides or conducts business. Such election of a single carrier shall be made by the clinical laboratory and an agreement made between the carrier and the laboratory shall be forwarded to the Secretary of Health and Human Services. Nothing in this subsection shall be construed to require a laboratory to select a single carrier under this subsection.

SEC. 15622. RESTRICTIONS ON DIRECT BILLING FOR LABORATORY SERVICES.

(a) REQUIREMENT FOR DIRECT BILLING.—Section 1833(h) (42 U.S.C. 1395l(h)) is amended by adding at the end the following new paragraph:

''(7)(A) Effective for services furnished on or October 1, 1996, an individual or entity that performs clinical laboratory diagnostic tests shall not present or cause to be presented a claim, bill, or demand for payment to any person, other than the individual receiving such services or the health plan designated by such person, except that (i) in the case of a test performed by one laboratory at the request of another laboratory, which meets the requirements of clause (i), (ii), or (iii) of paragraph (5)(A), payment may be made to the requesting laboratory, and (ii) the Secretary may by regulation establish appropriate exceptions to the requirement of this subparagraph.

''(B)(i) Any person that collects any amounts that were billed in violation of paragraph (7)(A) above shall be liable for such amounts to the person from whom such amounts were collected.

''(ii) Any person that furnishes clinical laboratory services for which payment is made under paragraph (1)(D)(i) or paragraph (2)(D)(i) that knowingly violates subparagraph (A) is subject to a civil money penalty of not more than $10,000 for each such violation. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under this paragraph in the same manner as such provisions apply

with respect to a penalty or proceeding under section 1128A(a).

''(iii)(I) Any individual or entity that the Secretary determines has repeatedly violated subparagraph (A) may be excluded from participation in any Federal health care program. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to an exclusion under this paragraph in the same manner as such provisions apply with respect to a penalty or proceeding under section 1128A(a).

''(II) The provisions of section 1128(e) of the Social Security Act shall apply to any exclusion under clause (iii)(I) in the same manner as such provisions apply to a proceeding under section 1128.

''(iv) If the Secretary finds, after a reasonable notice and opportunity for a hearing, that a laboratory which holds a certificate pursuant to section 353 of the Public Health Service Act has on a repeated basis violated subparagraph (A), the Secretary may suspend, revoke, or limit such certification in accordance with the procedures established in section 353(k) of Public Health Service Act.

''(C) For purposes of this paragraph, the following definitions shall apply:

''(i) The term 'Federal health care program' means—

''(I) any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded, in whole or in part, by the United States Government; or

''(II) any State health care program, as defined in section 1128(h).

''(ii) The term 'health plan' means any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by an insurer, except that such term does not include any of the following:

''(I) Coverage only for accident, dental, vision, disability income, or long-term care insurance, or any combination thereof.

''(II) Medicare supplemental health insurance.

''(III) Coverage issued as a supplement to liability insurance.

''(IV) Liability insurance, including general liability insurance and automobile liability insurance.

''(V) Worker's compensation or similar insurance.

''(VI) Automobile medical-payment insurance.

''(VII) Coverage for a specified disease or illness.

''(VIII) A hospital or fixed indemnity policy.

(b) LOOK BACK PROVISIONS TO ASSURE SAVINGS.—

(1) IN GENERAL.—Section 1833(h)(4)(B) (42 U.S.C. 1395l(h)(4)(B)), as amended by section 15604(b), is amended—

(A) in clause (vii), by striking ''and'' at the end;

(B) in clause (viii)—

(i) by inserting ''and before January 1, 2000,'' after ''1996,'', and

(ii) by striking the period at the end and inserting '', and''; and

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

''(ix) after December 31, 1999, is equal to such percentage of such median as the Secretary establishes under paragraph (8)(B), or, if the Secretary does not act under paragraph (8)(B), is equal to 65 percent of such median.''.

(2) PROCESS FOR REDUCTIONS.—Section 1833(h) (42 U.S.C. 1395l(h)), as amended by subsection (a), is amended by adding at the end the following new paragraph:

''(8)(A) On July 31, 1999, the Secretary shall estimate—

''(i) the amount of expenditures under this section for clinical diagnostic laboratory tests which will be made in the period from January 1, 1997, through September 30, 2002, and

''(ii) the amount of expenditures which would have been made under this section for clinical diagnostic laboratory tests in the period from January 1, 1997, through September 30, 2002, if paragraph (7) had not been enacted.

''(B) If the amount estimated under subparagraph (A)(i) is greater than 97 percent of the amount estimated under subparagraph (A)(ii), the Secretary shall establish a limitation amount under paragraph (4)(B)(ix) such that, when such limitation amount is considered, the amount estimated under subparagraph (A)(i) is 97 percent of the amount estimated under subparagraph (A)(ii).

''(C) The Director of the Congressional Budget Office (hereafter in this subparagraph referred to as the 'Director') shall—

''(i) independently estimate the amounts specified in subparagraph (A) and compute any limitation amount required under subparagraph (B), and

''(ii) submit a report on such estimates and computation to Congress not later than August 31, 1999.

The Secretary shall provide the Director with such data as the Director reasonably requires to prepare such estimates and computation.''.

PART 4—QUALITY STANDARDS FOR DURABLE MEDICAL EQUIPMENT

SEC. 15631. RECOMMENDATIONS FOR QUALITY STANDARDS FOR DURABLE MEDICARE EQUIPMENT.

(a) APPOINTMENT OF TASK FORCE BY SECRETARY.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall establish a broadly based task force to develop recommendations for quality standards for durable medical equipment under part B of the medicare program.

(2) COMPOSITION.—The task force shall include individuals selected by the Secretary from representatives of suppliers of items of durable medical equipment under part B, consumers, and other users of such equipment. In appointing members, the Secretary shall assure representation from various geographic regions of the United States.

(3) NO COMPENSATION FOR SERVICE.—Members of the task force shall not receive any compensation for service on the task force.

(4) TERMINATION.—The task force shall terminate 30 days after it submits the report described in subsection (b).

(b) REPORT.—Not later than 1 year after the date of the enactment of this Act, the task force established under subsection (a) shall submit to the Secretary its recommendations for quality standards for durable medicare equipment under part B of the medicare program.

Subtitle H—Provisions Relating to Medicare Parts A and B

PART 1—PAYMENTS FOR HOME HEALTH SERVICES

SEC. 15701. PAYMENT FOR HOME HEALTH SERVICES.

(a) IN GENERAL.—Title XVIII (42 U.S.C. 1395 et seq.), as amended by section 15106, is amended by adding at the end the following new section:

''PAYMENT FOR HOME HEALTH SERVICES

''SEC. 1894. (a) IN GENERAL.—

''(1) PER VISIT PAYMENTS.—Subject to subsection (c), the Secretary shall make per visit payments beginning with fiscal year 1997 to a home health agency in accordance with this section for each type of home health service described in paragraph (2) furnished to an individual who at the time the service is furnished is under a plan of care by the home health agency under this title (without regard to whether or not the item or service was furnished by the agency or by others under arrangement with them made by the agency, or otherwise).

''(2) TYPES OF SERVICES.—The types of home health services described in this paragraph are the following:

''(A) Part-time or intermittent nursing care provided by or under the supervision of a registered professional nurse.

''(B) Physical therapy.

''(C) Occupational therapy.

''(D) Speech-language pathology services.

''(E) Medical social services under the direction of a physician.

''(F) To the extent permitted in regulations, part-time or intermittent services of a home health aide who has successfully completed a training program approved by the Secretary.

''(b) ESTABLISHMENT OF PER VISIT RATE FOR EACH TYPE OF SERVICES.—

''(1) IN GENERAL.—The Secretary shall, subject to paragraph (3), establish a per visit payment rate for a home health agency in an area for each type of home health service described in subsection (a)(2). Such rate shall be equal to the national per visit payment rate determined under paragraph (2) for each such type, except that the labor-related portion of such rate shall be adjusted by the area wage index applicable under section 1886(d)(3)(E) for the area in which the agency is located (as determined without regard to any reclassification of the area under section 1886(d)(8)(B) or a decision of the Medicare Geographic Classification Review Board or the Secretary under section 1886(d)(10) for cost reporting periods beginning after October 1, 1995).

''(2) NATIONAL PER VISIT PAYMENT RATE.—The national per visit payment rate for each type of service described in subsection (a)(2)—

''(A) for fiscal year 1997, is an amount equal to the national average amount paid per visit under this title to home health agencies for such type of service during the most recent 12-month cost reporting period ending on or before June 30, 1994, increased (in a compounded manner) by the home health market basket percentage increase for fiscal years 1995, 1996, and 1997; and

''(B) for each subsequent fiscal year, is an amount equal to the national per visit payment rate in effect for the preceding fiscal year, increased by the home health market basket percentage increase for such subsequent fiscal year minus 2 percentage points.

''(3) REBASING OF RATES.—The Secretary shall provide for an update to the national per visit payment rates under this subsection for cost reporting periods beginning not later than the first day of the fifth fiscal year which begins after fiscal year 1997, and not later than every 5 years thereafter, to reflect the most recent available data.

''(4) HOME HEALTH MARKET BASKET PERCENTAGE INCREASE.—For purposes of this subsection, the term 'home health market basket percentage increase' means, with respect to a fiscal year, a percentage (estimated by the Secretary before the beginning of the fiscal year) determined and applied with respect to the types of home health services described in subsection (a)(2) in the same manner as the market basket percentage increase under section 1886(b)(3)(B)(iii) is determined and applied to inpatient hospital services for the fiscal year.

''(c) PER EPISODE LIMIT.—

''(1) AGGREGATE LIMIT.—

''(A) IN GENERAL.—Except as provided in paragraph (2), a home health agency may not receive aggregate per visit payments under

subsection (a) for a fiscal year in excess of an amount equal to the sum of the following products determined for each case-mix category for which the agency receives payments:

''(i) The number of episodes of each case-mix category during the fiscal year; multiplied by

''(ii) the per episode limit determined for such case-mix category for such fiscal year.

''(B) ESTABLISHMENT OF PER EPISODE LIMITS.—

''(i) IN GENERAL.—The per episode limit for a fiscal year for any case-mix category for the area in which a home health agency is located is equal to—

''(I) the mean number of visits for each type of home health service described in subsection (a)(2) furnished during an episode of such case-mix category in such area during fiscal year 1994, adjusted by the case-mix adjustment factor determined in clause (ii) for the fiscal year involved; multiplied by

''(II) the per visit payment rate established under subsection (b) for such type of home health service for the fiscal year for which the determination is being made.

''(ii) CASE MIX ADJUSTMENT FACTOR.—For purposes of clause (i), the case-mix adjustment factor for a year is the factor determined by the Secretary to assure that aggregate payments for home health services under this section during the year will not exceed the payment for such services during the previous year as a result of changes in the number and type of home health visits within case-mix categories over the previous year.

''(iii) REBASING OF PER EPISODE AMOUNTS.—Beginning with fiscal year 1999 and every 2 years thereafter, the Secretary shall revise the mean number of home health visits determined under clause (i)(I) for each type of home health service visit described in subsection (a)(2) furnished during an episode in a case-mix category to reflect the most recently available data on the number of visits.

''(iv) DETERMINATION OF APPLICABLE AREA.—For purposes of determining per episode limits under this subparagraph, the area in which a home health agency is considered to be located shall be such area as the Secretary finds appropriate for purposes of this subparagraph.

''(C) CASE-MIX CATEGORY.—For purposes of this paragraph, the term 'case-mix category' means each of the 18 case-mix categories established under the Phase II Home Health Agency Prospective Payment Demonstration Project conducted by the Health Care Financing Administration. The Secretary may develop an alternate methodology for determining case-mix categories.

''(D) EPISODE.—

''(i) IN GENERAL.—For purposes of this paragraph, the term 'episode' means the continuous 120-day period that—

''(I) begins on the date of an individual's first visit for a type of home health service described in subsection (a)(2) for a case-mix category, and

''(II) is immediately preceded by a 60-day period in which the individual did not receive visits for a type of home health service described in subsection (a)(2).

''(ii) TREATMENT OF EPISODES SPANNING COST REPORTING PERIODS.—The Secretary shall provide for such rules as the Secretary considers appropriate regarding the treatment of episodes under this paragraph which begin during a cost reporting period and end in a subsequent cost reporting period.

''(E) EXEMPTIONS AND EXCEPTIONS.—The Secretary may provide for exemptions and exceptions to the limits established under this paragraph for a fiscal year as the Secretary deems appropriate, to the extent such exemptions and exceptions do not result in greater payments under this section than the exemptions and exceptions provided under section 1861(v)(1)(L)(ii) in fiscal year 1994, increased by the home health market basket percentage increase for the fiscal year involved (as defined in subsection (b)(4)).

''(2) RECONCILIATION OF AMOUNTS.—

''(A) OVERPAYMENTS TO HOME HEALTH AGENCIES.—Subject to subparagraph (B), if a home health agency has received aggregate per visit payments under subsection (a) for a fiscal year in excess of the amount determined under paragraph (1) with respect to such home health agency for such fiscal year, the Secretary shall reduce payments under this section to the home health agency in the following fiscal year in such manner as the Secretary considers appropriate (including on an installment basis) to recapture the amount of such excess.

''(B) EXCEPTION FOR HOME HEALTH SERVICES FURNISHED OVER A PERIOD GREATER THAN 165 DAYS.—

''(i) IN GENERAL.—For purposes of subparagraph (A), the amount of aggregate per visit payments determined under subsection (a) shall not include payments for home health visits furnished to an individual on or after a continuous period of more than 165 days after an individual begins an episode described in subsection (c)(1)(D) (if such period is not interrupted by the beginning of a new episode).

''(ii) REQUIREMENT OF CERTIFICATION.—Clause (i) shall not apply if the agency has not obtained a physician's certification with respect to the individual requiring such visits that includes a statement that the individual requires such continued visits, the reason for the need for such visits, and a description of such services furnished during such visits.

''(C) SHARE OF SAVINGS.—

''(i) BONUS PAYMENTS.—If a home health agency has received aggregate per visit payments under subsection (a) for a fiscal year in an amount less than the amount determined under paragraph (1) with respect to such home health agency for such fiscal year, the Secretary shall pay such home health agency a bonus payment equal to 50 percent of the difference between such amounts in the following fiscal year, except that the bonus payment may not exceed 5 percent of the aggregate per visit payments made to the agency for the year.

''(ii) INSTALLMENT BONUS PAYMENTS.—The Secretary may make installment payments during a fiscal year to a home health agency based on the estimated bonus payment that the agency would be eligible to receive with respect to such fiscal year.

''(d) MEDICAL REVIEW PROCESS.—The Secretary shall implement a medical review process (with a particular emphasis on fiscal years 1997 and 1998) for the system of payments described in this section that shall provide an assessment of the pattern of care furnished to individuals receiving home health services for which payments are made under this section to ensure that such individuals receive appropriate home health services. Such review process shall focus on low-cost cases described in subsection (e)(3) and cases described in subsection (c)(2)(B) and shall require recertification by intermediaries at 30, 60, 90, 120, and 165 days into an episode described in subsection (c)(1)(D).

''(e) ADJUSTMENT OF PAYMENTS TO AVOID CIRCUMVENTION OF LIMITS.—

''(1) IN GENERAL.—The Secretary shall provide for appropriate adjustments to payments to home health agencies under this section to ensure that agencies do not circumvent the purpose of this section by—

''(A) discharging patients to another home health agency or similar provider;

''(B) altering corporate structure or name to avoid being subject to this section or for the purpose of increasing payments under this title; or

''(C) undertaking other actions considered unnecessary for effective patient care and intended to achieve maximum payments under this title.

''(2) TRACKING OF PATIENTS THAT SWITCH HOME HEALTH AGENCIES DURING EPISODE.—

''(A) DEVELOPMENT OF SYSTEM.—The Secretary shall develop a system that tracks home health patients that receive home health services described in subsection (a)(2) from more than 1 home health agency during an episode described in subsection (c)(1)(D).

''(B) ADJUSTMENT OF PAYMENTS.—The Secretary shall adjust payments under this section to each home health agency that furnishes an individual with a type of home health service described in subsection (a)(2) to ensure that aggregate payments on behalf of such individual during such episode do not exceed the amount that would be paid under this section if the individual received such services from a single home health agency.

''(3) LOW-COST CASES.—The Secretary shall develop a system designed to adjust payments to a home health agency for a fiscal year to eliminate any increase in growth of the percentage of low-cost episodes for which home health services are furnished by the agency over such percentage determined for the agency for the 12-month cost reporting period ending on June 30, 1994. The Secretary shall define a low-cost episode in a manner that provides that a home health agency has an incentive to be cost efficient in delivering home health services and that the volume of such services does not increase as a result of factors other than patient needs.

''(f) REPORT BY MEDICARE PAYMENT REVIEW COMMISSION.—During the first 3 years in which payments are made under this section, the Medicare Payment Review Commission shall annually submit a report to Congress on the effectiveness of the payment methodology established under this section that shall include recommendations regarding the following:

''(1) Case-mix and volume increases.

''(2) Quality monitoring of home health agency practices.

''(3) Whether a capitated payment for home care patients receiving care during a continuous period exceeding 165 days is warranted.

''(4) Whether public providers of service are adequately reimbursed.

''(5) The adequacy of the exemptions and exceptions to the limits provided under subsection (c)(1)(E).

''(6) The appropriateness of the methods provided under this section to adjust the per episode limits and annual payment updates to reflect changes in the mix of services, number of visits, and assignment to case categories to reflect changing patterns of home health care.

''(7) The geographic areas used to determine the per episode limits.

''(g) NO EFFECT ON NON-MEDICARE SERVICES.—Nothing in this section may be construed to affect the provision of or payment for home health services for which payment is not made under this title.''.

(b) PAYMENT FOR PROSTHETICS AND ORTHOTICS UNDER PART A.—Section 1814(k) (42 U.S.C. 1395f(k)) is amended—

(1) by inserting ''and prosthetics and orthotics'' after ''durable medical equipment''; and

(2) by inserting ''and 1834(h), respectively'' after ''1834(a)(1)''.

(c) CONFORMING AMENDMENTS.—

(1) PAYMENTS UNDER PART A.—Section 1814(b) (42 U.S.C. 1395f(b)), as amended by section 15522(b), is amended in the matter preceding paragraph (1) by striking ''1888 and 1888A'' and inserting ''1888, 1888A, and 1894''.

(2) TREATMENT OF ITEMS AND SERVICES PAID UNDER PART B.—

(A) PAYMENTS UNDER PART B.—Section 1833(a)(2) (42 U.S.C. 1395l(a)(2)) is amended—

(i) by amending subparagraph (A) to read as follows:

''(A) with respect to home health services—

''(i) that are a type of home health service described in section 1894(a)(2), and which are furnished to an individual who (at the time the item or service is furnished) is under a plan of care of a home health agency, the amount determined under section 1894; or

''(ii) that are not described in clause (i) (other than a covered osteoporosis drug) (as defined in section 1861(kk)), the lesser of—

''(I) the reasonable cost of such services, as determined under section 1861(v), or

''(II) the customary charges with respect to such services;''.

(ii) by striking ''and'' at the end of subparagraph (E);

(iii) by adding ''and'' at the end of subparagraph (F); and

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

''(G) with respect to items and services described in section 1861(s)(10)(A), the lesser of—

''(i) the reasonable cost of such services, as determined under section 1861(v), or

''(ii) the customary charges with respect to such services,

or, if such services are furnished by a public provider of services, or by another provider which demonstrates to the satisfaction of the Secretary that a significant portion of its patients are low-income (and requests that payment be made under this provision), free of charge or at nominal charges to the public, the amount determined in accordance with section 1814(b)(2);''.

(B) REQUIRING PAYMENT FOR ALL ITEMS AND SERVICES TO BE MADE TO AGENCY.—

(i) IN GENERAL.—The first sentence of section 1842(b)(6) (42 U.S.C. 1395u(b)(6)), as amended by section 15525(a)(1), is amended—

(I) by striking ''and (E)'' and inserting ''(E)''; and

(II) by striking the period at the end and inserting the following: '', and (F) in the case of types of home health services described in section 1894(a)(2) furnished to an individual who (at the time the item or service is furnished) is under a plan of care of a home health agency, payment shall be made to the agency (without regard to whether or not the item or service was furnished by the agency, by others under arrangement with them made by the agency, or otherwise).''.

(ii) CONFORMING AMENDMENT.—Section 1832(a)(1) (42 U.S.C. 1395k(a)(1)), as amended by section 15525(a)(3), is amended by striking ''section 1842(b)(6)(E);'' and inserting ''subparagraphs (E) and (F) of section 1842(b)(6);''.

(C) EXCLUSIONS FROM COVERAGE.—Section 1862(a) (42 U.S.C. 1395y(a)), as amended by section 15525(a)(2) and section 15609B(a), is amended—

(i) by striking ''or'' at the end of paragraph (16);

(ii) by striking the period at the end of paragraph (17) and inserting ''; or''; and

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

''(18) where such expenses are for home health services furnished to an individual who is under a plan of care of the home health agency if the claim for payment for such services is not submitted by the agency.''.

(3) SUNSET OF REASONABLE COST LIMITATIONS.—Section 1861(v)(1)(L) (42 U.S.C. 1395x(v)(1)(L)) is amended by adding at the end the following new clause:

''(iv) This subparagraph shall apply only to services furnished by home health agencies during cost reporting periods ending on or before September 30, 1996.''.

(d) LIMITATION ON PART A COVERAGE.—

(1) IN GENERAL.—Section 1812(a)(3) (42 U.S.C. 1395d(a)(3)) is amended by striking the semicolon and inserting ''for up to 165 days during any spell of illness;''.

(2) CONFORMING AMENDMENT.—Section 1812(b) (42 U.S.C. 1395d(b)) is amended—

(A) by striking ''or'' at the end of paragraph (2),

(B) by striking the period at the end of paragraph (3) and inserting ''; or'', and

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

''(4) home health services furnished to the individual during such spell after such services have been furnished to the individual for 165 days during such spell.''.

(3) EXCLUSION OF ADDITIONAL PART B COSTS FROM DETERMINATION OF PART B MONTHLY PREMIUM.—Section 1839(a) (42 U.S.C. 1395r(a)) is amended—

(A) in the second sentence of paragraph (1), by striking ''enrollees.'' and inserting ''enrollees (except as provided in paragraph (5)).''; and

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

''(5) In estimating the benefits and administrative costs which will be payable from the Federal Supplementary Medical Insurance Trust Fund for a year (beginning with 1996), the Secretary shall exclude an estimate of any benefits and costs attributable to home health services for which payment would have been made under part A during the year but for paragraph (4) of section 1812(b).''.

(4) EFFECTIVE DATE.—The amendments made by this subsection shall apply to spells of illness beginning on or after October 1, 1995.

(e) EFFECTIVE DATE.—Except as provided in subsection (d)(4), the amendments made by this section shall apply to cost reporting periods beginning on or after October 1, 1996.

SEC. 15702. MAINTAINING SAVINGS RESULTING FROM TEMPORARY FREEZE ON PAYMENT INCREASES FOR HOME HEALTH SERVICES.

(a) BASING UPDATES TO PER VISIT COST LIMITS ON LIMITS FOR FISCAL YEAR 1993.—Section 1861(v)(1)(L)(iii) (42 U.S.C. 1395x(v)(1)(L)(iii)) is amended by adding at the end the following sentence: ''In establishing limits under this subparagraph, the Secretary may not take into account any changes in the costs of the provision of services furnished by home health agencies with respect to cost reporting periods which began on or after July 1, 1994, and before July 1, 1996.''.

(b) NO EXCEPTIONS PERMITTED BASED ON AMENDMENT.—The Secretary of Health and Human Services shall not consider the amendment made by subsection (a) in making any exemptions and exceptions pursuant to section 1861(v)(1)(L)(ii) of the Social Security Act.

SEC. 15703. EXTENSION OF WAIVER OF PRESUMPTION OF LACK OF KNOWLEDGE OF EXCLUSION FROM COVERAGE FOR HOME HEALTH AGENCIES.

Section 9305(g)(3) of OBRA–1986, as amended by section 426(d) of the Medicare Catastrophic Coverage Act of 1988 and section 4207(b)(3) of OBRA–1990 (as renumbered by section 160(d)(4) of the Social Security Act Amendments of 1994), is amended by striking ''December 31, 1995'' and inserting ''September 30, 1996''.

SEC. 15704. REPORT ON RECOMMENDATIONS FOR PAYMENTS AND CERTIFICATION FOR HOME HEALTH SERVICES OF CHRISTIAN SCIENCE PROVIDERS.

Not later than July 1, 1996, the Secretary of Health and Human Services shall submit recommendations to Congress regarding an appropriate methodology for making payments under the medicare program for home health services furnished by Christian Science providers who meet applicable requirements of the First Church of Christ, Scientist, Boston, Massachusetts, and appropriate criteria for the certification of such providers for purposes of the medicare program.

SEC. 15705. EXTENSION OF PERIOD OF HOME HEALTH AGENCY CERTIFICATION.

Section 1891(c)(2)(A) (42 U.S.C. 1395bbb(c)(2)(A)) is amended—

(1) by striking ''15 months'' and inserting ''36 months''; and

(2) by striking the second sentence and inserting the following: ''The Secretary shall establish a frequency for surveys of home health agencies within this 36-month interval commensurate with the need to assure the delivery of quality home health services.''.

PART 2—MEDICARE SECONDARY PAYER IMPROVEMENTS

SEC. 15711. EXTENSION AND EXPANSION OF EXISTING REQUIREMENTS.

(a) DATA MATCH.—

(1) Section 1862(b)(5)(C) (42 U.S.C. 1395y(b)(5)(C)) is amended by striking clause (iii).

(2) Section 6103(l)(12) of the Internal Revenue Code of 1986 is amended by striking subparagraph (F).

(b) APPLICATION TO DISABLED INDIVIDUALS IN LARGE GROUP HEALTH PLANS.—

(1) IN GENERAL.—Section 1862(b)(1)(B) (42 U.S.C. 1395y(b)(1)(B)) is amended—

(A) in clause (i), by striking ''clause (iv)'' and inserting ''clause (iii)'',

(B) by striking clause (iii), and

(C) by redesignating clause (iv) as clause (iii).

(2) CONFORMING AMENDMENTS.—Paragraphs (1) through (3) of section 1837(i) (42 U.S.C. 1395p(i)) and the second sentence of section 1839(b) (42 U.S.C. 1395r(b)) are each amended by striking ''1862(b)(1)(B)(iv)'' each place it appears and inserting ''1862(b)(1)(B)(iii)''.

(c) EXPANSION OF PERIOD OF APPLICATION TO INDIVIDUALS WITH END STAGE RENAL DISEASE.—Section 1862(b)(1)(C) (42 U.S.C. 1395y(b)(1)(C)) is amended—

(1) in the first sentence, by striking ''12-month'' each place it appears and inserting ''24-month'', and

(2) by striking the second sentence.

SEC. 15712. IMPROVEMENTS IN RECOVERY OF PAYMENTS.

(a) PERMITTING RECOVERY AGAINST THIRD PARTY ADMINISTRATORS OF PRIMARY PLANS.—Section 1862(b)(2)(B)(ii) (42 U.S.C. 1395y(b)(2)(B)(ii)) is amended—

(1) by striking ''under this subsection to pay'' and inserting ''(directly, as a third-party administrator, or otherwise) to make payment'', and

(2) by adding at the end the following: ''The United States may not recover from a third-party administrator under this clause in cases where the third-party administrator would not be able to recover the amount at issue from the employer or group health plan for whom it provides administrative services due to the insolvency or bankruptcy of the employer or plan.''.

(b) EXTENSION OF CLAIMS FILING PERIOD.—Section 1862(b)(2)(B) (42 U.S.C. 1395y(b)(2)(B)) is amended by adding at the end the following new clause:

''(v) CLAIMS-FILING PERIOD.—Notwithstanding any other time limits that may exist for

filing a claim under an employer group health plan, the United States may seek to recover conditional payments in accordance with this subparagraph where the request for payment is submitted to the entity required or responsible under this subsection to pay with respect to the item or service (or any portion thereof) under a primary plan within the 3-year period beginning on the date on which the item or service was furnished.''.

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

SEC. 15713. PROHIBITING RETROACTIVE APPLICATION OF POLICY REGARDING ESRD BENEFICIARIES ENROLLED IN PRIMARY PLANS.

For purposes of carrying out section 1862(b)(1)(C) of the Social Security Act, the Secretary of Health and Human Services shall apply the policy directive issued by the Administrator of the Health Care Financing Administration on April 24, 1995, only with respect to items and services furnished on or after such date.

PART 3—FAILSAFE

SEC. 15721. FAILSAFE BUDGET MECHANISM.

(a) IN GENERAL.—Title XVIII, as amended by sections 15106(a) and 15701(a), is amended by adding at the end the following new section:

''FAILSAFE BUDGET MECHANISM

''SEC. 1895. (a) REQUIREMENT OF PAYMENT ADJUSTMENTS TO ACHIEVE MEDICARE BUDGET TARGETS.—If the Secretary determines under subsection (e)(3)(C) before a fiscal year (beginning with fiscal year 1998) that—

''(1) the fee-for-service expenditures (as defined in subsection (f)) for a sector of medicare services (as defined in subsection (b)) for the fiscal year, will exceed

''(2) the allotment specified under subsection (c)(2) for such fiscal year (taking into account any adjustment in the allotment under subsection (h) for that fiscal year),

then, notwithstanding any other provision of this title, there shall be an adjustment (consistent with subsection (d)) in applicable payment rates or payments for items and services included in the sector in the fiscal year so that such expenditures for the sector for the year will be reduced by 133⅓ percent of the amount of such excess.

''(b) SECTORS OF MEDICARE SERVICES DESCRIBED.—

''(1) IN GENERAL.—For purposes of this section, items and services included under each of the following subparagraphs shall be considered to be a separate 'sector' of medicare services:

''(A) Inpatient hospital services.

''(B) Home health services.

''(C) Extended care services (for inpatients of skilled nursing facilities).

''(D) Hospice care.

''(E) Physicians' services (including services and supplies described in section 1861(s)(2)(A)) and services of other health care professionals (including certified registered nurse anesthetists, nurse practitioners, physician assistants, and clinical psychologists) for which separate payment is made under this title.

''(F) Outpatient hospital services and ambulatory facility services.

''(G) Durable medical equipment and supplies, including prosthetic devices and orthotics.

''(H) Diagnostic tests (including clinical laboratory services and x-ray services).

''(I) Other items and services.

''(2) CLASSIFICATION OF ITEMS AND SERVICES.—The Secretary shall classify each type of items and services covered and paid for separately under this title into one of the sectors specified in paragraph (1). After publication of such classification under subsection (e)(1), the Secretary is not authorized to make substantive changes in such classification.

''(c) ALLOTMENT.—

''(1) ALLOTMENTS FOR EACH SECTOR.—For purposes of this section, subject to subsection (h)(1), the allotment for a sector of medicare services for a fiscal year is equal to the product of—

''(A) the total allotment for the fiscal year established under paragraph (2), and

''(B) the allotment proportion (specified under paragraph (3)) for the sector and fiscal year involved.

''(2) TOTAL ALLOTMENT.—

''(A) IN GENERAL.—For purposes of this section, the total allotment for a fiscal year is equal to—

''(i) the medicare benefit budget for the fiscal year (as specified under subparagraph (B)), reduced by

''(ii) the amount of payments the Secretary estimates will be made in the fiscal year under the MedicarePlus program under part C.

In making the estimate under clause (ii), the Secretary shall take into account estimated enrollment and demographic profile of individuals electing MedicarePlus products.

''(B) MEDICARE BENEFIT BUDGET.—For purposes of this subsection, subject to subparagraph (C), the 'medicare benefit budget'—

''(i) for fiscal year 1997 is $208.0 billion;

''(ii) for fiscal year 1998 is $217.1 billion;

''(iii) for fiscal year 1999 is $228.4 billion;

''(iv) for fiscal year 2000 is $246.4 billion;

''(v) for fiscal year 2001 is $265.5 billion;

''(vi) for fiscal year 2002 is $288.0 billion; and

''(vii) for a subsequent fiscal year is equal to the medicare benefit budget under this subparagraph for the preceding fiscal year increased by the product of (I) 1.05, and (II) 1 plus the annual percentage increase in the average number of medicare beneficiaries from the previous fiscal year to the fiscal year involved.

''(3) MEDICARE ALLOTMENT PROPORTION DEFINED.—

''(A) IN GENERAL.—For purposes of this section and with respect to a sector of medicare services for a fiscal year, the term 'medicare allotment proportion' means the ratio of—

''(i) the baseline-projected medicare expenditures (as determined under subparagraph (B)) for the sector for the fiscal year, to

''(ii) the sum of such baseline expenditures for all such sectors for the fiscal year.

''(B) BASELINE-PROJECTED MEDICARE EXPENDITURES.—In this paragraph, the 'baseline, projected medicare expenditures' for a sector of medicare services—

''(i) for fiscal year 1996 is equal to fee-for-service expenditures for such sector during fiscal year 1995, increased by the baseline annual growth rate for such sector of medicare services for fiscal year 1996 (as specified in table in subparagraph (C)); and

''(ii) for a subsequent fiscal year is equal to the baseline-projected medicare expenditures under this subparagraph for the sector for the previous fiscal year increased by the baseline annual growth rate for such sector for the fiscal year involved (as specified in such table).

''(C) BASELINE ANNUAL GROWTH RATES.—The following table specifies the baseline annual growth rates for each of the sectors for different fiscal years:

''For the following sector—	Baseline annual growth rates for fiscal year—						
	1996	1997	1998	1999	2000	2001	2002 and thereafter
(A) Inpatient hospital services	5.7%	5.6%	6.0%	6.1%	5.7%	5.5%	5.2%
(B) Home health services	17.2%	15.1%	11.7%	9.1%	8.4%	8.1%	7.9%
(C) Extended care services	19.7%	12.3%	9.3%	8.7%	8.6%	8.4%	8.0%
(D) Hospice care	32.0%	24.0%	18.0%	15.0%	12.0%	10.0%	9.0%
(E) Physicians' services	12.4%	9.7%	8.7%	9.0%	9.3%	9.6%	10.1%
(F) Outpatient hospital services	14.7%	13.9%	14.5%	15.0%	14.1%	13.9%	14.0%
(G) Durable medical equipment and supplies	16.1%	15.5%	13.7%	12.4%	13.2%	13.9%	14.5%
(H) Diagnostic tests	13.1%	11.3%	11.0%	11.4%	11.4%	11.5%	11.9%
(I) Other items and services	11.2%	10.2%	10.9%	12.0%	11.6%	11.6%	11.8%

''(d) MANNER OF PAYMENT ADJUSTMENT.—

''(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, the Secretary shall apply a payment reduction for a sector for a fiscal year in such a manner as to—

''(A) make a change in payment rates (to the maximum extent practicable) at the time payment rates are otherwise changed or subject to change for that fiscal year; and

''(B) provide for the full appropriate adjustment so that the fee-for-service expenditures for the sector for the fiscal year will approximate (and not exceed) the allotment for the sector for the fiscal year.

''(2) TAKING INTO ACCOUNT VOLUME AND CASH FLOW.—In providing for an adjustment in payments under this subsection for a sector for a fiscal year, the Secretary shall take into account (in a manner consistent with actuarial projections)—

''(A) the impact of such an adjustment on the volume or type of services provided in such sector (and other sectors), and

''(B) the fact that an adjustment may apply to items and services furnished in a fiscal year (payment for which may occur in a subsequent fiscal year),

in a manner that is consistent with assuring that total fee-for-services expenditures for each sector for the fiscal year will not exceed the allotment under subsection (c)(1) for such sector for such year.

''(3) PROPORTIONALITY OF REDUCTIONS WITHIN A SECTOR.—In making adjustments under this subsection in payment for items and services included within a sector of medicare services for a fiscal year, the Secretary shall provide for such an adjustment that results (to the maximum extent feasible) in the

same percentage reductions in aggregate Federal payments under parts A and B for the different classes of items and services included within the sector for the fiscal year.

''(4) APPLICATION TO PAYMENTS MADE BASED ON PROSPECTIVE PAYMENT RATES DETERMINED ON A FISCAL YEAR BASIS.—

''(A) IN GENERAL.—In applying subsection (a) with respect to items and services for which payment is made under part A or B on the basis of rates that are established on a prospective basis for (and in advance of) a fiscal year, the Secretary shall provide for the payment adjustment under such subsection through an appropriate reduction in such rates established for items and services furnished (or, in the case of payment for operating costs of inpatient hospital services of subsection (d) hospitals and subsection (d) Puerto Rico hospitals (as defined in paragraphs (1)(B) and (9)(A) of section 1886(d)), discharges occurring) during such year.

''(B) DESCRIPTION OF APPLICATION TO SPECIFIC SERVICES.—The payment adjustment described in subparagraph (A) applies for a fiscal year to at least the following:

''(i) UPDATE FACTOR FOR PAYMENT FOR OPERATING COSTS OF INPATIENT HOSPITAL SERVICES OF PPS HOSPITALS.—To the computation of the applicable percentage increase specified in section 1886(d)(3)(B)(i) for discharges occurring in the fiscal year.

''(ii) HOME HEALTH SERVICES.—To the extent payment amounts for home health services are based on per visit payment rates under section 1894, to the computation of the increase in the national per visit payment rates established for the year under section 1894(b)(2)(B).

''(iii) HOSPICE CARE.—To the update of payment rates for hospice care under section 1814(i) for services furnished during the fiscal year.

''(iv) UPDATE FACTOR FOR PAYMENT OF OPERATING COSTS OF INPATIENT HOSPITAL SERVICES OF PPS-EXEMPT HOSPITALS.—To the computation of the target amount under section 1886(b)(3) for discharges occurring during the fiscal year.

''(v) COVERED NON-ROUTINE SERVICES OF SKILLED NURSING FACILITIES.—To the computation of the facility per stay limits for the year under section 1888A(d) for covered non-routine services of a skilled nursing facility (as described in such section).

''(5) APPLICATION TO PAYMENTS MADE BASED ON PROSPECTIVE PAYMENT RATES DETERMINED ON A CALENDAR YEAR BASIS.—

''(A) IN GENERAL.—In applying subsection (a) for a fiscal year with respect to items and services for which payment is made under part A or B on the basis of rates that are established on a prospective basis for (and in advance of) a calendar year, the Secretary shall provide for the payment adjustment under such subsection through an appropriate reduction in such rates established for items and services furnished at any time during such calendar year as follows:

''(i) For fiscal year 1997, the reduction shall be made for payment rates during calendar year 1997 in a manner so as to achieve the necessary payment reductions for such fiscal year for items and services furnished during the first 3 quarters of calendar year 1997.

''(ii) For a subsequent fiscal year, the reduction shall be made for payment rates during the calendar year in which the fiscal year ends in a manner so as to achieve the necessary payment reductions for such fiscal year for items and services furnished during the first 3 quarters of the calendar year, but also taking into account the payment reductions made in the first quarter of the fiscal year resulting from payment reductions made under this paragraph for the previous calendar year.

''(iii) Payment rate reductions effected under this subparagraph for a calendar year and applicable to the last 3 quarters of the fiscal year in which the calendar year ends shall continue to apply during the first quarter of the succeeding fiscal year.

''(B) APPLICATION IN SPECIFIC CASES.—The payment adjustment described in subparagraph (A) applies for a fiscal year to at least the following:

''(i) UPDATE IN CONVERSION FACTOR FOR PHYSICIANS' SERVICES.—To the computation of the conversion factor under subsection (d) of section 1848 used in the fee schedule established under subsection (b) of such section, for items and services furnished during the calendar year in which the fiscal year ends.

''(ii) PAYMENT RATES FOR OTHER HEALTH CARE PROFESSIONALS.—To the computation of payments for professional services of certified registered nurse anesthetists under section 1833(l), nurse midwives, physician assistants, nurse practitioners and clinical nurse specialists under section 1833(r), clinical psychologists, clinical social workers, physical or occupational therapists, and any other health professionals for which payment rates are based (in whole or in part) on payments for physicians' services, for services furnished during the calendar year in which the fiscal year ends.

''(iii) UPDATE IN LAB FEE SCHEDULE.—To the computation of the fee schedule amount under section 1833(h)(2) for clinical diagnostic laboratory services furnished during the calendar year in which the fiscal year ends.

''(iv) UPDATE IN REASONABLE CHARGES FOR VACCINES.—To the computation of the reasonable charge for vaccines described in section 1861(s)(10) for vaccines furnished during the calendar year in which the fiscal year ends.

''(v) DURABLE MEDICAL EQUIPMENT-RELATED ITEMS.—To the computation of the payment basis under section 1834(a)(1)(B) for covered items described in section 1834(a)(13), for items furnished during the calendar year in which the fiscal year ends.

''(vi) RADIOLOGIST SERVICES.—To the computation of conversion factors for radiologist services under section 1834(b), for services furnished during the calendar year in which the fiscal year ends.

''(vii) SCREENING MAMMOGRAPHY.—To the computation of payment rates for screening mammography under section 1834(c)(1)(C)(ii), for screening mammography performed during the calendar year in which the fiscal year ends.

''(viii) PROSTHETICS AND ORTHOTICS.—To the computation of the amount to be recognized under section 1834(h) for payment for prosthetic devices and orthotics and prosthetics, for items furnished during the calendar year in which the fiscal year ends.

''(ix) SURGICAL DRESSINGS.—To the computation of the payment amount referred to in section 1834(i)(1)(B) for surgical dressings, for items furnished during the calendar year in which the fiscal year ends.

''(x) PARENTERAL AND ENTERAL NUTRITION.—To the computation of reasonable charge screens for payment for parenteral and enteral nutrition under section 1834(h), for nutrients furnished during the calendar year in which the fiscal year ends.

''(xi) AMBULANCE SERVICES.—To the computation of limits on reasonable charges for ambulance services, for services furnished during the calendar year in which the fiscal year ends.

''(6) APPLICATION TO PAYMENTS MADE BASED ON COSTS DURING A COST REPORTING PERIOD.—

''(A) IN GENERAL.—In applying subsection (a) for a fiscal year with respect to items and services for which payment is made under part A or B on the basis of costs incurred for items and services in a cost reporting period, the Secretary shall provide for the payment adjustment under such subsection for a fiscal year through an appropriate proportional reduction in the payment for costs for such items and services incurred at any time during each cost reporting period any part of which occurs during the fiscal year involved, but only (for each such cost reporting period) in the same proportion as the fraction of the cost reporting period that occurs during the fiscal year involved.

''(B) APPLICATION IN SPECIFIC CASES.—The payment adjustment described in subparagraph (A) applies for a fiscal year to at least the following:

''(i) CAPITAL-RELATED COSTS OF HOSPITAL SERVICES.—To the computation of payment amounts for inpatient and outpatient hospital services under sections 1886(g) and 1861(v) for portions of cost reporting periods occurring during the fiscal year.

''(ii) OPERATING COSTS FOR PPS-EXEMPT HOSPITALS.—To the computation of payment amounts under section 1886(b) for operating costs of inpatient hospital services of PPS-exempt hospitals for portions of cost reporting periods occurring during the fiscal year.

''(iii) DIRECT GRADUATE MEDICAL EDUCATION.—To the computation of payment amounts under section 1886(h) for reasonable costs of direct graduate medical education costs for portions of cost reporting periods occurring during the fiscal year.

''(iv) INPATIENT RURAL PRIMARY CARE HOSPITAL SERVICES.—To the computation of payment amounts under section 1814(j) for inpatient rural primary care hospital services for portions of cost reporting periods occurring during the fiscal year.

''(v) EXTENDED CARE SERVICES OF A SKILLED NURSING FACILITY.—To the computation of payment amounts under section 1861(v) for post-hospital extended care services of a skilled nursing facility (other than covered non-routine services subject to section 1888A) for portions of cost reporting periods occurring during the fiscal year.

''(vi) REASONABLE COST CONTRACTS.—To the computation of payment amounts under section 1833(a)(1)(A) for organizations for portions of cost reporting periods occurring during the fiscal year.

''(vii) HOME HEALTH SERVICES.—Subject to paragraph (4)(B)(ii), for payment amounts for home health services, for portions of cost reporting periods occurring during such fiscal year.

''(7) OTHER.—In applying subsection (a) for a fiscal year with respect to items and services for which payment is made under part A or B on a basis not described in a previous paragraph of this subsection, the Secretary shall provide for the payment adjustment under such subsection through an appropriate proportional reduction in the payments (or payment bases for items and services furnished) during the fiscal year.

''(8) ADJUSTMENT OF PAYMENT LIMITS.—The Secretary shall provide for such proportional adjustment in any limits on payment established under part A or B for payment for items and services within a sector as may be appropriate based on (and in order to properly carry out) the adjustment on the amount of payment under this subsection in the sector.

''(9) REFERENCES TO PAYMENT RATES.—Except as the Secretary may provide, any reference in this title (other than this section) to a payment rate is deemed a reference to such a rate as adjusted under this subsection.

''(e) PUBLICATION OF DETERMINATIONS; JUDICIAL REVIEW.—

''(1) ONE-TIME PUBLICATION OF SECTORS AND GENERAL PAYMENT ADJUSTMENT METHODOLOGY.—Not later than October 1, 1996, the Secretary shall publish in the Federal Register the classification of medicare items and services into the sectors of medicare services under subsection (b) and the general methodology to be used in applying payment adjustments to the different classes of items and services within the sectors.

''(2) INCLUSION OF INFORMATION IN PRESIDENT'S BUDGET.—

''(A) IN GENERAL.—With respect to fiscal years beginning with fiscal year 1999, the President shall include in the budget submitted under section 1105 of title 31, United States Code, information on—

''(i) the fee-for-service expenditures, within each sector, for the second previous fiscal year, and how such expenditures compare to the adjusted sector allotment for that sector for that fiscal year; and

''(ii) actual annual growth rates for fee-for-service expenditures in the different sectors in the second previous fiscal year.

''(B) RECOMMENDATIONS REGARDING GROWTH FACTORS.—The President may include in such budget for a fiscal year (beginning with fiscal year 1998) recommendations regarding percentages that should be applied (for one or more fiscal years beginning with that fiscal year) instead of the baseline annual growth rates under subsection (c)(3)(C). Such recommendations shall take into account medically appropriate practice patterns.

''(3) DETERMINATIONS CONCERNING PAYMENT ADJUSTMENTS.—

''(A) RECOMMENDATIONS OF COMMISSION.—By not later than March 1 of each year (beginning with 1997), the Medicare Payment Review Commission shall submit to the Secretary and the Congress a report that analyzes the previous operation (if any) of this section and that includes recommendations concerning the manner in which this section should be applied for the following fiscal year.

''(B) PRELIMINARY NOTICE BY SECRETARY.—Not later than May 15 preceding the beginning of each fiscal year (beginning with fiscal year 1998), the Secretary shall publish in the Federal Register a notice containing the Secretary's preliminary determination, for each sector of medicare services, concerning the following:

''(i) The projected allotment under subsection (c) for such sector for the fiscal year.

''(ii) Whether there will be a payment adjustment for items and services included in such sector for the fiscal year under subsection (a).

''(iii) If there will be such an adjustment, the size of such adjustment and the methodology to be used in making such a payment adjustment for classes of items and services included in such sector.

''(iv) Beginning with fiscal year 1999, the fee-for-service expenditures for such sector for the second preceding fiscal year.

Such notice shall include an explanation of the basis for such determination. Determinations under this subparagraph and subparagraph (C) shall be based on the best data available at the time of such determinations.

''(C) FINAL DETERMINATION.—Not later than September 1 preceding the beginning of each fiscal year (beginning with fiscal year 1998), the Secretary shall publish in the Federal Register a final determination, for each sector of medicare services, concerning the matters described in subparagraph (B) and an explanation of the reasons for any differences between such determination and the preliminary determination for such fiscal year published under subparagraph (B).

''(4) LIMITATION ON ADMINISTRATIVE OR JUDICIAL REVIEW.—There shall be no administrative or judicial review under section 1878 or otherwise of—

''(A) the classification of items and services among the sectors of medicare services under subsection (b),

''(B) the determination of the amounts of allotments for the different sectors of medicare services under subsection (c),

''(C) the determination of the amount (or method of application) of any payment adjustment under subsection (d), or

''(D) any adjustment in an allotment effected under subsection (h).

''(f) FEE-FOR-SERVICE EXPENDITURES DEFINED.—In this section, the term 'fee-for-service expenditures', for items and services within a sector of medicare services in a fiscal year, means amounts payable for such items and services which are furnished during the fiscal year, and—

''(1) includes types of expenses otherwise reimbursable under parts A and B (including administrative costs incurred by organizations described in sections 1816 and 1842) with respect to such items and services, and

''(2) does not include amounts paid under part C.

''(g) EXPEDITED PROCESS FOR ADJUSTMENT OF SECTOR GROWTH RATES.—

''(1) OPTIONAL INCLUSION OF LEGISLATIVE PROPOSAL.—The President may include in recommendations under subsection (e)(2)(B) submitted with respect to a fiscal year a specific legislative proposal that provides only for the substitution of percentages specified in the proposal for one or more of the baseline annual growth rates (specified in the table in subsection (c)(3)(C) or in a previous legislative proposal under this subsection) for that fiscal year or any subsequent fiscal year.

''(2) CONGRESSIONAL CONSIDERATION.—

''(A) IN GENERAL.—The percentages contained in a legislative proposal submitted under paragraph (1) shall apply under this section if a joint resolution (described in subparagraph (B)) approving such proposal is enacted, in accordance with the provisions of subparagraph (C), before the end of the 60-day period beginning on the date on which such proposal was submitted. For purposes of applying the preceding sentence and subparagraphs (B) and (C), the days on which either House of Congress is not in session because of an adjournment of more than three days to a day certain shall be excluded in the computation of a period.

''(B) JOINT RESOLUTION OF APPROVAL.—A joint resolution described in this subparagraph means only a joint resolution which is introduced within the 10-day period beginning on the date on which the President submits a proposal under paragraph (1) and—

''(i) which does not have a preamble;

''(ii) the matter after the resolving clause of which is as follows: 'That Congress approves the proposal of the President providing for substitution of percentages for certain baseline annual growth rates under section 1895 of the Social Security Act, as submitted by the President on _____.', the blank space being filled in with the appropriate date; and

''(iii) the title of which is as follows: 'Joint resolution approving Presidential proposal to substitute certain specified percentages for baseline annual growth rates under section 1895 of the Social Security Act, as submitted by the President on _____.', the blank space being filled in with the appropriate date.

''(C) PROCEDURES FOR CONSIDERATION OF RESOLUTION OF APPROVAL.—Subject to subparagraph (D), the provisions of section 2908 (other than subsection (a)) of the Defense Base Closure and Realignment Act of 1990 shall apply to the consideration of a joint resolution described in subparagraph (B) in the same manner as such provisions apply to a joint resolution described in section 2908(a) of such Act.

''(D) SPECIAL RULES.—For purposes of applying subparagraph (C) with respect to such provisions—

''(i) any reference to the Committee on Armed Services of the House of Representatives shall be deemed a reference to an appropriate Committee of the House of Representatives (specified by the Speaker of the House of Representatives at the time of submission of a legislative proposal under paragraph (1)) and any reference to the Committee on Armed Services of the Senate shall be deemed a reference to the Committee on Finance of the Senate;

''(ii) any reference to a resolution of which a committee shall be discharged from further consideration shall be deemed to be a reference to the first such resolution introduced; and

''(iii) any reference to the date on which the President transmits a report shall be deemed a reference to the date on which the President submits the legislative proposal under paragraph (1).

''(h) LOOK-BACK ADJUSTMENT IN ALLOTMENTS TO REFLECT ACTUAL EXPENDITURES.—

''(1) IN GENERAL.—If the Secretary determines under subsection (e)(3)(B) with respect to a particular fiscal year (beginning with fiscal year 1999) that the fee-for-service expenditures for a sector of medicare services for the second preceding fiscal year—

''(A) exceeded the adjusted allotment for such sector for such year (as defined in paragraph (2)), then the allotment for the sector for the particular fiscal year shall be reduced by 133⅓ percent of the amount of such excess, or

''(B) was less than the adjusted allotment for such sector for such year, then the allotment for the sector for the particular fiscal year shall be increased by the amount of such deficit.

''(2) ADJUSTED ALLOTMENT.—The adjusted allotment under this paragraph for a sector for a fiscal year is—

''(A) the amount that would be computed as the allotment under subsection (c) for the sector for the fiscal year if the actual amount of payments made in the fiscal year under the MedicarePlus program under part C in the fiscal year were substituted for the amount described in subsection (c)(2)(A)(ii) for that fiscal year,

''(B) adjusted to take into account the amount of any adjustment under paragraph (1) for that fiscal year (based on expenditures in the second previous fiscal year).

''(i) PROSPECTIVE APPLICATION OF CERTAIN NATIONAL COVERAGE DETERMINATIONS.—In the case of a national coverage determination that the Secretary projects will result in significant additional expenditures under this title (taking into account any substitution for existing procedures or technologies), such determination shall not become effective before the beginning of the fiscal year that begins after the date of such determination and shall apply to contracts under part C entered into (or renewed) after the date of such determination.''.

(b) REPORT OF TRUSTEES ON GROWTH RATE IN PART A EXPENDITURES.—Section 1817 (42 U.S.C. 1395i) is amended by adding at the end the following new subsection:

''(k) Each annual report provided in subsection (b)(2) shall include information regarding the annual rate of growth in program expenditures that would be required to maintain the financial solvency of the Trust Fund and the extent to which the provisions of section 1895 restrain the rate of growth of expenditures under this part in order to achieve such solvency.''.

PART 4—ADMINISTRATIVE SIMPLIFICATION

SEC. 15731. STANDARDS FOR MEDICARE INFORMATION TRANSACTIONS AND DATA ELEMENTS.

Title XVIII, as amended by section 15031, is amended by inserting after section 1806 the following new section:

''STANDARDS FOR MEDICARE INFORMATION TRANSACTIONS AND DATA ELEMENTS

''SEC. 1807. (a) ADOPTION OF STANDARDS FOR DATA ELEMENTS.—

''(1) IN GENERAL.—Pursuant to subsection (b), the Secretary shall adopt standards for information transactions and data elements of medicare information and modifications to the standards under this section that are—

''(A) consistent with the objective of reducing the administrative costs of providing and paying for health care; and

''(B) developed or modified by a standard setting organization (as defined in subsection (h)(8)).

''(2) SPECIAL RULE RELATING TO DATA ELEMENTS.—The Secretary may adopt or modify a standard relating to data elements that is different from the standard developed by a standard setting organization, if—

''(A) the different standard or modification will substantially reduce administrative costs to health care providers and health plans compared to the alternative; and

''(B) the standard or modification is promulgated in accordance with the rulemaking procedures of subchapter III of chapter 5 of title 5, United States Code.

''(3) SECURITY STANDARDS FOR HEALTH INFORMATION NETWORK.—

''(A) IN GENERAL.—Each person, who maintains or transmits medicare information or data elements of medicare information and is subject to this section, shall maintain reasonable and appropriate administrative, technical, and physical safeguards—

''(i) to ensure the integrity and confidentiality of the information;

''(ii) to protect against any reasonably anticipated—

''(I) threats or hazards to the security or integrity of the information; and

''(II) unauthorized uses or disclosures of the information; and

''(iii) to otherwise ensure compliance with this section by the officers and employees of such person.

''(B) SECURITY STANDARDS.—The Secretary shall establish security standards and modifications to such standards with respect to medicare information network services, health plans, and health care providers that—

''(i) take into account—

''(I) the technical capabilities of record systems used to maintain medicare information;

''(II) the costs of security measures;

''(III) the need for training persons who have access to medicare information; and

''(IV) the value of audit trails in computerized record systems; and

''(ii) ensure that a medicare information network service, if it is part of a larger organization, has policies and security procedures which isolate the activities of such service with respect to processing information in a manner that prevents unauthorized access to such information by such larger organization.

The security standards established by the Secretary shall be based on the standards developed or modified by standard setting organizations. If such standards do not exist, the Secretary shall rely on the recommendations of the Medicare Information Advisory Committee (established under subsection (g)) and shall consult with appropriate government agencies and private organizations in accordance with paragraph (5).

''(4) IMPLEMENTATION SPECIFICATIONS.—The Secretary shall establish specifications for implementing each of the standards and the modifications to the standards adopted pursuant to paragraph (1) or (3).

''(5) ASSISTANCE TO THE SECRETARY.—In complying with the requirements of this section, the Secretary shall rely on recommendations of the Medicare Information Advisory Committee established under subsection (g) and shall consult with appropriate Federal and State agencies and private organizations. The Secretary shall publish in the Federal Register the recommendations of the Medicare Information Advisory Committee regarding the adoption of a standard under this section.

''(b) STANDARDS FOR INFORMATION TRANSACTIONS AND DATA ELEMENTS.—

''(1) IN GENERAL.—The Secretary shall adopt standards for transactions and data elements to make medicare information uniformly available to be exchanged electronically, that is—

''(A) appropriate for the following financial and administrative transactions: claims (including coordination of benefits) or equivalent encounter information, enrollment and disenrollment, eligibility, premium payments, and referral certification and authorization; and

''(B) related to other financial and administrative transactions determined appropriate by the Secretary consistent with the goals of improving the operation of the health care system and reducing administrative costs.

''(2) UNIQUE HEALTH IDENTIFIERS.—

''(A) ADOPTION OF STANDARDS.—The Secretary shall adopt standards providing for a standard unique health identifier for each individual, employer, health plan, and health care provider for use in the medicare information system. In developing unique health identifiers for each health plan and health care provider, the Secretary shall take into account multiple uses for identifiers and multiple locations and specialty classifications for health care providers.

''(B) PENALTY FOR IMPROPER DISCLOSURE.—A person who knowingly uses or causes to be used a unique health identifier under subparagraph (A) for a purpose that is not authorized by the Secretary shall—

''(i) be fined not more than $50,000, imprisoned not more than 1 year, or both; or

''(ii) if the offense is committed under false pretenses, be fined not more than $100,000, imprisoned not more than 5 years, or both.

''(3) CODE SETS.—

''(A) IN GENERAL.—The Secretary, in consultation with the Medicare Information Advisory Committee, experts from the private sector, and Federal and State agencies, shall—

''(i) select code sets for appropriate data elements from among the code sets that have been developed by private and public entities; or

''(ii) establish code sets for such data elements if no code sets for the data elements have been developed.

''(B) DISTRIBUTION.—The Secretary shall establish efficient and low-cost procedures for distribution (including electronic distribution) of code sets and modifications made to such code sets under subsection (c)(2).

''(4) ELECTRONIC SIGNATURE.—

''(A) IN GENERAL.—The Secretary, after consultation with the Medicare Information Advisory Committee, shall promulgate regulations specifying procedures for the electronic transmission and authentication of signatures, compliance with which will be deemed to satisfy Federal and State statutory requirements for written signatures with respect to information transactions required by this section and written signatures on enrollment and disenrollment forms.

''(B) PAYMENTS FOR SERVICES AND PREMIUMS.—Nothing in this section shall be construed to prohibit the payment of health care services or health plan premiums by debit, credit, payment card or numbers, or other electronic means.

''(5) TRANSFER OF INFORMATION BETWEEN HEALTH PLANS.—The Secretary shall develop rules and procedures—

''(A) for determining the financial liability of health plans when health care benefits are payable under two or more health plans; and

''(B) for transferring among health plans appropriate standard data elements needed for the coordination of benefits, the sequential processing of claims, and other data elements for individuals who have more than one health plan.

''(6) COORDINATION OF BENEFITS.—If, at the end of the 5-year period beginning on the date of the enactment of this section, the Secretary determines that additional transaction standards for coordinating benefits are necessary to reduce administrative costs or duplicative (or inappropriate) payment of claims, the Secretary shall establish further transaction standards for the coordination of benefits between health plans.

''(7) PROTECTION OF TRADE SECRETS.—Except as otherwise required by law, the standards adopted under this section shall not require disclosure of trade secrets or confidential commercial information by an entity operating a medicare information network.

''(c) TIMETABLES FOR ADOPTION OF STANDARDS.—

''(1) INITIAL STANDARDS.—Not later than 18 months after the date of the enactment of this section, the Secretary shall adopt standards relating to the information transactions, data elements of medicare information and security described in subsections (a) and (b).

''(2) ADDITIONS AND MODIFICATIONS TO STANDARDS.—

''(A) IN GENERAL.—The Secretary shall review the standards adopted under this section and shall adopt additional or modified standards, that have been developed or modified by a standard setting organization, as determined appropriate, but not more frequently than once every 12 months. Any addition or modification to such standards shall be completed in a manner which minimizes the disruption and cost of compliance.

''(B) ADDITIONS AND MODIFICATIONS TO CODE SETS.—

''(i) IN GENERAL.—The Secretary shall ensure that procedures exist for the routine maintenance, testing, enhancement, and expansion of code sets.

''(ii) ADDITIONAL RULES.—If a code set is modified under this paragraph, the modified code set shall include instructions on how data elements of medicare information that were encoded prior to the modification may be converted or translated so as to preserve the informational value of the data elements that existed before the modification. Any modification to a code set under this paragraph shall be implemented in a manner that minimizes the disruption and cost of complying with such modification.

''(d) REQUIREMENTS FOR HEALTH PLANS.—

''(1) IN GENERAL.—If a person desires to conduct any of the information transactions described in subsection (b)(1) with a health plan as a standard transaction, the health plan shall conduct such standard transaction in a timely manner and the information transmitted or received in connection with such transaction shall be in the form of standard data elements of medicare information.

''(2) SATISFACTION OF REQUIREMENTS.—A health plan may satisfy the requirement imposed on such plan under paragraph (1) by directly transmitting standard data elements of medicare information or submitting nonstandard data elements to a medicare information network service for processing into standard data elements and transmission.

''(3) TIMETABLES FOR COMPLIANCE WITH REQUIREMENTS.—Not later than 24 months after the date on which standards are adopted under subsections (a) and (b) with respect to any type of information transaction or data element of medicare information or with respect to security, a health plan shall comply with the requirements of this section with respect to such transaction or data element.

''(4) COMPLIANCE WITH MODIFIED STANDARDS.—If the Secretary adopts a modified standard under subsection (a) or (b), a health plan shall be required to comply with the modified standard at such time as the Secretary determines appropriate taking into account the time needed to comply due to the nature and extent of the modification. However, the time determined appropriate under the preceding sentence shall be not earlier than the last day of the 180-day period beginning on the date such modified standard is adopted. The Secretary may extend the time for compliance for small health plans, if the Secretary determines such extension is appropriate.

''(e) GENERAL PENALTY FOR FAILURE TO COMPLY WITH REQUIREMENTS AND STANDARDS.—

''(1) GENERAL PENALTY.—

''(A) IN GENERAL.—Except as provided in paragraph (2), the Secretary shall impose on any person that violates a requirement or standard—

''(i) with respect to medicare information transactions, data elements of medicare information, or security imposed under subsection (a) or (b); or

''(ii) with respect to health plans imposed under subsection (d);

a penalty of not more than $100 for each such violation of a specific standard or requirement, but the total amount imposed for all such violations of a specific standard or requirement during the calendar year shall not exceed $25,000.

''(B) PROCEDURES.—The provisions of section 1128A (other than subsections (a) and (b) and the second sentence of subsection (f)) shall apply to the imposition of a civil money penalty under this paragraph in the same manner as such provisions apply to the imposition of a penalty under such section 1128A.

''(C) DENIAL OF PAYMENT.—Except as provided in paragraph (2), the Secretary may deny payment under this title for an item or service furnished by a person if the person fails to comply with an applicable requirement or standard for medicare information relating to that item or service.

''(2) LIMITATIONS.—

''(A) NONCOMPLIANCE NOT DISCOVERED.—A penalty may not be imposed under paragraph (1) if it is established to the satisfaction of the Secretary that the person liable for the penalty did not know, and by exercising reasonable diligence would not have known, that such person failed to comply with the requirement or standard described in paragraph (1).

''(B) FAILURES DUE TO REASONABLE CAUSE.—

''(i) IN GENERAL.—Except as provided in clause (ii), a penalty may not be imposed under paragraph (1) if—

''(I) the failure to comply was due to reasonable cause and not to willful neglect; and

''(II) the failure to comply is corrected during the 30-day period beginning on the first date the person liable for the penalty knew, or by exercising reasonable diligence would have known, that the failure to comply occurred.

''(ii) EXTENSION OF PERIOD.—

''(I) NO PENALTY.—The period referred to in clause (i)(II) may be extended as determined appropriate by the Secretary based on the nature and extent of the failure to comply.

''(II) ASSISTANCE.—If the Secretary determines that a health plan failed to comply because such plan was unable to comply, the Secretary may provide technical assistance to such plan during the period described in clause (i)(II). Such assistance shall be provided in any manner determined appropriate by the Secretary.

''(C) REDUCTION.—In the case of a failure to comply which is due to reasonable cause and not to willful neglect, any penalty under paragraph (1) that is not entirely waived under subparagraph (B) may be waived to the extent that the payment of such penalty would be excessive relative to the compliance failure involved.

''(f) EFFECT ON STATE LAW.—

''(1) GENERAL EFFECT.—

''(A) GENERAL RULE.—Except as provided in subparagraph (B), a provision, requirement, or standard under this section shall supersede any contrary provision of State law, including a provision of State law that requires medical or health plan records (including billing information) to be maintained or transmitted in written rather than electronic form.

''(B) EXCEPTIONS.—A provision, requirement, or standard under this section shall not supersede a contrary provision of State law if the Secretary determines that the provision of State law should be continued for any reason, including for reasons relating to prevention of fraud and abuse or regulation of controlled substances.

''(2) PUBLIC HEALTH REPORTING.—Nothing in this section shall be construed to invalidate or limit the authority, power, or procedures established under any law providing for the reporting of disease or injury, child abuse, birth, or death, public health surveillance, or public health investigation or intervention.

''(g) MEDICARE INFORMATION ADVISORY COMMITTEE.—

''(1) ESTABLISHMENT.—There is established a committee to be known as the Medicare Information Advisory Committee (in this subsection referred to as the 'committee').

''(2) DUTIES.—The committee shall—

''(A) advise the Secretary in the development of standards under this section; and

''(B) be generally responsible for advising the Secretary and the Congress on the status and the future of the medicare information network.

''(3) MEMBERSHIP.—

''(A) IN GENERAL.—The committee shall consist of 9 members of whom—

''(i) 3 shall be appointed by the President;

''(ii) 3 shall be appointed by the Speaker of the House of Representatives after consultation with the minority leader of the House of Representatives; and

''(iii) 3 shall be appointed by the President pro tempore of the Senate after consultation with the minority leader of the Senate.

The appointments of the members shall be made not later than 60 days after the date of the enactment of this section. The President shall designate 1 member as the Chair.

''(B) EXPERTISE.—The membership of the committee shall consist of individuals who are of recognized standing and distinction in the areas of information systems, information networking and integration, consumer health, or health care financial management, and who possess the demonstrated capacity to discharge the duties imposed on the committee.

''(C) TERMS.—Each member of the committee shall be appointed for a term of 5 years, except that the members first appointed shall serve staggered terms such that the terms of not more than 3 members expire at one time.

''(D) INITIAL MEETING.—Not later than 30 days after the date on which a majority of the members have been appointed, the committee shall hold its first meeting.

''(4) REPORTS.—Not later than 1 year after the date of the enactment of this section, and annually thereafter, the committee shall submit to Congress and the Secretary a report regarding—

''(A) the extent to which entities using the medicare information network are meeting the standards adopted under this section and working together to form an integrated network that meets the needs of its users;

''(B) the extent to which such entities are meeting the security standards established pursuant to this section and the types of penalties assessed for noncompliance with such standards;

''(C) any problems that exist with respect to implementation of the medicare information network; and

''(D) the extent to which timetables under this section are being met.

Reports made under this subsection shall be made available to health care providers, health plans, and other entities that use the medicare information network to exchange medicare information.

''(h) DEFINITIONS.—For purposes of this section:

''(1) CODE SET.—The term 'code set' means any set of codes used for encoding data elements, such as tables of terms, enrollment information, and encounter data.

''(2) COORDINATION OF BENEFITS.—The term 'coordination of benefits' means determining and coordinating the financial obligations of health plans when health care benefits are payable under such a plan and under this title (including under a MedicarePlus product).

''(3) MEDICARE INFORMATION.—The term 'medicare information' means any information that relates to the enrollment of individuals under this title (including information relating to elections of MedicarePlus products under section 1805) and the provision of health benefits (including benefits provided under such products) under this title.

''(4) MEDICARE INFORMATION NETWORK.—The term 'medicare information network' means the medicare information system that is formed through the application of the requirements and standards established under this section.

''(5) MEDICARE INFORMATION NETWORK SERVICE.—The term 'medicare information network service' means a public or private entity that—

''(A) processes or facilitates the processing of nonstandard data elements of medicare information into standard data elements;

''(B) provides the means by which persons may meet the requirements of this section; or

''(C) provides specific information processing services.

''(6) HEALTH PLAN.—The term 'health plan' means a plan which provides, or pays the cost of, health benefits. Such term includes the following, or any combination thereof:

''(A) Part A or part B of this title, and includes a MedicarePlus product.

''(B) The medicaid program under title XIX and the MediGrant program under title XXI.

''(C) A medicare supplemental policy (as defined in section 1882(g)(1)).

''(D) Worker's compensation or similar insurance.

''(E) Automobile or automobile medical-payment insurance.

''(F) A long-term care policy, other than a fixed indemnity policy.

''(G) The Federal Employees Health Benefit Plan under chapter 89 of title 5, United States Code.

''(H) An employee welfare benefit plan, as defined in section 3(1) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(1)), but only to the extent the plan is established or maintained for the purpose of providing health benefits.

''(7) INDIVIDUALLY IDENTIFIABLE MEDICARE INFORMATION.—The term 'individually identifiable medicare information' means medicare enrollment information, including demographic information collected from an individual, that—

''(A) is created or received by a health care provider, health plan, employer, or medicare information network service, and

''(B) identifies an individual.

''(8) STANDARD SETTING ORGANIZATION.—The term 'standard setting organization' means a standard setting organization accredited by the American National Standards Institute.

''(9) STANDARD TRANSACTION.—The term 'standard transaction' means, when referring to an information transaction or to data elements of medicare information, any transaction that meets the requirements and implementation specifications adopted by the Secretary under subsections (a) and (b).''.

PART 5—OTHER PROVISIONS RELATING TO PARTS A AND B

SEC. 15741. CLARIFICATION OF MEDICARE COVERAGE OF ITEMS AND SERVICES ASSOCIATED WITH CERTAIN MEDICAL DEVICES APPROVED FOR INVESTIGATIONAL USE.

(a) COVERAGE.—Nothing in title XVIII of the Social Security Act may be construed to prohibit coverage under part A or part B of the medicare program of items and services associated with the use of a medical device in the furnishing of inpatient hospital services (as defined for purposes of part A of the medicare program) solely on the grounds that the device is not an approved device, if—

(1) the device is an investigational device; and

(2) the device is used instead of an approved device.

(b) CLARIFICATION OF PAYMENT AMOUNT.—Notwithstanding any other provision of title XVIII of the Social Security Act, the amount of payment made under the medicare program for any item or service associated with the use of an investigational device in the furnishing of inpatient hospital services (as defined for purposes of part A of the medicare program) may not exceed the amount of the payment which would have been made under the program for the item or service if the item or service were associated with the use of an approved device.

(c) DEFINITIONS.—In this section—

(1) the term ''approved device'' means a medical device which has been approved for marketing under pre-market approval under the Federal Food, Drug, and Cosmetic Act or cleared for marketing under a 510(k) notice under such Act; and

(2) the term ''investigational device'' means a medical device (other than a device described in paragraph (1)) which is approved for investigational use under section 520(g) of the Federal Food, Drug, and Cosmetic Act.

SEC. 15742. ADDITIONAL EXCLUSION FROM COVERAGE.

(a) IN GENERAL.—Section 1862(a) (42 U.S.C. 1395y(a)), as amended by section 15525(a)(2), section 15609B(a), and section 15701(c)(2)(C), is amended—

(1) by striking ''or'' at the end of paragraph (17),

(2) by striking the period at the end of paragraph (18) and inserting ''; or'', and

(3) by inserting after paragraph (18) the following new paragraph:

''(19) where such expenses are for items or services, or to assist in the purchase, in whole or in part, of health benefit coverage that includes items or services, for the purpose of causing, or assisting in causing, the death, suicide, euthanasia, or mercy killing of a person.''.

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

SEC. 15743. COMPETITIVE BIDDING FOR CERTAIN ITEMS AND SERVICES.

(a) ESTABLISHMENT OF DEMONSTRATION.—Not later than 1 year after the date of the enactment of this Act, the Secretary of Health and Human Services shall establish and operate over a 2-year period a demonstration project in 2 geographic regions selected by the Secretary under which (notwithstanding any provision of title XVIII of the Social Security Act to the contrary) the amount of payment made under the medicare program for a selected item or service (other than clinical diagnostic laboratory tests) furnished in the region shall be equal to the price determined pursuant to a competitive bidding process which meets the requirements of subsection (b).

(b) REQUIREMENTS FOR COMPETITIVE BIDDING PROCESS.—The competitive bidding process used under the demonstration project under this section shall meet such requirements as the Secretary may impose to ensure the cost-effective delivery to medicare beneficiaries in the project region of items and services of high quality.

(c) DETERMINATION OF SELECTED ITEMS OR SERVICES.—The Secretary shall select items and services to be subject to the demonstration project under this section if the Secretary determines that the use of competitive bidding with respect to the item or service under the project will be appropriate and cost-effective. In determining the items or services to be selected, the Secretary shall consult with an advisory taskforce which includes representatives of providers and suppliers of items and services (including small business providers and suppliers) in each geographic region in which the project will be effective.

SEC. 15744. DISCLOSURE OF CRIMINAL CONVICTIONS RELATING TO PROVISION OF HOME HEALTH SERVICES.

(a) IN GENERAL.—Section 1891 (42 U.S.C. 1395bbb) is amended by adding at the end the following new subsection:

''(g) The Secretary, and each State or local survey agency or other State agency responsible for monitoring compliance of home health agencies with requirements, shall make available, upon request of any person, information the Secretary or agency has on individuals who have been convicted of felonies relating to the provision of home health services.''.

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

SEC. 15745. REQUIRING RENAL DIALYSIS FACILITIES TO MAKE SERVICES AVAILABLE ON A 24-HOUR BASIS.

(a) IN GENERAL.—Section 1881(b)(1) (42 U.S.C. 1395rr(b)(1)) is amended by striking the period at the end and inserting the following: '', together with a requirement (in the case of a renal dialysis facility) that the facility make institutional dialysis services and supplies available on a 24-hour basis (either directly or through arrangements with providers of services or other renal dialysis facilities that meet the requirements of such subparagraph) and that the facility provide notice informing its patients of the other providers of services or renal dialysis facilities (if any) with whom the facility has made such arrangements.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to items and services furnished on or after January 1, 1996.

Subtitle I—Clinical Laboratories

SEC. 15801. EXEMPTION OF PHYSICIAN OFFICE LABORATORIES.

Section 353(d) of the Public Health Service Act (42 U.S.C. 263a(d)) is amended—

(1) by redesignating paragraphs (2), (3), and (4) as paragraphs (3), (4), and (5) and by adding after paragraph (1) the following:

''(2) EXEMPTION OF PHYSICIAN OFFICE LABORATORIES.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), a clinical laboratory in a physician's office (including an office of a group of physicians) which is directed by a physician and in which examinations and procedures are either performed by a physician or by individuals supervised by a physician solely as an adjunct to other services provided by the physician's office is exempt from this section.

''(B) EXCEPTION.—A clinical laboratory described in subparagraph (A) is not exempt from this section when it performs a pap smear (Papanicolaou Smear) analysis.

''(C) DEFINITION.—For purposes of subparagraph (A), the term 'physician' has the same meaning as is prescribed for such term by section 1861(r) of the Social Security Act (42 U.S.C. 1395x(r)).'';

(2) in paragraph (3) (as so redesignated) by striking ''(3)'' and inserting ''(4)''; and

(3) in paragraphs (4) and (5) (as so redesignated) by striking ''(2)'' and inserting ''(3)''.

Subtitle J—Lock-Box Provisions for Medicare Part B Savings from Growth Reductions

SEC. 15901. ESTABLISHMENT OF MEDICARE GROWTH REDUCTION TRUST FUND FOR PART B SAVINGS.

Part B of title XVIII is amended by inserting after section 1841 the following new section:

''MEDICARE GROWTH REDUCTION TRUST FUND

''SEC. 1841A. (a)(1) There is hereby created on the books of the Treasury of the United States a trust fund to be known as the 'Federal Medicare Growth Reduction Trust Fund' (in this section referred to as the 'Trust Fund'). The Trust Fund shall consist of such gifts and bequests as may be made as provided in section 201(i)(1) and amounts appropriated under paragraph (2).

''(2) There are hereby appropriated to the Trust Fund, out of any amounts in the Treasury not otherwise appropriated, amounts equivalent to 100 percent of the Secretary's estimate of the reductions in outlays under this part that are attributable to the Medicare Preservation Act of 1995. The amounts appropriated by the preceding sentence shall be transferred from time to time (not less frequently than monthly) from the general fund in the Treasury to the Trust Fund.

''(3)(A) Subject to subparagraph (B), with respect to monies transferred to the Trust Fund, no transfers, authorizations of appropriations, or appropriations are permitted.

''(B) Beginning with fiscal year 2003, the Secretary may expend funds in the Trust Fund to carry out this title, but only to the extent provided by Congress in advance through a specific amendment to this section.

''(b) The provisions of subsections (b) through (e) of section 1841 shall apply to the Trust Fund in the same manner as they apply to the Federal Supplementary Medical Insurance Trust Fund, except that the Board of Trustees and Managing Trustee of the

Trust Fund shall be composed of the members of the Board of Trustees and the Managing Trustee, respectively, of the Federal Supplementary Medical Insurance Trust Fund.''.

The CHAIRMAN. No further amendment is in order except the amendment in the nature of a substitute numbered 2 printed in the designated place in the CONGRESSIONAL RECORD, which may be offered only by the gentleman from Missouri [Mr. GEPHARDT] or his designee, is considered read, is debatable for 1 hour, equally divided and controlled by the proponent and an opponent of the amendment and is not subject to amendment.

Does the gentleman from Missouri [Mr. GEPHARDT] choose to control the time, or is he designating a Member to do so on his behalf?

Mr. GIBBONS. Mr. Chairman, I have been designated, along with the gentleman from Michigan [Mr. DINGELL].

The CHAIRMAN. Who seeks time in opposition?

Mr. ARCHER. Mr. Chairman, I seek time in opposition.

Mr. BLILEY. Mr. Chairman, I seek time in opposition as well.

AMENDMENT IN THE NATURE OF A SUBSTITUTE OFFERED BY MR. GIBBONS

Mr. GIBBONS. Mr. Chairman, I offer an amendment in the nature of a substitute.

The CHAIRMAN. The Clerk will designate the amendment in the nature of a substitute.

The text of the amendment in the nature of a substitute is as follows:

Amendment in the nature of a substitute offered by Mr. GIBBONS:

Strike all after the enacting clause and insert the following:

TITLE XV—MEDICARE

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

(a) SHORT TITLE.—This title may be cited as the ''Medicare Enhancement Act of 1995''.

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

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

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

Subtitle A—Provisions Relating to Medicare Part A

Sec. 15001. Reductions in inflation updates for inpatient hospital services.
Sec. 15002. Continuation of current reduction in payments for capital-related costs for inpatient hospital services.
Sec. 15003. Elimination of certain additional payments for outlier cases.
Sec. 15004. Clarification of treatment of transfers.
Sec. 15005. Prospective payment for skilled nursing facilities.
Sec. 15006. Maintaining savings resulting from temporary freeze on payment increases for skilled nursing facilities.

Subtitle B—Provisions Relating to Medicare Part B

Sec. 15101. Payment for physicians' services.
Sec. 15102. Freeze in updates to payment amounts for certain items and services.
Sec. 15103. Reduction in effective beneficiary coinsurance rate for certain hospital outpatient services.
Sec. 15104. Expanding coverage of preventive benefits.
Sec. 15105. Reduction in payment for capital-related costs of hospital outpatient services.
Sec. 15106. Part B premium.
Sec. 15107. Ensuring payment for physician and nurse for jointly furnished anesthesia services.

Subtitle C—Provisions Relating to Parts A and B

PART 1—MEDICARE SECONDARY PAYOR

Sec. 15201. Extension of existing secondary payer requirements.
Sec. 15202. Clarification of time and filing limitations.
Sec. 15203. Clarification of liability of third party–administrators.
Sec. 15204. Clarification of payment amounts to medicare.
Sec. 15205. Conditions for double damages.

PART 2—OTHER PROVISIONS RELATING TO PARTS A AND B

Sec. 15221. Making additional choices of health plans available to beneficiaries.
Sec. 15222. Teaching hospital and graduate medical education trust fund.
Sec. 15223. Revisions in determination of amount of payment for medical education.
Sec. 15224. Payments for home health services.
Sec. 15225. Requiring health maintenance organizations to cover appropriate range of services.
Sec. 15226. Clarification of medicare coverage of items and services associated with certain medical devices approved for investigational use.
Sec. 15227. Commission on the Future of Medicare and the Protection of the Health of the Nation's Senior Citizens.

Subtitle D—Preventing Fraud and Abuse

PART 1—AMENDMENTS TO ANTI-FRAUD AND ABUSE PROVISIONS APPLICABLE TO MEDICARE, MEDICAID, AND STATE HEALTH CARE PROGRAMS

Sec. 15301. Anti-kickback statutory provisions.
Sec. 15302. Civil money penalties.
Sec. 15303. Private right of action.
Sec. 15304. Amendments to exclusionary provisions in fraud and abuse program.
Sec. 15305. Sanctions against practitioners and persons for failure to comply with statutory obligations relating to quality of care.
Sec. 15306. Revisions to criminal penalties.
Sec. 15307. Definitions.
Sec. 15308. Effective date.

PART 2—INTERPRETIVE RULINGS ON KICKBACKS AND SELF-REFERRAL

Sec. 15311. Establishment of process for issuance of interpretive rulings.
Sec. 15312. Effect of issuance of interpretive ruling.
Sec. 15313. Imposition of fees.

PART 3—DIRECT SPENDING FOR ANTI-FRAUD ACTIVITIES UNDER MEDICARE

Sec. 15321. Direct spending for anti-fraud activities under medicare.

PART 4—PREEMPTION OF STATE CORPORATE PRACTICE LAWS UNDER MEDICARE

Sec. 15331. Preemption of State laws prohibiting corporate practice of medicine for purposes of medicare.

PART 5—MEDICARE ANTI-FRAUD AND ABUSE COMMISSION

Sec. 15341. Establishment of Medicare Anti-Fraud and Abuse Commission.
Sec. 15342. Functions of Commission.
Sec. 15343. Organization and compensation.
Sec. 15344. Staff of Commission.
Sec. 15345. Authority of Commission.
Sec. 15346. Termination.
Sec. 15347. Authorization of appropriations.

Subtitle A—Provisions Relating to Medicare Part A

SEC. 15001. REDUCTIONS IN INFLATION UPDATES FOR INPATIENT HOSPITAL SERVICES.

(a) PPS HOSPITALS.—Section 1886(b)(3)(B)(i) (42 U.S.C. 1395ww(b)(3)(B)(i)) is amended by striking subclauses (XI), (XII), and (XIII) and inserting the following:

''(XI) for each of the fiscal years 1996 through 2002, the market basket percentage increase minus 0.5 percentage point for hospitals located in a rural area and the market basket percentage increase minus 1.0 percentage point for all other hospitals, and

''(XII) for fiscal year 2003 and each subsequent fiscal year, the market basket percentage increase for hospitals in all areas.''.

(b) PPS-EXEMPT HOSPITALS.—Section 1886(b)(3)(B)(ii) (42 U.S.C. 1395ww(b)(3)(B)(ii)) is amended—

(1) in subclause (V)—

(A) by striking ''thorugh 1997'' and inserting ''through 1995'', and

(B) by striking ''and'' at the end;

(2) by redesignating subclause (VI) as subclause (VII); and

(3) by inserting after subclause (V) the following new subclause:

''(VI) fiscal years 1996 through 2002, is the market basket percentage increase minus 0.5 percentage point for hospitals located in a rural area and the market basket percentage increase minus 1.0 percentage point for all other hospitals, and''.

SEC. 15002. CONTINUATION OF CURRENT REDUCTION IN PAYMENTS FOR CAPITAL-RELATED COSTS FOR INPATIENT HOSPITAL SERVICES.

(a) REDUCTION IN PAYMENTS FOR PPS HOSPITALS.—Section 1886(g)(1)(A) (42 U.S.C. 1395ww(g)(1)(A)) is amended in the second sentence by striking ''through 1995'' and inserting ''through 2002''.

(b) REDUCTION IN PAYMENTS FOR PPS-EXEMPT HOSPITALS.—Section 1886(g) (42 U.S.C. 1395ww(g)) is amended by adding at the end the following new paragraph:

''(4)(A) Except as provided in subparagraph (B), in determining the amount of the payments that may be made under this title with respect to all the capital-related costs of inpatient hospital services furnished during fiscal years 1996 through 2002 of a hospital which is not a subsection (d) hospital or a subsection (d) Puerto Rico hospital, the Secretary shall reduce the amounts of such payments otherwise determined under this title by 10 percent.

''(B) Subparagraph (A) shall not apply to payments with respect to the capital-related costs of any hospital that is a sole community hospital (as defined in subsection (d)(5)(D)(iii) or a rural primary care hospital (as defined in section 1861(mm)(1)).''.

SEC. 15003. ELIMINATION OF CERTAIN ADDITIONAL PAYMENTS FOR OUTLIER CASES.

(a) INDIRECT MEDICAL EDUCATION.—Section 1886(d)(5)(B)(i)(I) (42 U.S.C. 1395ww(d)(5)(B)(i)(I)) is amended—

(1) by striking ''the sum of''; and

(2) by striking ''and the amount paid to the hospital under subparagraph (A)''.

(b) DISPROPORTIONATE SHARE ADJUSTMENTS.—Section 1886(d)(5)(F)(ii)(I) (42 U.S.C. 1395ww(d)(5)(F)(ii)(I)) is amended—

(1) by striking ''the sum of''; and

(2) by striking ''and the amount paid to the hospital under subparagraph (A) for that discharge''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to discharges occurring on or after October 1, 1995.

SEC. 15004. CLARIFICATION OF TREATMENT OF TRANSFERS.

(a) IN GENERAL.—Section 1886(d)(5)(I) (42 U.S.C. 1395ww(d)(5)(I)) is amended by adding at the end the following new clause:

''(iii) In making adjustments under clause (i) for transfer cases, the Secretary shall treat as a transfer any transfer to a hospital (without regard to whether or not the hospital is a subsection (d) hospital), a unit thereof, or a skilled nursing facility.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to discharges occurring on or after October 1, 1995.

SEC. 15005. PROSPECTIVE PAYMENT FOR SKILLED NURSING FACILITIES.

Section 1888 (42 U.S.C. 1395yy) is amended by adding at the end the following:

''(e) Notwithstanding any other provision of this title, the Secretary shall, for cost reporting periods beginning on or after October 1, 1996, provide for payment for routine costs of extended care services in accordance with a prospective payment system established by the Secretary, subject to the limitations in subsections (f) through (h).

''(f)(1) The amount of payment under subsection (e) shall be determined on a per diem basis.

''(2) The Secretary shall compute the routine costs per diem in a base year (determined by the Secretary) for each skilled nursing facility, and shall update the per diem rate on the basis of a market basket and other factors as the Secretary determines appropriate.

''(3) The per diem rate applicable to a skilled nursing facility may not exceed the following limits—

''(A) With respect to skilled nursing facilities located in rural areas, the limit shall be equal to 112 percent of the mean per diem routine costs in a base year (determined by the Secretary) for freestanding skilled nursing facilities located in rural areas within the same region, as updated by the same percentage determined under paragraph (2).

''(B) With respect to skilled nursing facilities located in urban areas, the limit shall be equal to 112 percent of the mean per diem routine costs in a base year (determined by the Secretary) for freestanding skilled nursing facilities located in urban areas within the same region, updated by the same percentage determined under paragraph (2).

''(g) In the case of a hospital-based skilled nursing facility or a skilled nursing facility receiving payment under subsection (d) as of the date of enactment of this provision, the amount of payment to the facility based on application of subsections (e) and (f) may not be less than the per diem rate applicable to the facility for routine costs on the date of enactment of this provision.

''(h) Notwithstanding any other provision of this title, the Secretary shall, for cost reporting periods beginning on or after October 1, 1998, provide for payment for all costs of extended care services (including routine service costs, ancillary costs, and capital-related costs) in accordance with a prospective payment system established by the Secretary. The Secretary shall adjust the payment amounts under this subsection in a manner to assure that the aggregate payments made under this subsection in a fiscal year result in a 5 percent reduction (as estimated by the Secretary) in the amount of payments that would otherwise have been made for such fiscal year.

''(i) The Secretary may provide for such exceptions as the Secretary determines appropriate to the amount of payment based on application of subsections (e) though (h).''

SEC. 15006. MAINTAINING SAVINGS RESULTING FROM TEMPORARY FREEZE ON PAYMENT INCREASES FOR SKILLED NURSING FACILITIES.

(a) BASING UPDATES TO PER DIEM COST LIMITS ON LIMITS FOR FISCAL YEAR 1993.—

(1) IN GENERAL.—The last sentence of section 1888(a) (42 U.S.C. 1395yy(a)) is amended by adding at the end the following: ''(except that such updates may not take into account any changes in the routine service costs of skilled nursing facilities occurring during cost reporting periods which began during fiscal year 1994 or fiscal year 1995).''.

(2) NO EXCEPTIONS PERMITTED BASED ON AMENDMENT.—The Secretary of Health and Human Services shall not consider the amendment made by paragraph (1) in making any adjustments pursuant to section 1888(c) of the Social Security Act.

(b) PAYMENTS DETERMINED ON PROSPECTIVE BASIS.—Any change made by the Secretary of Health and Human Services in the amount of any prospective payment paid to a skilled nursing facility under section 1888(d) of the Social Security Act for cost reporting periods beginning on or after October 1, 1995, may not take into account any changes in the costs of services occurring during cost reporting periods which began during fiscal year 1994 or fiscal year 1995.

Subtitle B—Provisions Relating to Medicare Part B

SEC. 15101. PAYMENT FOR PHYSICIANS' SERVICES.

(a) REPLACEMENT OF VOLUME PERFORMANCE STANDARD WITH CUMULATIVE EXPENDITURE TARGET.—Section 1848(f)(2) (42 U.S.C. 1395w–4(f)(2)) is amended to read as follows:

''(f) CUMULATIVE EXPENDITURE TARGET.—

''(1) SPECIFICATION OF TARGET.—

''(A) FISCAL YEAR 1996.—The cumulative expenditure target for all physicians' services and for each category of such services for fiscal year 1996 shall be equal to the product of—

''(i) 1 plus the Secretary's estimate of the percentage change in the medicare economic index for 1996 (described in the fourth sentence of section 1842(b)(3)) (divided by 100),

''(ii) 1 plus the Secretary's estimate of the percentage change (divided by 100) in the average number of individuals enrolled under this part (other than private plan enrollees) from fiscal year 1995 to fiscal year 1996,

''(iii) 1 plus the Secretary's estimate of the projected percentage growth in real gross domestic product per capita (divided by 100) from fiscal year 1995 to fiscal year 1996, plus 2 percentage points, and

''(iv) 1 plus the Secretary's estimate of the percentage change (divided by 100) in expenditures for all physicians' services or of the category of physicians' services in fiscal year 1996 (compared with fiscal year 1995) which will result from changes in law, determined without taking into account estimated changes in expenditures due to changes in the volume and intensity of physicians' services or changes in expenditures resulting from changes in the update to the conversion factor under subsection (d),

minus 1 and multiplied by 100.

''(B) SUBSEQUENT FISCAL YEARS.—The cumulative expenditure target for all physicians' services and for each category of physicians' services for fiscal year 1997 and each subsequent fiscal year shall be equal to the cumulative expenditure target determined under this paragraph for the previous fiscal year, increased by the product of—

''(i) 1 plus the Secretary's estimate of the percentage change in the medicare economic index for the fiscal year involved (described in the fourth sentence of section 1842(b)(3)) (divided by 100),

''(ii) 1 plus the Secretary's estimate of the percentage change (divided by 100) in the average number of individuals enrolled under this part (other than private plan enrollees) from the previous fiscal year to the fiscal year involved,

''(iii) 1 plus the Secretary's estimate of the projected percentage growth in real gross domestic product per capita (divided by 100) from the previous fiscal year to the fiscal year involved, plus 2 percentage points, and

''(iv) 1 plus the Secretary's estimate of the percentage change (divided by 100) in expenditures for all physicians' services or of the category of physicians' services in the fiscal year (compared with the previous fiscal year) which will result from changes in law, determined without taking into account estimated changes in expenditures due to changes in the volume and intensity of physicians' services or changes in expenditures resulting from changes in the update to the conversion factor under subsection (d)(3),

minus 1 and multiplied by 100.''.

''(2) EXCLUSION OF SERVICES FURNISHED TO PRIVATE PLAN ENROLLEES.—In this subsection, the term 'physicians' services' with respect to a fiscal year does not include services furnished to an individual enrolled under this part who has elected to receive benefits under this title for the fiscal year through enrollment with an eligible organization with a risk-sharing contract under section 1876.''.

(b) ESTABLISHING UPDATE TO CONVERSION FACTOR TO MATCH SPENDING UNDER CUMULATIVE EXPENDITURE TARGET.—

(1) IN GENERAL.—Section 1848(d) (42 U.S.C. 1395w–4(d)(3)) is amended—

(A) by striking paragraph (2);

(B) by amending paragraph (3) to read as follows:

''(3) UPDATE.—

''(A) IN GENERAL.—Subject to subparagraph (E), for purposes of this section the update for a year (beginning with 1997) is equal to the product of—

''(i) 1 plus the Secretary's estimate of the percentage increase in the medicare economic index (described in the fourth sentence of section 1842(b)(3)) for the year (divided by 100), and

''(ii) 1 plus the Secretary's estimate of the update adjustment factor for the year (divided by 100),

minus 1 and multiplied by 100.

''(B) UPDATE ADJUSTMENT FACTOR.—The 'update adjustment factor' for a year for a category of physicians' services is equal to the quotient of—

''(i) the difference between (I) the sum of the allowed expenditures for physicians' services in such category furnished during each of the years 1995 through the year involved and (II) the sum of the amount of actual expenditures for physicians' services furnished in such category during each of the years 1995 through the previous year; divided by

''(ii) the Secretary's estimate of allowed expenditures for physicians' services in such category furnished during the year.

''(C) DETERMINATION OF ALLOWED EXPENDITURES.—For purposes of subparagraph (B),

allowed expenditures for physicians' services in a category of physicians' services shall be determined as follows (as estimated by the Secretary):

''(i) In the case of allowed expenditures for 1995, such expenditures shall be equal to actual expenditures for services furnished during the 12-month period ending with June of 1995.

''(ii) In the case of allowed expenditures for 1996 and each subsequent year, such expenditures shall be equal to allowed expenditures for the previous year, increased by the cumulative expenditure target under subsection (f) for the fiscal year which begins during the year.

''(D) DETERMINATION OF ACTUAL EXPENDITURES.—For purposes of subparagraph (B), the amount of actual expenditures for physicians' services in a category of physicians' services furnished during a year shall be equal to the amount of expenditures for such services during the 12-month period ending with June of the previous year.

''(E) RESTRICTION ON VARIATION FROM MEDICARE ECONOMIC INDEX.—Notwithstanding the amount of the update adjustment factor determined under subparagraph (B) for a year, the update in the conversion factor under this paragraph for the year may not be—

''(i) greater than 103 percent of the Secretary's estimate of the percentage increase in the medicare economic index (described in the fourth sentence of section 1842(b)(3)) for the year; or

''(ii) less than 92.5 percent of the Secretary's estimate of the percentage increase in the medicare economic index (described in the fourth sentence of section 1842(b)(3)) for the year.''; and

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

''(4) REPORTING REQUIREMENTS.—

''(A) IN GENERAL.—Not later than November 1 of each year (beginning with 1996), the Secretary shall transmit to the Congress a report that describes the update in the conversion factor for physicians' services (as defined in subsection (f)(3)(A)) in the following year.

''(B) COMMISSION REVIEW.—The Medicare Payment Review Commission shall review the report submitted under subparagraph (A) for a year and shall submit to the Congress, by not later than December 1 of the year, a report containing its analysis of the conversion factor for the following year.''.

(2) EFFECTIVE DATE.—The amendments made by this subsection shall apply to physicians' services furnished on or after January 1, 1997.

(c) ESTABLISHMENT OF SINGLE CONVERSION FACTOR FOR 1996.—Section 1848(d)(1) (42 U.S.C. 1395w–4(d)(1)) is amended—

(1) by redesignating subparagraph (C) as subparagraph (D); and

(2) by inserting after subparagraph (B) the following new subparagraph:

''(C) SPECIAL RULE FOR 1996.—For 1996, the conversion factor under this subsection shall be $34.60 for all physicians' services.''.

SEC. 15102. FREEZE IN UPDATES TO PAYMENT AMOUNTS FOR CERTAIN ITEMS AND SERVICES.

(a) CLINICAL DIAGNOSTIC LABORATORY TESTS.—Section 1833(h)(2)(A)(ii)(IV) (42 U.S.C. 1395l(h)(2)(A)(ii)(IV)) is amended striking ''1994 and 1995'' and inserting ''1994, 1995, 1996, and 1997''.

(b) DURABLE MEDICAL EQUIPMENT.—

(1) COVERED ITEMS.—Section 1834(a)(14) (42 U.S.C. 1395m(a)(14)) is amended—

(A) by striking ''and'' at the end of subparagraph (A);

(B) in subparagraph (B)—

(i) by striking ''a subsequent year'' and inserting ''1993, 1994, and 1995'', and

(ii) by striking the period at the end and inserting ''; and''; and

(C) by adding at the end the following:

''(C) for 1996 and 1997, 0 percentage points; and

''(D) for a subsequent year, the percentage increase in the consumer price index for all urban consumers (U.S. urban average) for the 12-month period ending with June of the previous year.''.

(2) ORTHOTICS AND PROSTHETICS.—Section 1834(h)(4)(A)(iii) (42 U.S.C. 1395m(h)(4)(A)(iii)) is amended by striking ''1994 and 1995'' and inserting ''1994, 1995, 1996, and 1997''.

(c) AMBULATORY SURGICAL CENTER SERVICES.—The Secretary of Health and Human Services shall not provide for any inflation update in the payment amounts under subparagraphs (A) and (B) of section 1833(i)(2) of the Social Security Act for fiscal years 1996 and 1997.

SEC. 15103. REDUCTION IN EFFECTIVE BENEFICIARY COINSURANCE RATE FOR CERTAIN HOSPITAL OUTPATIENT SERVICES.

(a) IN GENERAL.—

(1) AMBULATORY SURGICAL CENTER PROCEDURES.—Section 1833(i)(3)(B)(i)(II) (42 U.S.C. 1395l(i)(3)(B)(i)(II)) is amended—

(A) by striking ''of 80 percent''; and

(B) by striking the period at the end and inserting the following: '', less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A).''.

(2) RADIOLOGY SERVICES AND DIAGNOSTIC PROCEDURES.—Section 1833(n)(1)(B)(i)(II) (42 U.S.C. 1395l(n)(1)(B)(i)(II)) is amended—

(A) by striking ''of 80 percent''; and

(B) by striking the period at the end and inserting the following: '', less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A).''.

(b) REDUCTION IN BENEFICIARY COINSURANCE RATE.—Section 1866(a)(2) (42 U.S.C. 1395cc(a)(2)) is amended by adding at the end the following new subparagraph:

''(E)(i) In the case of services furnished during a year for which the amount of payment under part B is determined under section 1833(i) or section 1833(n), clause (ii) of subparagraph (A) shall be applied by reducing '20 percent' by the percentage established for the year under clause (ii).

''(ii) The percentage established for a year under this clause shall be the percentage which, if applied for the year, will result in a reduction in projected total coinsurance payments under part B during the year in an amount equal to the Secretary's estimate of the reduction in expenditures under part B which would have occurred as a result of the enactment of section 15103(a) of the Medicare Enhancement Act of 1995 if this subparagraph were not in effect for the year.

''(iii) The Secretary shall establish and publish the percentage established for a year under this clause not later than October 1 preceding the year involved (or not later than December 1, 1995, in the case of the percentage established for 1996).''.

(c) EFFECTIVE DATE.—The amendments made by subsections (a) and (b) shall apply to services furnished during portions of cost reporting periods occurring on or after January 1, 1996.

SEC. 15104. EXPANDING COVERAGE OF PREVENTIVE BENEFITS.

(a) PROVIDING ANNUAL SCREENING MAMMOGRAPHY FOR WOMEN OVER AGE 49.—Section 1834(c)(2)(A) (42 U.S.C. 1395m(c)(2)(A)) is amended—

(1) in clause (iv), by striking ''but under 65 years of age,''; and

(2) by striking clause (v).

(b) COVERAGE OF SCREENING PAP SMEAR AND PELVIC EXAMS.—

(1) COVERAGE OF PELVIC EXAM; INCREASING FREQUENCY OF COVERAGE OF PAP SMEAR.—Section 1861(nn) (42 U.S.C. 1395x(nn)) is amended—

(A) in the heading, by striking ''Smear'' and inserting ''Smear; Screening Pelvic Exam'';

(B) by striking ''(nn)'' and inserting ''(nn)(1)'';

(C) by striking ''3 years'' and all that follows and inserting ''3 years, or during the preceding year in the case of a woman described in paragraph (3).''; and

(D) by adding at the end the following new paragraphs:

''(2) The term 'screening pelvic exam' means an pelvic examination provided to a woman if the woman involved has not had such an examination during the preceding 3 years, or during the preceding year in the case of a woman described in paragraph (3), and includes a clinical breast examination.

''(3) A woman described in this paragraph is a woman who—

''(A) is of childbearing age and has not had a test described in this subsection during each of the preceding 3 years that did not indicate the presence of cervical cancer; or

''(B) is at high risk of developing cervical cancer (as determined pursuant to factors identified by the Secretary).''.

(2) WAIVER OF DEDUCTIBLE.—The first sentence of section 1833(b) (42 U.S.C. 1395l(b)), as amended by subsection (a)(2), is amended—

(A) by striking ''and (5)'' and inserting ''(5)''; and

(B) by striking the period at the end and inserting the following: '', and (6) such deductible shall not apply with respect to screening pap smear and screening pelvic exam (as described in section 1861(nn)).''.

(3) CONFORMING AMENDMENTS.—(A) Section 1861(s)(14) (42 U.S.C. 1395x(s)(14)) is amended by inserting ''and screening pelvic exam'' after ''screening pap smear''.

(B) Section 1862(a)(1)(F) (42 U.S.C. 1395y(a)(1)(F)) is amended by inserting ''and screening pelvic exam'' after ''screening pap smear''.

(c) COVERAGE OF COLORECTAL SCREENING.—

(1) IN GENERAL.—Section 1834 (42 U.S.C. 1395m) is amended by inserting after subsection (c) the following new subsection:

''(d) FREQUENCY AND PAYMENT LIMITS FOR SCREENING FECAL-OCCULT BLOOD TESTS, SCREENING FLEXIBLE SIGMOIDOSCOPIES, AND SCREENING COLONOSCOPY.—

''(1) FREQUENCY LIMITS FOR SCREENING FECAL-OCCULT BLOOD TESTS.—Subject to revision by the Secretary under paragraph (4), no payment may be made under this part for a screening fecal-occult blood test provided to an individual for the purpose of early detection of colon cancer if the test is performed—

''(A) in the case of an individual under 65 years of age, more frequently than is provided in a periodicity schedule established by the Secretary for purposes of this subparagraph; or

''(B) in the case of any other individual, within the 11 months following the month in which a previous screening fecal-occult blood test was performed.

''(2) SCREENING FLEXIBLE SIGMOIDOSCOPIES.—

''(A) PAYMENT AMOUNT.—The Secretary shall establish a payment amount under section 1848 with respect to screening flexible sigmoidoscopies provided for the purpose of early detection of colon cancer that is consistent with payment amounts under such section for similar or related services, except that such payment amount shall be established without regard to subsection (a)(2)(A) of such section.

''(B) FREQUENCY LIMITS.—Subject to revision by the Secretary under paragraph (4), no payment may be made under this part for a screening flexible sigmoidoscopy provided to

an individual for the purpose of early detection of colon cancer if the procedure is performed—

''(i) in the case of an individual under 65 years of age, more frequently than is provided in a periodicity schedule established by the Secretary for purposes of this subparagraph; or

''(ii) in the case of any other individual, within the 59 months following the month in which a previous screening flexible sigmoidoscopy was performed.

''(3) SCREENING COLONOSCOPY FOR INDIVIDUALS AT HIGH RISK FOR COLORECTAL CANCER.—

''(A) PAYMENT AMOUNT.—The Secretary shall establish a payment amount under section 1848 with respect to screening colonoscopy for individuals at high risk for colorectal cancer (as determined in accordance with criteria established by the Secretary) provided for the purpose of early detection of colon cancer that is consistent with payment amounts under such section for similar or related services, except that such payment amount shall be established without regard to subsection (a)(2)(A) of such section.

''(B) FREQUENCY LIMIT.—Subject to revision by the Secretary under paragraph (4), no payment may be made under this part for a screening colonoscopy for individuals at high risk for colorectal cancer provided to an individual for the purpose of early detection of colon cancer if the procedure is performed within the 47 months following the month in which a previous screening colonoscopy was performed.

''(C) FACTORS CONSIDERED IN ESTABLISHING CRITERIA FOR DETERMINING INDIVIDUALS AT HIGH RISK.—In establishing criteria for determining whether an individual is at high risk for colorectal cancer for purposes of this paragraph, the Secretary shall take into consideration family history, prior experience of cancer, a history of chronic digestive disease condition, and the presence of any appropriate recognized gene markers for colorectal cancer.

''(4) REVISION OF FREQUENCY.—

''(A) REVIEW.—The Secretary shall review periodically the appropriate frequency for performing screening fecal-occult blood tests, screening flexible sigmoidoscopies, and screening colonoscopy based on age and such other factors as the Secretary believes to be pertinent.

''(B) REVISION OF FREQUENCY.—The Secretary, taking into consideration the review made under clause (i), may revise from time to time the frequency with which such tests and procedures may be paid for under this subsection.''.

(2) CONFORMING AMENDMENTS.—(A) Paragraphs (1)(D) and (2)(D) of section 1833(a) (42 U.S.C. 1395l(a)) are each amended by striking ''subsection (h)(1),'' and inserting ''subsection (h)(1) or section 1834(d)(1),''.

(B) Clauses (i) and (ii) of section 1848(a)(2)(A) (42 U.S.C. 1395w–4(a)(2)(A)) are each amended by striking ''a service'' and inserting ''a service (other than a screening flexible sigmoidoscopy provided to an individual for the purpose of early detection of colon cancer or a screening colonoscopy provided to an individual at high risk for colorectal cancer for the purpose of early detection of colon cancer)''.

(C) Section 1862(a) (42 U.S.C. 1395y(a)) is amended—

(i) in paragraph (1)—

(I) in subparagraph (E), by striking ''and'' at the end;

(II) in subparagraph (F), by striking the semicolon at the end and inserting '', and''; and

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

''(G) in the case of screening fecal-occult blood tests, screening flexible sigmoidoscopies, and screening colonoscopy provided for the purpose of early detection of colon cancer, which are performed more frequently than is covered under section 1834(d);''; and

(ii) in paragraph (7), by striking ''paragraph (1)(B) or under paragraph (1)(F)'' and inserting ''subparagraphs (B), (F), or (G) of paragraph (1)''.

(d) PROSTATE CANCER SCREENING TESTS.—

(1) IN GENERAL.—Section 1861(s)(2) (42 U.S.C. 1395x(s)(2)) is amended—

(A) by striking ''and'' at the end of subparagraph (N) and subparagraph (O); and

(B) by inserting after subparagraph (O) the following new subparagraph:

''(P) prostate cancer screening tests (as defined in subsection (oo)); and''.

(2) TESTS DESCRIBED.—Section 1861 (42 U.S.C. 1395x) is amended by adding at the end the following new subsection:

''Prostate Cancer Screening Tests

''(oo) The term 'prostate cancer screening test' means a test that consists of a digital rectal examination or a prostate-specific antigen blood test (or both) provided for the purpose of early detection of prostate cancer to a man over 40 years of age who has not had such a test during the preceding year.''.

(3) PAYMENT FOR PROSTATE-SPECIFIC ANTIGEN BLOOD TEST UNDER CLINICAL DIAGNOSTIC LABORATORY TEST FEE SCHEDULES.—Section 1833(h)(1)(A) (42 U.S.C. 1395l(h)(1)(A)) is amended by inserting after ''laboratory tests'' the following: ''(including prostate cancer screening tests under section 1861(oo) consisting of prostate-specific antigen blood tests)''.

(4) CONFORMING AMENDMENT.—Section 1862(a) (42 U.S.C. 1395y(a)), as amended by subsection (c)(3)(C), is amended—

(A) in paragraph (1)—

(i) in subparagraph (F), by striking ''and'' at the end,

(ii) in subparagraph (G), by striking the semicolon at the end and inserting '', and'', and

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

''(H) in the case of prostate cancer screening test (as defined in section 1861(oo)) provided for the purpose of early detection of prostate cancer, which are performed more frequently than is covered under such section;''; and

(B) in paragraph (7), by striking ''or (G)'' and inserting ''(G), or (H)''.

(e) DIABETES SCREENING BENEFITS.—

(1) DIABETES OUTPATIENT SELF-MANAGEMENT TRAINING SERVICES.—

(A) IN GENERAL.—Section 1861(s)(2) (42 U.S.C. 1395x(s)(2)), as amended by subsection (d)(1), is amended—

(i) by striking ''and'' at the end of subparagraph (N);

(ii) by striking ''and'' at the end of subparagraph (O); and

(iii) by inserting after subparagraph (O) the following new subparagraph:

''(P) diabetes outpatient self-management training services (as defined in subsection (pp)); and''.

(B) DEFINITION.—Section 1861 (42 U.S.C. 1395x), as amended by subsection (d)(2), is amended by adding at the end the following new subsection:

''DIABETES OUTPATIENT SELF-MANAGEMENT TRAINING SERVICES

''(pp)(1) The term 'diabetes outpatient self-management training services' means educational and training services furnished to an individual with diabetes by or under arrangements with a certified provider (as described in paragraph (2)(A)) in an outpatient setting by an individual or entity who meets the quality standards described in paragraph (2)(B), but only if the physician who is managing the individual's diabetic condition certifies that such services are needed under a comprehensive plan of care related to the individual's diabetic condition to provide the individual with necessary skills and knowledge (including skills related to the self-administration of injectable drugs) to participate in the management of the individual's condition.

''(2) In paragraph (1)—

''(A) a 'certified provider' is an individual or entity that, in addition to providing diabetes outpatient self-management training services, provides other items or services for which payment may be made under this title; and

''(B) an individual or entity meets the quality standards described in this paragraph if the individual or entity meets quality standards established by the Secretary, except that the individual or entity shall be deemed to have met such standards if the individual or entity meets applicable standards originally established by the National Diabetes Advisory Board and subsequently revised by organizations who participated in the establishment of standards by such Board, or is recognized by the American Diabetes Association as meeting standards for furnishing the services.''.

(C) CONSULTATION WITH ORGANIZATIONS IN ESTABLISHING PAYMENT AMOUNTS FOR SERVICES PROVIDED BY PHYSICIANS.—In establishing payment amounts under section 1848(a) of the Social Security Act for physicians' services consisting of diabetes outpatient self-management training services, the Secretary of Health and Human Services shall consult with appropriate organizations, including the American Diabetes Association, in determining the relative value for such services under section 1848(c)(2) of such Act.

(2) BLOOD-TESTING STRIPS FOR INDIVIDUALS WITH DIABETES.—

(A) INCLUDING STRIPS AS DURABLE MEDICAL EQUIPMENT.—Section 1861(n) (42 U.S.C. 1395x(n)) is amended by striking the semicolon in the first sentence and inserting the following: '', and includes blood-testing strips for individuals with diabetes without regard to whether the individual has Type I or Type II diabetes (as determined under standards established by the Secretary in consultation with the American Diabetes Association);''.

(2) PAYMENT FOR STRIPS BASED ON METHODOLOGY FOR INEXPENSIVE AND ROUTINELY PURCHASED EQUIPMENT.—Section 1834(a)(2)(A) (42 U.S.C. 1395m(a)(2)(A)) is amended—

(A) by striking ''or'' at the end of clause (ii);

(B) by adding ''or'' at the end of clause (iii); and

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

''(iv) which is a blood-testing strip for an individual with diabetes,''.

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after January 1, 1996.

SEC. 15105. REDUCTION IN PAYMENT FOR CAPITAL-RELATED COSTS OF HOSPITAL OUTPATIENT SERVICES.

Section 1861(v)(1)(S)(ii)(I) (42 U.S.C. 1395x(v)(1)(S)(ii)(I)) is amended by striking ''through 1998'' and inserting ''through 2002''.

SEC. 15106. PART B PREMIUM.

Section 1839(e)(1) (42 U.S.C. 1395r(e)(1)) is amended—

(1) in subparagraph (A), by striking ''1995'' and inserting ''1996'', and

(2) in subparagraph (B)(v), by inserting ''and 1996'' after ''1995''.

SEC. 15107. ENSURING PAYMENT FOR PHYSICIAN AND NURSE FOR JOINTLY FURNISHED ANESTHESIA SERVICES.

(a) PAYMENT FOR JOINTLY FURNISHED SINGLE CASE.—

(1) PAYMENT TO PHYSICIAN.—Section 1848(a)(4) (42 U.S.C. 1395w–4(a)(4)) is amended by adding at the end the following new subparagraph:

''(C) PAYMENT FOR SINGLE CASE.—Notwithstanding section 1862(a)(1)(A), with respect to physicians' services consisting of the furnishing of anesthesia services for a single case that are furnished jointly with a certified registered nurse anesthetist, if the carrier determines that the use of both the physician and the nurse anesthetist to furnish the anesthesia service was not medically necessary, the fee schedule amount for the physicians' services shall be equal to 50 percent (or 55 percent, in the case of services furnished during 1996 or 1997) of the fee schedule amount applicable under this section for anesthesia services personally performed by the physician alone (without regard to this subparagraph). Nothing in this subparagraph may be construed to affect the application of any provision of law regarding balance billing.''.

(2) PAYMENT TO CRNA.—Section 1833(l)(4)(B) (42 U.S.C. 1395l(l)(4)(B)) is amended by adding at the end the following new clause:

''(iv) Notwithstanding section 1862(a)(1)(A), in the case of services of a certified registered nurse anesthetist consisting of the furnishing of anesthesia services for a single case that are furnished jointly with a physician, if the carrier determines that the use of both the physician and the nurse anesthetist to furnish the anesthesia service was not medically necessary, the fee schedule amount for the services furnished by the certified registered nurse anesthetist shall be equal to 50 percent (or 40 percent, in the case of services furnished during 1996 or 1997) of the fee schedule amount applicable under section 1848 for anesthesia services personally performed by the physician alone (without regard to this clause).''.

(b) EFFECTIVE DATE.—The amendments made by subsections (a) shall apply to services furnished on or after July 1, 1996.

Subtitle C—Provisions Relating to Parts A and B

PART 1—MEDICARE SECONDARY PAYER

SEC. 15201. EXTENSION OF EXISTING SECONDARY PAYER REQUIREMENTS.

(a) DATA MATCH.—

(1) Section 1862(b)(5)(C) (42 U.S.C. 1395y(b)(5)(C)) is amended by striking clause (iii).

(2) Section 6103(l)(12) of the Internal Revenue Code of 1986 is amended by striking subparagraph (F).

(b) APPLICATION TO DISABLED INDIVIDUALS IN LARGE GROUP HEALTH PLANS.—

(1) IN GENERAL.—Section 1862(b)(1)(B) (42 U.S.C. 1395y(b)(1)(B)) is amended—

(A) in clause (i), by striking ''clause (iv)'' and inserting ''clause (iii)'',

(B) by striking clause (iii), and

(C) by redesignating clause (iv) as clause (iii).

(2) CONFORMING AMENDMENTS.—Paragraphs (1) through (3) of section 1837(i) (42 U.S.C. 1395p(i)) and the second sentence of section 1839(b) (42 U.S.C. 1395r(b)) are each amended by striking ''1862(b)(1)(B)(iv)'' each place it appears and inserting ''1862(b)(1)(B)(iii)''.

(c) PERIOD OF APPLICATION TO INDIVIDUALS WITH END STAGE RENAL DISEASE.—Section 1862(b)(1)(C) (42 U.S.C. 1395y(b)(1)(C)) is amended—

(1) in the first sentence, by striking ''12-month'' each place it appears and inserting ''18-month'', and

(2) by striking the second sentence.

SEC. 15202. CLARIFICATION OF TIME AND FILING LIMITATIONS.

(a) IN GENERAL.—Section 1862(b)(2)(B) (42 U.S.C. 1395y(b)(2)(B)) is amended by adding at the end the following new clause:

''(v) TIME, FILING, AND RELATED PROVISIONS UNDER PRIMARY PLAN.—Requirements under a primary plan as to the filing of a claim, time limitations for the filing of a claim, information not maintained by the Secretary, or notification or pre-admission review, shall not apply to a claim by the United States under clause (ii) or (iii).''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) applies to items and services furnished after 1993.

SEC. 15203. CLARIFICATION OF LIABILITY OF THIRD PARTY–ADMINISTRATORS.

(a) IN GENERAL.—Section 1862(b)(2)(B)(ii) (42 U.S.C. 1395y(b)(2)(B)(ii)) is amended by inserting '', or which determines claims under the primary plan'' after ''primary plan''.

(b) CLAIMS BETWEEN PARTIES OTHER THAN THE UNITED STATES.— Section 1862(b)(2)(B) (42 U.S.C. 1395y(b)(2)(B)), (as amended by section 15201(a)) is further amended by adding at the end the following new clause:

''(vi) CLAIMS BETWEEN PARTIES OTHER THAN THE UNITED STATES.—A claim by the United States under clause (ii) or (iii) shall not preclude claims between other parties.''.

(c) EFFECTIVE DATE.—The amendments made by the previous subsections apply to items and services furnished after 1993.

SEC. 15204. CLARIFICATION OF PAYMENT AMOUNTS TO MEDICARE.

(a) IN GENERAL.—Section 1862(b)(2)(B)(i) (42 U.S.C. 1395y(b)(2)(B)(i)) is amended to read as follows:

''(i) REPAYMENT REQUIRED.—

''(I) Any payment under this title, with respect to any item or service for which payment by a primary plan is required under the preceding provisions of this subsection, shall be conditioned on reimbursement to the appropriate Trust Fund established by this title when notice or other information is received that payment for that item or service has been or should have been made under those provisions. If reimbursement is not made to the appropriate Trust Fund before the expiration of the 60-day period that begins on the date such notice or other information is received, the Secretary may charge interest (beginning with the date on which the notice or other information is received) on the amount of the reimbursement until reimbursement is made (at a rate determined by the Secretary in accordance with regulations of the Secretary of the Treasury applicable to charges for late payments).

''(II) The amount owed by a primary plan under the first sentence of subclause (I) is the lesser of the full primary payment required (if that amount is readily determinable) and the amount paid under this title for that item or service.''.

(b) CONFORMING AND TECHNICAL AMENDMENTS.—

(1) Subparagraphs (A)(i)(I) and (B)(i) of section 1862(b)(1) (42 U.S.C. 1395y(b)(1)) are each amended by inserting ''(or eligible to be covered)'' after ''covered''.

(2) Section 1862(b)(1)(C)(ii) (42 U.S.C. 1395y(b)(1)(C)(ii)) is amended by striking ''covered by such plan''.

(3) The matter in section 1861(b)(2)(A) (42 U.S.C. 1395x(b)(2)(A)) preceding clause (i) is amended by striking '', except as provided in subparagraph (B),''.

(c) EFFECTIVE DATE.—The amendments made by the previous subsections apply to items and services furnished after 1993.

SEC. 15205. CONDITIONS FOR DOUBLE DAMAGES.

(a) IN GENERAL.—Section 1862(b)(2)(B)(ii) (42 U.S.C. 1395y(b)(2)(B)(ii)) is amended—

(1) by striking '', in accordance with paragraph (3)(A)'', and

(2) by inserting '', unless the entity demonstrates that it did not know, and could not have known, of its obligation to pay'' after ''against that entity''.

(b) CONFORMING AMENDMENT.—Section 1862(b)(3)(A) (42 U.S.C. 1395y(b)(3)(A)) is amended by striking ''(or appropriate reimbursement)''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished after 1993.

PART 2—OTHER PROVISIONS RELATING TO PARTS A AND B

SEC. 15221. MAKING ADDITIONAL CHOICES OF HEALTH PLANS AVAILABLE TO BENEFICIARIES.

(a) DEFINITION OF PPO.—Section 1876 (42 U.S.C. 1395mm) is amended by adding at the end the following new subsection:

''(k)(1) A preferred provider organization (as defined in paragraph (2)) shall be considered to be an eligible organization under this section.

''(2) In this section, the term 'preferred provider organization' means an organization that—

''(A) would be an eligible organization (as defined in subsection (b)) if—

''(i) clauses (ii) through (iv) of subsection (b)(2)(A) did not apply,

''(ii) subsection (b)(2)(C) did not apply, and

''(iii) subsection (b)(2)(D) only applied (in the case of services not provided under this title) to the physicians' services the organization provides; and

''(B) permits enrollees to obtain benefits through any lawful provider.

Nothing in subparagraph (B) shall be construed as requiring that the benefits for services provided through providers that do not have a contract with the organization be the same as those for services provided through providers that have such contracts so long as an enrollee's liabilities do not exceed the liabilities that the enrollee would have under parts A and B if the individual were not enrolled under this section.''.

(b) PARTIAL RISK PAYMENT METHODS.—Section 1876 (42 U.S.C. 1395mm) is further amended by adding at the end the following new subsection:

''(l) Notwithstanding the previous provisions of this section, at the election of an eligible organization the Secretary may establish an alternative partial-risk-sharing mechanism for making payment to the organization under this section. Under such mechanism fee-for-service payments would be made to the organization for some services provided under the contract, under such conditions and subject to such restrictions as the Secretary may determine.''.

(c) CONFORMING AMENDMENT.—Section 1876 (42 U.S.C. 1395mm) is further amended—

(1) in the heading by striking ''ORGANIZATIONS AND COMPETITIVE MEDICAL PLANS'' and inserting ''ORGANIZATIONS, COMPETITIVE MEDICAL PLANS, AND PREFERRED PROVIDER ORGANIZATIONS'', and

(2) in subsection (c)(3)(E)(ii), by inserting ''(if any)'' after ''the restrictions''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to contract years beginning on or after January 1, 1996.

SEC. 15222. TEACHING HOSPITAL AND GRADUATE MEDICAL EDUCATION TRUST FUND.

(a) TEACHING HOSPITAL AND GRADUATE MEDICAL EDUCATION TRUST FUND.—The Social Security Act (42 U.S.C. 300 et seq.) is amended by adding at the end the following title:

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

''PART A—ESTABLISHMENT OF FUND

''SEC. 2101. ESTABLISHMENT OF FUND.

''(a) IN GENERAL.—There is established in the Treasury of the United States a fund to be known as the Teaching Hospital and Graduate Medical Education Trust Fund (in this title referred to as the 'Fund'), consisting of amounts transferred to the Fund under subsection (c), amounts appropriated to the Fund pursuant to subsections (d) and (e)(3), and such gifts and bequests as may be deposited in the Fund pursuant to subsection (f). Amounts in the Fund are available until expended.

''(b) EXPENDITURES FROM FUND.—Amounts in the Fund are available to the Secretary for making payments under section 2111.

''(c) TRANSFERS TO FUND.—

''(1) IN GENERAL.—From the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, the Secretary shall, for fiscal year 1996 and each subsequent fiscal year, transfer to the Fund an amount determined by the Secretary for the fiscal year involved in accordance with paragraph (2).

''(2) DETERMINATION OF AMOUNTS.—For purposes of paragraph (1), the amount determined under this paragraph for a fiscal year is an estimate by the Secretary of an amount equal to 75 percent of the difference between—

''(A) the nationwide total of the amounts that would have been paid under section 1876(a)(4) during the year but for the exclusion of medical education payments from the adjusted average per capita cost pursuant to section 1876(a)(4)(B)(ii); and

''(B) the nationwide total of the amounts paid under section 1876(a)(4) during the year.

''(3) ALLOCATION BETWEEN MEDICARE TRUST FUNDS.—In providing for a transfer under paragraph (1) for a fiscal year, the Secretary shall provide for an allocation of the amounts involved between part A and part B of title XVIII (and the trust funds established under the respective parts) as reasonably reflects the proportion of payments for the indirect costs of medical education and direct graduate medical education costs of hospitals associated with the provision of services under each respective part.

''(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Fund such sums as may be necessary for each of the fiscal years 1996 through 2002.

''(e) INVESTMENT.—

''(1) IN GENERAL.—The Secretary of the Treasury shall invest such amounts of the Fund as such Secretary determines are not required to meet current withdrawals from the Fund. Such investments may be made only in interest-bearing obligations of the United States. For such purpose, such obligations may be acquired on original issue at the issue price, or by purchase of outstanding obligations at the market price.

''(2) SALE OF OBLIGATIONS.—Any obligation acquired by the Fund may be sold by the Secretary of the Treasury at the market price.

''(3) AVAILABILITY OF INCOME.—Any interest derived from obligations acquired by the Fund, and proceeds from any sale or redemption of such obligations, are hereby appropriated to the Fund.

''(f) ACCEPTANCE OF GIFTS AND BEQUESTS.—The Fund may accept on behalf of the United States money gifts and bequests made unconditionally to the Fund for the benefit of the Fund or any activity financed through the Fund.

''PART B—PAYMENTS TO TEACHING HOSPITALS

''SEC. 2111. FORMULA PAYMENTS TO TEACHING HOSPITALS.

''(a) IN GENERAL.—In the case of each teaching hospital that in accordance with subsection (b) submits to the Secretary a payment document for fiscal year 1996 or any subsequent fiscal year, the Secretary shall make payments for the year to the teaching hospital for the direct and indirect costs of operating approved medical residency training programs. Such payments shall be made from the Fund, and shall be made in accordance with a formula established by the Secretary.

''(b) PAYMENT DOCUMENT.—For purposes of subsection (a), a payment document is a document containing such information as may be necessary for the Secretary to make payments under such subsection to a teaching hospital for a fiscal year. The document is submitted in accordance with this subsection if the document is submitted not later than the date specified by the Secretary, and the document is in such form and is made in such manner as the Secretary may require. The Secretary may require that information under this subsection be submitted to the Secretary in periodic reports.''.

(b) NATIONAL ADVISORY COUNCIL ON POSTGRADUATE MEDICAL EDUCATION.—

(1) IN GENERAL.—There is established within the Department of Health and Human Services an advisory council to be known as the National Advisory Council on Postgraduate Medical Education (in this title referred to as the ''Council'').

(2) DUTIES.—The council shall provide advice to the Secretary on appropriate policies for making payments for the support of postgraduate medical education in order to assure an adequate supply of physicians trained in various specialities, consistent with the health care needs of the United States.

(3) COMPOSITION.—

(A) IN GENERAL.—The Secretary shall appoint to the Council 15 individuals who are not officers or employees of the United States. Such individuals shall include not less than 1 individual from each of the following categories of individuals or entities:

(i) Organizations representing consumers of health care services.

(ii) Physicians who are faculty members of medical schools, or who supervise approved physician training programs.

(iii) Physicians in private practice who are not physicians described in clause (ii).

(iv) Practitioners in public health.

(v) Advanced-practice nurses.

(vi) Other health professionals who are not physicians.

(vii) Medical schools.

(viii) Teaching hospitals.

(ix) The Accreditation Council on Graduate Medical Education.

(x) The American Board of Medical Specialities.

(xi) The Council on Postdoctoral Training of the American Osteopathic Association.

(xii) The Council on Podiatric Medical Education of the American Podiatric Medical Association.

(B) REQUIREMENTS REGARDING REPRESENTATIVE MEMBERSHIP.—To the greatest extent feasible, the membership of the Council shall represent the various geographic regions of the United States, shall reflect the racial, ethnic, and gender composition of the population of the United States, and shall be broadly representative of medical schools and teaching hospitals in the United States.

(C) EX OFFICIO MEMBERS; OTHER FEDERAL OFFICERS OR EMPLOYEES.—The membership of the Council shall include individuals designated by the Secretary to serve as members of the Council from among Federal officers or employees who are appointed by the President, or by the Secretary (or by other Federal officers who are appointed by the President with the advice and consent of the Senate). Individuals designated under the preceding sentence shall include each of the following officials (or a designee of the official):

(i) The Secretary of Health and Human Services.

(ii) The Secretary of Veterans Affairs.

(iii) The Secretary of Defense.

(4) CHAIR.—The Secretary shall, from among members of the council appointed under paragraph (3)(A), designate an individual to serve as the chair of the council.

(5) TERMINATION.—The Council terminates December 31, 1999.

(c) REMOVE MEDICAL EDUCATION AND DISPROPORTIONATE SHARE HOSPITAL PAYMENTS FROM CALCULATION OF ADJUSTED AVERAGE PER CAPITA COST.—

(1) IN GENERAL.—Section 1876(a)(4) (42 U.S.C. 1395mm(a)(4)) is amended—

(A) by striking ''(4)'' and inserting ''(4)(A)''; and

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

''(B) In determining the adjusted average per capita cost for a contract year under subparagraph (A), the Secretary shall exclude any amounts which the Secretary estimates would be payable under this title during the year for—

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

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

(2) PAYMENTS TO HOSPITALS OF AMOUNTS ATTRIBUTABLE TO DSH.—Section 1886 (42 U.S.C. 1395ww) is amended by adding at the end the following new subsection:

''(j)(1) In addition to amounts paid under subsection (d)(5)(F), the Secretary is authorized to pay hospitals which are eligible for such payments for a fiscal year supplemental amounts that do not exceed the limit provided for in paragraph (2).

''(2) The sum of the aggregate amounts paid pursuant to paragraph (1) for a fiscal year shall not exceed the Secretary's estimate of 75 percent of the amount excluded from the adjusted average per capita cost for the fiscal year pursuant to section 1876(a)(4)(B)(i).''.

SEC. 15223. REVISIONS IN DETERMINATION OF AMOUNT OF PAYMENT FOR MEDICAL EDUCATION.

(a) INDIRECT MEDICAL EDUCATION.—

(1) IN GENERAL.—Section 1886(d)(5)(B) (42 U.S.C. 1395ww(d)(5)(B)) is amended by adding at the end the following new clauses:

''(v) In determining such adjustment with respect to a hospital for discharges occurring on or after October 1, 1995, and on or before September 30, 2002—

''(I) the total number of interns and residents counted by the Secretary may not exceed the number of interns and residents counted with respect to the hospital as of August 1, 1995, and

''(II) the number of interns and residents counted by the Secretary who are not primary care residents (as defined in subsection (h)(5)(H)) may not exceed the number of such residents counted with respect to the hospital as of such date.

''(vi) In calculating the number of full-time-equivalent interns and residents of a hospital in determining such adjustment with respect to the hospital, the Secretary shall provide for a weighting factor of .50 with respect to each intern and resident who

is not in an initial residency period (as defined in subsection (h)(5)(F)).''.

(2) PAYMENT FOR INTERNS AND RESIDENTS PROVIDING OFF-SITE SERVICES.—Section 1886(d)(5)(B)(iv) (42 U.S.C. 1395ww(d)(5)(B)(iv)) is amended by striking ''any entity'' and all that follows through ''and residents)'' and inserting ''any other entity under an agreement with the hospital''.

(b) DIRECT MEDICAL EDUCATION.—

(1) LIMITATION ON NUMBER OF RESIDENTS.—Section 1886(h)(4) (42 U.S.C. 1395ww(h)(4)) is amended by adding at the end the following new subparagraph:

''(F) LIMITATION ON NUMBER OF RESIDENTS FOR CERTAIN FISCAL YEARS.—Such rules shall provide that for purposes of a cost reporting period beginning on or after October 1, 1995, and on or before September 30, 2002—

''(i) the total number of full-time-equivalent residents determined under this paragraph with respect to an approved medical residency training program may not exceed the number of full-time-equivalent residents with respect to the program as of August 1, 1995, and

''(ii) the number of full-time-equivalent residents determined under this paragraph with respect to the program who are not primary care residents (as defined in paragraph (5)(H)) may not exceed the number of such residents counted with respect to the program as of such date.''.

(2) CONTINUATION OF FREEZE ON UPDATES TO FTE RESIDENT AMOUNTS.—Section 1886(h)(2)(D)(ii) (42 U.S.C. 1395ww(h)(2)(D)(ii)) is amended by striking ''fiscal year 1994 or fiscal year 1995'' and inserting ''fiscal years 1994, 1995, 1996, or 1997''.

(3) PERMITTING PAYMENT TO NON-HOSPITAL PROVIDERS.—Section 1886 (42 U.S.C. 1395ww) is amended by adding at the end the following new subsection:

''(j) Beginning with cost reporting periods beginning on or after July 1, 1996, notwithstanding any other provision of this title, the Secretary may make payments (in such amounts and in such form as the Secretary considers appropriate) to entities other than hospitals for the direct costs of medical education, if such costs are incurred in the operation of an approved medical residency training program described in subsection (h).''.

(c) EXPANDING DEFINITION OF PRIMARY CARE RESIDENTS.—Section 1886(h)(5)(H) (42 U.S.C. 1395ww(h)(5)(H)) is amended by inserting ''obstetrics and gynecology,'' after ''geriatric medicine,''.

(d) EFFECTIVE DATE.—Except as provided otherwise in this section (or in the amendments made by this section), the amendments made by this section apply to hospital cost reporting periods beginning on or after October 1, 1995.

SEC. 15224. PAYMENTS FOR HOME HEALTH SERVICES.

(a) REDUCTIONS IN COST LIMITS.—Section 1861(v)(1)(L)(i) (42 U.S.C. 1395x(v)(1)(L)(i)) is amended—

(1) by inserting ''and before October 1, 1996,'' after ''July 1, 1987'' in subclause (III),

(2) by striking the period at the end of the matter following subclause (III), and inserting '', and'',

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

''(IV) October 1, 1996, 105 percent of the median of the labor-related and nonlabor per visit costs for free standing home health agencies.''.

(b) DELAY IN UPDATES.—Section 1861(v)(1)(L)(iii) (42 U.S.C. 1395x(v)(1)(L)(iii)) is amended by striking ''July 1, 1996'' and inserting ''October 1, 1996''.

(c) ADDITIONS TO COST LIMITS.—Section 1861(v)(1)(L) (42 U.S.C. 1395x(v)(1)(L)) is amended by adding at the end the following new clauses:

''(iv) For services furnished by home health agencies for cost reporting periods beginning on or after October 1, 1996, the Secretary shall provide for an interim system of limits. Payment shall be the lower of—

''(I) costs determined under the preceding provisions of this subparagraph, or

''(II) an agency-specific per beneficiary annual limit calculated from the agency's 12-month cost reporting period ending on or after January 1, 1994 and on or before December 31, 1994 based on reasonable costs (including non-routine medical supplies), updated by the home health market basket index. The per beneficiary limitation shall be multiplied by the agency's unduplicated census count of Medicare patients for the year subject to the limitation. The limitation shall represent total Medicare reasonable costs divided by the unduplicated census count of Medicare patients.

''(v) For services furnished by home health agencies for cost reporting periods beginning on or after October 1, 1996, the following rules shall apply:

''(I) For new providers and those providers without a 12-month cost reporting period ending in calendar year 1994, the per beneficiary limit shall be equal to the mean of these limits (or the Secretary's best estimates thereof) applied to home health agencies as determined by the Secretary. Home health agencies that have altered their corporate structure or name may not be considered new providers for payment purposes.

''(II) For beneficiaries who use services furnished by more than one home health agency, the per beneficiary limitation shall be pro-rated among agencies.

''(vi) Home health agencies whose cost or utilization experience is below 125 percent of the mean national or census region aggregate per beneficiary cost or utilization experience for 1994, or best estimates thereof, and whose year-end reasonable costs are below the agency-specific per beneficiary limit, shall receive payment equal to 50 percent of the difference between the agency's reasonable costs and its limit for fiscal years 1996, 1997, 1998, and 1999. Such payments may not exceed 5 percent of an agency's aggregate Medicare reasonable cost in a year.

''(vii) Effective January 1, 1997, or as soon as feasible, the Secretary shall modify the agency specific per beneficiary annual limit described in clause (iv) to provide for regional or national variations in utilization. For purposes of determining payment under clause (iv), the limit shall be calculated through a blend of 75 percent of the agency-specific cost or utilization experience in 1994 with 25 percent of the national or census region cost or utilization experience in 1994, or the Secretary's best estimates thereof.''.

(d) USE OF INTERIM FINAL REGULATIONS.—The Secretary shall implement the payment limits described in section 1861(v)(1)(L)(iv) of the Social Security Act by publishing in the Federal Register a notice of interim final payment limits by August 1, 1996 and allowing for a period of public comments thereon. Payments subject to these limits will be effective for cost reporting periods beginning on or after October 1, 1996, without the necessity for consideration of comments received, but the Secretary shall, by Federal Register notice, affirm or modify the limits after considering those comments.

(e) STUDIES.—The Secretary shall expand research on a prospective payment system for home health agencies that shall tie prospective payments to an episode of care, including an intensive effort to develop a reliable case mix adjuster that explains a significant amount of the variances in costs. The Secretary shall develop such a system for implementation in fiscal year 2000.

(f) PAYMENTS DETERMINED ON PROSPECTIVE BASIS.—Title XVIII is amended by adding at the end the following new section:

''PROSPECTIVE PAYMENT FOR HOME HEALTH SERVICES

''SEC. 1893. (a) Notwithstanding section 1861(v), the Secretary shall, for cost reporting periods beginning on or after fiscal year 2000, provide for payments for home health services in accordance with a prospective payment system, which pays home health agencies on a per episode basis, established by the Secretary.

''(b) Such a system shall include the following:

''(1) Per episode rates under the system shall be 15 percent less than those that would otherwise occur under fiscal year 2000 Medicare expenditures for home health services.

''(2) All services covered and paid on a reasonable cost basis under the Medicare home health benefit as of the date of the enactment of the Medicare Enhancement Act of 1995, including medical supplies, shall be subject to the per episode amount. In defining an episode of care, the Secretary shall consider an appropriate length of time for an episode the use of services and the number of visits provided within an episode, potential changes in the mix of services provided within an episode and their cost, and a general system design that will provide for continued access to quality services. The per episode amount shall be based on the most current audited cost report data available to the Secretary.

''(c) The Secretary shall employ an appropriate case mix adjuster that explains a significant amount of the variation in cost.

''(d) The episode payment amount shall be adjusted annually by the home health market basket index. The labor portion of the episode amount shall be adjusted for geographic differences in labor-related costs based on the most current hospital wage index.

''(e) The Secretary may designate a payment provision for outliers, recognizing the need to adjust payments due to unusual variations in the type or amount of medically necessary care.

''(f) A home health agency shall be responsible for coordinating all care for a beneficiary. If a beneficiary elects to transfer to, or receive services from, another home health agency within an episode period, the episode payment shall be pro-rated between home health agencies.''.

(g) LIMITATION ON PART A COVERAGE.—

(1) IN GENERAL.—Section 1812(a)(3) (42 U.S.C. 1395d(a)(3)) is amended by striking the semicolon and inserting ''for up to 160 visits during any spell of illness;''.

(2) CONFORMING AMENDMENT.—Section 1812(b) (42 U.S.C. 1395d(b)) is amended—

(A) by striking ''or'' at the end of paragraph (2),

(B) by striking the period at the end of paragraph (3) and inserting ''; or'', and

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

''(4) home health services furnished to the individual during such spell after such services have been furnished to the individual for 160 visits during such spell.''.

(3) EXCLUSION OF ADDITIONAL PART B COSTS FROM DETERMINATION OF PART B MONTHLY PREMIUM.—Section 1839(a) (42 U.S.C. 1395r(a)) is amended—

(A) in the second sentence of paragraph (1), by striking ''enrollees.'' and inserting ''enrollees (except as provided in paragraph (5)).''; and

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

''(5) In estimating the benefits and administrative costs which will be payable from the Federal Supplementary Medical Insurance Trust Fund for a year (beginning with 1996), the Secretary shall exclude an estimate of any benefits and costs attributable to home health services for which payment would have been made under part A during the year but for paragraph (4) of section 1812(b).''.

(4) EFFECTIVE DATE.—The amendments made by this subsection shall apply to spells of illness beginning on or after October 1, 1995.

(h) REQUIRING BILLING AND PAYMENT TO BE BASED ON SITE WHERE SERVICE FURNISHED.—Section 1891 (42 U.S.C. 1395bbb) is amended by adding at the end the following new subsection:

''(g) A home health agency shall submit claims for payment for home health services under this title only on the basis of the geographic location at which the service is furnished.''.

(i) MAINTAINING SAVINGS RESULTING FROM TEMPORARY FREEZE ON PAYMENT INCREASES.—

(1) BASING UPDATES TO PER VISIT COST LIMITS ON LIMITS FOR FISCAL YEAR 1993.—Section 1861(v)(1)(L)(iii) (42 U.S.C. 1395x(v)(1)(L)(iii)) is amended by adding at the end the following sentence: ''In establishing limits under this subparagraph, the Secretary may not take into account any changes in the costs of the provision of services furnished by home health agencies with respect to cost reporting periods which began on or after July 1, 1994, and before July 1, 1996.''.

(2) NO EXCEPTIONS PERMITTED BASED ON AMENDMENT.—The Secretary of Health and Human Services shall not consider the amendment made by paragraph (1) in making any exemptions and exceptions pursuant to section 1861(v)(1)(L)(ii) of the Social Security Act.

SEC. 15225. REQUIRING HEALTH MAINTENANCE ORGANIZATIONS TO COVER APPROPRIATE RANGE OF SERVICES.

(a) IN GENERAL.—Section 1876(c) (42 U.S.C. 1395mm(c)) is amended by adding at the end the following new paragraph:

''(9) The organization shall not deny any health care professionals, based solely on the license or certification as applicable under State law, the ability to participate in providing services covered under the contract under this section, or be reimbursed or indemnified or by a network plan for providing such services under the contract.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to risk-sharing contracts under section 1876 of the Social Security Act which entered into or renewed on or after January 1, 1996.

SEC. 15226. CLARIFICATION OF MEDICARE COVERAGE OF ITEMS AND SERVICES ASSOCIATED WITH CERTAIN MEDICAL DEVICES APPROVED FOR INVESTIGATIONAL USE.

(a) COVERAGE.—Nothing in title XVIII of the Social Security Act may be construed to prohibit coverage under part A or part B of the medicare program of items and services associated with the use of a medical device in the furnishing of inpatient or outpatient hospital services (including outpatient diagnostic imaging services) for which payment may be made under the program solely on the grounds that the device is not an approved device, if—

(1) the device is an investigational device; and

(2) the device is used instead of either an approved device or a covered procedure.

(b) CLARIFICATION OF PAYMENT AMOUNT.—Notwithstanding any other provision of title XVIII of the Social Security Act, the amount of payment made under the medicare program for any item or service associated with the use of an investigational device in the furnishing of inpatient or outpatient hospital services (including outpatient diagnostic imaging services) for which payment may be made under the program may not exceed the amount of the payment which would have been made under the program for the item or service if the item or service were associated with the use of an approved device or a covered procedure.

(c) DEFINITIONS.—In this section—

(1) the term ''approved device'' means a medical device (or devices) which has been approved for marketing under pre-market approval under the Federal Food, Drug, and Cosmetic Act or cleared for marketing under a 510(k) notice under such Act; and

(2) the term ''investigational device'' means—

(A) a medical device or devices (other than a device described in paragraph (1)) approved for investigational use under section 520(g) of the Federal Food, Drug, and Cosmetic Act, or

(B) an investigational combination product under section 503(g) of the Federal Food, Drug, and Cosmetic Act which includes a device (or devices) authorized for use under section 505(i) of such Act.

SEC. 15227. COMMISSION ON THE FUTURE OF MEDICARE AND THE PROTECTION OF THE HEALTH OF THE NATION'S SENIOR CITIZENS.

(a) ESTABLISHMENT.—There is established a commission to be known as the Commission on the Future of Medicare and the Protection of the Health of the Nation's Senior Citizens (in this section referred to as the ''Commission'').

(b) DUTIES.—

(1) IN GENERAL.—The Commission shall—

(A) analyze indicators of the health status of individuals in the United States who are eligible for benefits under the medicare program;

(B) make specific recommendations on actions which may be taken to improve the medicare program which would promote the health of medicare beneficiaries;

(C) analyze the effect of changes in the medicare program (including changes in medicare payments) on the access to and delivery of health care services to individuals who are not medicare beneficiaries;

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

(E) make specific recommendations to the Congress respecting a comprehensive approach to preserve the medicare program for the period during which such individuals are eligible for medicare.

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

(A) The amount and sources of Federal funds to finance the medicare program.

(B) The most efficient and effective manner of administering the program.

(C) Methods used by other nations to finance the delivery of health care services to their citizens.

(D) The financial impact on the medicare program of increases in the number of individuals in the United States without health insurance coverage.

(c) MEMBERSHIP.—

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

(A) The President shall appoint 3 members.

(B) The Majority Leader of the Senate shall appoint 3 members.

(C) The Minority Leader of the Senate shall appoint 3 members.

(D) The Speaker of the House of Representatives shall appoint 3 members.

(E) The Minority Leader of the House of Representatives shall appoint 3 members.

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

(3) VACANCIES.—Any vacancy in the membership of the Commission shall be filled in the manner in which the original appointment was made and shall not affect the power of the remaining members to execute the duties of the Commission.

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

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

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

(d) STAFF AND CONSULTANTS.—

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

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

(e) POWERS.—

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

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

(3) COST ESTIMATES BY CONGRESSIONAL BUDGET OFFICE.—

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

(B) The Commission shall reimburse the Director of the Congressional Budget Office for expenses relating to the employment in the office of the Director of such additional staff as may be necessary for the Director to comply with requests by the Commission under subparagraph (A).

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

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

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

(7) OBTAINING INFORMATION.—The Commission may secure directly from any Federal agency information necessary to enable it to carry out its duties, if the information may be disclosed under section 552 of title 5, United States Code. Upon request of the Chairman of the Commission, the head of such agency shall furnish such information to the Commission.

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

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

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

(f) REPORT.—Not later than May 1, 1997, the Commission shall submit to Congress a report containing its findings and recommendations regarding how to protect and preserve the medicare program in a financially solvent manner until 2030 (or, if later, throughout the period of projected solvency of the Federal Old-Age and Survivors Insurance Trust Fund). The report shall include detailed recommendations for appropriate legislative initiatives respecting how to accomplish this objective.

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

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

Subtitle D—Preventing Fraud and Abuse

PART 1—AMENDMENTS TO ANTI-FRAUD AND ABUSE PROVISIONS APPLICABLE TO MEDICARE, MEDICAID, AND STATE HEALTH CARE PROGRAMS

SEC. 15301. ANTI-KICKBACK STATUTORY PROVISIONS.

(a) REVISION TO PENALTIES.—

(1) PERMITTING SECRETARY TO IMPOSE CIVIL MONETARY PENALTY.—Section 1128A(a) (42 U.S.C. 1320a–7a(a)) is amended—

(A) by striking ''or'' at the end of paragraphs (1) and (2);

(B) by striking the semicolon at the end of paragraph (3) and inserting ''; or''; and

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

''(4) carries out any activity in violation of paragraph (1) or (2) of section 1128B(b);''.

(2) DESCRIPTION OF CIVIL MONETARY PENALTY APPLICABLE.—Section 1128A(a) (42 U.S.C. 1320a–7a(a)) is amended—

(A) by striking ''given).'' at the end of the first sentence and inserting the following: ''given or, in cases under paragraph (4), $50,000 for each such violation).''; and

(B) by striking ''claim.'' at the end of the second sentence and inserting the following: ''claim (or, in cases under paragraph (4), damages of not more than three times the total amount of remuneration offered, paid, solicited, or received.''.

(3) INCREASE IN CRIMINAL PENALTY.—Paragraphs (1) and (2) of section 1128B(b) (42 U.S.C. 1320a–7b(b)) are each amended—

(A) by striking ''$25,000'' and inserting ''$50,000''; and

(B) by striking the period at the end and inserting the following: '', and shall be subject to damages of not more than three times the total remuneration offered, paid, solicited, or received.''.

(b) REVISIONS TO EXCEPTIONS.—

(1) EXCEPTION FOR DISCOUNTS.—Section 1128B(b)(3)(A) (42 U.S.C. 1320a–7b(b)(3)(A)) is amended by striking ''program;'' and inserting ''program and is not in the form of a cash payment;''.

(2) EXCEPTION FOR PAYMENTS TO EMPLOYEES.—Section 1128B(b)(3)(B) (42 U.S.C. 1320a–7b(b)(3)(B)) is amended by inserting at the end ''if the amount of remuneration under the arrangement is consistent with the fair market value of the services and is not determined in a manner that takes into account (directly or indirectly) the volume or value of any referrals, except that such employee can be paid remuneration in the form of a productivity bonus based on services personally performed by the employee.''.

(3) EXCEPTION FOR WAIVER OF COINSURANCE BY CERTAIN PROVIDERS.—Section 1128B(b)(3)(D) (42 U.S.C. 1320a–7b(b)(3)(D)) is amended to read as follows:

''(D) a waiver or reduction of any coinsurance or other copayment if—

''(i) the waiver or reduction is made pursuant to a public schedule of discounts which the person is obligated as a matter of law to apply to certain individuals,

''(ii) the waiver or reduction is made pursuant to an established program and applies to a defined group of individuals whose incomes do not exceed 150 percent (or such higher percentage as the Secretary may permit) of the official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved,

''(iii) the waiver or reduction of coinsurance is not offered as part of any advertisement or solicitation and the person offering the waiver or reduction determines in good faith that the individual is in financial need,

''(iv) the person offering the waiver or reduction fails to collect the coinsurance or other payment after making reasonable collection efforts, or

''(v) the waiver or reduction of coinsurance is in accordance with a cost sharing schedule or a supplemental benefit package which may be offered by a managed care plan (as defined in section 1128(j)); and''.

(4) NEW EXCEPTION FOR CAPITATED PAYMENTS.—Section 1128B(b)(3) (42 U.S.C. 1320a–7b(b)(3)) is amended—

(A) by striking ''and'' at the end of subparagraph (D);

(B) by striking the period at the end of subparagraph (E) and inserting ''; and''; and

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

''(F) any reduction in cost sharing or increased benefits given to an individual, any amounts paid to a provider for an item or service furnished to an individual, or any discount or reduction in price given by the provider for such an item or service, if the individual is enrolled with and such item or service is covered under any of the following:

''(i) A health plan which is furnishing items or services under a risk-sharing contract under section 1876 or section 1903(m).

''(ii) A health plan receiving payments on a prepaid basis, under a demonstration project under section 402(a) of the Social Security Amendments of 1967 or under section 222(a) of the Social Security Amendments of 1972; and

''(G) any amounts paid to a provider for an item or service furnished to an individual or any discount or reduction in price given by the provider for such an item or service, if the individual is enrolled with and such item or service is covered under a health plan under which the provider furnishing the item or service is paid by the health plan for furnishing the item or service only on a capitated basis pursuant to a written arrangement between the plan and the provider in which the provider assumes financial risk for furnishing the item or service.''.

(c) AUTHORIZATION FOR THE SECRETARY TO ISSUE REGULATIONS.—Section 1128B(b) (42 U.S.C. 1320a–7b(b)) is amended by adding at the end the following new paragraph:

''(4) The Secretary is authorized to impose by regulation such other requirements as needed to protect against program or patient abuse with respect to any of the exceptions described in paragraph (3).''.

(d) CLARIFICATION OF OTHER ELEMENTS OF OFFENSE.—Section 1128B(b) (42 U.S.C. 1320a–7b(b)) is amended—

(1) in paragraph (1)(A), by striking ''in return for referring'' and inserting ''to refer'';

(2) in paragraph (1)(B), by striking ''in return for purchasing, leasing, ordering, or arranging for or recommending'' and inserting ''to purchase, lease, order, or arrange for or recommend''; and

(3) by adding at the end of paragraphs (1) and (2) the following sentence: ''A violation exists under this paragraph if one or more purposes of the remuneration is unlawful under this paragraph.''.

SEC. 15302. CIVIL MONEY PENALTIES.

(a) PROHIBITION AGAINST OFFERING INDUCEMENTS TO INDIVIDUALS ENROLLED UNDER PLANS.—

(1) OFFER OF REMUNERATION.—Section 1128A(a) (42 U.S.C. 1320a–7a(a)), as amended by section 15301(a)(1), is amended—

(A) by striking ''; or'' at the end of paragraph (3) and inserting a semicolon;

(B) by striking the semicolon at the end of paragraph (4) and inserting ''; or''; and

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

''(5) offers, pays, or transfers remuneration to any individual eligible for benefits under title XVIII of this Act, or under a State health care program (as defined in section 1128(h)) that such person knows or should know is likely to influence such individual to order or receive from a particular provider, practitioner, or supplier any item or service for which payment may be made, in whole or in part, under title XVIII, or a State health care program, other than to influence an individual enrolled in a managed care plan or a point-of-service plan (as defined in section 1128(j)) to receive benefits under the plan in accordance with established practice patterns for the delivery of medically necessary services;''.

(2) REMUNERATION DEFINED.—Section 1128A(i) (42 U.S.C. 1320a–7a(i)) is amended by adding at the end the following new paragraph:

''(6) The term 'remuneration' includes the waiver or reduction of coinsurance amounts, and transfers of items or services for free or for other than fair market value, except that such term does not include the waiver or reduction of coinsurance amounts by a person or entity, if—

''(A) the waiver or reduction is made pursuant to a public schedule of discounts which the person is obligated as a matter of law to apply to certain individuals,

''(B) the waiver or reduction is made pursuant to an established program and applies to a defined group of individuals whose incomes do not exceed 150 percent (or such higher percentage as the Secretary may permit) of the official poverty line (as defined by the Office of Management and Budget,

and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved,

''(C) the waiver or reduction of coinsurance is not offered as part of any advertisement or solicitation and the person offering the waiver or reduction determines in good faith that the individual is in financial need,

''(D) the person offering the waiver or reduction fails to collect the coinsurance or other payment after making reasonable collection efforts, or

''(E) the waiver or reduction of coinsurance is in accordance with a cost sharing schedule or a supplemental benefit package which may be offered by a managed care plan under section 1128(j).''.

(b) ADDITIONAL OFFENSES.—Section 1128A(a) of such Act, as amended by section 15301(a)(1) and subsection (a)(1), is further amended—

(1) by striking ''or'' at the end of paragraph (4);

(2) by striking the semicolon at the end of paragraph (5) and inserting ''; or''; and

(3) by inserting after paragraph (5) the following new paragraphs:

''(6) engages in a practice which has the effect of limiting or discouraging (as compared to other plan enrollees) the utilization of medically necessary health care services covered by law or under the service contract by title XIX or other publicly subsidized patients, including but not limited to differential standards for the location and hours of service offered by providers participating in the plan;

''(7) substantially fails to cooperate with a quality assurance program or a utilization review activity; or

''(8) engaging in a pattern of failing substantially to provide or authorize medically necessary items and services that are required to be provided to an individual covered under a health plan (as defined in section 1128(j)) or public program for the delivery of or payment for health care items or services, if the failure has adversely affected (or had a substantial likelihood of adversely affecting) the individual;''.

''(9) submits false or fraudulent statements, data or information on claims to the Secretary, a State health care agency, or any other Federal, State or local agency charged with implementation or oversight of a health plan or a public program that the person knows or should know is fraudulent;''.

(c) MODIFICATIONS OF AMOUNTS OF PENALTIES AND ASSESSMENTS.—Section 1128A(a) (42 U.S.C. 1320a–7a(a)), as amended by section 15301(a), subsection (a)(1), and subsection (b), is amended in the matter following paragraph (9)—

(1) by striking ''$2,000'' and inserting ''$10,000'';

(2) by inserting after ''under paragraph (4), $50,000 for each such violation'' the following: ''; in cases under paragraph (5), $10,000 for each such offer, payment, or transfer; in cases under paragraphs (6) through (9), an amount not to exceed $10,000 for each such determination by the Secretary''; and

(3) by striking ''twice the amount'' and inserting ''three times the amount''.

(d) INTEREST ON PENALTIES.—Section 1128A(f) (42 U.S.C. 1320a–7a(f)) is amended by adding after the first sentence the following: ''Interest shall accrue on the penalties and assessments imposed by a final determination of the Secretary in accordance with an annual rate established by the Secretary under the Federal Claims Collection Act. The rate of interest charged shall be the rate in effect on the date the determination becomes final and shall remain fixed at that rate until the entire amount due is paid. In addition, the Secretary is authorized to recover the costs of collection in any case where the penalties and assessments are not paid within 30 days after the determination becomes final, or in the case of a compromised amount, where payments are more than 90 days past due. In lieu of actual costs, the Secretary is authorized to impose a charge of up to 10 percent of the amount of penalties and assessments owed to cover the costs of collection.''.

(e) AUTHORIZATION TO ACT.—

(1) IN GENERAL.—The first sentence of section 1128A(c)(1) (42 U.S.C. 1320a–7a(c)(1)) is amended by striking all that follows ''(b)'' and inserting the following: ''unless, within one year after the date the Secretary presents a case to the Attorney General for consideration, the Attorney General brings an action in a district court of the United States.''.

(2) EFFECTIVE DATE.—The amendment made by this paragraph (1) shall apply to cases presented by the Secretary of Health and Human Services for consideration on or after the date of the enactment of this Act.

(f) CLARIFICATION OF PENALTY IMPOSED ON EXCLUDED PROVIDER FURNISHING SERVICES.—Section 1128A(a)(1)(D) (42 U.S.C. 1320a–7a(a)(1)(D)) is amended by inserting ''who furnished the service'' after ''in which the person''.

SEC. 15303. PRIVATE RIGHT OF ACTION.

Section 1128A (42 U.S.C. 1320a–7a) is amended by adding at the end the following new subsection:

''(m)(1) Subject to paragraphs (2) and (3), a carrier offering an insured health plan and the sponsor of a self-insured health plan that suffers financial harm as a direct result of the submission of claims by an individual or entity for payment for items and services furnished under the plan which makes the individual or entity subject to a civil monetary penalty under this section may, in a civil action against the individual or entity in the United States District Court, obtain damages against the individual or entity and such equitable relief as is appropriate.

''(2) A carrier or sponsor may bring a civil action under this subsection only if the carrier or sponsor provides the Secretary and the Attorney General with written notice of the intent to bring an action under this subsection, the identities of the individuals or entities the carrier or sponsor intends to name as defendants to the action, and all information the carrier or sponsor possesses regarding the activity that is the subject of the action that may materially affect the Secretary's decision to initiate a proceeding to impose a civil monetary penalty under this section against the defendants.

''(3) A carrier or sponsor may bring a civil action under this subsection only if any of the following conditions are met:

''(A) During the 60-day period that begins on the date the Secretary receives the written notice described in paragraph (2), the Secretary does not notify the carrier or sponsor that the Secretary intends to initiate a proceeding to impose a civil monetary penalty under this section against the defendants.

''(B) If the Secretary notifies the carrier or sponsor during the 60-day period described in subparagraph (A) that the Secretary intends to initiate a proceeding to impose a civil monetary penalty under this section against the defendants, the Secretary subsequently notifies the carrier or sponsor that the Secretary no longer intends to initiate such a proceeding against the defendants.

''(C) After the expiration of the 2-year period that begins on the date the Secretary notifies the carrier or sponsor that the Secretary intends to initiate a proceeding to impose a civil monetary penalty under this section against the defendants, the Secretary has not made a good faith effort to initiate such a proceeding against the defendants.

''(4) No action may be brought under this subsection more than 6 years after the date of the activity with respect to which the action is brought.''.

SEC. 15304. AMENDMENTS TO EXCLUSIONARY PROVISIONS IN FRAUD AND ABUSE PROGRAM.

(a) MANDATORY EXCLUSION OF INDIVIDUAL CONVICTED OF CRIMINAL OFFENSE RELATED TO HEALTH CARE FRAUD.—

(1) IN GENERAL.—Section 1128(a) (42 U.S.C. 1320a–7(a)) is amended by adding at the end the following new paragraph:

''(3) FELONY CONVICTION RELATING TO FRAUD.—Any individual or entity that has been convicted under Federal or State law, in connection with the delivery of a health care item or service on or after January 1, 1997, or with respect to any act or omission on or after such date in a program operated by or financed in whole or in part by any Federal, State, or local government agency, of a criminal offense consisting of a felony relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct.''.

(2) CONFORMING AMENDMENT.—Section 1128(b)(1) (42 U.S.C. 1320a–7(b)(1)) is amended—

(A) in the heading, by striking ''CONVICTION'' and inserting ''MISDEMEANOR CONVICTION''; and

(B) by striking ''criminal offense'' and inserting ''criminal offense consisting of a misdemeanor''.

(b) ESTABLISHMENT OF MINIMUM PERIOD OF EXCLUSION FOR CERTAIN INDIVIDUALS AND ENTITIES SUBJECT TO PERMISSIVE EXCLUSION FROM MEDICARE AND STATE HEALTH CARE PROGRAMS.—

(1) IN GENERAL.—Section 1128(c)(3) (42 U.S.C. 1320a–7(c)(3)) is amended by adding at the end the following new subparagraphs:

''(D) In the case of an exclusion of an individual or entity under paragraphs (1), (2), or (3) of subsection (b), the period of exclusion shall be a minimum of 3 years, unless the Secretary determines that an alternative period is appropriate because of aggravating or mitigating circumstances.

''(E) In the case of an exclusion of an individual or entity under paragraph (4) or (5) of subsection (b), the period of the exclusion shall not be less than the period during which the individual's or entity's license to provide health care is revoked, suspended, or surrendered, or the individual or the entity is excluded or suspended from a Federal or State health care program.

''(F) In the case of an exclusion of an individual or entity under subsection (b)(6)(B), the period of the exclusion shall be not less than 1 year.''.

(2) CONFORMING AMENDMENT.—Section 1128(c)(3)(A) (42 U.S.C. 1320a–7(c)(3)(A)) is amended by striking ''subsection (b)(12)'' and inserting ''paragraph (1), (2), (3), (4), (6)(B), or (12) of subsection (b)''.

SEC. 15305. SANCTIONS AGAINST PRACTITIONERS AND PERSONS FOR FAILURE TO COMPLY WITH STATUTORY OBLIGATIONS RELATING TO QUALITY OF CARE.

(a) MINIMUM PERIOD OF EXCLUSION FOR PRACTITIONERS AND PERSONS FAILING TO MEET STATUTORY OBLIGATIONS.—

(1) IN GENERAL.—The second sentence of section 1156(b)(1) (42 U.S.C. 1320c-5(b)(1)) is amended by striking ''may prescribe)'' and inserting ''may prescribe, except that such period may not be less than one year)''.

(2) CONFORMING AMENDMENT.—Section 1156(b)(2) (42 U.S.C. 1320c-5(b)(2)) is amended by striking ''shall remain'' and inserting

''shall (subject to the minimum period specified in the second sentence of paragraph (1)) remain''.

(b) AMOUNT OF CIVIL MONEY PENALTY.—Section 1156(b)(3) (42 U.S.C. 1320c-5(b)(3)) is amended by striking ''the actual or estimated cost'' and inserting the following: ''$10,000 for each instance''.

(c) REPEAL OF ''UNWILLING OR UNABLE'' CONDITION FOR IMPOSITION OF SANCTION.—Section 1156(b)(1) (42 U.S.C. 1320c-5(b)(1)) is amended—

(1) in the second sentence, by striking ''and determines'' and all that follows through ''such obligations,'' and

(2) by striking the third sentence.

SEC. 15306. REVISIONS TO CRIMINAL PENALTIES.

(a) TREBLE DAMAGES FOR CRIMINAL SANCTIONS.—Section 1128B (42 U.S.C. 1320a–7b) is amended by adding at the end the following new subsection:

''(f) In addition to the fines that may be imposed under subsection (a) or (c) any individual found to have violated the provisions of any of such subsections may be subject to treble damages.''.

(b) IDENTIFICATION OF COMMUNITY SERVICE OPPORTUNITIES.—Section 1128B (42 U.S.C. 1320a–7b), as amended by subsection (a), is further amended by adding at the end the following new subsection:

''(g) The Secretary shall—

''(1) in consultation with State and local health care officials, identify opportunities for the satisfaction of community service obligations that a court may impose upon the conviction of an offense under this section, and

''(2) make information concerning such opportunities available to Federal and State law enforcement officers and State and local health care officials.''.

SEC. 15307. DEFINITIONS.

Section 1128 (42 U.S.C. 1320a–7) is amended by adding at the end the following new subsection:

''(j) OTHER DEFINITIONS RELATING TO HEALTH PLANS.—

''(1) HEALTH PLAN.—The term 'health plan' means—

''(A) any contract of health insurance, including any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization group contract, that is provided by a carrier in a State; or

''(B) an employee welfare benefit plan or other arrangement insofar as the plan or arrangement provides health benefits in a State and is funded in a manner other than through the purchase of one or more policies or contracts described in subparagraph (A).

''(2) MANAGED CARE PLAN.—The term 'managed care plan' means a health plan that provides for items and services covered under the plan primarily through providers in the provider network of the plan.

''(3) POINT-OF-SERVICE PLAN.—The term 'point-of-service plan' means a health plan other than a managed care plan that permits an enrollee to receive benefits through a provider network.

''(4) PROVIDER NETWORK.—The term 'provider network' means, with respect to a health plan, providers who have entered into an agreement with the plan under which such providers are obligated to provide items and services covered under the plan to individuals enrolled in the plan.''.

SEC. 15308. EFFECTIVE DATE.

The amendments made by this part shall take effect January 1, 1997.

PART 2—INTERPRETIVE RULINGS ON KICKBACKS AND SELF-REFERRAL

SEC. 15311. ESTABLISHMENT OF PROCESS FOR ISSUANCE OF INTERPRETIVE RULINGS.

(a) ESTABLISHMENT.—Not later than 1 year after the date of the enactment of this Act, the Secretary of Health and Human Services (acting through the Inspector General of the Department of Health and Human Services) shall establish a process under which individuals and entities may submit a request to the Secretary for an interpretive ruling regarding the provisions of section 1128B(b) of the Social Security Act or part 3 which relate to kickbacks, bribes, and rebates, or the provisions of section 1877 of the Social Security Act.

(b) DEADLINE FOR REJECTION OF REQUEST.—If the Secretary of Health and Human Services rejects a request for an interpretive ruling submitted under this section, the Secretary shall notify the individual submitting the request of the rejection not later than 60 days after receiving the request.

SEC. 15312. EFFECT OF ISSUANCE OF INTERPRETIVE RULING.

(a) NO LEGAL EFFECT.—If the Secretary of Health and Human Services issues an interpretive ruling under section 15311, the ruling shall not be binding upon the Secretary, the party requesting the ruling, or any other party.

(b) PUBLICATION OF RULINGS.—The Secretary of Health and Human Services shall publish each interpretive ruling issued under section 15311 in the Federal Register.

SEC. 15313. IMPOSITION OF FEES.

(a) IN GENERAL.—The Secretary of Health and Human Services shall require an individual or entity requesting an interpretive ruling under section 15311 to submit a fee.

(b) AMOUNT.—The amount of the fee required under subsection (a) shall be equal to the costs incurred by the Secretary in responding to the request.

PART 3—DIRECT SPENDING FOR ANTI-FRAUD ACTIVITIES UNDER MEDICARE

SEC. 15321. DIRECT SPENDING FOR ANTI-FRAUD ACTIVITIES UNDER MEDICARE.

Title XVIII (42 U.S.C. 1395 et seq.), as amended by section 15224(f), is amended by adding at the end the following new section:

''APPROPRIATIONS FOR COMBATING FRAUD AND ABUSE

''SEC. 1894. (a) DIRECT SPENDING FOR PAYMENT SAFEGUARD ACTIVITIES.—

''(1) IN GENERAL.—There are appropriated from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund for each fiscal year such amounts as are necessary to carry out the payment safeguard activities described in paragraph (2), subject to paragraph (3).

''(2) ACTIVITIES DESCRIBED.—The payment safeguard activities described in this paragraph are as follows:

''(A) Review of activities of providers of services or other individuals and entities furnishing items and services for which payment may be made under this title (including skilled nursing facilities and home health agencies), including medical and utilization review and fraud review.

''(B) Audit of cost reports.

''(C) Determinations as to whether payment should not be, or should not have been, made under this title by reason of section 1862(b), and recovery of payments that should not have been made.

''(D) Education of providers of services, beneficiaries, and other persons with respect to payment integrity and benefit quality assurance issues.

''(3) AMOUNTS SPECIFIED.—The amount appropriated under paragraph (1) for a fiscal year is as follows:

''(A) For fiscal year 1996, such amount shall be not less than $430,000,000 and not more than $440,000,000.

''(B) For fiscal year 1997, such amount shall be not less than $490,000,000 and not more than $500,000,000.

''(C) For fiscal year 1998, such amount shall be not less than $550,000,000 and not more than $560,000,000.

''(D) For fiscal year 1999, such amount shall be not less than $620,000,000 and not more than $630,000,000.

''(E) For fiscal year 2000, such amount shall be not less than $670,000,000 and not more than $680,000,000.

''(F) For fiscal year 2001, such amount shall be not less than $690,000,000 and not more than $700,000,000.

''(G) For fiscal year 2002, such amount shall be not less than $710,000,000 and not more than $720,000,000.

''(b) DIRECT SPENDING FOR MEDICARE-RELATED ACTIVITIES OF INSPECTOR GENERAL.—

''(1) IN GENERAL.—There are appropriated from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund to the Inspector General of the Department of Health and Human Services for each fiscal year such amounts as are necessary to enable the Inspector General to carry out activities relating to the medicare program (as described in paragraph (2)), subject to paragraph (3).

''(2) ACTIVITIES DESCRIBED.—The activities described in this paragraph are as follows:

''(A) Prosecuting medicare-related matters through criminal, civil, and administrative proceedings.

''(B) Conducting investigations relating to the medicare program.

''(C) Performing financial and performance audits of programs and operations relating to the medicare program.

''(D) Performing inspections and other evaluations relating to the medicare program.

''(E) Conducting provider and consumer education activities regarding the requirements of this title.

''(3) AMOUNTS SPECIFIED.—The amount appropriated under paragraph (1) for a fiscal year is as follows:

''(A) For fiscal year 1996, such amount shall be $130,000,000.

''(B) For fiscal year 1997, such amount shall be $181,000,000.

''(C) For fiscal year 1998, such amount shall be $204,000,000.

''(D) For each subsequent fiscal year, the amount appropriated for the previous fiscal year, increased by the percentage increase in aggregate expenditures under this title for the fiscal year involved over the previous fiscal year.

''(c) ALLOCATION OF PAYMENTS AMONG TRUST FUNDS.—The appropriations made under subsection (a) and subsection (b) shall be in an allocation as reasonably reflects the proportion of such expenditures associated with part A and part B.''.

PART 4—PREEMPTION OF STATE CORPORATE PRACTICE LAWS UNDER MEDICARE

SEC. 15331. PREEMPTION OF STATE LAWS PROHIBITING CORPORATE PRACTICE OF MEDICINE FOR PURPOSES OF MEDICARE.

Title XVIII (42 U.S.C. 1395 et seq.) is amended by adding at the end the following new section:

''PERMITTING CORPORATIONS TO SERVE AS PROVIDERS

''SEC. 1893. The Secretary may not refuse to treat any individual or entity as a provider of services under this title or refuse to

make payment under this title to the individual or entity on the grounds that the individual or entity is prohibited from practicing medicine under a provision of State or local law which prohibits a corporation from practicing medicine.''.

PART 5—MEDICARE ANTI-FRAUD AND ABUSE COMMISSION

SEC. 15341. ESTABLISHMENT OF MEDICARE ANTI-FRAUD AND ABUSE COMMISSION

(a) IN GENERAL.—There is established a commission to be known as the ''Medicare Anti-Fraud and Abuse Commission'' (in this title referred to as the ''Commission'').

(b) COMPOSITION.—The Commission shall be composed of 8 members as follows:

(1) OFFICIALS.—

(A) The Secretary of Health and Human Services (or the Secretary's designee).

(B) The Inspector General of the Department of Health and Human Services (or the Inspector General's designee).

(C) The Administrator of the Health Care Financing Administration (or the Administrator's designee).

(2) PUBLIC MEMBERS.—Five members, appointed by the President, of which—

(A) one shall be a representative of physicians;

(B) one shall be a representative of hospital administrators;

(C) one shall be a representative of medicare carriers;

(D) one shall be a representative of medicare peer review organizations; and

(E) one shall be a representative of medicare beneficiaries.

In making appointments under this paragraph of an individual who is a representative of persons or organizations, the President shall consider the recommendations of national organizations that represent such persons or organizations. The President shall report to Congress, within 90 days after the date of the enactment of this Act, the names of the members appointed under this paragraph.

(c) TERMS.—Each member shall be appointed for the life of the Commission. A vacancy in the Commission shall be filled in the manner in which the original appointment was made.

SEC. 15342. FUNCTIONS OF COMMISSION.

(a) IN GENERAL.—The Commission shall—

(1) investigate the nature, magnitude, and cost of health care fraud and abuse in the medicare program, and

(2) identify and develop the most effective methods of preventing, detecting, and prosecuting or litigating such fraud and abuse, with particular emphasis on coordinating public and private prevention, detection, and enforcement efforts.

(b) PARTICULARS.—Among other items, the Commission shall examine at least the following:

(1) Mechanisms to provide greater standardization of claims administration in order to accommodate fraud prevention and detection.

(2) Mechanisms to allow more freedom of the medicare program to exchange information for coordinating case development and prosecution or litigation efforts, without undermining patient and provider privacy protections or violating anti-trust laws.

(3) Criteria for physician referrals to facilities in which they (or family members) have a financial interest.

(4) The availability of resources to the medicare program to combat fraud and abuse.

(c) REPORT.—After approval by a majority vote, a quorum being present, the Commission shall transmit to Congress a report on its activities. The report shall be transmitted not later than 18 months after the date that a majority of the public members of the Commission have been appointed. The report shall contain a detailed statement of the Commission's findings, together with such recommendations as the Commission considers appropriate.

SEC. 15343. ORGANIZATION AND COMPENSATION.

(a) ORGANIZATION.—

(1) QUORUM.—A majority of the members of the Commission shall constitute a quorum but a lesser number may hold hearings.

(2) CHAIRMAN.—The Commission shall elect one of its members to serve as chairman of the Commission.

(3) MEETINGS.—The Commission shall meet at the call of the chairman or a majority of its members. Meetings of the Commission are open to the public under section 10(a)(10) of the Federal Advisory Committee Act, except that the Commission may conduct meetings in executive session but only if a majority of the members of the Commission (a quorum being present) approve going into executive session.

(b) COMPENSATION OF MEMBERS.—Members of the Commission shall serve without compensation, but shall be reimbursed for travel, subsistence, and other necessary expenses incurred in the performance of their duties as members of the Commission.

SEC. 15344. STAFF OF COMMISSION.

(a) IN GENERAL.—The Commission may appoint and fix the compensation of a staff director and such other additional personnel as may be necessary to enable the Commission to carry out its functions, without regard to the laws, rules, and regulations governing appointment and compensation and other conditions of service in the competitive service.

(b) DETAIL OF FEDERAL EMPLOYEES.—Upon request of the chairman, any Federal employee who is subject to such laws, rules, and regulations, may be detailed to the Commission to assist it in carrying out its functions under this title, and such detail shall be without interruption or loss of civil service status or privilege.

(c) EXPERTS AND CONSULTANTS.—The Commission may procure temporary and intermittent services under section 3109(b) of title 5, United States Code, but at rates for individuals not to exceed the daily equivalent of 120 percent of the maximum annual rate of basic pay payable for GS–15 of the General Schedule.

SEC. 15345. AUTHORITY OF COMMISSION.

(a) HEARINGS AND SESSIONS.—The Commission may, for the purpose of carrying out this title, hold hearings, sit and act at times and places, take testimony, and receive evidence as the Commission considers appropriate. The Commission may administer oaths or affirmations to witnesses appearing before it.

(b) OBTAINING OFFICIAL DATA.—

(1) IN GENERAL.—The Commission may secure directly from any department or agency of the United States information necessary to enable it to carry out this title. Upon request of the chairman of the Commission, the head of that department or agency shall furnish that information to the Commission.

(2) ACCESS TO INFORMATION.—Information obtained by the Commission is available to the public in the same manner in which information may be made available under sections 552 and 552a of title 5, United States Code.

(c) GIFTS, BEQUESTS, AND DEVISES.—The Commission may accept, use, and dispose of gifts, bequests, or devises of services or property for the purpose of aiding or facilitating the work of the Commission.

(d) MAILS.—The Commission may use the United States mails in the same manner and under the same conditions as other departments and agencies of the United States.

(e) ADMINISTRATIVE SUPPORT SERVICES.—Upon the request of the Commission, the Administrator of General Services shall provide to the Commission, on a reimbursable basis, the administrative support services necessary for the Commission to carry out its responsibilities under this title.

(f) SUBPOENA POWER.—

(1) IN GENERAL.—The Commission may issue subpoenas requiring the attendance and testimony of witnesses and the production of any evidence relating to any matter which the Commission is authorized to investigate under this title. The attendance of witnesses and the production of evidence may be required from any place within the United States at any designated place of hearing within the United States.

(2) FAILURE TO OBEY A SUBPOENA.—If a person refuses to obey a subpoena issued under paragraph (1), the Commission may apply to a United States district court for an order requiring that person to appear before the Commission to give testimony, produce evidence, or both, relating to the matter under investigation. The application may be made within the judicial district where the hearing is conducted or where that person is found, resides, or transacts business. Any failure to obey the order of the court may be punished by the court as civil contempt.

(3) SERVICE OF SUBPOENAS.—The subpoenas of the Commission shall be served in the manner provided for subpoenas issued by a United States district court under the Federal Rules of Civil Procedure for the United States district courts.

(4) SERVICE OF PROCESS.—All process of any court to which application is to be made under paragraph (2) may be served in the judicial district in which the person required to be served resides or may be found.

SEC. 15346. TERMINATION.

The Commission shall terminate 90 days after the date the report is submitted under section 15342(c).

SEC. 15347. AUTHORIZATION OF APPROPRIATIONS.

There are authorized to be appropriated to the Commission such sums as are necessary to carry out its functions, to remain available until expended.

The CHAIRMAN. The Chair would point out that one opponent is all that the rule allows. The gentleman from Texas [Mr. ARCHER] will be recognized in opposition.

Mr. ARCHER. Mr. Chairman, I ask unanimous consent to yield half of my time to the gentleman from Virginia [Mr. BLILEY] so that he may control that time.

The CHAIRMAN. Is there objection to the request of the gentleman from Texas?

There was no objection.

Mr. GIBBONS. Mr. Chairman, I would ask unanimous consent that I may allocate half of my time to the gentleman from Michigan [Mr. DINGELL] so that he may control that time.

The CHAIRMAN. Is there objection to the request of the gentleman from Florida?

There was no objection.

The CHAIRMAN. The gentleman from Florida [Mr. GIBBONS] is recognized for 15 minutes.

Mr. GIBBONS. Mr. Chairman, I yield myself such time as I may consume.

Mr. Chairman, we have completed an historic debate, 3 hours on probably

the biggest bill that has been considered by this body in my 33 years. Yesterday, we spent not 3 hours, but 4 hours on shrimp. So much for priorities. So much for Speaker GINGRICH's belief about what is important in America.

Mr. Chairman, we have a substitute. Now I am going to let everybody in on a secret. It is not going to be adopted. The Republicans knew that when they made it in order. They have all received their marching orders. If they vote for this, they get fired. But despite all of that, this substitute does the work.

Mr. Chairman, I yield 5 minutes to the gentleman from Maryland [Mr. CARDIN].

(Mr. CARDIN asked and was given permission to revise and extend his remarks.)

Mr. CARDIN. Mr. Chairman, first and foremost the substitute that is before us will deal with the solvency of the Medicare trust fund. It provides for $90 billion of savings to go into the Medicare trust fund providing for solvency to the year 2006. We have followed the suggestions of the trustees.

It is equivalent to the Republican bill in solvency. The Republican bill originally was advertised that it was going to go to the year 2014. They have later changed it to 2010. If we take away the magic wand of taking general funds into the trust fund, it is 2006.

Mr. Chairman, our bill is equivalent to the Republican bill on solvency for 10 years. Why do we have in the Republican bill three times more cuts in Medicare? It is not needed for the solvency. They do not use it for the solvency. It is used for a tax cut, paid for by the Medicare beneficiaries.

Mr. Chairman, they can use all the language they want about lock-boxes and that we have in the tax bill separate ways to pay for the tax bill, but I ask my colleagues to answer a simple question: If we do not pass this Medicare bill, the tax bill cannot go into effect, can it? Because we must have the savings from this bill in order to finance the tax cut.

Pure and simple, our seniors are being asked to pay for the tax cut. The substitute envisions no such thing. As a consequence of these draconian cuts, seniors are forced into plans that take away their choice. They have to pay more, $1,000 a year, just to maintain the same benefits. We have gone through that. If seniors have to pay more for the same benefits, it is a cut.

The Democratic substitute does not do that. The Democratic substitute provides for $90 billion of savings to go into the Medicare trust fund without jeopardizing our seniors' ability to have affordable health care.

There is no increase, no increase in the premium costs to our beneficiaries. Unlike the Republican bill that changes current law and allows the Medicare Part B premium to go up to $87 a month, the substitute that we are submitting, the premiums would be $30 a month less, $360 a year less.

For seniors who have limited income, who already have the highest out-of-pocket costs of any group of Americans, that is a large increase. Our substitute does not do that.

Mr. Chairman, let me talk for a moment to my friends who are part of the coalition budget. This substitute is better on deficit reduction, because we do not believe in the tax cut. If you add the revenue lost to the Treasury by the tax cut of $245 billion to the $90 billion of savings that we have in this bill, we get $335 billion in deficit reduction compared to $270 on the Republican side.

We are $65 billion better off, better off on deficit reduction, as a result of the substitute that is before you. I would encourage my coalition Members to take a look at that particular point.

We also provide for reform in our substitute. We move forward rather than backward on fraud and abuse. We strengthen, not weaken, fraud and abuse. We do not weaken the standards for civil penalties that is in the Republican bill. We provide additional protection, so that we can go after fraud and abuse.

Do not take the Democrats' word on it. Do not take the Republicans' word on it. The inspector general has said, an independent person, that the Republican bill threatens the ability to go after fraud and abuse. We move forward, not backward, in providing additional benefits to our seniors.

We provide for colorectal screening and annual mammography testing. Why? Because medical technology tells us that these tests are needed today. If we do not provide these tests, we are moving backward in providing seniors the care that they need. Our bill moves forward, not backward. Seniors already have too high out-of-pocket costs. They need these types of screenings.

Mr. Chairman, I say to Members that we have a choice before us. We do not have to vote for the extreme, mean-spirited Republican approach that would slash Medicare in order to pay for tax cuts. We have a substitute before us that provides for the solvency of the Medicare trust fund, provides for reform in the Medicare system, protects our seniors, protects the system, and deals with solvency.

Mr. Chairman, I urge Members to support the Democrat substitute.

□ 1530

Mr. ARCHER. Mr. Chairman, I yield 2 minutes to the gentleman from California [Mr. HERGER], a respected member of the committee.

Mr. HERGER. Mr. Chairman, in April, the Medicare trustees stated that if nothing was done, Medicare would begin going broke next year, and become functionally bankrupt by the year 2002. Mr. Chairman, the Republican reforms proposed in the Medicare preservation act will preserve, will protect and will strengthen Medicare for future generations.

Mr. Chairman, there are clear and distinct differences between the Republican plan that guarantees Medicare's survival and the Democratic substitute. While the Republican plan saves Medicare for the next generation—the Democrat bill only saves Medicare through the next election.

While the Republican bill fixes Medicare for the long-term without increasing co-payments or deductibles, the Democrat substitute is nothing more than a band-aid, producing, at best, a short-term solution to this gaping problem. In fact, by the time the baby boomers retire, the Democrat alternative will have left Medicare with a projected deficit of over $300 billion.

Conversely, the Republican plan is specific and realistic and gives seniors the right to choose the Medicare plan that best suits their individual health care needs. Seniors will have the right to choose a HMO or a medisave account or they have the right to stay where they currently are, with their current doctor or hospital.

The Democrat plan, on the other hand, doesn't give seniors the right to choose—trapping them in the same one size fits all program.

Mr. Chairman, our choice is clear, we can either stay with our present broken-down 1965 model Medicare system or we can move ahead to a much improved 1995 model. I urge my colleagues to oppose this substitute and support the Republican Medicare preservation act.

Mr. DINGELL. Mr. Chairman, I yield myself 3 minutes.

Mr. Chairman, my Republican colleagues have made it plain they have a low regard for the intellect of the American senior citizens. They accuse us of frightening the senior citizens and also the hospitals. The hard fact is that the hospitals and the senior citizens have had the daylights scared out of them by this Republican plan.

Because the people, contrary to what might be thought, understand what is going on. My Republican colleagues expect seniors to accept an absurd declaration that, unless we destroy the Medicare plan now, it will destroy itself. What is really very simple here is this: If you drop the tax cut for the rich, none of these Medicare cuts are necessary.

Do Democrats want to protect Medicare? Of course. Remember, we created it over united Republican opposition. When I was sitting in the chair 30 years ago and we passed that legislation, 93 percent of my Republican colleagues voted against Medicare.

Do we wish to protect trust fund soundness? Of course. Now, there is a difference. My Republican colleagues accomplish that goal by raising senior citizens' taxes through higher premiums, reducing Social Security checks from which premiums are deducted, kicking the seniors out of their own doctor's office, denying them choice, shoving them into HMos which senior citizens do not want, closing

local hospital emergency rooms, repealing nursing home standards that protect patients in nursing homes, allowing doctors to perform office tests in the office sink, and taking away the right of citizens to recover from malpractice.

They do this also by eliminating statutory protections against fraud and abuse. The Secretary of HHS, the Department of Justice and the Inspector General all warned that this is a direct consequence of the language in this bill.It is not necessary, as the Republicans do, to cut the budget of the Inspector General of HHS, who deals with waste, fraud and abuse. We Democrats think there is a better way. The gentleman from Florida, [Mr. GIBBONS], the gentleman from Washington [Mr. MCDERMOTT], and I offer this substitute to show the way.

It ensures the solvency of the Medicare part A trust fund for exactly the same length of time that the Republican claim for their bill, the year 2006. It saves the amount that the trustees tell us needs to be saved, $90 billion. It should not and it will not cost the seniors more.

How do we do it? Simple. We are not proposing a tax cut for the rich. If we take the tax cut off the table, it is not that difficult. The substitute is good. I urge that we follow this course, that we accept the leadership of the Democratic proposal on the solvency issue. I am happy to offer it with my colleagues, the gentleman from Washington [Mr. MCDERMOTT and the gentleman from Florida [Mr. GIBBONS] and I urge support of the amendment.

Mr. Chairman, the Republicans have made clear in this debate that they have a very low regard for the intellect of America's senior citizens. They expect seniors to accept without question their absurd declaration that unless we destroy the Medicare program now, it will destroy itself.

I say to my Republican colleagues, it's this simple: Drop your tax cut for the rich, and none of these Medicare cuts will be necessary.

Do we want to protect Medicare? Of course we do.

Do we want to ensure that the trust fund is sound, today, tomorrow, and for years to come. Of course we do.

The Republicans think that to accomplish that goal, they should raise seniors' taxes, reduce their Social Security checks, kick them out of their own doctors' offices, shove them into HMO's they don't want, close their local hospitals, repeal the nursing home standards that protect them, allow doctors to perform office tests in the kitchen sink, and then take away their right to recover when their doctor commits malpractice.

We think there is a better way.

Mr. GIBBONS, Mr. MCDERMOTT, and I are offering this substitute today to show the American people that there is a better way. it ensures the solvency of the Medicare part A trust fund. It does so for exactly the same length of time the Republicans claim for their bill, the year 2006. And it does so by saving the amount of money that the Medicare Trustees tell us needs to be saved: $90 billion. And it won't cost seniors more.

Specifically, this proposal includes: Only modest reductions in hospital payments—about half of what the Republican bill cuts—but protection for rural and urban hospitals that serve the uninsured; tough provisions to enhance prevention, detection, and prosecution of fraud and abuse; the nursing home quality standards in current law, which the Republicans would repeal.

Also, fair reductions in physician payments so that the AMA's members share the burden, rather than make out like bandits in a backroom holdup; reduced copayments for seniors; less than half the Republican cuts in home health care; and new preventive services, including more frequent mammography, colorectal screening, pap smears, and diabetes services.

How, you may ask, do we pay for this? The answer is simple: We aren't the ones proposing a $245 billion tax cut targeted to the rich. If you take the tax cut off the table, I say to my Republican colleagues, it's really not that difficult.

Mr. Chairman, this substitute is a good one. It is the right approach to the Medicare trust fund solvency issue. I am pleased to offer it with Mr. GIBBONS and Mr. MCDERMOTT. I urge support for the amendment.

Mr. Chairman, before I conclude, I want to express my thanks, and the thanks of all the Democratic members of the Commerce Committee, to the Democratic staff of the committee—Bridget Taylor, Kay Holcombe, Reid Stuntz, Chris Knauer, David Tittsworth, Nick Karamanos, Carla Hultberg, Elaine Sheets, Candy Butler, and Sharon Davis. I add our thanks to Karen Nelson from the Staff of Subcommittee ranking member HENRY WAXMAN, and to the staffs of all the Democratic members of the committee.

I also want to commend the excellent staff of the Ways and Means Committee Democrats, with whom we worked closely and cooperatively on this bill and this substitute. And of course, I want to thank the legislative counsels, Ed Grossman and Noah Wofsy, for their invaluable help.

Mr. BLILEY. Mr. Chairman, I yield myself 3 minutes.

Before we go too much further, I do want to recognize the long days and nights put in by the staff of both the Committee on Commerce and the Committee on Ways and Means. I would like to make note of my troops, Mary McGrane, Howard Cohen, Melody Harned, Bud Albright, Jon Cohrssen, David Lusk, Mike Collins, Eric Bergren and Margaret Daze. We could not have made it this far without them.

Mr. Chairman, my colleagues, including the ranking Member from Michigan, talk about being tough on fraud, waste and abuse. Well, I would say to the Inspector General or to the Justice Department, to HHS, read our bill. Let us compare. Our bill allows $250,000 in criminal fines for individuals and $500,000 for corporations. It outlaws fraud and provides for fines and prison terms up to life. Their bill sets criminal fines at $50,000 maximum. Our bill, false statements makes it a felony, 5-year prison term, up to $500,000 fine. Their bill, false statements, sets fines at $50,000.

Our bill, theft, embezzlement makes it a felony, 10-year prison term, $500,000 fine. Their bill, no mention.

Our bill, bribery, graft, 15-year prison term, $500,000 fine. Their bill, no mention.

Obstruction of criminal investigation of health care crime, 5-year prison term, $500,000 fine. Their bill, no mention.

Democrats talk about our bill going light on fraud, and it is just plain wrong. Our bill is tough, much tougher than theirs. Once again, the Republicans deal with facts. The Democrats' talk does not withstand scrutiny.

Mr. GIBBONS. Mr. Chairman, I yield 1 minute to the gentlewoman from Texas [Ms. JACKSON-LEE].

(Ms. JACKSON-LEE asked and was given permission to revise and extend her remarks.)

Ms. JACKSON-LEE. Mr. Chairman, I thank the gentleman from Florida for yielding time to me, and I thank the gentleman from Michigan [Mr. DINGELL].

I am gratified that we have come today to be realistic about Medicare. If I can briefly talk about the facts, this captures the Republican plan on Medicare, the locking up of innocent seniors who simply came to protest and oppose $270 billion in cuts. They opposed the $24 million that Houston-Harris County hospitals will lose over a 7-year period. They oppose the increase in premiums.

Maybe I need to tell Members a little story about Ms. McDougall and a third grade class. In the class was a group with sweat shirts with R, and in the class was a group with sweat shirts with D. A little round-faced boy looked at the board, and Mrs. McDougall had $270 billion in cuts, increased premiums, losing physicians and some of our most needed hospitals. She asked the little boy, what does that mean to you? He applauded and said, tax cuts for the wealthy. Then she turned and asked the little round-faced girl with bright eyes. And she said, it is a loss for all America, but, she said, you know what, Mrs. McDougall, we are going to fix it.

That is what the Democrats are going to do. We are going to fix it. Vote for the substitute and vote down a disastrous plan for seniors.

Mr. ARCHER. Mr. Chairman, I yield 2 minutes to the gentleman from Pennsylvania [Mr. ENGLISH], a valued member of the Committee on Ways and Means.

Mr. ENGLISH of Pennsylvania. Mr. Chairman, Mark Twain once said ''One of the most striking differences between a cat and a lie is that a cat only has nine lives.'' You have heard and will continue to hear that Republicans are cutting Medicare to pay for tax cuts. Members of this body who oppose saving Medicare have fabricated the Medicare tax-cut connection because it is useful politically.

Here are the facts: The tax bill approved by the House in April was financed on a pay-as-you-go basis. The

tax provisions were paid for before the debate on Medicare reform even began. The savings came from welfare reform, lowering discretionary spending, and interest savings. We cut spending as we cut taxes and everyone here knows it.

Even so, you will hear that Republicans are cutting Medicare to pay for tax cuts.

Even after the Ways and Means Committee adopted my amendment to establish a Medicare lock-box—a Medicare Preservation trust fund—to lock in savings from the bill into the Medicare Program. The bill now contains my language making it illegal to use Medicare savings for tax cuts. Under the English-Whitefield local-box, the savings in Medicare will be used only to save Medicare. Most of the Members on the other side voted for the similar lock-box Mr. CRAPO offered this spring. They liked it back then. Even so, you will hear them claim that Republicans are cutting Medicare to pay for tax cuts.

Writing in the Washington Post on October 11, Robert Samuelson noted, ''To listen to the Democrats, you'd think that every spending cut is needed to provide 'a tax break for the rich.' Medicare is being cut to help the wealthy; so is Medicaid, the school lunch program and welfare. The litany is endless. Maybe this makes good rhetoric, but it flunks first-grade arithmetic.''

Mr. Chairman, only one plan saves Medicare, and keeps the savings from reform in Medicare. Reject this empty, placebo Band-Aid substitute, which doesn't even contain our lock-box protections.

Mr. BLILEY. Mr. Chairman, I yield 2 minutes to the gentleman from Louisiana [Mr. TAUZIN].

(Mr. TAUZIN asked and was given permission to revise and extend his remarks.)

Mr. TAUZIN. Mr. Chairman, I first want to give you some good news. I just talked to mom again in her hospital room. She is up on her feet and doing much better. She apparently exerted herself too much to the senior Olympics last week where she won three medals in the Baton Rouge State competition. The third medal was bronze for javelin throwing. So do not mess with mom. She is doing fine.

Let me first of all make it clear that what we are debating now finally is their comparison of two alternative plans, which I would hope we would have debated all day instead of motives and intentions and everything else. We are finally looking at the two alternative plans. And the plan we are examining now is a plan that simply says, we are going to try to save about $90 billion of waste, fraud, abuse, inefficiencies in the Medicare program in order that it not be bankrupt as opposed to the plan offered that saves as much as $270 billion out of waste, fraud, abuse, and inefficiencies in the program. Why one not the other?

Well, if we only want to Band-Aid the Medicare Program through the next election cycle, we have an alternative now we can vote for. If we want to fix it permanently, structurally, not for just the election but for the generation to follow, if we want to make sure that working Americans are not, after this election, taxed by payroll deduction increases that could double the payroll tax deduction, if we want to avoid that, then we have offered a plan that produces savings for the program and solvency for the next generation. That is the choice.

Even the blue dog Democrats have offered a third alternative which unfortunately is not on the floor. They recommended $170 billion in savings. President Clinton recommended $192 billion in savings. At least we are getting down to it here.

What is the right number in order to fix the program temporarily or permanently?

We propose a permanent fix. We propose fixing the program so it does not go bankrupt, not just for the election but for the next generation.

Mr. DINGELL. Mr. Chairman, I yield 2 minutes to the distinguished gentleman from Michigan [Mr. STUPAK].

Mr. STUPAK. Mr. Chairman, just a speaker or two ago said that he had a plan that will cut down on fraud, waste, and abuse and then read a list of fines and costs and fines and costs and fines and costs that he prevails upon people.

The problem is, he never gets to the fines and costs because he has raised the legal standard that must be met in order to bring any kind of a case against someone who is ripping off the system. Having been a police officer for 13 years, you try to conduct an investigation, you keep putting a hurdle up higher and higher for law enforcement here to do their job.

□ 1545

But my colleagues' answer to fraud and abuse is, ''After you catch them we'll put more fines and costs.''

In the Democratic plans that have been presented, Mr. Chairman, we have asked our colleagues to look at things that do not raise the standard, but will make it easier to give law enforcement the tools they need to crack down on fraud, waste, and abuse; things such as putting civil penalties in the antikickback statute, giving subpoena power, something very simple. We do not have it under Medicare. Give us grand jury investigations; that was denied. Give us competitive bidding for durable medical equipment so we are not paying $28 for foam rubber mattresses that we can buy downtown for $19.95 or for the oxygen that will cost $280 under Medicare that only costs $123 for the VA. Let us competitively bid to cut down on the waste, and our colleagues said no. There is no provision against bundling. For every time there is a medical piece, they add another price to it and put it all together bundled up in one big package so they can charge more. That was what we saw happening in Medicare.

The way my colleagues can save this program is by cracking down on the fraud, waste, and abuse, but their answer is raise the standards for investigation, make it more difficult, make it harder on the seniors by putting all that money into fraud, waste, and abuse, and we have nothing to show for it.

Mr. BLILEY. Mr. Chairman, I yield 1½ minutes to the gentleman from Kentucky [Mr. WHITFIELD].

Mr. WHITFIELD. Mr. Chairman, as my colleagues know, the October 16 issue of the Wall Street Journal reported that New Yorker Henry Sheinkoph would be a key strategist for President Clinton and the Democrats in the 1996 election. In this article Mr. Sheinkoph boasts, ''I subscribe to terror. Terror works because it makes people hate.'' Scare tactics are also being used by the national Democratic Party to obstruct our efforts to save and strengthen the Medicare system.

The Democratic Party will not tell us that their part A tax has increased 23 times since the inception of this program. The part B premium has doubled in the last 8 years.

Four months ago this Congress passed a long-awaited and needed tax reduction for the American people. While it was not a tax reduction for the wealthy, it did provide a tax reduction for working men and women with children. While we do not apologize for that tax reduction, we will not allow savings in the Medicare plan over the next 7 years to be used to pay for our tax reductions.

This bill, the Republican bill, includes a lockbox provision which will establish a trust fund. All moneys saved under the plan will be appropriated to the trust fund. Money in the fund can only be used to provide care for the elderly, and cannot be used for any other purpose.

The Republican Medicare plan provides comprehensive change for a long-term solution. The Democratic plan is a Band-Aid approach that cannot and will not provide a long term solution.

Mr. ARCHER. Mr. Chairman, I yield 3 minutes to the gentleman from Connecticut [Mr. SHAYS], a member of the Committee on the Budget who has made a giant contribution over the years toward Medicare reform.

Mr. SHAYS. Mr. Chairman, I was asking some of my colleagues how are we doing. They said we are doing well, but it is tough when people are just throwing charges that are not true, and it is tough when the charges are not true, and they are not true. But it is easy when we have a bill like this to defend. Republicans, be proud of what has been done. Be proud of the fact that there are no increases in copayments. Be proud of the fact that there are no increases in deductibles. Be proud of the fact that you have not increased premiums. They will stay at 31½ percent. In fact, be proud of the fact that in one case we did increase

premiums for the most wealthy. The most wealthy are going to have to pay more for Medicare part B. If someone is single and making $100,000, they will have to pay more for Medicare part B. If someone is married and makes over $150,000, they will have to pay more for Medicare part B. We are telling the most affluent that they have a rule to play in this.

Mr. Chairman, their bill lets the wealthy get all the benefits the poor get. Give me a break.

When I look at this bill, I know we have three major goals. We are going to get our financial house in order. We are going to do that and balance our budget. We are going to save our trust funds. We are going to protect them, and we are going to preserve them, and we are going to strengthen them, and we are also going to change this social, and corporate, and farming welfare state into an opportunity society. but we are going to save our Medicare trust fund, and how are we going to save it? In part because of a strong criminal fraud that we have in our bill.

When my colleagues voted against the rule, they voted against making crime in health care a Federal offense because in our rule we make health care fraud a Federal offense. We make it a Federal offense not just in Government programs, but in private programs as well. Theft and embezzlement, a federal offense. False statements, a federal offense. Bribe and graft, a Federal offense. Illegal enumerations, Federal offense. Obstruction of justice, a Federal offense. My colleagues voted against it when they voted against the rule. In our bill, contrary to what the previous speaker said, we have injunctive relief, we have subpoena power, we have grand jury disclosure. It is in our bill. Read it. My colleagues and continually distorting the facts, and, when the American people know what we have done, they are going to like it, and when I speak to the American people and my constituents, they say why would I object to a plan that does not increase copayments, does not increase deductible, does not increase my premium, allows me to have private care? My colleagues are into the old system. They are not giving their constituents choice. We are going what the gentleman from Missouri [Mr. GEPHARDT] did in 1980. He said we should allow people in Medicare to get into a private-sector plan. The problem is he is 20 years later not in step.

Mr. DINGELL. Mr. Chairman, I yield myself 15 seconds to point out that my good friend's district would be cut $251 million between now and the year 2002 to give to the wealthy a large and unrequested tax cut.

Mr. Chairman, I yield 1 minute to the gentlewoman from North Carolina [Mrs. CLAYTON].

ANNOUNCEMENT BY THE CHAIRMAN

The CHAIRMAN. The Chair will take this opportunity to remind the gentlewoman that wearing of badges is against the House rules.

Mrs. CLAYTON. Mr. Chairman, I will observe that.

PARLIAMENTARY INQUIRIES

Mr. THOMAS. Mr. Chairman, I have a parliamentary inquiry.

The CHAIRMAN. The gentleman will state his parliamentary inquiry.

Mr. THOMAS. Mr. Chairman, are the wearing of buttons, or sloganeering, or communicative badges against the rules of the House?

The CHAIRMAN. The Chair has stated that on several occasions today.

Mr. THOMAS. Mr. Chairman, if someone is wearing that when addressing the House, they are violating the rules of the House?

The CHAIRMAN. The are indeed.

Mr. THOMAS. Mr. Chairman, if they have been informed of that, they are, therefore, willfully violating the rules of the House?

The CHAIRMAN. The Chair just reminds all Members that the rules are here to maintain a level of comity in the House and it would be proper for all Members to observe the rules.

Mrs. CLAYTON. Mr. Chairman, let me make a statement.

Did I not say I would be glad to observe that? Did the Chair not hear me? Did anyone else hear me? I said I will be glad to observe that rule, so it is not willful.

Mr. WILLIAMS. Mr. Chairman, I have a parliamentary inquiry.

The CHAIRMAN. The gentleman will state his parliamentary inquiry.

Mr. WILLIAMS. Mr. Chairman, would wearing a paper bag over one's head violate the same rule of the House?

The CHAIRMAN. The gentleman knows the answer to that. Let us move on.

Mr. WILLIAMS. No, the gentleman would not ask the question if he knew the answer.

The CHAIRMAN. The Chair's guess is that the gentleman does know.

Mr. WILLIAMS. Mr. Chairman, I am not asking for a guess. I am asking for a parliamentary ruling. Would wearing a paper bag over one's head, as has been done by some of our Republican colleagues in previous Congresses, violate the same rule of the House?

The CHAIRMAN. The Chair would respond by saying that the Chair was not here at the time, but the Chair's understanding was that that was ruled a breach of decorum at the time, and the Chair promises the gentleman that, if he sees anyone with a bag over their head today, he will ask them to remove it.

The Chair recognizes the gentlewoman from North Carolina [Mrs. CLAYTON].

Mrs. CLAYTON. Mr. Chairman, I have really risen to speak in behalf of the amendment, and I do want to say that the Democrats have provided, I think, a reasonable alternative, a reasonable plan, that addresses saving health care. It also reads for senior citizens. Medicare needs to be reformed. Why? Because the trustees said it needed to be reformed to make sure there was financial stability.

But also, since my colleague raised the concern of the badge I was wearing, let me tell him why I had worn that badge inadvertently into the House and really in error. It was not meant to affront the House. But I do want to say it so my colleague understands: ''Shame on you. No to the Republican plan.''

Mr. Chairman, I may not be able to wear that, but I can say it over and over again:

> Shame on you, balancing the budget on the most vulnerable people in society. No to any plan that is so atrocious it does not indicate what it would do to poor people, senior citizens, rural communities, and inner cities, and no rule removes that moral obligation for the shame on your conscience.

The CHAIRMAN. The Committee will rise informally in order that the House may receive a message.

MESSAGE FROM THE PRESIDENT

The SPEAKER pro tempore (Mr. STEARNS) assumed the Chair.

The SPEAKER pro tempore. The Chair will receive a message.

MESSAGE FROM THE PRESIDENT

A message in writing from the President of the United States was communicated to the House by Mr. Edwin Thomas, one of his secretaries.

The SPEAKER pro tempore The committee will resume its sitting.

MEDICARE PRESERVATION ACT OF 1995

The Committee resumed its sitting.

Mr. BLILEY. Mr. Chairman, I yield 1½ minutes to the gentleman from Florida [Mr. STEARNS], a member of the committee.

Mr. STEARNS. Mr. Chairman, to the gentleman from Florida [Mr. GIBBONS], my good friend, to the gentleman from Michigan [Mr. DINGELL], to the minority leader, the gentleman from Missouri [Mr. GEPHARDT], let me first of all say, Your argument about tax cuts for the rich is clearly false, but let's really look at this argument in two ways.

First of all, Mr. Chairman, all the tax cuts were paid for before we even started talking about Medicare. Confirmed by CBO, these tax cuts were paid for as follows: welfare reform is $90 billion in savings; FCC spectrum auction is $15 billion; Uranium Enrichment Corporation is $2 million; and appropriation reductions are $38 billion in savings. My friends in the House and to all Americans, you should realize that they were paid for—$245 billion—was saved even before we even started talking about saving Medicare.

So the point is that there is nothing about this tax cut that is coming from Medicare savings or going for the rich.